A COMPLETE

explanation of your plan

Evidence of Coverage and
Plan Document
Health Net of California HMO
PLAN 69T

Important benefit information – please read.

Dear Health Net Member:

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

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

Thank you for choosing Health Net.

Schedule changes in 2006

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

Changes to this Plan

Copayments have been increased from $10 to $15 for the following:

Visit to Physician, Physician Assistant, or Nurse Practitioner at a contracting Physician Group $15
Visit to Physician, Physician Assistant, or Nurse Practitioner at a contracting Physician Group for treatment of Severe Mental Illness or Serious Emotional Disturbances of a Child $15
Specialist consultation $15
Physician visit to Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net) $15
Periodic health evaluation (2 years and older) $15
Vision or hearing examination $15
Allergy testing $15
Allergy injection services $15
Other immunizations (age 19 and older) $15
All other injections (including hormonal therapy related to a Gender Identity Disorder (GID)) $15
Physical therapy $15
Occupational therapy $15
Speech therapy $15
Respiratory therapy $15
Elective abortions in Contracting Physician Group's office $15
Sterilization of females in Contracting Physician Group's office $15
Sterilization of males in Contracting Physician Group's office $15
Surgery in Contracting Physician Group's office $15
Assistance at surgery in Contracting Physician Group's office $15

Changes made under Family planning:

Norplant Device:
Insertion, including the cost of the device ..... No longer covered
Voluntary removal (requested by Member) ..... Copayment is changed from 50% to $60

About This Booklet

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

Method of Provider Reimbursement

Health Net uses financial incentives and various risk sharing arrangements when paying providers. You may request more information about our payment methods by contacting the Member Services Department at the telephone number on your Health Net ID Card, your Physician Group or your Primary Care Physician.

Summary of Plan

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

Please read this *Evidence of Coverage* carefully.

Use of Special Words

Special words used in this *Evidence of Coverage* (EOC) to explain your Plan have their first letter capitalized and appear in "Definitions," Section 900.

The following words are used frequently:

- "**You**" refers to anyone in your family who is covered; that is, anyone who is eligible for coverage in this Plan and who has been enrolled.
- "**Employee**" has the same meaning as the word "you" above.
- "**We**" or "**Our**" refers to Health Net.
- "**Subscriber**" means the primary covered person, generally an Employee of a Group.
- "**Physician Group**" or "Participating Physician Group (PPG)" means the medical group the individual Member selected as the source of all covered medical care.
- "**Primary Care Physician**" is the individual Physician each Member selected who will provide or authorize all covered medical care.
- "**Group**" is the business entity (usually an employer or Trust) that contracts with Health Net to provide this coverage to you.
- "**Plan**" and "**EOC**" have similar meanings. You may think of these as meaning your Health Net benefits.

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Section-100

INTRODUCTION TO HEALTH NET

Subsection-A

How to Obtain Care

When you enroll in this Plan, you must select a contracting Physician Group where you want to receive all of your medical care. That Physician Group will provide or authorize all medical care.

Your Health Net ID Card shows your selected contracting Physician Group's name, address, and telephone number. Call them directly to make an appointment.

Some Hospitals and other providers do not provide one or more of the following services that may be covered under your *Evidence of Coverage* and that you or your Family Member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic or the Member Services Department at 1-800-522-0088 to ensure that you can obtain the health care services that you need.

Transition of Care For New Enrollees

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

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

For definitions of acute condition, serious chronic condition and terminal illness see “Definitions” section 900.

Health Net may provide coverage for completion of services from such a provider, subject to applicable Copayments and any exclusions and limitations of this Plan. You must request the coverage within 60 days of your Group’s effective date unless you can show that it was not reasonably possible to make the request within 60 days of your Group’s effective date, and you make the request as soon as reasonably possible. The nonparticipating provider must be willing to accept the same contract terms applicable to providers currently contracted with Health Net, who are not capitated and who practice in the same or similar geographic region. If the provider does not accept such terms, Health Net is not obligated to provide coverage with that provider.

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

Selecting a Contracting Physician Group

Family Members may select different contracting Physician Groups. However, each person must select a contracting Physician Group close enough to his or her residence or place of work to allow reasonable access to medical care. Please call the Member Services Department at the number shown on your Health Net I.D. Card if you need a provider directory or if you have questions involving reasonable access to care. The provider directory is also available on the Health Net website at *www.healthnet.com/uc.*

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

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

THE CONTINUED PARTICIPATION OF ANY ONE PHYSICIAN, HOSPITAL OR OTHER PROVIDER CANNOT BE GUARANTEED.

THE FACT THAT A PHYSICIAN OR OTHER PROVIDER MAY PERFORM, PRESCRIBE, ORDER, RECOMMEND OR APPROVE A SERVICE, SUPPLY OR HOSPITALIZATION DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY, OR MAKE IT A COVERED SERVICE.

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

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

Your Financial Responsibility
Your Physician Group will authorize and coordinate all your care, providing you with medical services or supplies. You are financially responsible only for any required Copayment described in "Schedule of Benefits and Copayments," Section 200.

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

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

Subsection-B

Emergency and Urgently Needed Care

WHAT TO DO WHEN YOU NEED MEDICAL CARE IMMEDIATELY

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

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

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

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

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

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

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

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

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

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

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

Definitions Related To Emergency And Urgently Needed Care

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

Emergency Care is any otherwise covered service that a reasonable person with an average knowledge of health and medicine would seek if he or she was having serious symptoms (including symptoms of Severe Mental Illness and Serious Emotional Disturbances of a Child), and believed that without immediate treatment, any of the following would occur:

His or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger);

His or her bodily functions, organs or parts would become seriously damaged; or.

His or her bodily organs or parts would seriously malfunction

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

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

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

Emergency Care will also include additional screening, examination, and evaluation by a Physician (or other health care provider acting within the scope of his or her license) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate such condition, within the capability of the facility.

Health Net will make any final decisions about Emergency Care.

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

Prescription Drugs

If you purchase a covered Prescription Drug for a medical Emergency or Urgently Needed Care from a Nonparticipating Pharmacy, this Plan will reimburse you for the retail cost of the drug less any required Copayment shown in “Schedule of Benefits and Copayments,” Section 200. You will have to pay for the Prescription Drug when it is dispensed.

To be reimbursed, you must file a claim with Health Net. Call our Member Services Department at the telephone number on your Health Net ID Card to obtain claim forms and information.

Note:

The Prescription Drugs portion of “Exclusions and Limitations,” Section 600, and the requirements of the Recommended Drug List also apply when drugs are dispensed by a Nonparticipating Pharmacy.

Section-200

SCHEDULE OF BENEFITS AND COPAYMENTS

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

Percentages shown below are based on amounts agreed to in advance by Health Net and the Member's Physician Group or other health care provider.

You must pay the stated Copayments when you receive the services. No more than one copayment per visit will apply to all Covered Services provided within the Contracting Physician Group's office selected by the Member. The amount of the copayment will be equal to the copayment required for the service received during that visit with the highest charge listed in this Section.

No copayments are required for children from birth to age 2 for routine preventive office visits, including covered immunizations.

Pediatric Immunizations are covered at no charge for children up to age 19 when not received as part of an office visit.

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

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

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

Exceptions

The emergency room or urgent care center Copayment will not apply:

- If you receive care from an emergency room or urgent care center operated by your Physician Group. (But a visit to one of their facilities will be considered an office visit, and any Copayment required for office visits will apply.)
- If you are admitted to a Hospital as an inpatient directly from the emergency room or urgent care center.

Office Visits

	Copayment
(See "Non-Severe Mental Disorders and Chemical Dependency Benefits" in this section for the applicable Copayments.)	
Visit to Physician, Physician Assistant, or Nurse Practitioner at a contracting Physician Group	$15
Visit to Physician, Physician Assistant, or Nurse Practitioner at a contracting Physician Group for treatment of Severe Mental Illness or Serious Emotional Disturbances of a Child	$15
Specialist consultation	$15
Physician visit to Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net)	$15
Periodic health evaluation (birth through 24 months)	$0
Periodic health evaluation (2 years and older)	$15
Vision or hearing examination	$15

Note

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

Hospital Visits by Physician

	Copayment
Physician visit to Hospital or Skilled Nursing Facility	$0

Allergy, Immunizations, and Injections

	Copayment
Allergy testing	$15
Allergy injection services	$15
Allergy serum	$0
Immunizations for occupational purposes or foreign travel	20%
Other immunizations (birth through age 18)	$0
Other immunizations (age 19 and older)	$15
Injections for Infertility	50%
All other injections (including hormonal therapy related to a Gender Identity Disorder (GID))	$15

Note

Injections for Infertility are not covered when provided in connection with services which are not covered by this Plan. (Refer to "Conception by Medical Procedures," portion of "Exclusions and Limitations," Section 600.)

Rehabilitation Therapy

	Copayment
Physical therapy	$15
Occupational therapy	$15
Speech therapy	$15
Respiratory therapy	$15

Note

These services will be covered when Medically Necessary.

Coverage for physical, occupational and speech rehabilitation therapy services is subject to certain limitations as described under the heading "Rehabilitation Therapy" of "Exclusions and Limitations," Section 600.

Care for Conditions of Pregnancy

	Copayment
Prenatal or postnatal office visit	$0
Newborn care office visit (birth through 30 days)	$0
Physician visit to the mother or newborn at a Hospital	$0
Normal delivery, including Cesarean section	$0
Complications of pregnancy, including Medically Necessary abortions	$0
Elective abortions in Contracting Physician Group's office	$15
Elective abortions in Hospital	$0
Genetic testing of fetus	$0
Circumcision of newborn (birth through 30 days)	$0

Note

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

Family Planning

	Copayment
Infertility services (all covered services that diagnose, evaluate, or treat Infertility)	50%
Sterilization of females in Contracting Physician Group's office	$15

Sterilization of females in Hospital.....$0
Sterilization of males in Contracting Physician Group's office $15
Sterilization of males in Hospital.....$0
Contraceptive devices ..... Not covered
Norplant Device:
Medically necessary removal $60
Voluntary removal (requested by Member) $60

Note

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

Other Professional Services

Copayment

Surgery in Hospital $0
Surgery in Contracting Physician Group's office.....$15
Transgender surgery $0
Assistance at surgery in Hospital $0
Assistance at surgery in Contracting Physician Group's office $15
Administration of anesthetics.....$0
Chemotherapy $0
Laboratory and X-ray services.....$0
Medical social services.....$0
Patient education.....$0
Nuclear medicine (use of radioactive materials) $0
Renal dialysis.....$0
Organ, tissue, or bone marrow transplant.....$0

Note

Surgery includes surgical reconstruction of a breast incident to a mastectomy, including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedemas.
Transgender surgery requires prior authorization from Health Net. Transgender surgery and services related to the surgery, that are authorized by Health Net are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member. Reasonable travel and lodging costs, as determined by Health Net, for a Member to undergo an authorized transgender surgery are included within the lifetime benefit maximum.

Medical Supplies

Copayment

Durable Medical Equipment, nebulizers (including face masks and tubing) and orthotics (such as bracing, supports and casts) $0
Diabetic supplies.....$0
Hearing Aids (2 standard Hearing Aids every 36 months up to $2,000 total benefit maximum)..... 50%
Corrective footwear..... 50%
Prostheses (internal or external) $0
Blood or blood products.....$0

Note

Diabetic Supplies and orthotics which are covered under medical supplies include blood glucose monitors, insulin pumps and corrective footwear. Please see "Diabetic Equipment" in "Covered Services and Supplies," Section 500.
A standard Hearing Aid is one that restores adequate hearing to the member and is determined to be Medically Necessary and authorized by the members Physician Group. If the member or physician choose a more expensive aid (such as a digital hearing aid) the member is responsible for any amount which exceeds the cost for a standard hearing aid.

Home Health Care Services

	Copayment
Home health visits	$0

Hospice Services

	Copayment
Hospice care	$0

Ambulance Services

	Copayment
Ground ambulance	$0
Air ambulance	$0

Inpatient Hospital Services

	Copayment
(See "Non-Severe Mental Disorders and Chemical Dependency Benefits" in this section for the applicable Copayments.)	
Room and board in a semi-private room or special care unit including ancillary (additional) services	$250
Room and board in a semi-private room or special care unit including ancillary (additional) services for treatment of Severe Mental Illness or Serious Emotional Disturbances of a Child	$250

Exception

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

Note

The above Copayment is applicable for each admission.

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

COPAYMENTS

Outpatient Hospital Services

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

Note

Other professional services performed in the outpatient department of a Hospital, such as a visit to a Physician (office visit), laboratory and X-ray services, physical therapy, etc., are subject to the same Copayment which is required when these services are performed at your Group Physician's office.

Look under the headings for the various services such as office visits, neuromuscular rehabilitation, and other professional services to determine the Copayment.

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

Skilled Nursing Facility Services

	Copayment
Room and board in a semiprivate room with ancillary (additional) services	$0

Limitation

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

Prescription Drug Benefits

Copayment

Retail Pharmacy (up to a 30 day supply)

Level I Drugs (primarily generic) listed in the Health Net Recommended Drug List $10
Level II Drugs (primarily brand), peak flow meters, inhaler spacers, insulin and diabetic supplies when listed in the Recommended Drug List $20
Level III Drugs (or drugs not listed in the Health Net Recommended Drug List) $35
Lancets $0
Smoking cessation drugs 50%
Sexual dysfunction drugs (including injections) (up to two doses per week or eight tablets per month) 50%
Oral Infertility drugs 50%
Contraceptive devices (Diaphragms and Cervical Caps only) $20
Diaphragm $20
Insulin $20

The Level II Brand Name Drug Copayment will be applicable for all covered Diabetic Supplies.

Insulin needles and syringes will be dispensed in the amount required by your Physician for a 30-day period. You must pay one copayment for the 30-day supply.

Blood Glucose monitoring test strips and lancets will be dispensed in 50-unit, 100-unit or 200-unit packages for each 30-day period. You must pay one Copayment for each package.

Maintenance Drugs through the Mail Order Program (up to a 90 day supply)

Level I Drugs (primarily generic) listed in the Health Net Recommended Drug List $20
Level II Drugs (primarily brand) listed in the Health Net Recommended Drug List $40
Level III Drugs (or Drugs not listed in the Health Net Recommended Drug List) $70

Notes:

You will be charged a Copayment or Coinsurance for each Prescription Drug Order.

Your financial responsibility for covered Prescription Drugs varies by the type of drug dispensed. For a complete description of Prescription Drug benefits, exclusions and limitations, please refer to the "Prescription Drugs" portions of the "Covered Services and Supplies" and the "Exclusions and Limitations" sections.

Copayment Exceptions:

If the pharmacy's usual and customary charge is less than the applicable Copayment, you will only pay the pharmacy's usual and customary charge.

Generic Drugs will be dispensed when a Generic Drug equivalent is available, unless the Prescription Drug Order states “do not substitute,” “dispense as written,” or words of similar meaning in the Physician’s handwriting, in which case the specified drug will be dispensed. However, when a Generic Drug equivalent is available and a Brand Name Drug is dispensed at your request, you must pay the following:

- The Level I Drug Copayment, plus
- The difference between the cost of the Generic Drug and the Brand Name Drug

However, if the Prescription Drug Order states "do not substitute", "dispense as written" or words of similar meaning in the Physician’s handwriting, only the Level II or Level III Drug Copayment, as appropriate, will be applicable.

Prior Authorization requirements and related Copayment exceptions are described in the "Prescription Drugs" portion of the "Covered Services and Supplies" section 500.

Percentage Copayments will be based on Health Net’s contracted pharmacy rate.

Mail Order:

Up to a 90-consecutive-calendar-day supply of covered Maintenance Drugs will be dispensed at the applicable mail order Copayment or Coinsurance. However, when the retail Copayment is a percentage, the mail order Copayment is the same percentage of the cost to Health Net as the retail Copayment.

Diabetic Supplies:

Diabetic supplies (blood glucose testing strips, lancets, disposable needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (i.e., 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 a 30-day period.

Smoking Cessation Drugs

Drugs prescribed for smoking cessation are covered up to a twelve-week course of therapy per Calendar Year if you are concurrently enrolled in a comprehensive smoking cessation behavioral support program. The prescribing Physician must request Prior Authorization for coverage. For information regarding smoking cessation behavioral support programs available through Health Net, contact Member Services at the telephone number on your Health Net ID Card or visit the Health Net website at *www.healthnet.com/uc.*

Sexual Dysfunction Drugs

Drugs (including injectable medications) when Medically Necessary for treating sexual dysfunction are limited to two doses per week or eight tablets per month. Sexual dysfunction drugs are not available through the mail order program.

Non-Severe Mental Disorders and Chemical Dependency Benefits

Telephonic consultations	***Copayment***
Telephonic clinical consultations (limited to a maximum of 3 consultations per member per calendar year)	$0

Note

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

Professional Services	***Copayment***
Office visit	$15
Outpatient group therapy sessions for Non-Severe Mental Disorders	$0
Outpatient group therapy sessions for Chemical Dependency	$5
Physician inpatient visit	$0

Facility Services	***Copayment***
Inpatient Hospital Services	$250
Detoxification	$250
Residential Chemical Dependency program	$250
Outpatient Hospital Services	$15

Exceptions

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

The Mental Disorder Copayments and day or visit limits will not apply for Severe Mental Illness or Serious Emotional Disturbances of a Child. Services for these mental conditions, as defined in "Definitions," Section 900, require whatever Copayment would be required if the services were provided for a medical condition. Look under the headings for the various services such as office visits, outpatient services and inpatient Hospital services to determine the applicable Copayment. All other Mental Disorders will be subject to the Copayments and limits shown above.

Note

The above Copayment is applicable for each admission.

Section-300

OUT-OF-POCKET MAXIMUM

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

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

The OOPM amounts for Calendar Year 2006 are:

One Member..... $1,000

Family (three or more Members)..... $3,000

Exceptions to OOPM

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

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

- Copayments made for Prescription Drug benefits. However, Copayments for peak flow meters and inhaler spacers used for the treatment of asthma and diabetic supplies dispensed through a Participating Pharmacy will be applied to the OOPM amount. Copayments for self-injectable drugs, which are covered under the medical benefit, will also be applied to the OOPM amount.
- Copayments made for treatment of Mental Disorders or Chemical Dependency benefits, except for Copayments paid for treatment for severe mental illness or serious emotional disturbances of a child.

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

How the OOPM Works

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

- If an individual Member pays amounts for covered services in a Calendar Year that equal the OOPM amount shown above for an individual Member, no further payment is required for that Member for the remainder of the Calendar Year.
- Once an individual Member in a Family satisfies the individual OOPM, the remaining enrolled Family Members must continue to pay the Copayments until either (a) the aggregate of such Copayments paid by the Family reaches the Family OOPM or (b) each enrolled Family Member individually satisfies the individual OOPM.
- If amounts for covered services paid for all enrolled Members equal the OOPM amount shown for a family, no further payment is required from any enrolled Member of that family for the remainder of the Calendar Year for those services.
- Only amounts that are applied to the individual Member's OOPM amount may be applied to the family's OOPM amount. Any amount you pay for covered services for yourself that would otherwise apply to your individual OOPM but exceeds the above stated OOPM amount for one Member will be refunded to you by Health Net, and will not apply toward your family’s OOPM. Individual Members cannot contribute more than their individual OOPM amount to the Family OOPM

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

Health Net may change the OOPM amount on the first day of any Calendar Year. The OOPM amount for the following year is published annually in the fourth quarter issue of the Health Net newsletter. You may also call the Member Services Department to find out what the OOPM amount is for your Plan.

Section-400

ELIGIBILITY, ENROLLMENT, AND TERMINATION

Subsection-A

Who Is Eligible for Coverage

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

The University of California establishes its own medical plan criteria for employees and retirees based on the University of California Group Insurance Regulations ("Regulation") and any corresponding Administrative Supplements. Portions of those regulations are summarized below.

Subscriber

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

* Lecturers - see your benefits office for eligibility.

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

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

You may continue University medical plan coverage as an Retiree when you start collecting retirement or disability benefits from a University-sponsored defined benefit plan. You must also meet the following requirements:

(a) you meet the University's service credit requirements for Retiree medical eligibility;
(b) the effective date of your Retiree status is within 120 calendar days of the date employment ends (or the date of the Employee/Retiree's death for a Survivor); and
(c) you elect to continue medical coverage at the time of retirement.

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

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

Eligible Dependents(Family Members)

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

Spouse

Your legal spouse

Child

All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors. The following categories are eligible:

(a) your natural or legally adopted children;
(b) your stepchildren (natural or legally adopted children of your spouse) if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
(c) grandchildren of you or your spouse if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
(d) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental disability may continue to be covered past age 23 provided:

- the incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous,
- the child is claimed as your dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income; and
- the child lives with you if he or she is not your or your spouse's natural or adopted child.

Application must be made to the Plan at least 31 days before the child's 23rd birthday and is subject to approval by the Plan. The Plan may periodically request proof of continued disability. Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an incapacitated child, you may also apply for coverage for that child. The child must have had continuous group medical coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility.

Other Eligible Dependents (Family Members)

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

Effective January 1, 2005, the University will recognize an opposite-sex domestic partner as a family member that is eligible for coverage in UC-sponsored benefits if the employee/retiree or domestic partner is age 62 or older and eligible to receive Social Security benefits and both the employee/retiree and domestic partner are at least 18 years of age.

An adult dependent relative is no longer eligible for coverage effective January 1, 2004. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003 may continue coverage in UC-sponsored plans.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, an Retiree, a Survivor or a Family Member, but not under any combination of these. If an Employee and the Employee's spouse or domestic partner are both eligible Subscribers, each may enroll separately or one may cover the other as a Family Member. If they enroll separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's or domestic partner's coverage but not under both. Additionally, a child who is also eligible as an Employee may not have dual coverage through two University-sponsored medical plans.

Subsection-B

How to Enroll for Coverage

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are an Retiree, contact the University's Customer Service Center. Enrollment transactions may be completed by paper form or electronically, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the Univer-

sity's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

Employee

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

Newly Acquired Dependents

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

Spouse: On the date of Marriage

Newborn Child: A child newly born to the Subscriber or his or her spouse is automatically covered from the moment of birth through the 31st day of life. In order for coverage to continue beyond the 30th day of life, the Subscriber must enroll the newborn child through the employer within the Period of Initial Eligibility. The newborn's Period of Initial Eligibility begins on the date of birth and ends on the last working day within the 31 day period following that date.

If the mother is the Subscriber's spouse and an enrolled Member, the child will be assigned to the mother's Physician Group and may not transfer to another Physician Group until the first day of the calendar month following the birth. If the mother is not enrolled, the child will be automatically assigned to the Subscriber's Physician Group. If you want to choose another Physician Group for that child, the transfer will take effect only as stated in the "Transferring to Another Contracting Physician Group" portion of this section.

Adopted Child: For an Adopted Child, the earlier of:

(i) the date you or your Spouse has the legal right to control the child's health care, or
(ii) the date the child is placed in your physical custody.
(iii) If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.
(iv) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you decline enrollment for yourself or your eligible Family Members because of other group medical plan coverage and you lose that coverage involuntarily (or if the employer stops contributing toward the other coverage for you or your Family Members), you may be able to enroll yourself and those eligible Family Members during a PIE that starts on the day the other coverage is no longer in effect.

If you are in an HMO, POS or EPO Plan and you move or are transferred out of that Plan's service area, or will be away from the Plan's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan. Your PIE starts with the effective date of the move or the date you leave the Plan's service area.

At Other Times For Employees And Retirees

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

If you are an Employee and opt out of medical coverage or fail to enroll yourself or your eligible Family Members during a PIE or open enrollment period, you may enroll yourself and/or eligible Family Members at any other time upon completion of a 90 consecutive calendar day waiting period. The 90-day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits office and ends 90 consecutive calendar days later.

If you are an Employee or Retiree and fail to enroll eligible Family Members during a PIE or open enrollment period, you may enroll your eligible Family Members at any other time upon completion of a 90 consecutive calendar day waiting period. The 90-day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits office and ends 90 consecutive calendar days later.

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

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

If you are an Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan (or its Medicare version) you were enrolled in immediately before retiring. You must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin).

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

Date Enrollment Effective

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

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

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

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

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

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

(a) the date the Child becomes eligible, or
(b) a maximum of 60 days prior to the date your Child's enrollment transaction is completed.

Change in Coverage

In order to change from single to adult plus child(ren) coverage, or two adult coverage, or family coverage, or to add another Child to existing family coverage, contact the person who handles benefits at your location (or the University's Customer Service Center if you are an Retiree).

Effect of Medicare on Retiree Enrollment
If you are an Retiree and you and/or an enrolled Family Member is or becomes eligible for premium free Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous. This includes anyone who is entitled to Medicare benefits through their own or their spouse's non-University employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan. Beginning January 1, 2004, Retirees or their Family Member(s) who become eligible for premium free Medicare Part A and do not enroll in Part B, will permanently lose their UC-sponsored medical coverage.

Retirees and their Family Members who were eligible for premium free Medicare Part A, but declined to enroll in Part B of Medicare before January 1, 2004, are assessed a monthly offset fee by the University to cover increased costs. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B. Retirees or Family Members who are not eligible for premium free Part A will not be required to enroll in Part B, they will not be assessed an offset fee nor lose their UC-sponsored medical coverage. Documentation attesting to their ineligibility for Medicare Part A will be required. (Retirees/Family Members who are not entitled to Social Security and premium free Medicare Part A will not be required to enroll in Part B.)

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

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

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

Upon Medicare eligibility, you or your Family Member must complete a University of California Medicare Declaration form as well as submit a copy of your Medicare card. This notifies the University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration form is available through the University's Customer Service Center. Completed forms should be returned to University of California, Human Resources and Benefits, Health & Welfare Administration-Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-9911.

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

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

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

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

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

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

Subsection-C

Transferring to Another Contracting Physician Group

As stated in the "Selecting a Contracting Physician Group" portion of "Introduction to Health Net," Section 100, each person must select a contracting Physician Group close enough to his or her residence or place of work to

allow reasonable access to care. Please call the Member Services Department at the telephone number on your Health Net ID Card if you have questions involving reasonable access to care.

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

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

Exceptions
Health Net will not permit a once-a-month transfer at the Member's option, if the Member is confined to a Hospital. However, if you believe you should be allowed to transfer to another contracting Physician Group because of unusual or serious circumstances and you would like Health Net to give special consideration to your needs, please contact our Member Services Department at the telephone number on your Health Net ID Card for prompt review of your request.

Effective Date of Transfer

If we receive your request for a transfer on or before the 15th day of the month, the transfer will occur on the first day of the following month. (Example: Request received March 12, transfer effective April 1.)

If we receive your request for a transfer on or after the 16th day of the month, the transfer will occur on the first day of the second following month. (Example: Request received March 17, transfer effective May 1.)

If your request for a transfer is not allowed because of a pregnancy, illness, injury, hospitalization, or surgery, and you still wish to transfer after the medical condition or treatment for it has ended, please call the Member Services Department to process the transfer request. The transfer in a case like this will take effect on the first day of the calendar month following:

- The date the pregnancy ends.
- The date the treatment for the condition causing the delay ends.

For a newly eligible child who has been automatically assigned to a Contracting Physician Group, the transfer will not take effect until the first day of the calendar month following the date the child first becomes eligible. (Automatic assignment takes place with *newborn* and *adopted* children, and is described in the "How to Enroll for Coverage" provision earlier in this section.)

Changes made during the open enrollment period would be effective on the following January 1. However, any transfer which requires Health Net's approval of a health status questionnaire will not take effect until the first day of the calendar month following the date of such approval.

Subsection-D

Termination of Coverage

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

Deenrollment Due to Loss of Eligible Status

If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month in which premiums are taken from earnings based on an eligible appointment.

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

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he

or she no longer meets all the eligibility requirements. For information on deenrollment procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are an Retiree).

Deenrollment Due to Fraud

Coverage for you or your Family Members may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Such termination shall be effective upon the mailing of written notice to the Subscriber (and to the University if notice is given by the Plan). A Family Member who commits fraud or deception will be permanently deenrolled while any other Family Member and the Subscriber will be deenrolled for 18 months. If a Subscriber commits fraud or deception, the Subscriber and any Family Members will be deenrolled for 18 months.

Leave of Absence, Layoff or Retirement

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

Individual Members that Establish Residency Outside the Health Net Service Area

You will become ineligible if you establishe your primary residency outside the Health Net Service Area and do not work inside that area.

However, a child subject to a Medical Child Support Order, according to state or federal law, who moves out of the Health Net Service Area does not cease to be eligible for this Plan. But, while that child may continue to be enrolled, coverage of care received outside the Health Net Service Area will be limited to services provided in connection with Emergency Care or Urgently Needed Care.

Termination for Cause

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

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

If coverage is terminated for any of the above reasons, you forfeit all rights to enroll in the Health Net conversion plan, COBRA plan or any plan that is owned or operated by Health Net's parent company or its subsidiaries and lose the right to re-enroll in Health Net in the future. The termination is effective immediately on the date Health Net mails the notice of termination, unless Health Net has specified a later date in that notice.

Health Net will conduct a fair investigation of the facts before any termination transfer for any of the above reasons is carried out.

Your health status or requirements for health care services will not determine eligibility for coverage. If you believe that coverage was terminated because of health status or the need for health services, you may request a review of the termination by the Director of the California Department of Managed Health Care.

Optional Continuation of Coverage

- If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice "Continuation of Group Insurance Coverage", available from the University "At Your Service" website (http://atyourservice.ucop.edu). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions

about these provisions to your local Benefits Office or to the University's Customer Service Center if you are an Retiree.

Coverage Options Following Termination

- Under the Consolidation Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, enrolled persons who would lose coverage under the Health Net medical plan due to certain "Qualifying Events" are entitled to elect, without having to submit evidence of good health, continued coverage at their own expense. Continued coverage shall be the same as for active eligible employees and their eligible dependents under the University group plan. If coverage is modified for active eligible employees and their eligible dependents, it shall also be modified in the same manner for persons with continued coverage (Qualified Beneficiaries) and an appropriate adjustment in premiums may be made.

  Right to Continue Benefits- A right under this part is subject to the rest of these provisions:

  The Subscriber has the right to continue benefits under the plan for himself/herself and any enrolled dependents if coverage would have ended for either of the following Qualifying Events:

- **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 18 months. Please check with your Group to determine if you are eligible. Employment ended for a reason other than gross misconduct; or
- Work hours were reduced (including approved leave without pay or layoff).

  Each eligible dependent has the right to continue benefits under the plan under the following circumstances:

  In the case of an eligible dependent spouse, the spouse may continue coverage for himself or herself and for any enrolled dependent children if the spouse's coverage would have ended because of any of the following Qualifying Events:

- The Subscriber's employment ended for a reason other than gross misconduct; or
- The Subscriber's work hours were reduced (including approved leave without pay or layoff); or
- The Subscriber's death; or
- The Subscriber became entitled to Medicare benefits; or
- The Subscriber's spouse ceased to be an eligible dependent as a result of divorce, legal separation, or annulment.

  If coverage ends because the Subscriber's spouse ceased to be an eligible dependent as a result of divorce, legal separation, or annulment, please see "Notice" below.

  In the case of an eligible dependent child, the child may continue coverage for himself or herself if the child's coverage would have ended because of any of the following Qualifying Events:

- The Subscriber's employment ended for a reason other than gross misconduct; or
- The Subscriber's work hours were reduced (including approved leave without pay or layoff); or
- The Subscriber's death; or
- The Subscriber became entitled to Medicare benefits; or
- The Subscriber's divorce, legal separation, or annulment; or
- The eligible dependent child ceased to be an eligible dependent under the rules of the plan.

  If coverage for an eligible dependent ends due to Subscriber's divorce, legal separation, annulment or the Dependent ceases to be an Eligible Dependent under the rules of the plan, please see "Notice" below.

  If the Subscriber becomes entitled to Medicare due to age within 18 months before employment ended for a reason other than gross misconduct or work hours were reduced (including approved leave without pay or

layoff), the eligible dependent spouse or eligible dependent child may continue COBRA coverage for up to 36 months counted from the date the Subscriber became entitled to Medicare.

If a second Qualifying Event occurs to a Qualified Beneficiary who already has continuation coverage because employment has ended or work hours were reduced, that Qualified Beneficiary's coverage may be continued up to a maximum of 36 months from the date of the first Qualifying Event.

Notice- If coverage for an eligible dependent ends due to divorce, legal separation, or annulment, or if the eligible dependent child ceased to be an eligible dependent under the rules of the plan, written notice must be given of the Qualifying Event to the Employer at the local Benefits Office within sixty (60) days of the event or eligibility to elect continuation coverage will be lost.

Continuation- Once aware of a Qualifying Event, the Employer will give written election notice of the right to continue coverage to you (or to the Qualified Beneficiary in the event of your death). Such notice will state the amount of the premium required for the continued coverage. If a person wants to continue the coverage, the Election Notice must be completed and returned to the address below, along with the first month's premium within sixty (60) days of the later of: (1) the date the Qualifying Event, or (2) the date the Qualified Beneficiary received notice informing the person of the right to continue.

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

Benefits of the continuation plan are identical to this group plan and cost is explained below under the "Cost of Continuation Coverage".

The continued coverage period runs concurrently with any other University continuation provisions (e.g., during leave without pay) except continuation under the Family and Medical Leave Act (FMLA). Coverage will be continued from the date it would have ended until the first of these events occurs:

With respect to the Subscriber and any Qualified Beneficiaries, the day 18 months from the earlier of the date: (a) employment ends for a reason other than gross misconduct, or (b) work hours are reduced. But, coverage may continue for all Qualified Beneficiaries for up to 11 additional months while the Qualified Beneficiary is determined to be disabled under Title II or XVI of the United States Social Security Act if:

- The disability was determined to exist at the time, or during the first 60 days, of the 18 months of COBRA coverage, and
- The person gives Health Net written notice of the disability within sixty (60) days after the determination of disability is made and within 18 months after the date employment ended or work hours were reduced.

Health Net must be notified if there is a final determination under the United States Social Security Act that the person is no longer disabled. The notice must be provided within thirty (30) days after the final determination. The coverage will end on the first of the month that starts more than thirty (30) days after the determination.

With respect to Qualified Beneficiaries (other than the Subscriber), the day 36 months from the earliest of the date: (a) of the Subscriber's death; or (b) of the Subscriber's entitlement to Medicare Benefits; (c) of the Subscriber's divorce, annulment or legal separation from a spouse; or (d) the dependent child ceases to be an eligible dependent under the rules of the Plan. The 36 months will be counted from the date of the earliest Qualifying Event.

With respect to any Qualified Beneficiary:

- If the person fails to make any premium payment required for the continued coverage, the end of the period for which the person has made required payments.
- The day the person becomes covered (after the day the person made the election for continuation coverage) under any other group health plan, on an insured or uninsured basis. This item by itself will not prevent coverage from being continued until the end of any period for which preexisting conditions are excluded or benefits for them are limited under the other health plan.
- The day the person becomes entitled to Medicare benefits.
- The day the Employer no longer provides group health coverage to any of its employees.

California Extension of Continuation Coverage (CalCOBRA)- Employees entitled to COBRA continuation coverage due to employment termination on or after January 1, 1996 are entitled to extend medical coverage for themselves and their spouses after the initial 18-month COBRA period ends, provided the employee was at least age 60 on the date employment ended, had worked for the University for at least five continuous years immediately prior to termination, and was eligible for and elected COBRA continuation medical plan coverage in connection with the termination of employment. The former spouse of an employee or former employee is entitled to CalCOBRA, provided the former spouse continued coverage under COBRA as a Qualified Beneficiary. This continuation does not apply to children of a former employee. This continuation will end on the earlier of:

- The date the individual turns 65;
- The date the University no longer maintains the group plan, including any replacement plan;
- The date the individual is covered by a group medical plan not maintained by the University;
- The date the individual becomes entitled to Medicare; or
- With respect to the spouse or former spouse only, the date five years from the date COBRA ends for the spouse or former spouse.

If the Employee's coverage terminates, the spouse may continue coverage until one of the terminating events applies to the spouse. Health Net will notify eligible COBRA Qualified Beneficiaries before the end of the maximum eighteen month COBRA continuation period. If an eligible individual wishes to continue the coverage they must apply, in writing, to the medical carrier no later than 30 days before the end of the COBRA continuation period.

Cost of Continuation Coverage- The cost of the coverage will include any portion previously paid by the Employer and shall not be more than 102% of the applicable group rate during the period of basic COBRA coverage; or not more than 150% any time during the 11-month disability extension period (i.e., during the 19th through 29th months); or not more than 213% during the extension period allowed by CalCOBRA.

For information on Open Enrollment actions for which a Qualified Beneficiary may be eligible and/or any applicable plan modification and premium adjustment, contact University of California Human Resources and Benefits at (800) 888-8267 during the month of November.

- **Conversion Coverage:** Described below in the subsection titled "Conversion Privilege."
- **Extension of Benefits:** Described below in the subsection titled "Extension of Benefits."
- Federal Health Insurance Portability and Accountability Act (HIPAA): makes it easier for people covered under existing group health plans to maintain coverage regardless of pre-existing conditions when they change jobs or are unemployed for brief periods of time. California law provides similar and additional protections. Applicants
- who meet the following requirements are eligible to enroll in a guaranteed issue individual health plan from any health plan that offers individual coverage, including Health Net's Guaranteed HMO Plans, without medical underwriting. A health plan cannot reject your application for guaranteed issue individual health coverage if you meet the following requirements, agree to pay the required premiums and live or work in the plan's service area. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance. To be considered an eligible individual:

    1. The applicant must have a total of 18 months of coverage (including COBRA, if applicable) without a significant break (excluding any employer-imposed waiting periods) in coverage of more than 63 days.
    2. The most recent coverage must have been under a group health plan. COBRA and Cal-COBRA coverage are considered group coverage.
    3. The applicant must not be eligible for coverage under any group health plan, Medicare or Medicaid, and must not have other health insurance coverage.
    4. The individual's most recent coverage could not have been terminated due to fraud or nonpayment of premiums.
    5. If COBRA coverage was available, it must have been elected and such coverage must have been exhausted. This would include the new Cal-COBRA for employers with 2 to 20 employees.

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

Subsection-E

Extension of Benefits

When Benefits May Be Extended

Benefits may be extended beyond the date coverage would ordinarily end if;

- You lose your Health Net coverage because the Group Service Agreement is discontinued, and you are ***totally disabled*** at that time; or
- You lose your coverage for any reason other than discontinuance of the Group Service Agreement and you are a ***registered bed patient*** in a Hospital or Skilled Nursing Facility when coverage ends, and the hospitalization was covered by this Plan.

When benefits are extended, you will not be required to pay subscription charges. However, the Copayments shown in "Schedule of Benefits and Copayments," Section 200, will continue to apply.

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

Benefits will not be extended if coverage was terminated for cause as stated in "When Coverage Can Be Termination for Cause" provision of "Eligibility, Enrollment and Termination," Section 400.

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

- For the Subscriber it means that because of an illness or injury, the Subscriber is unable to engage in employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience; furthermore, the Subscriber must not be employed for wage or profit.
- For a family member it means that because of an illness or injury, that person is prevented from performing substantially all regular and customary activities usual for a person of his or her age and family status.

How to Obtain an Extension

Member Is Confined to a Hospital

If you are confined to a Hospital or Skilled Nursing Facility when your coverage ends, benefits will be extended to you automatically. You do not have to do anything to make it happen.

When you are discharged from a Hospital or Skilled Nursing Facility, no further extension is available, unless your coverage ended because the Group Service Agreement ended.

If your coverage ended because the Group Service Agreement between Health Net and the Group was terminated, and you are totally disabled and want to continue to have extended benefits, you must send a written request to Health Net within 90 days of the discharge date. The request must include your Physician Group's written certification that you are totally disabled.

Member Is *Not* Confined to a Hospital

If a Member is totally disabled and not confined to a Hospital or Skilled Nursing Facility when the Agreement ends, send a written request to Health Net within 90 days of the date the Agreement terminates. The request must include written certification by the Member's Physician Group that the Member is totally disabled.

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

When the Extension Ends

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

1. **For extensions provided only because of Hospital confinement:** If the Agreement between Health Net and the Group **has not been** terminated, then the Extension of Benefits will end on the earliest of the following dates:
   a. On the date the Member is discharged from the Hospital or Skilled Nursing Facility, even if the total disability continues.
   b. On the date the Member becomes covered by another private or group health insurance policy or plan.
   c. On the date that available benefits are exhausted.
2. **For extensions provided because of total disability which may or may not involve hospitalization:** If the Agreement between Health Net and the Group **has been** terminated, then the extension of benefits will end on the earliest of the following dates:
   a. On the date the Member is no longer totally disabled.
   b. On the date the Member becomes covered by a replacement health policy or plan obtained by the Group, and this coverage has no limitation for the disabling condition.
   c. On the date that available benefits are exhausted.
   d. On the last day of the 12-month period following the date the extension began, unless the Member is confined in a Hospital or Skilled Nursing Facility on that date for the disabling condition.

Other Coverage Affects Extension of Benefits

Other Group Coverage

Extended benefits will end as stated in #1 and #2 in the section immediately above titled “When the Extension Ends.”

If other group coverage exists that does not cause the extension of benefits to end, such as coverage through a new job or coverage that existed before the loss of Health Net coverage, Health Net will obtain reimbursement from the other Plan through the Coordination of Benefits process.

Also, when another health maintenance organization provides that coverage, Health Net may arrange for that HMO to be responsible for continuing medical care.

- **COBRA Continuation Coverage**
  If your Health Net coverage continues because you were eligible for and obtained federal COBRA continuation coverage, you have not yet lost your Health Net coverage. If you are still totally disabled when the COBRA continuation coverage ends, you may try to obtain an extension as described above in the section titled "How to Obtain an Extension."

- **Conversion Coverage**
  Conversion coverage affects extension of benefits when:

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

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

Subsection-F

Conversion Privilege

Who Is Eligible for Conversion Coverage

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

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

Who Is Not Eligible for Conversion Coverage

The following people are not eligible for conversion coverage:

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

How to Apply for Conversion Coverage

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

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

Conversion coverage must become effective immediately following the date Group coverage ends. There can be no lapse in coverage.

Section-500

COVERED SERVICES AND SUPPLIES

You are entitled to receive Medically Necessary services and supplies described below when they are authorized according to procedures Health Net and the contracting Physician Group have established. The fact that a Physician or other provider may perform, prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary, or make it a covered service.

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

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

Subsection-A

Medical Services and Supplies

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

Health Evaluations
For preventive health purposes, a periodic health evaluation and diagnostic preventive procedures are covered, based on recommendations published by the U.S. Preventive Services Task Force.

Vision and Hearing Examinations
Eye and ear examinations to determine the need for correction of vision and hearing are covered.

Obstetrician and Gynecologist (OB/GYN) Self-Referral
If you are a female Member you may obtain OB/GYN Physician services without first contacting your Primary Care Physician.

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

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

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

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

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

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

In addition, injectable medications (including Glucagon) approved by the FDA are covered for the Medically Necessary treatment of medical conditions when prescribed by the Member's Primary Care Physician and authorized by Health Net.

Self-injectable Drugs (other than insulin), needles and syringes used with these self-injectable drugs must be obtained through Health Net's contracted Specialty Pharmacy Vendor when Prior Authorization is obtained from

Health Net. Upon approval, Health Net will arrange for the distribution of drugs, needles and syringes from the appropriate Specialty Pharmacy Vendor. The Specialty Pharmacy Vendor will charge you for the appropriate Copayment or Coinsurance shown in "Schedule of Benefits and Copayments," Section 200.

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

Laboratory and X-ray Services
Laboratory and x-ray services and materials are covered.

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

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

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

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

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

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

"Routine patient care costs" are the costs associated with the standard provisions of Health Net, including drugs, items, devices, and services that would normally be covered under this *Evidence of Coverage,* if they were not provided in connection with a clinical trials program.

Please refer to the "All Services and Supplies" portion of "Exclusions and Limitations" Section 600 for more information.

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

Pregnancy
The coverage described below meets requirements for Hospital length of stay under the **Newborns' and Mothers' Health Protection Act of 1996**. Hospital and professional services for conditions of pregnancy are covered, including prenatal and postnatal care, delivery and newborn care. In cases of identified high-risk pregnancy, prenatal diagnostic procedures and genetic testing of the fetus are also covered. Please refer to the "Schedule of Benefits and Copayments," Section 200, for Copayment requirements.

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

If you are discharged earlier, your Physician may decide, at his or her discretion, that you should be seen at home or in the office within 48 hours of the discharge by a licensed health care provider whose scope of practice includes postpartum care and newborn care.

Abortions

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

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

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

Family Planning

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

Included in these other services are:

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

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

All other contraceptive services, supplies, or devices are not covered, except as stated in the "Prescription Drugs" portion of this section.

Medical Social Services

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

Patient Education

Wellness and other educational programs, including diabetes management programs, asthma management programs and counseling for conditions such as elevated cholesterol and obesity, are covered. These programs provide information on how to prevent illness or injury, and how to maintain good health. These services are provided by your Physician Group.

Home Health Care

The services of a Home Health Care Agency in the Member’s home are covered.

The Primary Care Physician will set up a treatment plan describing the length, type, and frequency of the visits to be provided.

These visits may include (but are not limited to) skilled nursing services, medical social services, infusion services, rehabilitation therapy (including physical, speech and occupational), pulmonary rehabilitation therapy and cardiac rehabilitation therapy. However, Custodial Care services, as described in the "Definitions" section 900 and private duty nursing are not covered. This treatment plan will be reviewed in the authorization process.

Ambulance Services

Air and ground ambulance services are covered.

The contracting Physician Group may order the ambulance themselves when they know of your need in advance. If circumstances result in you or others ordering an ambulance, your Physician Group must still be contacted as soon as possible, and they must authorize the services. All ambulance services provided as a result of a “911” emergency response system call will be covered, if the request was made for Emergency Care.

Hospice Care

Hospice care is available for Members diagnosed as terminally ill by a Member Physician and the contracting Physician Group. To be considered terminally ill, a Member must have been given a medical prognosis of one year or less to live.

Hospice care includes Physician services, counseling, medications, other necessary services and supplies, and homemaker services. The Member Physician will develop a plan of care for a Member who elects Hospice care.

In addition, up to five consecutive days of inpatient care for the Member may be authorized to provide relief for relatives or others caring for the Member.

Corrective Footwear

Corrective footwear for conditions not related to diabetes is covered as follows: one pair of custom-molded shoes (including inserts provided with the shoes) and/or three pairs of inserts (not including the non-customized removable inserts provided with the shoes) are covered per Calendar Year. Corrective footwear for the management and treatment of diabetes are covered under the "Diabetic Equipment" benefit as Medically Necessary.

Corrective footwear for the management and treatment of diabetes are covered as described under the "Diabetic Equipment" provision in this section.

Durable Medical Equipment

Durable Medical Equipment, which includes but is not limited to wheelchairs, crutches , bracing, supports, casts, nebulizers (including face masks and tubing) and Hospital beds, is covered and will be repaired or replaced when necessary. However, repair or replacement for loss or misuse is not covered. Health Net will decide whether to repair or replace an item. Durable Medical Equipment may have quantity limits or may not be covered as they are considered primarily for non-medical use. Nebulizers (including face masks and tubing) are not subject to quantity limits.

Diabetic Equipment

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

- Insulin pumps and all related necessary supplies
- Corrective footwear to prevent or treat diabetes-related complications
- Specific brands of blood glucose monitors and blood glucose testing strips*
- Blood glucose monitors designed to assist the visually impaired
- Ketone urine testing strips*
- Lancets and lancet puncture devices*
- Reusable pen delivery systems for the administration of insulin, including pen needles*
- Disposable insulin needles and syringes*

* These items (as well as insulin and Prescription Drugs for the treatment and management of diabetes) are covered under the Prescription Drug benefits. Please refer to the "Prescription Drugs" portion of this section for additional information.

Additionally, the following supplies are covered under the medical benefit as specified:

- Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin are provided through the prostheses benefit (see the "Prostheses" portion of this section).
- Glucagon is provided through the self-injectables benefit (see the "Immunization and Injections" portion of this section).

Self-management training, education and medical nutrition therapy will be covered, only when provided by licensed health care professionals with expertise in the management or treatment of diabetes. Please refer to the "Patient Education" portion of this section for more information.

Self-management training and education will be covered, if provided by licensed health care professionals with expertise in the management or treatment of diabetes.

Hearing Aids

Standard hearing devices inserted in or affixed to the outer ear to restore adequate hearing to the Member and are determined to be Medically Necessary and authorized by the Member's contracting Physician Group. Please refer to the "Schedule of Benefits" for more information.

Organ, Tissue, and Bone Marrow Transplants

Organ, tissue, and bone marrow transplants that are not Experimental or Investigational, are covered only if the transplant is authorized by Health Net and performed at a Health Net designated transplant center.

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

Medical Services, in connection with an organ, bone marrow or tissue transplant are covered as follows:

- For the enrolled Member who receives the transplant; and
- For the donor (whether or not an enrolled member). Benefits are reduced by any amounts paid or payable by the donor's own coverage.

Organ donation extends and enhances lives and is an option that you may want to consider. For more information on organ donations, including how to elect to be an organ donor, the subject please contact Member Services at the telephone number on the Health Net ID Card, or visit the Department of Health and Human Services organ donation website at www.organdonor.gov.

Prostheses

Internal and external prostheses required to replace a body part are covered. Examples are artificial legs, surgically implanted hip joints, devices to restore speaking after a laryngectomy and visual aids (excluding Eyewear) to assist the visually impaired with proper dosing of insulin.

Also covered are internally implanted devices such as heart pacemakers.

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

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

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

Blood

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

Inpatient Hospital Confinement

Care in a room of two or more beds or in a licensed special treatment unit is covered. Benefits for a private room are limited to the Hospital's most common charge for a two-bed room, unless a private room is determined to be Medically Necessary.

Outpatient Hospital Services

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

Professional services performed in the outpatient department of a Hospital (including but not limited to a visit to a Physician, rehabilitation therapy including physical, occupation, speech, and respiratory therapy, laboratory tests, X-rays, and radiation therapy) are subject to the same Copayment which is required when these services are performed at your Physician's office.

Copayments for surgery performed in a Hospital or outpatient surgery center may be different than copayments for professional or outpatient Hospital facility services. Please refer to "Outpatient Hospital Services" in "Schedule of Benefits and Copayments," Section 200 for more information.

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

Reconstructive Surgery

Reconstructive surgery to restore and achieve symmetry including surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease, to do either of the following:

- Improve function; or
- Create a normal appearance to the extent possible, unless the surgery offers only a minimal improvement in the appearance of the Member.

This does not include cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance or dental services or supplies or treatment for disorders of the jaw except as set out under "Dental Services" and "Disorders of the Jaw" portions of "Exclusions and Limitations," Section 600.

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

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

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

Skilled Nursing Facility

Care in a room of two or more is covered. Benefits for a private room are limited to the Hospital's most common charge for a two-bed room, unless a private room is Medically Necessary.

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

Benefits are limited to the number of days of care stated in “Schedule of Benefits and Copayments,” Section 200.

Phenylketonuria (PKU)

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

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

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

Other specialized formulas and nutritional supplements are not covered.

Second Opinion by a Physician

You have the right to request a second opinion when:

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

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

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

Surgically Implanted Drugs

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

Transgender Surgery and Services

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

Subsection-B

Prescription Drugs

Please read the "Prescription Drugs" portion of "Exclusions and Limitations," Section 600.

Covered Drugs and Supplies

Prescription Drugs must be dispensed for a condition, illness or injury that is covered by this Plan. Refer to the "Exclusion and Limitations" section 600, to find out if a particular condition is not covered.

Level I Drugs (Primarily Generic) and Level II Drugs (Primarily Brand)

Level I and Level II Drugs listed in the Health Net Recommended Drug List (also referred to as "the List") are covered, when dispensed by Participating Pharmacies and prescribed by a Physician from your selected Physician Group, an authorized referral Specialist or an emergent or urgent care Physician. Some Level I and Level II Drugs require Prior Authorization from Health Net in order to be covered. The fact that a drug is listed in the Recommended Drug List does not guarantee that your Physician will prescribe it for you for a particular medical condition.

Level III Drugs

Level III Drugs are Prescription Drugs that may be Generic Drugs or Brand Name Drugs, and are either:

- Specifically listed as Level III on the Recommended Drug List; or
- Not listed in the Health Net Recommended Drug List and are not excluded or limited from coverage.

Some Level III Drugs that are not on the List require Prior Authorization from Health Net to be covered. Some Prescription Drugs require Prior Authorization from Health Net in order to be covered.

Please refer to the “Recommended Drug List” portion of this section for more details.

Generic Equivalents to Brand Name Drugs

Generic Drugs will be dispensed instead of a Brand Name Drug when a Generic Drug equivalent is available, unless the Prescription Drug Order states “do not substitute,” “dispense as written,” or words of similar meaning in the Physician’s handwriting, in which case the specified drug will be dispensed. However, when a Generic Drug equivalent is available and a Brand Name Drug is dispensed at your request, you must pay the following:

- The Level I Drug Copayment, plus
- the difference between the cost of the Generic Drug and the Brand Name Drug.

However, if the Prescription Drug Order states "do not substitute," "dispense as written," or words of similar meaning in the Physician’s handwriting, only the Level II or Level III Drug Copayment, as appropriate, will be applicable.

Off-Label Drugs

A Prescription Drug prescribed for a use that is not stated in the indications and usage information published by the manufacturer is covered only if the drug is:

- Approved by the Food and Drug Administration.
- Prescribed or administered by a participating licensed health care professional for the treatment of:
    1. A life-threatening condition; or
    2. A chronic and seriously debilitating condition in which the drug is determined to be Medically Necessary to treat such condition.
- Recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following:
    1. The American Medical Association Drug Evaluations.
    2. The American Hospital Formulary Service Drug Information.

3. The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional."
4. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

- Otherwise Medically Necessary.

The following definitions apply to the terms mentioned in this provision only.

"Life-threatening" means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

"Chronic and seriously debilitating" refers to diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

Diabetic Drugs and Supplies

Prescription Drugs for the treatment of diabetes (including insulin) are covered as stated in the Recommended Drug List. Diabetic supplies are also covered including but not limited to reusable pen delivery systems, disposable insulin needles and syringes, disposable insulin pen needles, specific brands of blood glucose monitors and testing strips, Ketone test strips, lancet puncture devices and lancets when used in monitoring blood glucose levels. Additional supplies are covered under the medical benefit. Please refer to the "Medical Services and Supplies" portion of this Section under “Diabetic Equipment,“ for additional information. Refer to "Schedule of Benefits and Copayments," Section 200, for details about the supply amounts that are covered and the applicable Copayment.

Drugs and Equipment for the Treatment of Asthma

Prescription Drugs for the treatment of asthma are covered as stated in the Recommended Drug List. Inhaler spacers and peak flow meters used for the management and treatment of asthma are covered when Medically Necessary. Nebulizers (including face masks and tubing) are covered under the medical benefit. Please refer to the “Medical Services and Supplies” portion of this section under “Durable Medical Equipment” for additional information.

Smoking Cessation Coverage

Drugs that require a prescription in order to be dispensed for the relief of nicotine withdrawal symptoms are covered for the course of therapy stated in the "Prescription Drugs" portion of "Exclusions and Limitations," Section 600 and if the Member is concurrently enrolled in a comprehensive smoking cessation behavioral support program. The prescribing Physician must request Prior Authorization for coverage. For information regarding smoking cessation behavioral support programs available through Health Net, contact Member Services at the telephone number on your Health Net ID Card or visit the Health Net website at *www.healthnet.com/uc* .

Sexual Dysfunction Drugs

Drugs that establish, maintain or enhance sexual functioning are covered for sexual dysfunction when Medically Necessary. These Prescription Drugs are covered for up to the number of doses or tablets stated in the "Prescription Drugs" portion of "Schedule of Benefits and Copayments," Section 200.

Contraceptives

Oral contraceptives and emergency contraceptives are covered. Vaginal contraceptive devices include diaphragms and cervical caps, and are only covered when a Member Physician performs a fitting examination and prescribes the device. Such devices are only available through a prescription from a pharmacy and limited to one fitting and prescription per Calendar Year unless additional fittings or devices are Medically Necessary. For a complete list of contraceptive products covered under the Prescription Drug benefit, please refer to the Recommended Drug List. Injectable contraceptives are covered as a medical benefit when administered by a Physician.

Please refer to "Schedule of Benefits and Copayments," Section 200, under the heading "Family Planning" for information regarding contraceptives covered under the medical benefit. Additional contraceptive supplies and devices may be covered, refer to the "Medical Services and Supplies" portion of this section under the heading "Family Planning" for more information.

Appetite Suppressants or Drugs for Body Weight Reduction

Drugs that require a prescription in order to be dispensed for the treatment of obesity are covered when Medically Necessary for the treatment of morbid obesity as determined by Health Net. The prescribing Physician must request Prior Authorization for coverage.

The Recommended Drug List

What Is the Health Net Recommended Drug List?

Health Net developed the Recommended Drug List 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 Physicians and Specialists that they refer to this List when choosing drugs for patients who are Health Net Members. When your Physician prescribes medications listed in the Recommended Drug List, it is ensured that you are receiving a high quality and high value prescription medication. In addition, the Recommended Drug List identifies whether a Generic version of a Brand Name Drug exists, and whether the drug requires Prior Authorization. If the Generic version exists, it will be dispensed instead of the Brand Name version.

You may call the Member Services Department at the telephone number on your Health Net ID Card to find out if a particular drug is listed in the Recommended Drug List. You may also request a copy of the current List, and it will be mailed to you. The current List is also available on the Health Net website at *www.healthnet.com/uc*.

How Are Drugs Chosen for the Health Net Recommended Drug List?

The List is created and maintained by the Health Net Pharmacy and Therapeutics Committee. Before deciding whether to include a drug on the List, the Committee reviews medical and scientific publications, relevant utilization experience and Physician recommendations to assess the drug for its:

- Safety
- Effectiveness
- Cost-effectiveness (when there is a choice between two drugs having the same effect, the less costly drug will be listed)
- Side effect profile
- Therapeutic outcome

This Committee has quarterly meetings to review medications and to establish policies and procedures for drugs included in the List. The Recommended Drug List is updated as new clinical information and medications are approved by the FDA.

Who Is on the Health Net Pharmacy and Therapeutic Committee and How Are Decisions Made?

The Committee is made up of actively practicing Physicians of various medical specialties from Health Net Physician Groups, as well as clinical pharmacists. Voting members are recruited from contracting Physician Groups throughout California based on their experience, knowledge and expertise. In addition, the Pharmacy and Therapeutics Committee frequently consults with other medical experts to provide additional input to the Committee. A vote is taken before a drug is added to the Recommended Drug List. The voting members are not employees of Health Net. This ensures that decisions are unbiased and without conflict of interest.

Prior Authorization Process

Prior Authorization status is included in the Recommended Drug List – The List identifies which drugs require Prior Authorization. A Physician must get approval from Health Net before writing a Prescription Drug Order for a drug that is listed as requiring Prior Authorization, in order for the drug to be covered by Health Net. If a drug is not on the List, your Physician should call Health Net to determine if the drug requires Prior Authorization.

Urgent requests from Physicians are handled 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. Routine requests from Physicians are processed in a timely fashion, not to exceed 5 days, 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. Requests may be submitted by telephone or facsimile. Health Net will evaluate the submitted information upon receiving your Physician's request for Prior Authorization 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 Pharmacy and Therapeutics Committee as well as Physician experts. Your Physician may contact Health Net to obtain the usage guidelines for specific medications.

Once a medication is approved, its authorization becomes effective immediately.

Retail Pharmacies and the Mail Order Program

Purchase Drugs at Participating Pharmacies

You must purchase covered drugs at a Participating Pharmacy to receive the highest available benefits for Prescription Drugs under this Plan.

Health Net is contracted with many major pharmacies, supermarket-based pharmacies and privately owned pharmacies in California. To find a conveniently located Participating Pharmacy please visit our website at www.healthnet.com/uc or call the Member Services Department at the telephone number on your Health Net ID Card. Present the Health Net ID Card and pay the appropriate Copayment when the drug is dispensed.

Up to a 30-consecutive-calendar-day supply is covered for each Prescription Drug Order. 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. Medications taken on an "as-needed" basis may have a copayment based on a standard package, vial, ampoule, tube, or other standard units. 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.

If refills are stipulated on the Prescription Drug Order, a Participating Pharmacy may dispense up to a 30-consecutive-calendar-day supply for each Prescription Drug Order or for each refill at the appropriate time interval. If the Health Net ID Card is not available or eligibility cannot be determined:

- Pay the entire cost of the drug; and
- Submit a claim for possible reimbursement.

Health Net will reimburse you for the cost of the Prescription Drug, less any required Copayment shown in the "Schedule of Benefits and Copayments," Section 200.

Nonparticipating Pharmacies and Emergencies

During the first 30 days of your coverage, Prescription Drugs will be covered if dispensed by a Nonparticipating Pharmacy, but only if you are a new Member and have not yet received your Health Net ID Card. After 30 days, Prescription Drugs dispensed by a Non-Participating Pharmacy will be covered only for Emergency Care or Urgently Needed Care, as defined in "Definitions," Section 900.

If the above situations apply to you:

- Pay the full cost of the Prescription Drug that is dispensed; and
- Submit a claim to Health Net for possible reimbursement.

Health Net will reimburse you Prescription Drug covered expenses, less any required Copayment shown in "Schedule of Benefits and Copayments," Section 200.

If you present a Prescription Order for a Brand Name Drug, the pharmacist will offer a Generic Drug equivalent if commercially available. In cases of Emergency or Urgently Needed Care, you should advise the treating Physician of any drug allergies or reactions, including to any Generic Drugs.

There are no benefits through Nonparticipating Pharmacies after 30 days of coverage or if the Prescription Drug was not purchased for Emergency or Urgently Needed Care.

Note: The "Prescription Drug" portion of "Exclusions and Limitations," Section 600 and the requirements of the Recommended Drug List described above still apply when Prescription Drugs are dispensed by a Nonparticipating Pharmacy.

Claim forms will be provided by Health Net upon request or may be obtained from the Health Net website at www.healthnet.com/uc..

Drugs Dispensed by Mail Order

If your prescription is for a Maintenance Drug, you have the option of filling it through our convenient mail order program. To receive Prescription Drugs by mail send the following to the designated mail order administrator:

- The completed Prescription Mail Order Form;
- The original Prescription Drug Order (not a copy) written for up to a 90-consecutive-calendar-day-supply of a Maintenance Drug, when appropriate; and
- The appropriate Copayment.

You may obtain a Prescription Mail Order Form and further information by contacting the Member Services Department at the telephone number on your Health Net ID Card.

The mail order administrator may dispense up to a 90-consecutive-calendar-day supply of a covered Maintenance Drug and each refill allowed by that order. In some cases, a 90-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan, according to Food and Drug Administration (FDA) or Health Net's usage guidelines. If this is the case, the mail order may be less than a 90-consecutive-calendar-day supply.

UC members can also obtain their mail order prescriptions at a designated UC Medical Center pharmacy. To locate a UC Medical Center pharmacy, a listing is provided on the HR/Benefits website or contact Health Net customer service.

Note: Schedule II narcoticdrugs are not covered through our mail order program. Refer to the "Prescription Drug" portion of the "Exclusions and Limitations" section for more information.

Subsection-C

Mental Disorders and Chemical Dependency

Please read the " Mental Disorders or Chemical Dependency)" portion of "Exclusions and Limitations," Section 600.

The Mental Health and Chemical Dependency benefits are administered by a specialized health care service plan which contracts with Health Net to underwrite and administer these benefits.

To be covered, the Behavioral Health Administrator must authorize these services and supplies. In an emergency, call “911” or contact the Behavioral Health Administrator at the telephone number shown on your Health Net ID Card before receiving care.

The Behavioral Health Administrator will refer you to a nearby Participating Mental Health Professional. That professional will evaluate you. If you need treatment, the Participating Mental Health Professional will develop a treatment plan, and submit that plan to the Behavioral Health Administrator for review. When authorized by the Behavioral Health Administrator the proposed services will be covered by this Plan.

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

Transition of Care For New Enrollees

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

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

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

The following benefits are provided:

Outpatient Services

Outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy, and rehabilitative care are covered for up to the maximum number of visits shown in “Schedule of Benefits and Copayments," Section 200. Medication management care is also covered when appropriate.

Second Opinion

You may request a second opinion when:

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

To request an authorization for a second opinion contact the Behavioral Health Administrator. Participating Mental Health Professionals will review your request in accordance with the Behavioral Health Administrator’s second opinion policy. When you request a second opinion, you will be responsible for any applicable Copayments.

Second opinions will only be authorized for Participating Mental Health Professionals, unless it is demonstrated that an appropriately qualified Participating Mental Health Professional is not available. The Behavioral Health

Administrator will ensure that the provider selected for the second opinion is appropriately licensed and has expertise in the specific clinical area in question.

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

Inpatient Services

Inpatient treatment of a Mental Disorder or Chemical Dependency is covered for up to the maximum number of days shown in “Schedule of Benefits and Copayments," Section 200, under the “Inpatient Hospital Services”.

Covered services and supplies include:

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

Telephonic Consultations

Telephonic clinical consultations is covered for up to the maximum number of consultations shown in “Schedule of Benefits and Copayments," Section 200”.

Detoxification

Inpatient services for acute detoxification and treatment of acute medical conditions relating to Chemical Dependency are covered, except as stated in the "Mental Disorders and Chemical Dependency" portion of "Exclusion and Limitations," Section 600.

Serious Emotional Disturbances of a Child (SED)

The treatment and diagnosis of Serious Emotional Disturbances of a Child under the age of 18 is covered as shown in "Schedule of Benefits and Copayments," Section 200.

Severe Mental Illness

Treatment of Severe Mental Illness is covered as shown in "Schedule of Benefits and Copayments," Section 200. Look under the headings for office visits, outpatient services and inpatient hospital services to determine the applicable Copayment.

Covered services include treatment of:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder (including Autistic Disorder, Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders)
- Autism
- Anorexia nervosa
- Bulimia nervosa

Section-600

EXCLUSIONS AND LIMITATIONS

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

Subsection-A

Services and Supplies

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

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

Clinical Trials

Although routine patient care costs for clinical trials are covered, as described in the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 500, coverage for clinical trials does not include the following items:

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

Custodial or Domiciliary Care

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

Custodial Care is not covered even when the patient is under the care of a supervising or attending Physician and services are being ordered and prescribed to support and generally maintain the patient's condition, or provide for the patient's comforts, or ensure the manageability of the patient. Furthermore, Custodial Care is not covered even if ordered and prescribed services and supplies are being provided by a registered nurse, a licensed vocational nurse, a licensed practical nurse, a Physician Assistant or physical therapist.

Disposable Supplies for Home Use

This Plan does not cover disposable supplies for home use.

Experimental or Investigational Services

Experimental or Investigational drugs, devices, procedures or other therapies are generally not covered except when:

- Independent review deems them appropriate, please refer to the "Independent Medical Review of Investigational or Experimental Therapies" portion of "General Provisions," Section 700 for more information;
- Clinical trials for cancer patients are deemed appropriate according to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 500.

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

Ineligible Status
This Plan does not cover services or supplies provided before the Effective Date of coverage. Services or supplies provided after coverage through this Plan has ended are not covered, except as specified in the "Extension of Benefits" portion of “Eligibility, Enrollment and Termination,” Section 400.

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

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

Personal or Comfort Items
This Plan does not cover personal or comfort items.

Unlisted Services
This Plan does not cover services or supplies that are not specified as covered services or supplies in this *EOC,* unless coverage is required by state or federal law.

Subsection-B

Medical Services and Supplies

In addition to the exclusions and limitations shown in the “Services and Supplies" portion of this section, the following exclusions and limitations apply to medical services and supplies:

Acupuncture
This Plan does not cover any expenses related to the puncture of the skin for diagnostic or therapeutic (counter-irritation) purposes either manually through the use of needles or electrically through the use of needles or the Transcutaneous Electrical Nerve Stimulation (TENS) device.

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

This Plan does not cover treatments which use umbilical cord blood, cord blood stem cells or adult stem cells (nor their collection, preservation and storage) as such treatments are considered to be Experimental or Investigational in nature. See “General Provisions,” Section 700, for the procedure to request an Independent Medical Review of a Plan denial of coverage on the basis that it is considered Experimental or Investigational.

Chiropractic Services
This Plan does not cover Chiropractic services or supplies regardless of contracting Physician Group approval.

Conception by Medical Procedures
Artificial insemination is covered when a female Member and/or her male partner is infertile (refer to Infertility in "Definitions" section 900). However, if only the male partner is a Member and the female partner (who is not a Member) is infertile, artificial insemination will not be covered. The collection, storage or purchase of sperm is not covered.

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

- In-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or any process that involves harvesting, transplanting, or manipulating a human ovum. Also not covered are services or supplies (including injections and injectable medications) which prepare the Member to receive these services.
- Collection, storage or purchase of sperm or ova.

Contraceptives

Vaginal, oral contraceptives and emergency contraceptives are covered as described in the "Prescription Drugs" portion of "Covered Services and Supplies" Section 500. Vaginal contraceptives are include diaphragms and cervical caps, and are only covered when a Physician performs a fitting examination and prescribes the device. Such devices are only available through a prescription from a pharmacy and limited to one fitting and prescription per Calendar Year unless additional fittings or devices are Medically Necessary.

Injectable contraceptives (which are administered by a Physician) are covered as a medical benefit when administered by a Physician.

If Your Physician determines that none of the methods specified as covered by the Plan are medically appropriate, then the Plan will provide coverage for another FDA-approved prescription or contraceptive method as prescribed by Your Physician.

Cosmetic Services and Supplies

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

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

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

then,

- Surgery to remove or change the size (or appearance) of any part of the body;
- Surgery to reform or reshape skin or bone; or
- Surgery to remove or reduce skin or tissue are covered.

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

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

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

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

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

Dental Services

This Plan does not cover dental services or supplies except in the following situations:

Exceptions

- When immediate Emergency Care to sound natural teeth as a result of an accidental injury is required. Please refer to the "Emergency and Urgently Needed Care" portion of Section 100, "Introduction to Health Net," for more information.
- General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the Member requires that an ordinarily non-covered dental service which would normally be treated in a dentist's office and without general anesthesia must instead be treated in a Hospital or Outpatient Surgical Center. The general anesthesia and associated facility services must be Medically Necessary are

subject to the other exclusions and limitations of this *Evidence of Coverage,* and will only be covered under the following circumstances (a) Members who are under seven years of age or, (b) Members who are developmentally disabled or (c) Members whose health is compromised and general anesthesia is Medically Necessary.

- When Dental examinations and treatment of the gingival tissues (gums) are performed for the diagnosis or treatment of a tumor.
- For acupuncture treatment of postoperative dental Pain, but only when Acupuncture Services are covered under this Plan through American Specialty Health Plans of California, Inc. (ASH Plans).

The following services are not covered under any circumstances including those listed above.

- Routine care or treatment of teeth and gums including but not limited to dental abscesses, inflamed tissue or extraction of teeth.
- Spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints or orthotics (whether custom fit or not) or other dental appliances, and related surgeries to treat dental conditions.
- Dental implants (materials implanted into or on bone or soft tissue) and any surgery to prepare the jaw for implants.
- Follow-up treatment of an injury to sound natural teeth as a result of an accidental injury regardless of reason for such services.

Dietary or Nutritional Supplements

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

Disorders of the Jaw

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

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

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

Durable Medical Equipment

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

- Exercise equipment
- Hygienic equipment and supplies (to achieve cleanliness even when related to other covered medical services)
- Stockings, corrective shoes and arch supports
- Surgical dressings other than primary dressings that are applied by your Physician Group or a Hospital to lesions of the skin or surgical incisions.
- Jacuzzis and whirlpools
- Orthotics, unless custom made to fit the Member’s body. (Orthotics are supports, casts or braces for weak or ineffective joints or muscles.)

- Orthotics, whether or not custom fit, Orthodontic appliances to treat dental conditions related to the treatment of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders). TMJ disorder.
- Corrective footwear, (whether or not custom fit) that are not incorporated into cast, splint, brace or strapping of the foot, except when Medically Necessary for the management and treatment of diabetes, or when purchased by your Group as a specific benefit for orthotics corrective footwear as shown in the “Medical Supplies” portion of “Schedule of Benefits and Copayments,” Section 200 and the “Corrective Footwear” portion of “Covered Services and Supplies,” Section 500.
- Orthodontic appliances to treat dental conditions related to the treatment of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders).

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

Eyeglasses and Contact Lenses

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

Genetic Testing and Diagnostic Procedures

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

Mental Disorders

This Plan does not cover treatment of Mental Disorders except as specifically described.

This Plan does not cover care for mental retardation, mental health care as a condition of parole or probation, or court-ordered testing for Mental Disorders. Care for the treatment of mental retardation is not covered, however, this will not serve to prevent persons with mental retardation from obtaining other covered services under this plan.

Services and supplies for treating Mental Disorders are covered only as specified in the "Mental Disorders and Chemical Dependency Benefits" portion of "Covered Services and Supplies," Section 500.

Non-eligible Institutions

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

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

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

Any other nonprescription or over-the-counter drugs, medical equipment or supplies that can be purchased without a Prescription Drug Order is not covered even if a Physician writes a Prescription Drug Order for such drug, equipment or supply unless listed in the Recommended Drug List. However, if a higher dosage form of a nonprescription drug or over-the-counter drug is only available by prescription, that higher dosage drug may be covered when Medically Necessary.

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

Prescribed Drugs and Medications

This Plan only covers outpatient Prescription Drugs or medications as described in the "Prescription Drug Benefits" portion of "Covered Services and Supplies," Section 500.

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

Physicians Treating Immediate Family Members
This Plan does not cover routine or ongoing treatment or consultation provided by the Member's parent, spouse, Domestic Partner, child, stepchild or sibling. Members who receive routine or ongoing care from a member of their immediate family may be reassigned to another Physician.

Private Duty Nursing
This Plan does not cover private duty nursing in the home or for registered bed patients in a Hospital or long-term care facility.

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

Rehabilitation Therapy
Coverage for rehabilitation therapy is limited to Medically Necessary services provided by a licensed physical, speech or occupational therapist for treatment of conditions resulting from a Defined Disease, injury or surgical procedure. The services must be at a level of complexity that requires the judgment, knowledge and skills of a licensed physical, speech or occupational therapist, be based on a treatment plan and be provided by such therapist or under the therapist's direct supervision. Such services are not covered when medical documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals or when a Member has already met the treatment goals. See "General Provisions" Section 700, for the procedure to request Independent Medical Review of a Plan denial of coverage on the basis of Medical Necessity.

Reversal of Surgical Sterilization
This Plan does not cover services to reverse voluntary, surgically induced sterility.

Routine Physical Examinations
This Plan does not cover routine physical examinations for insurance, licensing, employment, school, camp, or other nonpreventive purposes.

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

Surrogate Pregnancy
This Plan covers services for a surrogate pregnancy, but when compensation is obtained for the surrogacy, the Plan shall have a lien on such compensation to recover its medical expense A surrogate pregnancy is one in which a woman has agreed to become pregnant with the intention of surrendering custody of the child to another person.

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

Unauthorized Services and Supplies
This Plan only covers medical services or supplies that are authorized by Health Net or the Physician Group according to Health Net's procedures, except for emergency services.

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

Subsection-C

Prescription Drugs

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

Note: Services or supplies excluded under the Prescription Drug benefits may be covered under your medical benefits portion of this Evidence of Coverage. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 500, for more information.

Additional exclusions and limitations:

Allergy Serum
Products to lessen or end allergic reactions are not covered. Allergy serum is covered as a medical benefit. See the "Allergy, Immunizations and Injections" portion of the "Schedule of Benefits and Copayments" Section 200 and the "Immunizations and Injections" portion of "Covered Services and Supplies" section.

Appetite Suppressants or Drugs for Body Weight Reduction
Drugs prescribed for the treatment of obesity are covered, when Medically Necessary for the treatment of morbid obesity. In such cases the drug will be subject to Prior Authorization from Health Net.

Compounded Drugs
Prescription orders that are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form using FDA approved drugs, are covered at the Level III Drug Copayment Coverage for compounded drugs is subject to Prior Authorization by the Plan and Medical Necessity. Compounded Drugs are not covered if there is a similar proprietary product available.

Contraceptives
Oral contraceptives and emergency contraceptives are covered. Vaginal contraceptives are limited to diaphragms and cervical caps and are only covered when a Member Physician performs a fitting examination and prescribes the device. Such devices are only available through a prescription from a pharmacy and limited to one fitting and prescription per Calendar Year unless additional fittings or devices are Medically Necessary. Injectable contraceptives are covered as a medical benefit when administered by a Physician. If your Physician determines that none of the methods specified as covered by the Plan are medically appropriate then the Plan will provide coverage for another FDA approved prescription or contraceptive method as prescribed by your Physician.

Devices
Coverage is limited to vaginal contraceptive devices, peak flow meters, inhaler spacers, and those devices listed under the "Diabetic Drugs and Supplies" provisions of the "Prescription Drugs" portion of "Covered Services and Supplies" Section 500.. No other devices are covered even if prescribed by a Member Physician, are not covered.

Diagnostic Drugs
Drugs used for diagnostic purposes are not covered. Diagnostic drugs are covered under the medical benefit when Medically Necessary.

Dietary or Nutritional Supplements
Drugs used as dietary or nutritional supplements, including vitamins and herbal remedies, are limited to drugs that are listed in the Recommended Drug List. Phenylketonuria (PKU) is covered under the medical benefit (see the "Phenylketonuria" portion of "Covered Services and Supplies" Section 500.

Drugs Prescribed for the Common Cold
Drugs when prescribed to shorten the duration of the common cold are not covered.

Drugs Prescribed for Cosmetic or Enhancement Purposes
Drugs that are prescribed for the following non-medical conditions are not covered: hair loss sexual performance, athletic performance, cosmetic purposes, antiaging for cosmetic purposes and, mental performance. Examples of drugs that are excluded when prescribed for such conditions include, but are not limited to, Penlac, Renova,

Retin-A, Vaniqua, Propecia, Lustra, Xenical or Meridia. This exclusion does not exclude coverage for drugs when pre-authorized as Medically Necessary to treat a diagnosed medical condition affecting memory, including but not limited to, Alzheimer's dementia. However, drugs prescribed for hormonal therapy for individuals who have been diagnosed with a covered Gender Identity Disorder (GID) may be covered.

Food and Drug Administration (FDA)
Supply amounts for prescriptions that exceed the FDA's indicated usage recommendation are not covered unless Medically Necessary and Prior Authorization is obtained from Health Net.

Hypodermic Syringes and Needles
Hypodermic syringes and needles are limited to disposable insulin needles, and syringes and reusable pen devices. Needles and syringes required to administer self-injected medications (other than insulin) will be provided when obtained through Health Net's Specialty Pharmacy Vendor under the Medical benefit (see the "Immunizations and Injections" portion of "Covered Services and Supplies," Section 500). All other syringes, devices and needles are not covered.

Injectable Drugs
Injectable drugs obtained through a prescription are limited to insulin and sexual dysfunction drugs when prescribed by a Physician. Other injectable medications are covered under the medical benefit (see the "Immunizations and Injections" portion of the "Covered Services and Supplies" Section 500). Surgically implanted drugs are covered under the medical benefit (see the "Surgically Implanted Drugs" portion of "Covered Services and Supplies" Section 500..

Irrigation Solutions
Irrigation solutions and saline solutions are not covered.

Lost, Stolen or Damaged Drugs
Drugs that are lost, stolen or damaged are not covered. You will have to pay the retail price for replacing them.

Nonapproved Uses
Drugs prescribed for indications approved by the Food and Drug Administration are covered. Off-label use of drugs is only covered when prescribed or administered by a licensed health care professional for the treatment of a life-threatening or chronic and seriously debilitating condition as described herein (see the "Off-Label Drugs" provision in the "Prescription Drugs" portion of "Covered Services and Supplies," Section 500) or if otherwise Medically Necessary.

Noncovered Services
Drugs prescribed for a condition or treatment that is not covered by this Plan are not covered. However, the Plan does cover Medically Necessary drugs for medical conditions directly related to noncovered services when complications exceed routine Follow-Up Care (such as life-threatening complications of cosmetic surgery).

Nonparticipating Pharmacies
Drugs dispensed by Nonparticipating Pharmacies are not covered, except as specified in the "Drugs Dispensed by a Nonparticipating Pharmacy" provision of "Covered Services and Supplies," Section 500.

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

Any other nonprescription or over-the-counter drugs, medical equipment or supplies that can be purchased without a Prescription Drug Order is not covered, or a drug where there is a non-prescription equivalent available even if a Physician writes a Prescription Drug Order for such drug, equipment or supply.

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

Nonprescription (Over-the-Counter) Drugs, Equipment and Supplies
Medical equipment and supplies (including insulin), that are available without a prescription, are covered only when prescribed by a Physician for the management and treatment of diabetes.

Any other nonprescription or over-the-counter drugs, medical equipment or supplies that can be purchased without a Prescription Drug Order is not covered even if a Physician writes a Prescription Drug Order for such drug, equipment or supply unless it is listed in the Recommended Drug List. However, if a higher dosage form of a nonprescription drug or over-the-counter drug is only available by prescription, that higher dosage drug will be covered when Medically Necessary.

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

Physician Is Not a Member Physician

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 because of a medical Emergency condition, illness, or injury, or as specifically stated.

Unit Dose or "Bubble" Packaging

Individual doses of medication dispensed in plastic, unit dose or foil packages and dosage forms used for convenience as determined by Health Net, are only covered when Medically Necessary or when the medication is only available in that form.

Quantity Limitation

Some drugs are subject to specific quantity limitations per copayment. Medications taken on an "as-needed" basis may have a Copayment based on a 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.

Smoking Cessation Coverage

Drugs that require a prescription in order to be dispensed for the relief of nicotine withdrawal symptoms are covered up to a twelve week course of therapy per Calendar Year if the Member is concurrently enrolled in a comprehensive smoking cessation behavioral support program. The prescribing Physician must request Prior Authorization for coverage. For information regarding smoking cessation behavioral support programs available through Health Net, contact Member Services at the telephone number on your Health Net ID Card or visit the Health Net website at *www.healthnet.com/uc* (see "Wellsite").

Medical Devices

Devices (other then diaphragms or cervical caps) even if prescribed by a Member Physician.

Compounded Drugs

Prescription orders that are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form using FDA approved drugs are covered at the Level III Drug Copayment only when the primary drug used is on the Health Net Recommended Drug List and being used for a FDA approved indication. Compounded drugs are not covered when the primary drug used, is a non-FDA approved drug. They are also not covered if there is a similar proprietary product available.

Subsection-D

Mental Disorders and Chemical Dependency

The exclusions and limitations in the "Services and Supplies" and "Medical Services and Supplies" portions of this section apply to Mental Disorders and Chemical Dependency.

Note: Services or supplies excluded under the Mental Disorders and Chemical Dependency benefits may be covered under your medical benefits portion of this *Evidence of Coverage*. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 500, for more information.

Mental health care as a condition of parole, probation or court-ordered testing for Mental Disorders is limited to Medically Necessary services and subject to this Plan's day or visit limits as shown in "Schedule of Benefits and Copayments," Section 200.

Services and supplies for treating Mental Disorders and Chemical Dependency are covered only as specified in the "Mental Disorders and Chemical Dependency" portion of "Covered Services and Supplies," Section 500. The treatment and diagnosis of Serious Emotional Disturbances of a Child under the age of 18 is covered as shown in "Schedule of Benefits and Copayments" Section 200. Look under the headings for office visits, outpatient services and inpatient Hospital services to determine the applicable Copayment.

Additional exclusions and limitations:

The following exclusions apply specifically to Mental Disorders and Chemical Dependency.

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

For Insurance
Services for obtaining or maintaining insurance are not covered.

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

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

Nonabstinence-Based Treatment
Chemical Dependency treatment not based on abstinence is not covered.

Noncontracting Providers or Facilities
Services, treatment or supplies rendered in a non-emergency by a non-participating provider or non-participating facility, are only covered when authorized by the Behavioral Health Administrator's Medical Director or his/her designee or otherwise provided by the Plan. For information on "Continuity of Care" through a non-Participating Mental Health Professional, please see the "Mental Disorders and Chemical Dependency" portion of "Covered Services and Supplies" Section 500.

This includes, but is not limited to those cases where the Behavioral Health Administrator refers a Member to a noncontracting provider or authorizes Emergency or Urgently Needed Care or a second opinion.

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

- Treatment ordered by a court of law.
- Treatment of chronic Pain. However, such treatment is covered as a medical benefit. See "Covered Services and Supplies" Section 500.
- Treatment for co-dependency.
- Treatment for psychological stress.
- Treatment of marital or family dysfunction.

Treatment for smoking cessation, weight reduction, obesity, stammering, sleeping disorders, stuttering or sexual addiction is not covered under the Mental Disorders and Chemical Dependency benefits of this Plan. However, treatment for morbid obesity is covered under the medical benefit as described in "Medical Services and Supplies"

in Covered Services and Supplies," Section 500. Treatment for smoking cessation is covered under the prescription drug benefit as described in the “Prescription Drugs” portion of "Covered Services and Supplies," Section 500. Treatment related to judicial or administrative proceedings that is not Medically Necessary is also not covered.

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

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

Nonstandard Therapies
Services that do not meet national standards for professional mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy applied behavioral analysis and crystal healing therapy are not covered.

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

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

Private Duty Nursing
Private duty nursing services in the home or in a Hospital are not covered.

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

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

Treatment by a Relative
Treatment or consultation provided by the Member's parents, siblings, children, current or former spouse, or any adults who live in the Member’s household, is not covered.

Congenital and Organic Disorders
Treatment of physiological diseases or defects, including but not limited to organic brain disease is not covered. However, some conditions shall be covered as shown in "Schedule of Benefits and Copayments," Section 200, provided that their level of severity meets the criteria described in the definitions of "Serious Emotional Disturbances of a Child" or "Severe Mental Illness."

Learning Disabilities
Testing, screening or treatment for learning disabilities are not covered. However, some conditions shall be covered as shown in "Schedule of Benefits and Copayments," Section 200, provided that their level of severity meets the criteria described in the definitions of "Serious Emotional Disturbances of a Child" or "Severe Mental Illness" and the conditions are treated by Participating Mental Health Professionals.

Detoxification in Newborns
Treatment of detoxification in newborns is not covered. However, these services are covered under the medical benefit (see the “Inpatient Hospital Confinement” portion of “Covered Services and Supplies,” Section 500.).

Excess Services
Services in excess of those authorized by the Behavioral Health Administrator's Medical Director or his/her designee, unless such services are determined to be Medically Necessary.

Section-700

GENERAL PROVISIONS

Subsection-A

When the Plan Ends

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

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

Subsection-B

When the Plan Changes

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

Health Net has the right to modify this Plan, including the right to change subscription charges according to the terms of the Group Service Agreement. Notice of modification will be sent to the Group. Except as required under "Eligibility, Enrollment and Termination" Section 400, Subsection D, "When Coverage Ends" regarding termination for non-payment, Health Net will not provide notice of such changes to plan Subscribers unless it is required to do so by law. The Group may have obligations under state or federal law to provide notification of these changes to plan Subscribers.

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

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

Subsection-C

Grievance, Appeals, External Independent Review and Arbitration

Grievance Procedures

If you are not satisfied with efforts to solve a problem with Health Net or your Physician Group, you must first file a grievance or appeal against Health Net by calling the Member Services Department at **1-800-522-0088** or by submitting a Member Grievance Form through the Health Net website at *www.healthnet.com/uc.* You may also file your complaint in writing by sending information to:

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

If your concern involves the Mental Disorders and Chemical Dependency program call Managed Health Network (MHN) at 1-800-227-1060, or write to:

Managed Health Network
Attention: Health Net Team
1600 Los Gamos Drive, Suite 300
San Rafael, CA 94903

Please include all information from your Health Net Identification Card and the details of the concern or problem.

We will:

- Confirm in writing within five calendar days that we received your request.

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

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

Independent Medical Review of Grievances Involving a Disputed Health Care Service

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

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

Eligibility

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

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

(B) You have received urgent or Emergency Care that a provider determined to have been Medically Necessary

(C) In the absence of the provider recommendation described in 1.(A) above, you have been seen by a Health Net Member Physician for the diagnosis or treatment of the medical condition for which you seek IMR;

2. The Disputed Health Care Service has been denied, modified, or delayed by Health Net or one of its contracting providers, based in whole or in part on a decision that the health care service is not Medically Necessary; and

3. You have filed a grievance with Health Net and the disputed decision is upheld by Health Net or the grievance remains unresolved after 30 days. Within the next six months, you may apply to the Department for IMR, or later, if the Department agrees to extend the application deadline. If your grievance requires expedited review you may bring it immediately to the Department's attention. The Department may waive the requirement that you follow Health Net's grievance process in extraordinary and compelling cases.

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

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

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

Independent Medical Review of Investigational or Experimental Therapies

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

Eligibility

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

If Health Net denies coverage of the recommended or requested therapy and you meet the eligibility requirements, Health Net will notify you within five business days of its decision and your opportunity to request external review of Health Net's decision through IMR. Health Net will provide you with an application form to request an IMR of Health Net's decision. The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of your request for IMR. If your Physician determines that the proposed therapy should begin promptly, you may request expedited review and the experts on the IMR panel will render a decision within seven days of your request. If the IMR panel recommends that Health Net cover the recommended or requested therapy, coverage for the services will be subject to the terms and conditions generally applicable to other benefits you are entitled to. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Health Net regarding the denial of the recommended or requested therapy. For more information, please call the Member Services Department at **1-800-522-0088**.

Department of Managed Health Care

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

If you have a grievance against Health Net, you should first telephone Health Net at **1-800-522-0088** and use our grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

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

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

Binding Arbitration

Sometimes disputes or disagreements may arise between you (including your enrolled Family Members, heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of this *Evidence of Coverage* or regarding other matters relating to or arising out of your Health Net membership. Typically such disputes are handled and resolved through the Health Net Grievance, Appeal and Independent Medical Review process described above. However, in the event that a dispute is not resolved in that process, Health Net uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise and whether or not other parties such as employer groups, health care providers or their agents or employees, are also involved. In addition, disputes with Health Net involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

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

Health Net's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitration's under this process. In the event that the total amount of damages claimed is $200,000 or less, the parties shall, within 30 days of submission of the demand for Arbitration to Health Net, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $200,000. In the event that total amount of damages is over $200,000, the parties shall, within 30 days of submission of the demand for arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then either party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

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

Health Net of California
Attention: Litigation Administrator
PO Box 4504
Woodland Hills, CA 91365-4505

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this *Evidence of Coverage*, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the

arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that State or Federal law provides for judicial review of Arbitration proceedings.

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

Effective July 1, 2002, Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are *not* required to submit disputes about certain "adverse benefit determinations" made by Health Net to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and Health Net may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Subsection-D

Involuntary Transfer to Another Primary Care Physician or Contracting Physician Group

Health Net has the right to transfer you to another Primary Care Physician or contracting Physician Group under certain circumstances. The following are examples of circumstances that may result in involuntary transfer:

- Refusal to Follow Treatment: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you continually refuse to follow recommended treatment or established procedures of Health Net, the Primary Care Physician, the contracting Physician Group.

  Health Net will offer you the opportunity to develop an acceptable relationship with another Primary Care Physician at the contracting Physician Group, or at another contracting Physician Group, if available. A transfer to another Physician Group will be at Health Net's discretion.

- Disruptive or Threatening Behavior: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you repeatedly disrupt the operations of the Physician Group or Health Net to the extent that the normal operations of either the Physician's office, the contracting Physician Group or Health Net are adversely impacted.

- Abusive Behavior: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you exhibit behavior that is abusive or threatening in nature toward the health care provider, his or her office staff, the contracting Physician Group or Health Net personnel.

- Inadequate Geographic Access to Care: You may be involuntarily transferred to an alternate Primary Care Physician or contracting Physician Group if it is determined that neither your residence nor place of work are within reasonable access to your current Primary Care Physician.

Other circumstances may exist where the treating Physician or Physicians have determined that there is an inability to continue to provide you care because the patient-Physician relationship has been compromised to the extent that mutual trust and respect have been impacted. In the U.S. the treating Physicians and contracting Physician Group must always work within the code of ethics established through the American Medical Association (AMA). (For information on the AMA code of ethics, please refer to the American Medical Association website at http://www.ama-assn.org). Under the code of ethics, the Physician will provide you with notice prior to discontinuing as your treating Physician that will enable you to contact Health Net and make alternate care arrangements.

Health Net will conduct a fair investigation of the facts before any involuntary transfer for any of the above reasons is carried out.

Subsection-E

Medical Malpractice Disputes

Any dispute alleging the medical malpractice, negligence and/or wrongful act of any health care provider shall not include Health Net and shall include only the provider subject to allegation.

Subsection-F

When A Third Party Causes A Member Injuries

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

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

You are in a car accident and the other driver is at fault; or

You slip and fall in a store because a wet spot was left on the floor.

STEPS YOU MUST TAKE

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

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

Telling Health Net and the medical providers the name and address of the third party, if you know it, the name and address of your lawyer, if you are using a lawyer, and describing how the injuries were caused;

Completing any paperwork that Health Net or the medical providers may reasonably require to assist in enforcing the lien;

Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions; Notifying the lienholders immediately upon you or your lawyer receiving any money from the third parties or their insurance companies; and

Holding any money that you or your lawyer receive from the, parties or their insurance companies in trust and reimbursing Health Net and the medical providers for the amount of the lien as soon as you are paid by the third party.

HOW THE AMOUNT OF YOUR REIMBURSEMENT IS DETERMINED

Your reimbursement to Health Net or the medical provider under this lien is based on the value of the services you receive and the costs of perfecting this lien. For purposes of determining the lien amount, the value of the services depends on how the provider was paid and will be determined as permitted by law. Unless the money that you receive came from a Workers' Compensation claim, the following applies:

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

The amount of the reimbursement that you owe Health Net or the Physician Group will also be reduced a pro rata share for any legal fees or costs that you paid from the money you received.

The amount that you will be required to reimburse Health Net or the Physician Group for services you receive under this Plan will not exceed one-third of the money that you receive if you do engage a lawyer, or one-half of the money you receive if you do not engage a lawyer.

Subsection-G

Relationship of Parties

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

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

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

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

Provider/Patient Relationship

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

Liability for Charges

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

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

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

Prescription Drug Liability

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

Continuity of Care Upon Termination of Provider Contract

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

In addition, a Member may request continued care from a provider whose contract is terminated if at the time of termination the Member was receiving care from such a provider for:

- An Acute Condition;
- A Serious Chronic Condition not to exceed twelve months from the contract termination date;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- A newborn up to 36 months of age not to exceed twelve months from the contract termination date;
- A Terminal Illness (for the duration of the Terminal Illness); or
- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment.

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

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable Copayments and any other exclusions and limitations of this Plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider’s contract termination. You must request continued care within 30 days of the provider’s date of termination unless you can show that it was not reasonably possible to make the request within 30 days of the provider’s date of termination and you make the request as soon as reasonably possible.

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

Contracting Administrators

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

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

Decision-Making Authority

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

Subsection-H

Coordination of Benefits

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

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

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

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

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

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

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

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

Definitions

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

A. **Plan**--A "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

   (1) **"Plan" includes** group insurance, closed panel (HMO, PPO or EPO) coverage or other forms of group or group-type coverage (whether insured or uninsured); Hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care.

   (Medicare is not included as a "Plan" with which Health Net engages in COB. We do, however, reduce benefits of this Plan by the amount paid by Medicare. For Medicare coordination of benefits please refer to the "Government Coverage" portion of this "General Provisions," Section 700.)

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

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

B. **Primary Plan or Secondary Plan**--The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when compared to another Plan covering the person.

When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the primary Plan's benefits.

C. **Allowable Expense**--This concept means a health care service or expense, including Deductibles and Copayments, that is covered at least in part by any of the plans covering the person. When a Plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an Allowable Expense.

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

(1) If a covered person is confined in a private room, the difference between the cost of a semi-private room in the Hospital and the private room, is not an Allowable Expense.

Exception:

If the patient's stay in a private hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the Plans routinely provides coverage for hospital private rooms, the expense or service is an Allowable Expense.

(2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

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

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

(5) The amount a benefit is reduced by the Primary Plan because of a covered person does not comply with the plan provisions is not an Allowable Expense.

Examples of these provisions are second surgical opinions, precertification of admissions and preferred provider arrangements.

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

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

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

Order of Benefit Determination Rules

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

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

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

There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major

medical coverages that are superimposed over base plan Hospital and surgical benefits and insurance-type coverages that are written in connection with a closed Panel Plan to provide out-of-network benefits.

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

D. **Order of Payment Rules**--The first of the following rules that describes which Plan pays its benefits before another Plan is the rule that will apply.

1. **Subscriber (Non-Dependent) vs. Dependent**--The Plan that covers the person other than as a dependent, for example as an employee, subscriber, or retiree, is primary, and the Plan that covers the person as a dependent is secondary.
2. **Child Covered By More Than One Plan**--The order of payment when a child is covered by more than one Plan is:
   a. **Birthday Rule**--The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the Plan that covered either of the parents longer is primary.
   b. **Court Ordered Responsible Parent**--If the terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the Plan is given notice of the court decree.
   c. **Parents Not Married, Divorced, or Separated**--If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      - The Plan of the Custodial Parent.
      - The Plan of the spouse of the Custodial Parent.
      - The Plan of the noncustodial parent.
      - The Plan of the spouse of the noncustodial parent.
3. **Active vs. Inactive Employee**--The Plan that covers a person as an employee who is neither laid off nor retired (or his or her dependent), is primary in relation to a Plan that covers the person as a laid off or retired employee (or his or her dependent). When the person has the same status under both Plans, the Plan provided by active employment is first to pay.

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

   Coverage provided an individual by one Plan as a retired worker and by another Plan as a dependent of an actively working spouse will be determined under the rule labeled D (1) above.
4. **COBRA Continuation Coverage**--If a person whose coverage is provided under a right of continuation provided by federal (COBRA) or state law (similar to COBRA) also is covered under another Plan, the Plan covering the person as an employee or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
5. **Longer or Shorter Length of Coverage**--If the preceding rules do not determine the order or payment, the Plan that covers the subscriber (non-dependent), retiree or dependent of either for the longer period is primary.
   a. **Two Plans Treated As One**--To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the covered person was eligible under the second within twenty-four hours after the first ended.
   b. **New Plan Does Not Include**--The start of a new Plan does not include:
      (i) A change in the amount or scope of a Plan's benefits.
      (ii) A change in the entity that pays, provides or administers the Plan's benefits.
      (iii) A change from one type of Plan to another (such as from a single employer Plan to that of a multiple employer Plan).

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

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

Effect on the Benefits of This Plan

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

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

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

Right to Receive and Release Information

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

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

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

Health Net's Right to Pay Others

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

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

Recovery of Excessive Payments by Health Net

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

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

Subsection-I

Government Coverage

Medicare Coordination of Benefits (COB) When you or your spouse reaches age 65, you may become eligible for Medicare based on age. You may also become eligible for Medicare before reaching age 65 due to disability or end stage renal disease.

If you are enrolled in this Plan as well as in both Medicare Part A and Part B, and are not an active employee, then this Plan coordinates benefits with Medicare. Please note that you must enroll in Medicare Part A and Part B to be eligible for Medicare Coordination of Benefits.

For services and supplies covered under Medicare Part A and Part B, claims are first submitted to the Medicare intermediary for determination and payment of allowable amounts. The Medicare intermediary then sends your medical care provider a Medicare Summary Notice (MSN), (formerly an Explanation of Medicare Benefits (EOMB)). In most cases, the MSN will indicate that the Medicare intermediary has forwarded the claim to Health Net for secondary coverage consideration. Health Net will process secondary claims received from the Medicare

intermediary. Secondary claims not received from the Medicare intermediary must be submitted to Health Net by you or the provider of service, and must include a copy of the MSN. Health Net and/or your medical provider is responsible for paying the difference between the Medicare paid amount and the Covered Services outlined in this *Evidence of Coverage*. This Plan will cover benefits as a supplemental payer only to the extent services are coordinated by your Primary Care Physician and authorized by Health Net.

If either you or your spouse is over the age of 65 and you are actively employed, neither you nor your spouse is eligible for Medicare Coordination of Benefits. For answers to questions regarding Medicare, contact:

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

Write to:

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

Medi-Cal

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

Veterans' Administration

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

Subsection-J

Workers' Compensation

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

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

Section-800

MISCELLANEOUS PROVISIONS

Cash Benefits

Health Net, in its role as a health maintenance organization, generally provides all covered services and supplies through a network of Contracting Physician Groups. Your Physician Group performs or authorizes all care, and you will not have to file claims.

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

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

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

Benefits Not Transferable

No person other than a properly enrolled Member is entitled to receive the benefits of this Plan. Your right to benefits is not transferable to any other person or entity.

If you use benefits fraudulently, your coverage will be canceled. Health Net has the right to take appropriate legal action.

Notice of Claim

In most instances, you will not need to file a claim to receive benefits this Plan provides. However, if you need to file a claim (for example, for Emergency or Urgently Needed Care from a non-Health Net provider), you must do so within one year from the date you receive the services or supplies. , Any claim filed more than one year from the date the expense was incurred will not be paid unless it is shown that it was not reasonably possible to file within that time limit, and that you have filed as soon as was reasonably possible.

Call the Member Services Department at the telephone number shown on your Health Net ID Card to obtain claim forms.

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

Health Net Commercial Claims
P.O. Box 14702
Lexington, KY 40512

If you need to file a claim for outpatient Prescription Drugs, please send a completed Prescription Drug claim form to:

Health Net
C/O Caremark
P.O. Box 853901
Richardson, TX 75085-3901

Please call Health Net Member Services at **1-800-522-0088** or visit our website at *www.healthnet.com/uc* to obtain a Prescription Drug claim form.

If you need to file a claim for Emergency Mental Disorders and Chemical Dependency, or for other covered Mental Disorders and Chemical Dependency Services provided upon referral by Managed Health Network (MHN), you must file the claim with MHN within one year after receiving those services. Any claim filed more than one year from the date the expense was incurred will not be paid unless it was shown that is was not reasonably possible to file the claim within one year, and that is was filed as soon as reasonably possible. You must use

MHN's forms in filing the claim, and you should send the claim to MHN at the address listed in the claim form or to MHN at:

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

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

Health Care Plan Fraud

Health care plan fraud is defined as a deception or misrepresentation by a provider, Member, employer or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by filing a claim that contains a false or deceptive statement is guilty of insurance fraud.

If you are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if you know of or suspect any illegal activity, call Health Net's toll-free Fraud Hotline at **1-800-977-3565**. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

Disruption of Care

Circumstances beyond Health Net's control may disrupt care; for example, a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant contracting Physician Group personnel, or a similar event.

If circumstances beyond Health Net's control result in your not being able to obtain the Medically Necessary covered services or supplies of this Plan, Health Net will make a good faith effort to provide or arrange for those services or supplies within the remaining availability of its facilities or personnel. In the case of an emergency, go to the nearest doctor or Hospital. See the "Emergency and Urgently Needed Care" section under "Introduction to Health Net" Section 100.

Sending and Receiving Notices

Any notice that Health Net is required to make will be mailed to the Group at the current address shown in Health Net's files. If the Subscriber or the Group is required to provide notice, the notice should be mailed to the corporate office of Health Net in Woodland Hills, California. The mailing address is shown on your Health Net ID Card.

Confidentiality of Medical Records

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

Notice Of Privacy Practices

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

This Notice tells you about the ways in which Health Net of California and Managed Health Network (referred to as "we" or "the Plan") may collect, use and disclose your protected health information and your rights concerning your protected health information. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by federal and state laws to provide you with this notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this notice while it is in effect. Some of the uses and disclosures described in this notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

How We May Use And Disclose Your Protected Health Information

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

- **Payment.** We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment.
- **Health Care Operations.** We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or customer service. In some cases, we may use or disclose the information for underwriting or determining premiums.
- **Treatment.** We may use and disclose your protected health information to assist your health care providers (doctors, dentists, pharmacies, Hospitals and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.
- **Plan Sponsor.** If you are enrolled through a group health plan, we may provide non-identifiable summaries of claims and expenses for enrollees in a group health plan to the plan sponsor, which is usually the employer. If the plan sponsor provides plan administration services, we may also provide access to health information to support its performance of health plan operations which may include but are not limited to claims audits or customer services functions. Health Net will only share health information upon a certification from the plan sponsor representing there are firewalls in place to ensure that only employees with a legitimate need to know will have access to health information in order to provide plan administration functions.
- **Enrolled Dependents and Family Members.** We will mail explanation of benefits forms and other mailings containing protected health information to the address we have on record for the subscriber of the health plan.

Other Permitted Or Required Disclosures

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.
- **Public Health Activities.** We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose protected health information to government agencies about abuse, neglect or domestic violence.
- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g., state insurance departments) for activities authorized by law.
- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Coroners, Funeral Directors, Organ Donation.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
- **Research.** Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

Other Uses Or Disclosures With An Authorization
Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

Your Rights Regarding Your Protected Health Information
You have certain rights regarding protected health information that the Plan maintains about you.

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

  If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.
- **Right to an Accounting of Disclosures by the Plan.** You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

  Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.
- **Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. ***We may not agree to your request.*** If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.
- **Right To Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this notice, even if you had previously agreed to receive an electronic copy.
- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting our privacy office. See the end of this notice for the contact information.

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

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

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

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

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

Address: **Health Net Privacy Office**
Attention: Director, Information Privacy
P.O. Box 9103
Van Nuys, CA 91409

You may also contact us at:

Telephone: **1-800-522-0088**
Fax: **1-818-676-8981**
Email: **Privacy@healthnet.com**

Section-900

DEFINITIONS

This section defines words that will help you understand your Plan. These words appear throughout this *Evidence of Coverage* with the initial letter of the word in capital letters.

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

Brand Name Drug is a Prescription Drug or medicine that has been registered under a brand or trade name by its manufacturer and is advertised and sold under that name, and indicated as a brand in the Medi-Span Span or similar third party national Database used by Health Net.

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

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

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

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

Custodial Care is care that is rendered to a patient to assist in support of the essentials of daily living such as help in walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets, and supervision of medications which are ordinarily self-administered, and which patient:

- Is disabled mentally or physically and such disability is expected to continue and be prolonged;
- Requires a protected, monitored, or controlled environment whether in an institution or in the home; and
- Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

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

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

1. Have a common residence. It is not necessary that the legal right to possess the common residence be in both names.
2. Not be married or a member of another domestic partnership with someone else that has not been terminated, dissolved or judged a nullity.
3. Not be related by blood in a way that would prevent them from being married to each other in this state.
4. Be at least 18 years of age.
5. Be capable of consenting to the domestic partnership.
6. Be either of the following:
    - Members of the same sex; or
    - Members of the opposite sex and one or both be eligible for Social Security benefits and one or both be over the age of 62.

7. Both file a Declaration of Domestic Partnership with the Secretary of State, or an equivalent document with another recognized state or local agency or both are persons of the same sex who have validly formed a legal union other than marriage in a jurisdiction outside of California which is substantially equivalent to a Domestic Partnership as defined under California law.

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

Durable Medical Equipment

- Serves a medical purpose (its reason for existing is to fulfill a medical need, and it is not useful to anyone in the absence of illness or injury).
- Withstands repeated use.
- Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities.

Effective Date is the date on which the Employee or Family Member becomes covered or entitled to benefits under this Evidence of Coverage. Call your local Payroll or Benefits Office to confirm your effective date.

Emergency Care is medically necessary medical or Hospital services required as a result of a medical condition manifesting itself by the sudden onset of acute symptoms of sufficient severity which may include severe pain, such that a layperson with an average knowledge of health and medicine would seek if he or she was having serious symptoms, and believed that without immediate treatment, any of the following would occur:

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

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

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

Emergency Care will also include additional screening, examination, and evaluation by a Physician (or other health care provider acting within the scope of his or her license) to determine if a psychiatric emergency medical condition exists and the care and treatment necessary to relieve or eliminate such condition, within the capability of the facility.

Health Net will make any final decisions about Emergency Care.

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

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

Please refer to "Independent Medical Review of Investigational or Experimental Therapies," "General Provisions," Section 700, for additional information.

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

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

Generic Drug is the pharmaceutical equivalent of a Brand Name Drug whose patent has expired and is available from multiple manufacturers as set out in the Medi-Span or similar third party database used by Health Net.

The Food and Drug Administration must approve the Generic Drug as meeting the same standards of safety, purity, strength, and effectiveness as the Brand Name Drug.

Group is the business organization (usually an employer or trust) to which Health Net has issued the Group Service Agreement to provide the benefits of this Plan.

Group Service Agreement is the contract Health Net has issued to the Group, in order to provide the benefits of this Plan.

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

Health Net Recommended Drug List (also known as **Recommended Drug List or the List)** is a list of the Prescription Drugs that are covered by this Plan. It is prepared and updated by Health Net and distributed to Members, Member Physicians and Participating Pharmacies and posted on the Health Net website at www.healthnet.com/uc. Some Drugs in the Recommended Drug List require Prior Authorization from Health Net in order to be covered.

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

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

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

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

Infertility exists when partners have experienced the following:

- The partners have had sexual relations on a recurring basis for one year with the intent of achieving pregnancy and childbirth;
- The partners have not used contraception, yet the female has not become pregnant; or if she became pregnant, could not achieve a live birth; and
- The female partner has not gone through menopause.

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

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

Level I Drugs are Prescription Drugs listed in the Health Net Recommended Drug List that are primarily Generic Drugs and are not excluded or limited from coverage.

Level II Drugs are Prescription Drugs listed in the Health Net Recommended Drug List that are primarily Brand Name Drugs and are not excluded or limited from coverage.

Level III Drugs are Prescription Drugs that are not listed in the Health Net Recommended Drug List (previously known as the formulary) or listed as Level III Drugs in the Recommended Drug List and are not excluded or limited from coverage. Some Level III Drugs require Prior Authorization from Health Net in order to be covered.

Maintenance Drugs are Prescription Drugs used to manage chronic or long term conditions where Members respond positively to drug treatment and dosage adjustments are either no longer required or are made infrequently.

Managed Health Network, Inc. (MHN), is a specialized health care service plan licensed by the California Department of Managed Care, which contracts with Health Net to underwrite and administer delivery of Mental

Disorder and Chemical Dependency services through a network of Participating Mental Health Practitioners and Participating Mental Health Facilities.

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

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

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

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

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

Member is the Subscriber or an enrolled Family Member.

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

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

- It is a clinically significant behavioral or psychological syndrome or pattern;
- It is associated with a painful symptom, such as distress;
- It impairs a patient's ability to function in one or more major life activities; or

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

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

Nonparticipating Pharmacy is a pharmacy that does not have an agreement with Health Net to provide Prescription Drugs to Members.

Nurse Practitioner (NP) is a registered nurse certified as a Nurse Practitioner by the California Board of Registered Nursing. The NP, through consultation and collaboration with Physicians and other health providers, may provide and make decisions about, health care.

Open Enrollment Period is an annual period, during which individuals who are eligible for coverage in this Plan may enroll for the first time, or transfer from one health plan provided by the Group to another. Subscribers, who were enrolled previously, may add their eligible dependents at this time. The University may hold Special Open Enrollment Periods in addition to the annual period in exceptional circumstances. For example: Financial insolvency of other carriers currently used by the University or loss of providers in the University's service areas.

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

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

Orthotic Devices are those devices which are rigid or semi-rigid, affixed to the body externally, and are required to support or correct a defect of form or function of a permanently inoperative or malfunctioning body part, or is required to restrict motion in a diseased or injured part of the body.

Out-of-Pocket Maximum is the maximum amount of Copayments you must pay for Covered Services for each Calendar Year. It is your responsibility to inform Health Net when you have satisfied the Out-of-Pocket Maximum, so it is important to keep all receipts for Copayments that were actually paid. Deductibles and Copayments, which are paid toward certain covered services, are not applicable to your Out-of-Pocket Maximum. These exceptions are specified in "Out-of-Pocket Maximum" Section 300.

Outpatient Surgical Center is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services.

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

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

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

Participating Mental Health Professional is a Physician or other professional who is licensed by the state of California to provide mental health care. The Participating Mental Health Professional must have a service contract with the Behavioral Health Administrator to provide Mental Disorder and Chemical Dependency rehabilitation services.

Participating Pharmacy is a licensed pharmacy that has a contract with Health Net to provide Prescription Drugs to Members of this Plan.

Period of Initial Eligibility (PIE) is the period during which an Employee or Family Member may enroll without furnishing proof of insurability. The PIE begins the day the Employee or Family Member becomes eligible and ends 31 calendar days from the first date of eligibility (or the preceding business day if the 31st day is on a weekend or a holiday).

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

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

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

Physician Group Service Area is the geographic area within a 30-mile radius of the Member's selected Contracting Physician Group. This service area concept exists to establish a geographic distance from the Member's selected Physician Group beyond which only Emergency Care and Urgently Needed Care are covered.

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

Prescription Drug is a drug or medicine that can be obtained only by a Prescription Drug Order. All Prescription Drugs are required to be labeled "Caution, Federal Law Prohibits Dispensing Without a Prescription." An exception is insulin and other diabetic supplies, which are considered to be a covered Prescription Drug.

Prescription Drug Order is a written or verbal order or refill notice for a specific drug, strength and dosage form (such as a tablet, liquid, syrup or capsule issued by a Member Physician.

Primary Care Physician is a Member Physician who coordinates and controls the delivery of covered services and supplies to the Member. Primary Care Physicians include general and family practitioners, internists, pediatricians, and obstetricians/gynecologists.

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

Recommended Drug List (also known as **Health Net Recommended Drug List** or **the List)** is a list of the Prescription Drugs that are covered by this Plan. It is prepared and updated by Health Net and distributed to Members, Member Physicians and Participating Pharmacies and posted on the Health Net website at *www.healthnet.com/uc*. Some Drugs in the Recommended Drug List require Prior Authorization from Health Net in order to be covered.

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

- As a result of the Mental Disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home or (ii) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year;
- The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a Mental Disorder; or
- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

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

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

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

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

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

Urgently Needed Care is any otherwise covered medical service that a reasonable person with an average knowledge of health and medicine would seek for treatment of an injury, unexpected illness or complication of an existing condition, including pregnancy, to prevent the serious deterioration of his or her health, but which does

not qualify as Emergency Care, as defined in this section. This may include services for which a person should reasonably have known an emergency did not exist.

PLAN ADMINISTRATION

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

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

Sponsorship and Administration of the Plan
The University of California is the Plan sponsor and administrator for the Plan described in this booklet. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
Health & Welfare Administration
300 Lakeside Drive, 12th Floor
Oakland, CA 94612
(800) 888-8267

Retirees may also direct questions to the University's Customer Service Center at the above phone number.

Claims under the Plan are processed by Health Net at the following address and phone number:

HEALTH NET
P.O. Box 9103
Van Nuys, CA 91409-9103
1-800-522-0088

Group Contract Number
The Group Contract Number for this Plan is: 92-2557406

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

Plan Year
The plan year is January 1 through December 31.

Continuation of the Plan
The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premiums that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California’s annual budget appropriation.

Financial Arrangements
The benefits under the Plan are provided by Health Net under a Group Service Agreement. The cost of the premiums are currently shared between you and the University of California.

Agent for Serving of Legal Process
Legal process may be served on Health Net at the address listed above.

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

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

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

Claims under the Plan
To file a claim or to appeal a denied claim, refer to pages 57 and 69 of this document.

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

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

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Locating information within this electronic Evidence of Coverage (EOC) is easy. First, start at the beginning of the EOC document. Press Control Find ("Ctl" "F") and type in the topic that you're trying to locate. The Find feature on your computer will immediately take you to the first reference to your topic in the EOC. Hit "Next" to find the next reference to your topic.

For more information, please contact us at:

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

Member Services
1-800-522-0088

Para los que hablan español
1.800.331.1777

Cantonese
1.877.891.9050

Mandarin
1.877.891.9053

Tagalog
1.877.891.9051

Vietnamese
1.877.339.8621

Telecommunications Device for the Deaf
1.800.995.0852

www.healthnet.com/uc