

Summary *of* Benefits *and* Disclosure *Form*

U C Blue & Gold HMO • Plan FMD

Effective 1/1/2020



Health Net®

DELIVERING CHOICES

When it comes to your health care, the best decisions are made with the best choices. Health Net of California, Inc. (Health Net) provides you with ways to help you receive the care you deserve. This Summary of Benefits and Disclosure Form (SB/DF) answers basic questions about this versatile plan.

If you have further questions, contact us:



By phone at 1-800-539-4072



Or write to: Health Net of California

P.O. Box 9103

Van Nuys, CA 91409-9103

This *Summary of benefits/disclosure form* (SB/DF) is only a summary of your health plan. The plan's *Evidence of Coverage* (EOC), which you will be issued electronically on Health Net's website at www.healthnet.com/uc, It is important for you to carefully read this SB/DF and the plan's EOC thoroughly once received, especially those sections that apply to those with special health care needs. This SB/DF includes a matrix of benefits in the section titled "Schedule of benefits and coverage."

PLEASE READ THIS IMPORTANT NOTICE ABOUT THE UC BLUE & GOLD HMO NETWORK HEALTH PLAN SERVICE AREA AND OBTAINING SERVICES FROM UC BLUE & GOLD HMO NETWORK PHYSICIAN AND HOSPITAL PROVIDERS

for emergency care, benefits for Physician and Hospital services under this **Health Net HMO Network** ("UC Blue & Gold HMO Network") plan are only available when you live or work in the UC Blue & Gold Network service area and use a UC Blue & Gold HMO Network Physician or Hospital. When you enroll in this UC Blue & Gold HMO Network plan, you may only use a Physician or Hospital who is in the UC Blue & Gold HMO Network and you must choose a UC Blue & Gold HMO Network Primary Care Physician (PCP). You may obtain ancillary or pharmacy covered services and supplies from any Health Net participating ancillary or pharmacy provider.

A few Enrollees who live or work in some remote or rural zip codes of the UC Blue & Gold Network service area may need to travel up to or exceeding thirty miles for access to a UC Blue & Gold Network provider. You can confirm if the zip code where you live or work is affected by calling the telephone number on your Health Net identification card, or by logging on to www.healthnet.com/uc.

OBTAINING COVERED SERVICES UNDER THE UC BLUE & GOLD HMO NETWORK PLAN

TYPE OF PROVIDER	HOSPITAL	PHYSICIAN	ANCILLARY	PHARMACY
AVAILABLE FROM	*Only Blue & Gold Network Hospitals	*Only Blue & Gold Network Physicians	All Health Net contracting ancillary providers	All Health Net participating pharmacies

** The benefits of this plan for Physician and Hospital services are only available for covered services received from a UC Blue & Gold HMO Network Physician or Hospital, except for (1) urgently needed care outside a 30-mile radius of your Physician Group and all emergency care; (2) referrals to non-UC Blue & Gold HMO Network providers are covered when the referral is issued by your UC Blue & Gold HMO Network Physician Group; and (3) covered services provided by a non-UC Blue & Gold HMO Network provider when authorized by Health Net. Please refer to "Specialists and referral care" in the "How the plan works" section and "Emergencies" in the "Benefits and coverage" section for more information.*

The coinsurance percentage you pay is based on the negotiated rate with the treating provider. UC Blue & Gold HMO Network providers may or may not have lower rates than Health Net's full network providers, to whom you may be referred by your PCP or your Physician Group for these specific services

The service area and a list of UC Blue & Gold HMO Network Physician and Hospital providers are listed online at our website: www.healthnet.com/uc. A copy of the *UC Blue & Gold HMO Network Provider* listing may be ordered online or by calling Health Net Member Services at the phone number on the back cover.



Not all physicians and hospitals who contract with Health Net are UC Blue & Gold HMO Network providers. Only those physicians and hospitals specifically identified as participating in the UC Blue & Gold HMO Network may provide services under this plan, except as described in the chart above.

Unless specifically stated otherwise, use of the following terms in this Summary of benefits/disclosure form (SB/DF) solely refer to *UC Blue & Gold HMO Network* as explained above.

- Health Net
- Health Net service area
- Hospital
- Member physician, participating physician group, primary care physician, physician, participating provider, contracting physician groups and contracting providers
- Network

If you have any questions about the *UC Blue & Gold HMO Network Service Area*, choosing your *UC Blue & Gold HMO Network* Primary Care Physician, how to access specialist care or your benefits, please call Health Net's Customer Contact Center at the phone number on the back cover.

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How the plan works

Please read the following information so you will know from whom health care may be obtained, or what physician group to use.

SELECTION OF PHYSICIANS AND PHYSICIAN GROUPS

- When you enroll with Health Net, you choose a contracting physician group. From your physician group, you select one doctor to provide basic health care; this is your Primary Care Physician (PCP).
- Health Net requires the designation of a Primary Care Physician. A Primary Care Physician provides and coordinates your medical care. You have the right to designate any Primary Care Physician who participates in our network and who is available to accept you or your family members, subject to the requirements of the physician group. For children, a pediatrician may be designated as the Primary Care Physician. Until you make this Primary Care Physician designation, Health Net designates one for you. For information on how to select a Primary Care Physician and for a list of the participating Primary Care Physicians in the Health Net Service Area, refer to the Health Net website at www.healthnet.com/uc. You can also call the Customer Contact Center at the number shown on your Health Net I.D. Card to request provider information.
- Whenever you or a covered family member needs health care, your PCP will provide the medically necessary care. Specialist care is also available, when referred by your PCP or physician group.
- You do not have to choose the same physician group or PCP for all members of your family. Physician groups, with names of physicians, are listed on the Health Net website at www.healthnet.com/uc in the *Health Net Directory*.

HOW TO CHOOSE A PHYSICIAN

Choosing a PCP is important to the quality of care you receive. To be comfortable with your choice, we suggest the following:

- Discuss any important health issues with your chosen PCP;
- Ask your PCP or the physician group about the specialist referral policies and hospitals used by the physician group; and
- Be sure that you and your family members have adequate access to medical care, by choosing a doctor located within 30 miles of your home or work.

SPECIALISTS AND REFERRAL CARE

If you need medical care that your PCP cannot provide, your PCP may refer you to a specialist or other health care provider for that care. Refer to the “Mental Disorders and Chemical Dependency Care” section below for information about receiving care for Mental Disorders and Chemical Dependency.

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, gynecological, reproductive or sexual health care from an in-network health care professional who specializes in obstetrics, gynecology or reproductive and sexual health. 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, gynecology or reproductive and sexual health, refer to the Health Net website at www.healthnet.com/uc.

MENTAL DISORDERS AND CHEMICAL DEPENDENCY CARE

Health Net contracts with MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator), which administers behavioral health services for mental disorders and chemical dependency conditions. For more information about how to receive care and the Behavioral Health Administrator's prior authorization requirements, please refer to the "Behavioral Health Services" section of this SB/DF.

CVS MINUTE CLINIC SERVICES

The CVS MinuteClinic is a health care facility, generally inside CVS/pharmacy stores, which is designed to offer an alternative to a Physician's office visit for the unscheduled treatment of non-emergency illnesses or injuries such as strep throat, pink eye or seasonal allergies. Visits to a CVS MinuteClinic are covered as shown in the "Schedule of Benefits and Coverage" section.

You do not need prior authorization or a referral from your primary care physician or contracting physician group in order to obtain access to CVS MinuteClinic services. However, a referral from the contracting Physician Group or Primary Care Physician is required for any Specialist consultations. For more detailed information about CVS MinuteClinics, please refer to the plan's EOC or contact Health Net at the telephone number shown on the back cover.

HOW TO ENROLL

Complete the enrollment form found in the enrollment packet and return the form to your employer. If a form is not included, your employer may require you to use an electronic enrollment form or an interactive voice response enrollment system. Please contact your employer for more information.

Some hospitals and other providers do not provide one or more of the following services that may be covered under the plan's *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**
- **Abortion**

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic, or call the Health Net Customer Contact Center at the phone number on the back cover to ensure that you can obtain the health care services that you need.

Schedule of benefits and coverage

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PLAN CONTRACT AND EVIDENCE OF COVERAGE (EOC) SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.


The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments are usually billed after the service is received.

Principal benefits and coverage matrix

Deductibles.....	None
Lifetime maximums.....	None


Out-of-Pocket maximum for medical plans

One member.....	\$1000
Family (two members or more)	\$3000

 Once your payments for covered services equals the amount shown above in any one calendar year, including covered services and supplies provided by MHN and American Specialty Health Plans of California, Inc. (ASH Plans), no additional copayments for covered services are required for the remainder of the calendar year. Once an individual member in a family meets the individual out-of-pocket maximum, the other enrolled family members must continue to pay copayments for covered services and supplies until the total amount of copayments paid by the family reaches the family out-of-pocket maximum or each enrolled family member individually meets the individual out-of-pocket maximum.

Payments for any services not covered by this plan will not count toward this calendar year out-of-pocket maximum, unless otherwise noted. You must continue to pay copayments for any services and supplies that do not apply to the out-of-pocket maximum.

Professional services

 The copayments below apply to professional services only. Services that are rendered in a hospital or an outpatient center are also subject to the hospital or outpatient center services copayment. See "Hospitalization services" and "Outpatient services" in this section to determine if any additional copayments may apply.

Visit to physician, physician assistant or nurse practitioner, at a contracting physician group	\$20
Specialist or specialty care consultations [■]	\$20
Visit to CVS MinuteClinic [◆]	\$20
Prenatal and postnatal office visits*	Covered in full
Normal delivery, cesarean section, newborn inpatient care	Covered in full
Treatment of complications of pregnancy	See note below**

Contraceptive devices (including but not limited to intrauterine devices (IUD) and Depo Provera injections)	Covered in full
Surgeon or assistant surgeon services [▲]	\$20
Surgeon or assistant surgeon services in Hospital [▲]	Covered in full
Administration of anesthetics	Covered in full
Physician visit to member's home at your physician's discretion and in accordance with criteria set by Health Net.....	\$20
Laboratory procedures	Covered in full
Diagnostic imaging (including x-ray) services.....	Covered in full
Rehabilitative therapy (includes physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)	\$20
Organ and stem cell transplants (non-experimental and non-investigational)	Covered in full
Chemotherapy.....	Covered in full
Radiation therapy.....	Covered in full
Vision and hearing examinations (for diagnosis or treatment, including refractive eye examinations)	\$20
Telehealth services through Teladoc [©]	Covered in full

▪ *Self-referrals are allowed for obstetrics, gynecological services, and reproductive and sexual health care services, including preventive care, pregnancy and gynecological ailments. Copayment requirements may differ depending on the services provided.*

♦ *Specialist referrals following care at the CVS MinuteClinic must be obtained through the contracting physician group. Preventive care services through the CVS MinuteClinic are subject to the copayment shown below under "Preventive care."*

▲ *Surgery includes surgical reconstruction of a breast incident to mastectomy (including lumpectomy), including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema. While Health Net and your physician group will determine the most appropriate services, the length of hospital stay will be determined solely by your PCP.*

© *Health Net contracts with Teladoc to provide telehealth services for medical, mental disorders and chemical dependency conditions. Teladoc services are not intended to replace services from your physician, but are a supplemental service. Teladoc consultations provide primary care services by telephone or secure online video. Teladoc physicians may be used when your physician's office is closed or you need quick access to a physician. Teladoc consultation services may be obtained by calling 1-800-TELADOC (800-835-2362) or visiting www.teladoc.com/uc. Before Teladoc services may be accessed, you must complete a Medical History Disclosure (MHD) form, which can be completed online at Teladoc's website at no charge or printed, completed and mailed or faxed to Teladoc.*

* Prenatal, postnatal and newborn care that are preventive care services are covered in full. See copayment listings for preventive care services below. If other non-preventive care services are received during the same office visit, the above copayment will apply for the non-preventive care services.

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

Preventive care

Preventive care services Covered in full



Preventive care services are covered for children and adults, as directed by your physician, based on the guidelines from the U.S. Preventive Services Task Force (USPSTF) Grade A&B recommendations, the Advisory Committee on Immunization Practices that have been adopted by the Center for Disease Control and Prevention, the guidelines for infants, children, adolescents and women’s preventive health care as supported by the Health Resources and Services Administration (HRSA).

Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, and preventive vision and hearing screening examinations, 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.

One breast pump and the necessary supplies to operate it (as prescribed by your physician) will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it. Breast pumps can be obtained by calling the Customer Contact Center at the phone number listed on the back cover of this booklet.

Allergy treatment and other injections (except for infertility injections)

- Allergy testing \$20
- Allergy serum Covered in full
- Allergy injection services \$20
- Immunizations -- To meet foreign travel requirements Covered in full
- Immunizations -- To meet occupational requirements Covered in full
- Injections (except for infertility)
- Office-based injectable medications (per dose)..... \$20


Certain injectable drugs which are considered self-administered are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefits even if they are administered in a physician’s office. If you need to have the provider administer the Specialty Drug, You will need to obtain the Specialty Drug through our contracted Specialty Pharmacy Vendor and bring it with you to the Physician’s office. Alternatively, you can coordinate delivery of the Specialty Drug directly to the provider office through our contracted Specialty Pharmacy Vendor. Please refer to "Specialty Drugs" portion of this "Schedule of benefits and coverage" section for the applicable copayment.



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


Outpatient facility services

- Outpatient facility services (other than surgery)..... Covered in full
- Outpatient surgery (surgery performed in a hospital or outpatient surgery center only)..... \$100

 *Outpatient care for infertility is described below in the "Infertility services" section.*

Hospitalization services


- Semi-private hospital room or special care unit with ancillary services, including maternity care (per admission; unlimited days)..... \$250
- Skilled nursing facility stay (per admission; limited to 100 days per calendar year)..... Covered in full
- Physician visit to hospital or skilled nursing facility..... Covered in full

 *The above inpatient hospitalization copayment is applicable for each admission of hospitalization for an adult, pediatric or newborn patient. If a newborn patient requires admission to a special care unit, a separate copayment for inpatient hospital services for the newborn patient will apply.*

Inpatient care for infertility is described below in the "Infertility services" section.

Emergency health coverage


- Emergency room (professional and facility charges)..... \$75
- Urgent care center (professional and facility charges)..... \$20

 *Copayments for emergency room or urgent care center visits will not apply if the member is admitted as an inpatient directly from the emergency room or urgent care center. A visit to one of the urgent care centers that is owned and operated by the member's physician group will be considered an office visit and the office visit copayment, if any, will apply.*

Ambulance services

- Ground ambulance Covered in full
- Air ambulance Covered in full

Prescription drug coverage

 *Please refer to the "Prescription drug program" section of this SB/DF for applicable definitions, benefit descriptions and limitations.*

Retail participating pharmacy (up to a 30-day supply)

- Tier 1 drugs includes most generic drugs and some low-cost preferred brand name drugs when listed in the Formulary..... \$5

Tier 2 drugs includes non-preferred generic drugs, preferred brand name drugs, insulin and diabetic supplies and certain brand name drugs with a generic equivalent when listed in the Formulary ♦	\$25
Tier 3 drugs includes non-preferred brand name drugs, brand name drugs with a generic equivalent (when medically necessary), drugs listed as Tier 3 in the Formulary, drugs indicated as "NF," if approved, or drugs not listed in the Formulary, if approved ♦	\$40
Appetite Suppressants	50%
Lancets	Covered in full
Preventive drugs and women's contraceptives*	Covered in full

Specialty Drugs (up to a 30 day supply)

Self-injectable drugs and drugs for the treatment of hemophilia, including blood factors, per prescription, maximum of 30 days per prescription	\$20
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Mail-order program (up to a 90-day supply of maintenance drugs)

UC Walk - up Service & CVS Caremark (up to a 90-day supply of maintenance medications) at designated Medical Center Pharmacies & CVS Retail Pharmacies

Tier 1 drugs includes most generic drugs and some low-cost preferred brand name drugs when listed in the Formulary	\$10
Tier 2 drugs includes non-preferred generic drugs, preferred brand name drugs, insulin and diabetic supplies and certain brand name drugs with a generic equivalent when listed in the Formulary ♦	\$50
Tier 3 drugs includes non-preferred brand name drugs, brand name drugs with a generic equivalent (when medically necessary), drugs listed as Tier 3 in the Formulary, drugs indicated as "NF," if approved, or drugs not on the Formulary ♦	\$80
Lancets	Covered in full
Preventive drugs and women's contraceptives*	Covered in full

For information about Health Net's Formulary, please call the Customer Contact Center at the telephone number on the back cover.

Orally administered anti-cancer drugs will have a copayment maximum of \$200 for an individual prescription of up to a 30-day supply.

Generic Drugs will be dispensed when a Generic Drug equivalent is available unless a Brand Name Drug is specifically requested by the Physician or the Member, subject to the Copayment requirements specified below.

If a Brand Name Drug is dispensed and its Generic Drug equivalent is covered as a Tier 1 or Tier 2 Drug, then the Brand Name Drug will be dispensed subject to the Copayment listed below:

- The Tier 1 Drug Copayment, plus*
- The difference in cost between the Brand Name Drug and the generic equivalent*

If a Brand Name Drug is dispensed and its Generic Drug equivalent is covered as a Tier 3 Drug, then the Brand Name Drug will be dispensed subject to the Copayment listed below:

- The Tier 3 Drug Copayment, plus*
- The difference in cost between the Brand Name Drug and the generic equivalent*

If medical necessity is determined the Health Net, the applicable drug copayment applies (Tier 2 for Formulary drugs or Tier 3 for non-preferred Formulary drugs). Medically necessity determinations are limited to 12 months.

** Preventive drugs, including smoking cessation drugs, and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations.*

Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single prescription drug order.

Percentage copayments will be based on Health Net's contracted pharmacy rate.

If the pharmacy's or the mail order administrator's retail price is less than the applicable copayment, then you will pay the pharmacy's or the mail order administrator's retail price. Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.

This plan uses the Formulary. The Health Net Formulary is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. The Formulary also shows which drugs are Tier 1, Tier 2 or Tier 3, so you know which copayment applies to the covered drug. Drugs that are not on the Formulary (that are not excluded or limited from coverage) are also covered at the Tier 3 drug copayment.

Some drugs require prior authorization from Health Net. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 72 hours, as appropriate and medically necessary, for the nature of the member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination. For a copy of the Formulary, call the Customer Contact Center at the number listed on the back cover of this booklet or visit our website at www.healthnet.com.

Medical Supplies

- Durable medical equipment (including nebulizers, face masks and tubing for the treatment of asthma) Covered in full
- Orthotics (such as bracing, supports and casts) Covered in full
- Diabetic Equipment See the "Prescription drug program" section of this SB/DF for diabetic supplies benefit information..... Covered in full
- Diabetic footwear Covered in full
- Prostheses..... Covered in full



Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under "Preventive care" in this section.



Diabetic equipment covered under the medical benefit (through "Diabetic equipment") includes blood glucose monitors designed for the visually impaired, insulin pumps and related supplies, and corrective footwear. Diabetic equipment and supplies covered under the prescription drug benefit include insulin, specific brands of blood glucose monitors and 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) and insulin syringes.

In addition, the following supplies are covered under the medical benefit as specified: visual aids (excluding eyewear) to assist the visually impaired with the proper dosing of insulin are provided through the prostheses benefit; Glucagon is provided through the self-injectable benefit. 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 (provided through the patient education benefit).

Mental Disorders and Chemical Dependency Benefits



Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services. For definitions of severe mental illness or serious emotional disturbances of a child, please refer to the Behavioral health section of this SB/DF, or call the Customer Contact Center at the number listed on the back cover of this booklet.

Severe Mental Illness and Serious Emotional Disturbances of a Child

- Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including medication management and drug therapy monitoring)
 - Visits 1-3 Covered in full
 - Visit 4 and after \$20
 - Group therapy session – Visits 1-3* Covered in full
 - Group therapy session – Visits 4 and after* \$20
- Outpatient services other than an office visit/professional consultation (psychological testing, outpatient

electroconvulsive therapy, biofeedback, applied behavior analysis, structured/intensive outpatient program treatment; day treatment; partial hospitalization; and therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day).....	Covered in full
Participating mental health professional visit to member's home (at the discretion of the participating mental health professional in accordance with the rules and criteria established by Behavioral Health Administrator)	\$20
Inpatient services at a hospital, behavioral health facility or residential treatment center (per admission).....	\$250
<u>Other Mental Disorders</u>	
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including medication management and drug therapy monitoring)	
Visits 1-3.....	Covered in full
Visit 4 and after	\$20
Group therapy session – Visits 1-3*	Covered in full
Group therapy session – Visits 4 and after*	\$20
Outpatient services other than an office visit/professional consultation (psychological testing, outpatient electroconvulsive therapy, biofeedback, applied behavior analysis, structured/intensive outpatient program treatment; day treatment; partial hospitalization; and therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day).....	Covered in full

Participating mental health professional visit to member's home (at the discretion of the participating mental health professional in accordance with the rules and criteria established by Behavioral Health Administrator)	\$20
Inpatient services at a hospital, behavioral health facility or residential treatment center (per admission).....	\$250

Chemical Dependency

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including medication management and drug therapy monitoring)	
Visits 1-3.....	Covered in full
Visit 4 and after	\$20
Group therapy session – Visits 1-3*	Covered in full
Group therapy session – Visits 4 and after*	\$20
Outpatient services other than an office visit/professional consultation (psychological testing, outpatient electroconvulsive therapy, biofeedback, applied behavior analysis, methadone maintenance, structured/intensive outpatient program treatment; day treatment; partial hospitalization; and therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day)	Covered in full
Participating mental health professional visit to member's home (at the discretion of the participating mental health professional in accordance with the rules and criteria established by Behavioral Health Administrator)	\$20
Inpatient services at a hospital, behavioral health facility or residential treatment center (per admission).....	\$250
Acute care detoxification at a hospital, behavioral health facility or residential treatment center (per admission).....	\$250

**If two or more members in the same family attend the same outpatient treatment session, only one copayment will be applied.*

Home health services

Home health services (copayment required for each visit) Covered in full per visit

Other services

Sterilization of females performed in Contracting Physician Group's office Covered in full

Sterilization of males performed in Contracting Physician Group's office \$20

Sterilization of males performed in a hospital (inpatient or outpatient) \$0

Hearing aids (2 standard aid(s) with a benefit maximum of \$2,000 every 36 months)** 50%

Blood or blood products except for drugs used to treat hemophilia, including blood factors* Covered in full

Renal dialysis Covered in full

Hospice services Covered in full



Infertility services and supplies are described below in the "Infertility services" section.

Sterilization of females and women's contraception methods and counseling, as supported by HRSA guidelines, are covered under "Preventive care" in this section.

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

***A standard hearing aid (analog or digital) is one that restores adequate hearing to the member and is determined medically necessary and authorized by the member's PPG.*

Infertility services

Infertility services and supplies (all covered services that diagnose, evaluate or treat infertility) 50%



Infertility services include Prescription Drugs, professional services, inpatient and outpatient care and treatment by injections.

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

Injections for infertility are covered only when provided in connection with services that are covered by this plan.

Chiropractic services



Benefits are administered by American Specialty Health Plans of California, Inc. (ASH Plans).

Office visits (24-visit maximum per calendar year, combined with acupuncture) \$20

Annual chiropractic appliance allowance.....\$50

Acupuncture services



Benefits are administered by American Specialty Health Plans of California, Inc. (ASH Plans).

Office visits (24-visit maximum per calendar year, combined with chiropractic) \$20

Limits of coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- Ambulance and paramedic services that do not result in transportation or that do not meet the criteria for emergency care, unless such services are medically necessary and prior authorization has been obtained.
- Artificial insemination for reasons not related to infertility;
- Biofeedback therapy is limited to medically necessary treatment of certain physical disorders such as incontinence and chronic pain, or when included as part of a comprehensive mental health treatment plan;
- Care for mental health care as a condition of parole or probation, or court-ordered testing for mental disorders, except when such services are medically necessary;
- Chiropractic or acupuncture services, except as provided by ASH Plans as shown in the "Schedule of benefits and coverage" section of this SB/DF;
- Conception by medical procedures (IVF and ZIFT);
- Corrective footwear is not covered unless medically necessary and custom made for the member or is a podiatric device to prevent or treat diabetes-related complications;
- Cosmetic services and supplies;
- Custodial or live-in care;
- Dental services. However, Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures are covered. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
- Disposable supplies for home use;
- Experimental or investigational procedures, except as set out under the "Clinical trials" and "If you have a disagreement with our plan" sections of this SB/DF;
- Genetic testing is not covered except when determined by Health Net to be medically necessary. The prescribing physician must request prior authorization for coverage;
- Noneligible institutions. This plan only covers medically necessary services or supplies provided by a licensed hospital, hospice, Medicare-approved skilled nursing facility, residential treatment center or other properly licensed medical facility as specified in the plan's EOC. Any institution that is not licensed to provide medical services and supplies, regardless of how it is designated, is not an eligible institution;
- Nontreatable disorders;
- Norplant;
- Orthoptics (eye exercises);
- Outpatient prescription drugs (except as noted under "Prescription drug program");
- Personal or comfort items;
- Physician self-treatment;
- Physician treating immediate family members;
- Private rooms when hospitalized, unless medically necessary;
- Private-duty nursing;
- Refractive eye surgery unless medically necessary, recommended by the member's treating physician and authorized by Health Net;
- Reversal of surgical sterilization;
- Routine foot care for treatment of corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes;

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- Routine physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp or other nonpreventive purposes;
 - Services and supplies not authorized by Health Net, the Behavioral Health Administrator or the physician group according to Health Net's procedures;
 - Services for a surrogate pregnancy are covered only when the surrogate is a Health Net member. However, when compensation is obtained for the surrogacy, Health Net shall have a lien on such compensation to recover its medical expense;
 - Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the plan's EOC;
 - Teladoc consultation services do not cover specialist services; and prescriptions for substances controlled by the DEA, non-therapeutic drugs or certain other drugs which may be harmful because of potential for abuse.
 - Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary; and
 - Treatment of obesity, weight reduction or weight management, except for treatment of morbid obesity. Certain services may be covered as preventive care services as described in the plan's EOC.
 - Services related to education or training, including for employment or professional purposes, except for behavioral health treatment for pervasive developmental disorder or autism;
 - State hospital treatment, except as the result of an emergency or urgently needed care;
 - Stress, except when rendered in connection with services provided for a treatable mental disorder;
 - Services for the treatment of chemical dependency (other than detoxification) are not covered.

The above is a partial list of the principal exclusions and limitations applicable to the medical portion of your Health Net plan. The EOC, which you will receive if you enroll in this plan, will contain the full list. Notwithstanding any exclusions or limitations described in the EOC, all medically necessary services for treatment of Severe Mental Illness or Serious Emotional Disturbance of a Child mental health conditions shall be covered.

Benefits and coverage

WHAT YOU PAY FOR SERVICES

The "Schedule of benefits and coverage" section explains your coverage and payment for services. Please take a moment to look it over.

TIMELY ACCESS TO CARE

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

You may contact Health Net at the number shown on the back cover, 7 days per week, 24 hours per day to access triage or screening services. Health Net provides access to covered health care services in a timely manner. For further information, please refer to the plan's EOC or contact the Health Net Customer Contact Center at the phone number on the back cover.

Please see the "Notice of Language Services" section for information regarding the availability of no cost interpreter services.

SPECIAL ENROLLMENT RIGHTS UNDER CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

The Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) creates a special enrollment period in which individuals and their dependent(s) are eligible to request enrollment in this plan within 60 days of becoming ineligible and losing coverage from the Access for Infants and Mothers Program (AIM) or a Medi-Cal plan.

NOTICE OF REQUIRED COVERAGE

Benefits of this plan provide coverage required by the Newborns' and Mothers' Health Protection Act of 1996 and the Women's Health and Cancer Right Act of 1998.

The Newborns' and Mothers' Health Protection Act of 1996 sets requirements for a minimum Hospital length of stay following delivery. Specifically, 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).

The Women's Health and Cancer Right Act of 1998 applies to medically necessary mastectomies and requires coverage for prosthetic devices and reconstructive surgery on either breast provided to restore and achieve symmetry.

COVERAGE FOR NEWBORNS

Children born after your date of enrollment are automatically covered at birth. To continue coverage, the child must be enrolled through your employer before the 30th day of the child's life. If the child is not enrolled within 30 days of the child's birth:

- Coverage will end the 31st day after birth; and
- You will have to pay your physician group for all medical care provided after the 30th day of your baby's life.

EMERGENCIES

Health Net covers emergency and urgently needed care throughout the world. If you need emergency or urgently needed care, seek care where it is immediately available. Depending on your circumstances, you may seek this care by going to your physician group (medical) or the Behavioral Health Administrator (mental disorder and chemical dependency) or to the nearest emergency facility or by calling **911**.

You are encouraged to use appropriately the **911** emergency response system, in areas where the system is established and operating, when you have an emergency medical condition (including severe mental disorder and serious emotional disturbances of a child) that requires an emergency response. All air and ground ambulance and ambulance transport services provided as a result of a **911** call will be covered, if the request is made for an emergency medical condition (including severe mental illness and serious emotional disturbances of a child).

All follow-up care (including severe mental illness and serious emotional disturbances of a child) after the urgency has passed and your condition is stable, must be provided or authorized by your physician group (medical) or the Behavioral Health Administrator (mental disorder and chemical dependency); otherwise, it will not be covered by Health Net.



Emergency Care includes medical screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. "Active labor" means labor at the time that either of the following could reasonably be expected to occur: 1) There is inadequate time to effect safe transfer to another hospital prior to delivery; or 2) a transfer poses a threat to the health and safety of the member or her 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.

All air and ground ambulance and ambulance transport services provided as a result of a **911** call will be covered, if the request is made for an emergency medical condition (including severe mental illness and serious emotional disturbances of a child).

Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

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

Emergency Psychiatric 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.*

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

MEDICALLY NECESSARY CARE

All services that are medically necessary will be covered by your Health Net plan (unless specifically excluded under the plan). All covered services or supplies are listed in the plan's EOC; any other services or supplies are not covered.

SECOND OPINIONS

You have the right to request a second opinion when:

- Your PCP 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 PCP or a referral physician is unable to diagnose your condition, or test results are conflicting.

When you request a second opinion, you will be responsible for any applicable copayments. To obtain a copy of Health Net's second opinion policy, call the Customer Contact Center at the phone number on the back cover.

CLINICAL TRIALS

Routine patient care costs for patients diagnosed with cancer or other life-threatening disease or condition who are accepted into phase I, II, III, or IV clinical trials are covered when medically necessary, recommended by the member's treating physician and authorized by Health Net. The physician must determine that participation has a meaningful potential benefit to the member and the trial has therapeutic intent. For further information, please refer to the plan's EOC.

EXTENSION OF BENEFITS

If you or a covered family member is totally disabled when your employer ends its group services agreement with Health Net, we will cover the treatment for the disability until one of the following occurs:

- A maximum of 12 consecutive months elapses from the termination date;
- Available benefits are exhausted;
- The disability ends; or
- The member becomes enrolled in another plan that covers the disability.

Your application for an extension of benefits for disability must be made to Health Net within 90 days after your employer ends its agreement with us. We will require medical proof of the total disability at specified intervals.

CONFIDENTIALITY AND RELEASE OF MEMBER INFORMATION

Health Net knows that personal information in your medical records is private. Therefore, we protect your personal health information in all settings (including oral, written and electronic information). The only time we would release your confidential information without your authorization is for payment, treatment, health care operations (including, but not limited to utilization management, quality improvement, disease or case management programs) or when permitted or required to do so by law, such as for court order or subpoena. We will not release your confidential claims details to your employer or their agent. Often Health Net is required to comply with aggregated measurement and data reporting requirements. In those cases, we protect your privacy by not releasing any information that identifies our members.

PRIVACY PRACTICES

Once you become a Health Net member, Health Net uses and discloses a member's protected health information and nonpublic personal financial information* for purposes of treatment, payment, health care operations, and where permitted or required by law. Health Net provides members with a Notice of Privacy Practices that describes how it uses and discloses protected health information; the individual's rights to access, to request amendments, restrictions, and an accounting of disclosures of protected health information; and the procedures for filing complaints. Health Net will provide you the opportunity to approve or refuse the release of your information for non-routine releases such as marketing. Health Net provides access to members to inspect or obtain a copy of the member's protected health information in designated record sets maintained by Health Net. Health Net protects oral, written and electronic information across the organization by using reasonable and appropriate security safeguards. These safeguards include limiting access to an individual's protected health information to only those who have a need to know in order to perform payment, treatment, health care operations or where permitted or required by law. Health Net releases protected health information to plan sponsors for administration of self-funded plans but does not release protected health information to plan sponsors/employers for insured products unless the plan sponsor is performing a payment or health care operation function for the plan. Health Net's entire Notice of Privacy Practices can be found in the plan's EOC, at www.healthnet.com/uc under "Privacy" or you may call the Customer Contact Center at the phone number on the back cover of this booklet to obtain a copy.

* *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.

TECHNOLOGY ASSESSMENT

New technologies are those procedures, drugs or devices that have recently been developed for the treatment of specific diseases or conditions or are new applications of existing procedures, drugs or devices. New technologies are considered investigational or experimental during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to be considered investigational or experimental if clinical study has not shown safety or effectiveness or if they are not considered standard care by the appropriate medical specialty. Approved technologies are integrated into Health Net benefits.

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

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

Utilization management

Utilization management is an important component of health care management. Through the processes of pre-authorization, concurrent and retrospective review and care management, we evaluate the services provided to our members to be sure they are medically necessary and appropriate for the setting and time. These processes help to maintain Health Net's high quality medical management standards.

PRE-AUTHORIZATION

Certain proposed services may require an assessment prior to approval. Evidence-based criteria are used to evaluate whether or not the procedure is medically necessary and planned for the appropriate setting (that is, inpatient, ambulatory surgery, etc.).

CONCURRENT REVIEW

This process continues to authorize inpatient and certain outpatient conditions on a concurrent basis while following a member's progress, such as during inpatient hospitalization or while receiving outpatient home care services.

DISCHARGE PLANNING

This component of the concurrent review process ensures that planning is done for a member's safe discharge in conjunction with the physician's discharge orders and to authorize post-hospital services when needed.

RETROSPECTIVE REVIEW

This medical management process assesses the appropriateness of medical services on a case-by-case basis after the services have been provided. It is usually performed on cases where pre-authorization was required but not obtained.

CARE OR CASE MANAGEMENT

Nurse care managers provide assistance, education and guidance to members (and their families) through major acute and/or chronic long-term health problems. The care managers work closely with members, their physicians and community resources.

If you would like additional information regarding Health Net's utilization management process, please call the Health Net Customer Contact Center at the phone number on the back cover.

Payment of fees and charges

YOUR COPAYMENT AND DEDUCTIBLES

The "Schedule of benefits and coverage" section explains your coverage and payment for services. Please take a moment to look it over.

PREPAYMENT FEES

Your employer will pay Health Net your monthly subscription charges for you and all enrolled family members. Check with your employer regarding any share that you may be required to pay. If your share ever increases, your employer will inform you in advance.

OTHER CHARGES

You are responsible for payment of your share of the cost of services covered by this plan. Amounts paid by you are called copayments, which are described in the "Schedule of benefits and coverage" section of this SB/DF. Beyond these charges the remainder of the cost of covered services will be paid by Health Net.

When the total amount of copayments you pay equals the out-of-pocket maximum shown in the "Schedule of benefits and coverage" section, you will not have to pay additional copayments for the rest of the year for most services provided or authorized by your physician group.



Payment for services not covered by this plan will not count toward the calendar year out-of-pocket maximum. Additionally, certain deductibles and copayments will not count toward the out-of-pocket maximum as shown in the "Schedule of benefits and coverage" section. For further information please refer to the plan's EOC.

LIABILITY OF SUBSCRIBER OR ENROLLEE FOR PAYMENT

If you receive health care services without the required referral or authorization from your PCP or physician group (medical), or the Behavioral Health Administrator (mental disorder and chemical dependency), you are responsible for the cost of these services.



Remember, this plan only covers services that are provided or authorized by a PCP or physician group or the Behavioral Health Administrator, except for emergency or out-of-area urgent care. Consult the Health Net HMO Directory for a full listing of Health Net-contracted physicians.

REIMBURSEMENT PROVISIONS

Payments that are owed by Health Net for services provided by or through your physician group (medical) or the Behavioral Health Administrator (mental disorder and chemical dependency) will never be your responsibility.

If you have out-of-pocket expenses for covered services, call the Health Net Customer Contact Center for a claim form and instructions. You will be reimbursed for these expenses less any required copayment or deductible. (Remember, you do not need to submit claims for medical services provided by your PCP or physician group.)

If you receive emergency services not provided or directed by your physician group (medical) or the Behavioral Health Administrator (mental disorder and chemical dependency), you may have to pay at the time you receive service. To be reimbursed for these charges, you should get a complete statement of the services received and, if possible, a copy of the emergency room report.

Please call the Health Net Customer Contact Center at the phone number on the back cover to obtain claim forms, and to find out whether you should send the completed form to your physician group (medical) or the Behavioral Health Administrator (mental disorder and chemical dependency) or to Health Net. Medical claims must be received by Health Net within one year of the date of service to be eligible for reimbursement.



How to file a claim:

For medical services, please send a completed claim form within one year of the date of service to:

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

Please call Health Net's Customer Contact Center at the phone number on the back cover of this booklet or visit our website at www.healthnet.com/uc to obtain the claim form.

For mental disorders and chemical dependency emergency services or for services authorized by MHN Services you must use the CMS (HCFA) - 1500 form. Please send the claim to MHN Services within one year of the date of service at the address listed on the claims form or to MHN Services at:

*MHN Services
P.O. Box 14621
Lexington, KY 40512-4621*

*Please call MHN Services at 1-800-663-9355 to obtain a claim form.
For outpatient prescription drugs, please send a completed prescription drug claim form to:*

*Health Net
C/O Caremark
P.O. Box 52136
Phoenix, AZ 85072*

Please call Health Net's Customer Contact Center at the phone number on the back cover of this booklet or visit our website at www.healthnet.com/uc to obtain a prescription drug claim form.

***For emergency chiropractic or acupuncture service or for the other approved services**, please send your completed claim form within one year of the date of services to:*

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



Claims for covered expenses filed more than one year from the date of service will not be paid unless you can show that it was not reasonably possible to file your claim within that time limit and that you have filed as soon as was reasonably possible.

PROVIDER REFERRAL AND REIMBURSEMENT DISCLOSURE

If you are considering enrolling in our plan, you are entitled to ask if the plan has special financial arrangements with our physicians that can affect the use of referrals and other services you may need. Health Net uses financial incentives and various risk sharing arrangements when paying providers. To get this information, call the Health Net Customer Contact Center at the phone number on the back cover. You can also contact your physician group or your PCP to find out about our physician payment arrangements.

Facilities

Health care services for you and eligible members of your family will be provided at:

- The facilities of the physician group you chose at enrollment; or
- A nearby Health Net-contracted hospital, if hospitalization is required.

Many Health Net contracting physician groups have either a physician on call 24 hours a day or an urgent care center available to offer access to care at all times.

The physician group you choose will also have a contractual relationship with local hospitals (for acute, subacute and transitional care) and skilled nursing facilities. These are listed in your *Health Net HMO Directory*.

PHYSICIAN GROUP TRANSFERS

You may switch doctors within the same physician group at any time. You may also transfer to another physician group monthly. Simply contact Health Net to have your transfer effective by the 1st of the following month.

Transfer requests will generally be honored unless you are confined to a hospital. (However, Health Net may approve transfers under this condition for certain unusual or serious circumstances. Please contact the Health Net Customer Contact Center at the phone number on the back cover of this booklet.)

CONTINUITY OF CARE

Transition of Care for New Enrollees

You may request continued care from a provider who does not contract with Health Net if at the time of your enrollment with Health Net you were receiving care for the conditions listed in the "Continuity of Care upon Termination of Provider Contract" provision immediately below. Health Net may provide coverage for completion of services from a non-participating provider, subject to applicable copayments and any exclusions and limitations of your 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 the 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.

Continuity of Care upon Termination of Provider Contract

If Health Net's contract with a physician group or other provider ends, Health Net will transfer any affected members to another contracted physician group or provider to ensure that care continues. Health Net will provide a written notice to affected members at least 60-days prior to termination of a contract with a physician group or an acute care hospital to which members are assigned for services. For all other hospitals that end their contract with Health Net, a written notice will be provided to affected members within five days after the effective date of the contract termination.

Health Net may provide coverage for completion of services from a provider whose contract has ended, subject to applicable copayments and any other exclusions and limitations of your 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 it is reasonably possible.

You 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 the conditions listed below.

The following conditions are eligible for continuation of care:

- an acute condition;
- a serious chronic condition not to exceed twelve months;
- a pregnancy (including the duration of the pregnancy and immediate postpartum care);

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- a newborn (up to 36 months of age, not to exceed twelve months);
 - a terminal illness (through the duration of the terminal illness);
 - a surgery or other procedure that has been authorized by Health Net (or by the member's prior health plan for new enrollee) as part of a documented course of treatment.

In addition, you may request continued care from a provider, including a hospital, if you have been enrolled in another Health Net HMO plan that included a larger network than this plan, Health Net will offer the same scope of continuity of care for completion of services, regardless of whether you had the opportunity to retain your current provider by selecting either:

- a Health Net product with an out of network benefit;
- a different Health Net HMO network product that included your current provider; or
- another health plan or carrier product.

To request continued care, you will need to complete a Continuity of Care Assistance Request Form. If you would like more information on how to request continued care or to request a copy of the Continuity of Care Assistance Request Form or of Health Net's continuity of care policy, please call the Health Net Customer Contact Center at the phone number on the back cover.

Renewing, continuing or ending coverage

RENEWAL PROVISIONS

The contract between Health Net and your employer is usually renewed annually. If your contract is amended or terminated, your employer will notify you in writing.

INDIVIDUAL CONTINUATION OF BENEFITS



Please examine your options carefully before declining coverage.

If your employment with your current employer ends, you and your covered family members may qualify for continued group coverage under:

- **COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985):** For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside of California. Please check with your group to determine if you and your covered dependents are eligible.
- **Cal-COBRA Continuation Coverage:** If you have exhausted COBRA and you live in the Health Net Service Area, you may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if you have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage, and you are not entitled to Medicare. If you are eligible, you have the opportunity to continue group coverage under this plan through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.
- **USERRA Coverage:** Under a federal law known as the Uniformed Services Employment and Reemployment Rights Act (USERRA), employers are required to provide employees who are absent from employment to serve in the uniformed services and their dependents who would

lose their group health coverage the opportunity to elect continuation coverage for a period of up to 24 months. Please check with your group to determine if you are eligible.

Also, you may be eligible for continued coverage for a disabling condition (for up to 12 months) if your employer terminates its agreement with Health Net. Please refer to the "Extension of benefits" section of this SB/DF for more information.

TERMINATION OF BENEFITS

The following information describes circumstances when your coverage in this plan may be terminated. For a more complete description of termination of benefits, please see the plan's EOC.

Termination for Nonpayment of Subscription Charges

Your coverage under this plan ends when the agreement between the employer and Health Net terminates due to nonpayment of the subscription charges by the employer. Health Net will provide your employer a 30-day grace period to submit the delinquent subscription charges. If your employer fails to pay the required subscription charges by the end of the 30-day grace period, the agreement between Health Net and your employer will be cancelled and Health Net will terminate your coverage at the end of the grace period.

Termination for Loss of Eligibility

Your coverage under this plan ends on the date you become ineligible. Some reasons that you may lose eligibility in this plan include, but are not limited to, the following situations:

- The agreement between the employer covered under this plan and Health Net ends;
- You cease to either live or work within Health Net's service area; or
- You no longer work for the employer covered under this plan.

Termination for Cause

Coverage under this Health Net plan may be terminated for good cause with a 30-day written notice for a member who commits any act or practice, which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the agreement, including:

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

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

How to Appeal Your Termination

You have a right to file a complaint if you believe that your coverage is improperly terminated or not renewed. A complaint is also called a grievance or an appeal. Refer to the "If You Have a Disagreement With Our Plan" section for information about how to appeal Health Net's decision to terminate your coverage.

If your coverage is terminated based on any reason other than for nonpayment of subscription charges and your coverage is still in effect when you submit your complaint, Health Net will continue your coverage until the review process is completed, subject to Health Net's receipt of the applicable

subscription charges. You must also continue to pay the deductible and copayments for any services and supplies received while your coverage is continued during the review process.

If your coverage has already ended when you submit your request for review, Health Net is not required to continue coverage. However, you may still request a review of Health Net's decision to terminate your coverage by following the complaint process described in the "If You Have a Disagreement With Our Plan" section.



If the person involved in any of the above activities is the enrolled employee, coverage under this plan will end as well for any covered dependents.

If you have a disagreement with our plan

The provisions referenced under this title as described below are applicable to services and supplies covered under this SB/DF. The California Department of Managed Health Care is responsible for regulating health care service plans.

If you have a grievance against Health Net, you should first telephone Health Net at the phone number on the back cover and use the plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, or a grievance that has not been satisfactorily resolved by Health Net, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

You may also be eligible for an independent medical review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-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.

MEMBER GRIEVANCE AND APPEALS PROCESS

If you are dissatisfied with the quality of care that you have received or feel that you have been incorrectly denied a service or claim, you may file a grievance or appeal.



How to file a grievance or appeal:

You may call the Customer Contact Center at the phone number on the back cover or submit a Member Grievance Form through the Health Net website at www.healthnet.com/uc:

You may also write to: *Health Net of California*
 P.O. Box 10348
 Van Nuys, CA 91410-0348

Please include all the information from your Health Net identification card as well as details of your concern or problem.

Health Net will acknowledge your grievance or appeal within five calendar days, review the information and tell you of our decision in writing within 30 days of receiving the grievance. For conditions where there is an immediate and serious threat to your health, including severe pain or the potential loss of life, limb or major bodily function, Health Net will notify you of the status of your grievance no later than three days from the receipt of all the required information. 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 process prior to applying to the Department of Managed Health Care for review of an urgent grievance.



In addition, you can request an independent medical review of disputed health care services from the Department of Managed Health Care if you believe that health care services eligible for coverage and payment under the plan was improperly denied, modified or delayed by Health Net or one of its contracting providers.

Also, if Health Net denies your appeal of a denial for lack of medical necessity, or denies or delays coverage for requested treatment involving experimental or investigational drugs, devices, procedures or therapies, you can request an independent medical review of Health Net's decision from the Department of Managed Health Care if you meet the eligibility criteria set out in the plan's EOC.

ARBITRATION

If you are not satisfied with the result of the grievance hearing and appeals process, you may submit the problem to binding arbitration. Health Net uses binding arbitration to settle disputes, including medical malpractice. When you enroll in Health Net, you agree to submit any disputes to arbitration, in lieu of a jury or court trial.

Additional plan benefit information

The following plan benefits show benefits available with your plan. For a more complete description of copayments, and exclusions and limitations of service, please see the plan's EOC.

Behavioral health services

Health Net contracts with MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator) which administers behavioral health services through a personalized, confidential and affordable mental disorder and chemical dependency care program.

Contact the Behavioral Health Administrator by calling the Health Net Customer Contact Center at the phone number on the back cover. The Behavioral Health Administrator will help you identify a participating mental health professional, a participating independent physician or a sub-contracted provider association (IPA) within the network, close to where you live or work, with whom you can make an appointment.

Certain services and supplies for mental disorders and chemical dependency may require prior authorization by the Behavioral Health Administrator in order to be covered.

Please refer to the plan's EOC for a more complete description of mental disorder and chemical dependency services and supplies, including those that require prior authorization by the Behavioral Health Administrator.

TRANSITION OF CARE FOR NEW ENROLLEES

If you are receiving ongoing care for an acute, serious, or chronic mental health condition from a provider not affiliated with the Behavioral Health Administrator when you enroll with Health Net, we may temporarily cover services provided by that provider, 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.

To request continued care, you will need to complete a Continuity of Care Assistance Request Form. If you would like more information on how to request continued care, or to request a copy of the Continuity of Care Assistance Request Form or of our continuity of care policy, please call the Health Net Customer Contact Center at the phone number on the back cover.

SERIOUS EMOTIONAL DISTURBANCES OF A CHILD

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*, as amended to date, other than a primary substance use disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following:

- 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

Severe mental illness includes 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 professionally recognized standards including, but not limited to, the most recent edition the *Diagnostic and Statistical Manual for Mental Disorders*, as amended to date), autism, anorexia nervosa, and bulimia nervosa.

OTHER MENTAL DISORDERS

Other mental disorders are all other mental disorders not listed as severe mental illness, serious emotional disturbances of a child or chemical dependency conditions.

CONTINUATION OF TREATMENT

If you are in treatment for a mental disorder or chemical dependency problem, call the telephone number shown on your Health Net ID card to receive assistance in transferring your care to a network provider.

WHAT'S COVERED

Please refer to the "Schedule of benefits and coverage" section of this SB/DF for the explanation of covered services and copayments.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)



Services or supplies for treatment of mental disorder and chemical dependency are subject to the plan's general exclusions and limitations. Please refer to the "Limits of coverage" section of this SB/DF for a list of what's not covered under this plan.

This is only a summary. Consult the plan's EOC to determine the exact terms and conditions of your coverage.

Prescription drug program

Health Net contracts with many major pharmacy chains, supermarket based pharmacies and privately owned neighborhood pharmacies in California. For a complete and up-to-date list of participating pharmacies, please visit our website at www.healthnet.com/uc or call the Health Net Customer Contact Center at the phone number on the back cover.

UC WALK-UP SERVICE THROUGH UC MEDICAL CENTER PHARMACIES AND CVS RETAIL PHARMACIES

To streamline access to prescription medications, Health Net and the UC Medical Center Pharmacies have partnered to offer UC members with the ability to fill up to a 90-day prescription for maintenance medications at UC designated Medical Center Pharmacies. Just like Health Net's current Mail Order Program, members can now obtain up to a 90-day supply for only two copays, at one of the UC-designated Medical Center pharmacies.

PRESCRIPTIONS BY MAIL DRUG PROGRAM

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period), you have the option of filling it through our convenient Prescriptions By Mail Drug Program. This program allows you to receive a 90-consecutive-calendar-day supply of maintenance medications. For complete information, call the Health Net Customer Contact Center at the phone number on the back cover.



Schedule II narcotic drugs (which are drugs that have a high abuse risk as classified by the Federal Drug Enforcement Administration) are not covered through mail order.

THE HEALTH NET FORMULARY

This plan uses the Formulary. The Health Net Formulary is the approved list of medications covered for illnesses and conditions. It was developed to identify the safest and most effective medications for Health Net members while attempting to maintain affordable pharmacy benefits.

We specifically suggest to all Health Net contracting PCPs and specialists that they refer to this Formulary when choosing drugs for patients who are Health Net members. When your physician prescribes medications listed in the Formulary, it ensures that you are receiving a high quality prescription medication that is also of high value.

The Formulary is updated regularly, based on input from the Health Net Pharmacy and Therapeutics (P&T) Committee. The Committee members are actively practicing physicians of various medical specialties and clinical pharmacists. Voting members are recruited from contracting physician groups throughout California based on their experience, knowledge and expertise. In addition, the P&T Committee frequently consults with other medical experts to provide additional input to the Committee. Updates to the Formulary and drug usage guidelines are made as new clinical information and new drugs become available. In order to keep the Formulary current, the P&T Committee evaluates clinical effectiveness, safety and overall value through:

- Medical and scientific publications;
- Relevant utilization experience; and
- Physician recommendations.

To obtain a copy of Health Net's most current Formulary, please visit our web site at www.healthnet.com/uc or call the Health Net Customer Contact Center at the phone number on the back cover.

WHAT IS "PRIOR AUTHORIZATION?"

Some drugs require prior authorization. This means that your doctor must contact Health Net in advance to provide the medical reason for prescribing the medication. You may obtain a list of drugs requiring prior authorization by visiting our website at www.healthnet.com/uc or call the Health Net Customer Contact Center at the phone number on the back cover.



How to request prior authorization:

Requests for prior authorization may be submitted by telephone or facsimile. Upon receiving your physician's request for prior authorization, Health Net will evaluate the information submitted and make a determination based on established clinical criteria for the particular medication. The criteria used for prior authorization are developed and based on input from the Health Net P&T Committee as well as physician specialist experts. Your physician may contact Health Net to obtain the usage guidelines for specific medications.

If authorization is denied by Health Net, you will receive written communication including the specific reason for denial. If you disagree with the decision, you may appeal the decision.

The appeal may be submitted in writing, by telephone or through e-mail. We must receive the appeal within 60 days of the date of the denial notice. Please refer to the plan's EOC for details regarding your right to appeal.

To submit an appeal:

- Call the Health Net Customer Contact Center at the phone number on the back cover;
- Visit www.healthnet.com/uc for information on e-mailing the Customer Contact Center; or
- Write to: Health Net Customer Contact Center
P.O. Box 9103
Van Nuys, CA 91409-9103

WHAT'S COVERED



Please refer to the "Schedule of benefits and coverage" section of this SB/DF for the explanation of covered services and copayments.

This plan covers the following:

- Tier 1 drugs - Drugs listed as Tier 1 on the Formulary that are not excluded from coverage (include most generic drugs and some low-cost preferred brand name drugs when listed in the Formulary);
- Tier 2 drugs – Drugs listed as Tier 2 on the Formulary that are not excluded from coverage (include non-preferred generic, preferred brand name drugs, insulin and diabetic supplies and certain brand name drugs with a generic equivalent when listed in the Formulary); and
- Tier 3 drugs - Drugs listed on the Formulary as Tier 3 (include non-preferred brand name drugs, brand name drugs with a generic equivalent when medically necessary, drugs listed as Tier 3 Drugs, drugs indicated as "NF", if approved, or drugs not listed in the Formulary).
- Preventive drugs and women's contraceptives

MORE INFORMATION ABOUT DRUGS THAT WE COVER

- Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.
- Prescription drug refills are covered, up to a 30-consecutive-day supply per prescription at a Health Net contracted pharmacy for one copayment. A copayment is required for each prescription. In some cases, a 30-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan according to the Food and Drug Administration (FDA) or Health Net's usage guidelines. If this is the case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply.
- Tier 3 drugs with a percentage copayment will have a copayment maximum of \$100 for each prescription filled at a retail pharmacy and a copayment maximum of \$300 for each prescription filled through the Mail Order program. Percentage copayments will be based on Health Net's contracted pharmacy rate.
- Mail order drugs are covered up to a 90-consecutive-calendar-day supply. When the retail pharmacy copayment is a percentage, the mail order copayment is the same percentage of the cost to Health Net as the retail pharmacy copayment.
- Prescription drugs for the treatment of asthma are covered as stated in the Formulary. Inhaler spacers and peak flow meters under the pharmacy benefit are covered when medically necessary. Nebulizers (including face masks and tubing) are covered under "Durable Medical Equipment" and educational programs for the management of asthma are covered under

"Patient Education" through the medical benefit. For information about copayments required for these benefits, please see the "Schedule of benefits and coverage" section of this SB/DF.

- Preventive drugs, including smoking cessation drugs, are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Covered contraceptives are FDA-approved contraceptives for women that are either available over-the-counter or are only available with a prescription. Vaginal, oral, transdermal and emergency contraceptives are covered under this pharmacy benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit. Refer to the plan's EOC for more information.
- Diabetic supplies (blood glucose testing strips, lancets, needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (that is, opened in order to dispense the product in quantities other than those packaged). When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times your physician has prescribed for up to a 30-day period. For more information about diabetic equipment and supplies, please see "Endnotes" in the "Schedule of benefits and coverage" section of this SB/DF.
- Self-injectable drugs (other than insulin) are considered specialty drugs and must be obtained through a contracted specialty pharmacy vendor. Specialty drugs require prior authorization and upon approval, the specialty pharmacy vendor will arrange for the dispensing of the drugs. Please refer to the plan's EOC for additional information.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)



Services or supplies excluded under pharmacy services may be covered under the medical benefits portion of your plan. In addition to the exclusion and limitations listed below, prescription drug benefits are subject to the plan's general exclusions and limitations. Consult the plan's EOC for more information.

- Allergy serum is covered as a medical benefit. See "allergy serum" benefit in the "Schedule of benefits and coverage" for details;
- Coverage for devices is limited to vaginal contraceptive devices, peak flow meters, spacer inhalers and diabetic supplies. No other devices are covered even if prescribed by a participating physician;
- Drugs prescribed for the treatment of obesity are covered, when medically necessary for the treatment of morbid obesity or when you meet Health Net Prior Authorization coverage requirements. In such cases, the drugs will be subject to prior authorization from Health Net;
- Drugs or medicines administered by a physician or physician's staff member;
- Drugs prescribed for routine dental treatment;
- Drugs prescribed to shorten the duration of the common cold;
- Drugs prescribed for sexual dysfunction when not medically necessary, including drugs that establish, maintain, or enhance sexual function or satisfaction;
- Experimental drugs (those that are labeled "Caution - Limited by Federal Law to investigational use only"). If you are denied coverage of a drug because the drug is investigational or experimental you will have a right to independent medical review. See "If you have a disagreement with our plan" section of this SB/DF for additional information;
- Hypodermic needles or syringes, except for insulin needles, syringes and specific brands of pen devices;

- Immunizing agents, injections (except for insulin), agents for surgical implantation, biological sera, blood, blood derivatives or blood plasma obtained through a prescription;
- Individual doses of medication dispensed in plastic, unit dose or foil packages unless medically necessary or only available in that form;
- Limits on quantity, dosage and treatment duration may apply to some drugs. Medications taken on an "as-needed" basis may have a copayment based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If medically necessary, your physician may request a larger quantity from Health Net;
- Medical equipment and supplies (including insulin), that are available without a prescription are covered when prescribed by a physician for the management and treatment of diabetes or for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations or for female contraception as approved by the FDA. Any other nonprescription drug, medical equipment or supply 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. However, if a higher dosage form of a prescription drug or over-the-counter (OTC) drug is only available by prescription, that higher dosage drug will be covered. If a drug that was previously available by prescription becomes available in an OTC form in the same prescription strength, then any prescription drugs that are similar agents and have comparable clinical effect(s) will only be covered when medically necessary and prior authorization is obtained from Health Net;
- Prescription drugs filled at pharmacies that are not in the Health Net pharmacy network or are not in California except in emergency or urgent care situations;
- Prescription drugs prescribed by a physician who is not a member physician or an authorized specialist are not covered, except when the physician's services have been authorized, or because of a medical emergency condition, illness or injury, for urgently needed care or as specifically stated;
- Once you have taken possession of medications, replacement of lost, stolen or damaged medications is not covered;
- Supply amounts for prescriptions that exceed the FDA's or Health Net's indicated usage recommendation are not covered unless medically necessary and prior authorization is obtained from Health Net. Drugs that are not approved by the FDA are not covered, except as described in the plan's EOC; and
- Drugs prescribed for a condition or treatment not covered by this plan are not covered. However, the plan does cover drugs for medical conditions that result from nonroutine complications of a noncovered service.

This is only a summary. Consult the plan's EOC to determine the exact terms and conditions of your coverage.

Chiropractic care program

Health Net has partnered with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable chiropractic coverage. With this program, you are free to obtain this care by selecting a contracted chiropractor from our *ASH Plans Contracted Chiropractor Directory*. Although you are always welcome to consult your PCP, you will not need a referral to see a contracted chiropractor.

WHAT'S COVERED



Please refer to the "Schedule of benefits and coverage" section of this SB/DF for the explanation of covered services and copayments.

- Office visits;
- Chiropractic items such as supports, collars, pillows, heel lifts, ice packs, cushions, orthotics, rib belts and home traction units prescribed by a ASH Plans contracted chiropractor and approved by ASH Plans; and
- All covered chiropractic services require pre-approval from ASH Plans except for a new patient examination by a contracted chiropractor and emergency chiropractic services.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)



Services or supplies excluded under the chiropractic care program may be covered under the medical benefits portion of your plan. Consult the plan's EOC for more information.

- Air conditioners, air purifiers, therapeutic mattresses, vitamins, minerals, nutritional supplements, durable medical equipment, appliances or comfort items;
- Charges for hospital confinement and related services;
- Charges for anesthesia;
- Conjunctive physical therapy not associated with spinal, muscle or joint adjustment;
- Diagnostic scanning, MRI, CAT scans or thermography;
- Exams or treatment of strictly non-neuromusculoskeletal disorders;
- Experimental or investigational chiropractic services. Only chiropractic services that are non-investigational, proven and meet professionally recognized standards of practice in the chiropractic provider community are covered. ASH Plans will determine what will be considered experimental or investigational;
- Hypnotherapy, behavioral training, sleep therapy, weight programs, educational programs, nonmedical self-help or self-care, or any self-help physical exercise training;
- Lab tests, x-rays, adjustments, physical therapy or other services not chiropractically necessary or classified as experimental;
- Pre-employment physicals or vocational rehabilitation arising from employment or covered under any public liability insurance;
- Treatment for temporomandibular joint syndrome (TMJ); and
- Treatment or services not authorized by ASH Plans or delivered by an ASH Plans contracted provider (except emergency chiropractic services or upon a referral to a non-contracted provider approved by ASH Plans).

This is only a summary. Consult the plan's EOC to determine the exact terms and conditions of your coverage.

Acupuncture care program

Health Net has partnered with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage. Although you are always welcome to consult your PCP, you will not need a referral to see a contracted acupuncturist.

With this program, you are free to obtain care by self-referring to a contracted acupuncturist from the *ASH Plans Contracted Acupuncturist Directory*. All covered services require pre-approval by ASH Plans except for:

- A new patient examination by a contracted acupuncturist and the provision or commencement, in the new patient examination, of medically necessary services that are covered acupuncture services, to the extent consistent with professionally recognized standards of practice; and
- Emergency acupuncture services.

When ASH Plans approves a treatment plan, the approved services for the subsequent office visits covered by the treatment plan include not only the approved services but also a re-examination in each subsequent office visit, if deemed necessary by the contracted acupuncturist, without additional approval by ASH Plans.

DEFINITION OF ACUPUNCTURE COVERED SERVICES

Medically necessary services provided by a contracted acupuncturist (or a non-contracted acupuncturist, when emergency acupuncture services are provided or a referral is approved by ASH Plans) for the following injuries, illnesses, diseases, functional disorders or conditions, when determined medically necessary.

WHAT'S COVERED



Please refer to the "Schedule of benefits and coverage" section of this SB/DF for the explanation of covered services and copayments.

This plan covers office visits for treatment of the following conditions:

- Neuromusculoskeletal conditions, including conditions such as fibromyalgia and myofascial pain
- Pain, including low back pain, post-operative pain, and post-operative dental pain
- Nausea, including adult post-operative nausea and vomiting, chemotherapy nausea and vomiting, and nausea of pregnancy
- Carpal tunnel syndrome
- Headaches
- Menstrual cramps
- Osteoarthritis
- Stroke rehabilitation
- Tennis elbow

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)



Services or supplies excluded under the acupuncture care program may be covered under the medical benefits portion of your plan. Consult the plan's EOC for more information.

- Devices, personal and comfort items;
- Diagnostic scanning, MRI, CAT scans or thermography;
- X-rays, laboratory tests, and x-ray second opinions;
- Exams or treatment other than for neuromusculoskeletal conditions, pain, nausea, or other covered conditions, as described under the definition of acupuncture services above;

-
- Treatment for asthma or addiction (including but not limited to drugs, alcohol, nicotine addiction, or smoking cessation);
 - Hypnotherapy, behavioral training, sleep therapy, weight programs, educational programs, self-help items or services, or physical exercise training;
 - Physical therapy services classified as experimental or investigational;
 - Physicals or vocational rehabilitation for employment or those covered under any public liability insurance
 - Experimental or investigational acupuncture services. Only acupuncture services that are non-investigational, proven and meet professionally recognized standards of practice in the acupuncture provider community are covered. ASH Plans will determine what will be considered experimental or investigational;
 - Charges for hospital confinement and related services;
 - Charges for anesthesia; and
 - Treatment or services not authorized by ASH Plans or not delivered by a contracted acupuncturist when authorization is required; treatment not delivered by a contracted acupuncturist (except emergency acupuncture services or upon referral to a non-contracted acupuncturist approved by ASH Plans).

This is only a summary. Consult the plan's EOC to determine the exact terms and conditions of your coverage.

Notice of Language Service

English

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call the Customer Contact Center at the number on your ID card or call Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). For California marketplace, call IFP On Exchange 1-888-926-4988 (TTY: 711) or Small Business 1-888-926-5133 (TTY: 711). For Group Plans through Health Net, call 1-800-522-0088 (TTY: 711).

Arabic

خدمات لغوية مجانية. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة اللازمة، يرجى التواصل مع مركز خدمة العملاء عبر الرقم المبين على بطاقتك أو الاتصال بالرقم الفرعي لخطة الأفراد والعائلة: 1-800-839-2172 (TTY: 711). للتواصل في كاليفورنيا، يرجى الاتصال بالرقم الفرعي لخطة الأفراد والعائلة عبر الرقم: 1-888-926-4988 (TTY: 711) أو المشروعات الصغيرة 1-888-926-5133 (TTY: 711). لخطط المجموعة عبر Health Net، يرجى الاتصال بالرقم 1-800-522-0088 (TTY: 711).

Armenian

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Օգնության համար զանգահարեք Համայնքային սպասարկման կենտրոն ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք Individual & Family Plan (IFP) Off Exchange՝ 1-800-839-2172 հեռախոսահամարով (TTY՝ 711): Կալիֆոռնիայի համար զանգահարեք IFP On Exchange՝ 1-888-926-4988 հեռախոսահամարով (TTY՝ 711) կամ Փոքր բիզնեսի համար՝ 1-888-926-5133 հեռախոսահամարով (TTY՝ 711): Health Net-ի Իմֆային ծրագրերի համար զանգահարեք 1-800-522-0088 հեռախոսահամարով (TTY՝ 711):

Chinese

免費語言服務。您可使用口譯員服務。您可請人將文件唸給您聽並請我們將某些文件翻譯成您的語言寄給您。如需協助，請撥打您會員卡上的電話號碼與客戶聯絡中心聯絡或者撥打健康保險交易市場外的 Individual & Family Plan (IFP) 專線：1-800-839-2172（聽障專線：711）。如為加州保險交易市場，請撥打健康保險交易市場的 IFP 專線 1-888-926-4988（聽障專線：711），小型企業則請撥打 1-888-926-5133（聽障專線：711）。如為透過 Health Net 取得的團保計畫，請撥打 1-800-522-0088（聽障專線：711）。

Hindi

बिना शुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, अपने आईडी कार्ड में दिए गए नंबर पर ग्राहक सेवा केंद्र को कॉल करें या व्यक्तिगत और फैमिली प्लान (आईएफपी) ऑफ एक्सचेंज: 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफोर्निया बाजारों के लिए, आईएफपी ऑन एक्सचेंज 1-888-926-4988 (TTY: 711) या स्मॉल बिजनेस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के माध्यम से ग्रुप प्लान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong

Tsis Muaj Tus Nqi Pab Txhais Lus. Koj tuaj yeem tau txais ib tus kws pab txhais lus. Koj tuaj yeem muaj ib tus neeg nyeem cov ntaub ntawv rau koj ua koj hom lus hais. Txhawm rau pab, hu xovtooj rau Neeg Qhua Lub Chaw Tiv Toj ntawm tus npawb nyob ntawm koj daim npav ID lossis hu rau Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) Ntawm Kev Sib Hloov Pauv: 1-800-839-2172 (TTY: 711). Rau California qhov chaw kiab khw, hu rau IFP Ntawm Qhov Sib Hloov Pauv 1-888-926-4988 (TTY: 711) lossis Lag Luam Me 1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hu rau 1-800-522-0088 (TTY: 711).

Japanese

無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプが必要な場合は、IDカードに記載されている番号で顧客連絡センターまでお問い合わせいただくか、Individual & Family Plan (IFP) (個人・家族向けプラン) Off Exchange: 1-800-839-2172 (TTY: 711) までお電話ください。カリフォルニア州のマーケットプレイスについては、IFP On Exchange 1-888-926-4988 (TTY: 711) または Small Business 1-888-926-5133 (TTY: 711) までお電話ください。Health Netによるグループプランについては、1-800-522-0088 (TTY: 711) までお電話ください。

Khmer

សេវាកម្មភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជនតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក ឬហៅទូរស័ព្ទទៅកាន់កម្មវិធី Off Exchange របស់គម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) តាមរយៈលេខ៖ 1-800-839-2172 (TTY: 711)។ សម្រាប់ទីផ្សាររដ្ឋ California សូមហៅទូរស័ព្ទទៅកាន់កម្មវិធី On Exchange របស់គម្រោង IFP តាមរយៈលេខ 1-888-926-4988 (TTY: 711) ឬក្រុមហ៊ុនអាជីវកម្មខ្នាតតូចតាមរយៈលេខ 1-888-926-5133 (TTY: 711)។ សម្រាប់គម្រោងជាក្រុមតាមរយៈ Health Net សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-522-0088 (TTY: 711)។

Korean

무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 고객센터 센터에 연락하시거나 개인 및 가족 플랜(IFP)의 경우 Off Exchange: 1-800-839-2172(TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스의 경우 IFP On Exchange 1-888-926-4988(TTY: 711), 소규모 비즈니스의 경우 1-888-926-5133(TTY: 711)번으로 전화해 주십시오. Health Net을 통한 그룹 플랜의 경우 1-800-522-0088(TTY: 711)번으로 전화해 주십시오.

Navajo

Doo bąąh ilinígóó saad bee háká ada'łiyeed. Ata' halne'ígíí da la' ná hádííóót'íí. Naaltsos da t'áá shí shízaad k'ehjí shichí' yídooltah nínízingo t'áá ná ákódoolnít. Ákót'éego shíká a'doowol nínízingo Customer Contact Center hoolyéhíjí' hodíílnih ninaaltsos nanítingo bee néého'dolzinígíí hodoonihjí' bikáá' éí doodago kojł' hółne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojł' hółne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí kojł' hółne' -888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí kojł' hółne' 1-800-522-0088 (TTY: 711).

Persian (Farsi)

خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای دریافت کمک، با مرکز تماس مشتریان به شماره روی کارت شناسایی یا طرح فردی و خانوادگی (IFP) Off Exchange) به شماره: 1-800-839-2172 (TTY:711) تماس بگیرید. برای بازار کالیفرنیا، با IFP On Exchange شماره 1-888-926-4988 (TTY:711) یا کسب و کار کوچک 1-888-926-5133 (TTY:711) تماس بگیرید. برای طرح های گروهی از طریق Health Net، با 1-800-522-0088 (TTY:711) تماس بگیرید.

Panjabi (Punjabi)

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਬਾਸੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਐਂਡ ਐਕਸਚੇਂਜ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਐਂਡ ਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੋਲ ਬਿਜਨੈਸ ਨੂੰ 1-888-926-5133 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਹੇਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਹਿਕ ਪਲੇਨਾਂ ਲਈ, 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь, звоните по телефону Центра помощи клиентам, указанному на вашей карте участника плана. Вы также можете позвонить в отдел помощи участникам не представленных на федеральном рынке планов для частных лиц и семей (IFP) Off Exchange 1-800-839-2172 (TTY: 711). Участники планов от California marketplace: звоните в отдел помощи участникам представленных на федеральном рынке планов IFP (On Exchange) по телефону 1-888-926-4988 (TTY: 711) или в отдел планов для малого бизнеса (Small Business) по телефону 1-888-926-5133 (TTY: 711). Участники коллективных планов, предоставляемых через Health Net: звоните по телефону 1-800-522-0088 (TTY: 711).

Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete, obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, comuníquese con el Centro de Comunicación con el Cliente al número que figura en su tarjeta de identificación o llame al plan individual y familiar que no pertenece al Mercado de Seguros de Salud al 1-800-839-2172 (TTY: 711). Para planes del mercado de seguros de salud de California, llame al plan individual y familiar que pertenece al Mercado de Seguros de Salud al 1-888-926-4988 (TTY: 711); para los planes de pequeñas empresas, llame al 1-888-926-5133 (TTY: 711). Para planes grupales a través de Health Net, llame al 1-800-522-0088 (TTY: 711).

Tagalog

Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, tumawag sa Customer Contact Center sa numerong nasa ID card ninyo o tumawag sa Off Exchange ng Planong Pang-indibidwal at Pampamilya (Individual & Family Plan, IFP): 1-800-839-2172 (TTY: 711). Para sa California marketplace, tumawag sa IFP On Exchange 1-888-926-4988 (TTY: 711) o Maliliit na Negosyo 1-888-926-5133 (TTY: 711). Para sa mga Planong Pang-grupo sa pamamagitan ng Health Net, tumawag sa 1-800-522-0088 (TTY: 711).

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โทรหาศูนย์ลูกค้าสัมพันธ์ได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือโทรหาฝ่ายแผนบุคคลและครอบครัวของเอกชน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โทรมา TTY: 711) สำหรับเซตแคลิฟอร์เนีย โทรหาฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โทรมา TTY: 711) หรือ ฝ่ายธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โทรมา TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โทรมา TTY: 711)

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi Trung Tâm Liên Lạc Khách Hàng theo số điện thoại ghi trên thẻ ID của quý vị hoặc gọi Chương Trình Bảo Hiểm Cá Nhân & Gia Đình (IFP) Phi Tập Trung: 1-800-839-2172 (TTY: 711). Đối với thị trường California, vui lòng gọi IFP Tập Trung 1-888-926-4988 (TTY: 711) hoặc Doanh Nghiệp Nhỏ 1-888-926-5133 (TTY: 711). Đối với các Chương Trình Bảo Hiểm Nhóm qua Health Net, vui lòng gọi 1-800-522-0088 (TTY: 711).

CA Commercial DMHC On and Off-Exchange Member Notice of Language Assistance

FLY017549EH00 (12/17)

Notice of Nondiscrimination

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. (Health Net) complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at:

Individual & Family Plan (IFP) Applicants 1-877-609-8711 (TTY: 711)

Group Plans through Health Net 1-800-522-0088 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way based on the characteristics above, you can file a grievance by calling Health Net's Customer Contact Center at the numbers above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you. You can also file a grievance by mail, fax or e-mail:

Health Net of California, Inc.
P.O. Box 10348
Van Nuys, California, 91410-0348

Fax: 1-877-831-6019

E-mail: Non-Member.Discrimination.Complaints@healthnet.com

If your health problem is urgent, if you already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at

1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the (OCR) Complaint Portal, at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

SBID:

CONTACT US

For more information, please contact us at:

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

Health Benefit Navigators
1-800-539-4072 (English) TTY: 711
1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

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