Health Net of California, Inc. (Health Net)

Disclosure Form

HSP

Small Business Group

Refer to the Summary of Benefits and Coverage (SBC) document to determine your share of costs for services and supplies that are covered by this plan.

HealthNet.com

Delivering Choices

When it comes to your health care, the best decisions are made with the best choices. Health Net provides you with ways to help you receive the care you deserve. The *Disclosure Form* answers basic questions about this Health Net PureCare Health Care Service Plan (HSP).

The coverage described in this *Disclosure Form* shall be consistent with the Essential Health Benefits coverage requirements in accordance with the Affordable Care Act (ACA). The Essential Health Benefits are not subject to any annual dollar limits.

The benefits described under this *Disclosure Form* do not discriminate on the basis of race, ethnicity, nationality, gender, gender identity, gender expression, age, disability, sexual orientation, genetic information, or religion, and are not subject to any pre-existing condition or exclusion period.

If you have further questions, contact us:

By phone at 1-800-522-0088

By mail at:

Health Net of California
P.O. Box 9103
Van Nuys, CA 91409-9103

Online at www.healthnet.com

This *Disclosure Form* (including any applicable *Disclosure Form Rider*) and the *Summary of Benefits and Coverage (SBC)* document provide a summary of your health plan. The plan's *Evidence of Coverage (EOC)*, which you will receive after you enroll, contains the exact terms and conditions of your Health Net coverage. You have the right to view the *EOC* prior to enrollment. To obtain a copy of the *EOC*, contact the Customer Contact Center at 1-800-522-0088. You should also consult the *Group Hospital and Professional Service Agreement* (issued to your employer) to determine governing contractual provisions. It is important for you to carefully read this *Disclosure Form*, the *SBC* and, once received, the plan's *EOC*, especially those sections that apply to those with special health care needs. This *Disclosure Form* includes a matrix of benefits in the section titled "Benefit Matrix." The *SBC*, which is issued in conjunction with this *Disclosure Form*, describes what your plan covers and what you pay for covered services and supplies.

Health Net HSP PureCare Network Rider (Rider)

Health Net of California, Inc. (“Health Net”) issues this Rider in conjunction with the accompanying coverage document. It describes available provider network for your Plan’s coverage. Please review this Rider along with the accompanying document to find out what this Plan covers and how much you will pay for covered services and supplies.

HEALTH NET HSP PURECARE NETWORK

PLEASE READ THIS IMPORTANT NOTICE ABOUT THE HEALTH NET HSP PURECARE NETWORK HEALTH PLAN SERVICE AREA AND OBTAINING SERVICES FROM PURECARE NETWORK PHYSICIAN AND HOSPITAL PROVIDERS.

Except for Emergency and Urgently Needed Care, benefits for physician and hospital services under this **Health Net HSP PureCare Network** ("PureCare Network") Plan are only available when you live or work in the PureCare Network service area and use a PureCare Network participating physician or hospital. When you enroll in this PureCare Network plan, you may only use a participating physician or hospital that is in the PureCare Network and you are required to choose a PureCare primary care physician. You may obtain ancillary, Pharmacy or Behavioral Health covered services and supplies from any Health Net Participating ancillary, Pharmacy or Behavioral Health Provider.

Obtaining Covered Services under the Health Net HSP Purecare Network Plan

Type of Provider	Available From
HOSPITAL	Only PureCare Network Hospitals*
PHYSICIAN	Only PureCare Network Physicians*
ANCILLARY	All Health Net Contracting Ancillary Providers
PHARMACY	All Health Net Participating Pharmacies
BEHAVIORAL HEALTH	All Health Net Contracting Behavioral Health Providers

* *The benefits of this Plan for Physician and Hospital services are only available for covered services received from a PureCare Network participating physician or Hospital, except for Emergency and Urgently Needed Care. Please refer to the coverage document for more details on referrals and how to obtain Emergency and Urgently Needed Care.*

Not all Physicians and Hospitals that contract with Health Net are PureCare Network participating providers. Only those Physicians and Hospitals specifically identified as participating providers in the PureCare Network may provide services under this Plan, except as described in the chart above.

The PureCare Network service area and a list of its participating physician and Hospital providers are shown in the Health Net HSP *PureCare Network Provider Directory*, which is available online at our website www.healthnet.com. You can also call the Health Net Customer Contact Center at **1-800-522-0088** to request provider information. The *HSP PureCare Network Provider Directory* is different from other Health Net Provider Directories.

Unless specifically stated otherwise, use of the following terms in this Evidence of Coverage solely refers to the PureCare Network as explained above.

- Health Net
- Health Net service area
- Hospital
- primary care physician, participating physician, participating provider and contracting Providers
- Network
- Provider Directory

If you have any questions about the PureCare Network service area, choosing a PureCare network primary care physician, how to access care or your benefits, please contact the Health Net Customer Contact Center at **1-800-522-0088**.

Health Net PureCare Network Alternative Access Standards

The PureCare Network includes participating Primary Care and Specialist Physicians, and Hospitals in the PureCare Network service area. However, Members residing in the following zip codes will need to travel as indicated to access a participating PCP and/or receive non-emergency Hospital services.

16– 30 Miles

Alameda County .....**94550** – Livermore (PCP and Hospital)

Contra Costa County .....**94509** – Antioch (Hospital), **94511** – Bethel Island (Hospital), **94513** – Brentwood (Hospital), **94514** – Byron (Hospital), **94548** – Knightsen (Hospital), **94561** – Oakley (Hospital)

Fresno County.....**93624** – Five Points (Hospital), **93630** – Kerman (Hospital), **93641** – Miramonte (Hospital), **93656** – Riverdale (Hospital), **93657** – Sanger (Hospital), **93660** – San Joaquin (Hospital), **93664** – Shaver Lake (PCP), **93667** – Tollhouse (Hospital), **93706** – Fresno (Hospital)

Kern County .....**93203** – Arvin (Hospital), **93222** – Frazier Park (Hospital), **93252** – Maricopa (PCP), **93255** – Onyx (PCP), **93263** –Shafter (Hospital), **93280** – Wasco (Hospital), **93287** – Woody (Hospital), **93308** – Bakersfield (Hospital), **93311** – Bakersfield (PCP and Hospital), **93313** – Bakersfield (Hospital), **93501** – Mojave (Hospital), **93504** – California

City (Hospital), **93505** – California City (Hospital), **93519** – Cantil (PCP), **93560** – Rosamond (PCP and Hospital)

Kings County .....**93239** – Kettleman City (PCP), **93266** – Stratford (Hospital)

Los Angeles County .....**90265** – Malibu (Hospital), **91390** – Santa Clarita (Hospital), **93532** – Lake Hughes (Hospital), **93535** – Lancaster (PCP and Hospital), **93536** – Lancaster (PCP and Hospital), **93543** – Littlerock (Hospital), **93544** – Llano (Hospital), **93553** – Pearblossom (Hospital), **93563** – Valyermo (Hospital), **93591** – Palmdale (Hospital)

Madera County.....**93610** – Chowchilla (Hospital), **93626** – Friant (Hospital), **93636** – Madera (Hospital), **93645** – O'Neals (Hospital)

Marin County .....**94937** – Inverness (Hospital), **94956** – Point Reyes Station (Hospital)

Merced County.....**93661** – Santa Rita Park (Hospital), **93665** – South Dos Palos (Hospital), **95333** – Le Grand (Hospital), **95341** – Merced (Hospital)

Placer County .....**95603** – Auburn (Hospital), **95604** – Auburn (Hospital), **95648** – Lincoln (Hospital), **95681** – Sheridan (Hospital)

Riverside County .....**92274** – Thermal (Hospital), **92536** – Aguanga (Hospital), **92539** – Anza (Hospital), **92544** – Hemet (Hospital), **92592** – Temecula (Hospital), **92593** - Temecula (Hospital) Sacramento County: **95615** Courtland (Hospital), **95638** – Herald (Hospital), **95641** – Isleton (Hospital), **95680** – Ryde (Hospital), **95690** – Walnut Grove (Hospital)

San Bernardino County ...**92285** – Yucca Valley (Hospital), **92301** – Adelanto (Hospital), **92347** – Hinkley (Hospital), **92365** -- Newberry Springs (PCP and Hospital), **92372** – Pinon Hills (Hospital), **92397** – Wrightwood (Hospital)

San Diego County .....**91901** – Alpine (Hospital), **91916** – Descanso (Hospital), **91917** – Dulzura (Hospital), **91931** – Imperial Beach (Hospital), **91963** – Potrero (Hospital), **92021** – El Cajon (Hospital), **92040** – Lakeside (Hospital), **92059** – Pala (Hospital), **92060** – Palomar Mountain (Hospital), **92061** – Pauma Valley (Hospital), **92065** – Ramona (Hospital), **92070** – Santa Ysabel (Hospital)

San Joaquin County.....**95206** – Stockton (Hospital), **95219** – Stockton (Hospital), **95376** – Tracy (Hospital), **95377** – Tracy (Hospital), **95378** – Tracy (Hospital), **95391** – Tracy (Hospital)

San Mateo County.....**94021** Loma Mar (Hospital), **94060** – Pescadero (Hospital)

Santa Clara County.....**95037** – Morgan Hill (Hospital), **95141** – San Jose (Hospital)

Santa Cruz County .....**95060** – Santa Cruz (Hospital)

Solano County .....**94512** Birds Landing (Hospital), **94571** – Rio Vista (Hospital), **94589** – Vallejo (Hospital), **94590** – Vallejo (Hospital), **94591** – Vallejo (Hospital)

Sonoma County .....**94923** – Bodega Bay (Hospital), **94952** – Petaluma (Hospital), **95412** – Annapolis (PCP), **95421** – Cazadero (Hospital), **95425** – Cloverdale (Hospital), **95450** – Jenner (Hospital), **95480** – Stewarts Point (PCP and Hospital), **95497** – Gualala (PCP)

Stanislaus County.....**95313** – Crows Landing (Hospital), **95329** – La Grange (Hospital), **95360** – Newman (Hospital), **95363** – Patterson (Hospital), **95386** – Waterford (Hospital)

Tulare County .....**93207** – California Hot Springs (Hospital), **93208** – Camp Nelson (Hospital), **93237** – Kaweah (Hospital), **93260** – Posey (Hospital),

93265 – Springville (Hospital), **93286** – Woodlake (Hospital), **93292** – Visalia (Hospital), **93603** – Badger (Hospital)

Beyond 30 Miles

Fresno County.....**93210** – Coalinga (Hospital: 58 miles), **93234** – Huron (Hospital: 43 miles), **93602** – Auberry (Hospital: 33 miles), **93605** – Big Creek (Hospital: 44 miles), **93608** – Cantua Creek (Hospital: 45 miles), **93621** – Dunlap (Hospital: 32 miles), **93622** – Firebaugh (Hospital: 45miles), **93627** – Helm (Hospital: 37 miles), **93628** – Hume (Hospital: 38 miles), **93634** – Lakeshore (Hospital: 49 miles), **93640** – Mendota (Hospital: 43 miles), **93642** – Mono Hot Springs (Hospital: 53 miles), **93664** – Shaver Lake (Hospital: 56 miles), **93668** – Tranquility (Hospital: 36 miles)

Kern County .....**93206** – Buttonwillow (Hospital: 35 miles), **93224** – Fellows (Hospital: 38 miles), **93225** – Frazier Park (Hospital: 33 miles), **93243** – Lebec (PCP: 38 miles and Hospital: 38 miles), **93249** – Lost Hills (PCP: 35 miles and Hospital: 54 miles), **93251** – McKittrick (Hospital: 41 miles), **93252** – Maricopa (Hospital: 40 miles), **93268** – Taft (Hospital: 33 miles), **93516** – Boron (Hospital: 42 miles), **93519** – Cantil (Hospital: 35 miles), **93523** – Edwards Air Force Base (Hospital: 39 miles), **93524** – Edwards Air Force Base (Hospital: 39 miles), **93596** – Boron (Hospital: 39 miles)

Kings County .....**93204** – Avenal (Hospital 45 miles), **93239** – Kettleman City (Hospital: 39 miles)

Los Angeles County .....**90704** – Avalon (PCP: 38 miles and Hospital: 38 miles)

Madera County.....**93601** – Ahwahnee (Hospital: 38 miles), **93604** – Bass Lake (Hospital: 36 miles), **93614** – Coarsegold (Hospital: 32 miles), **93643** – North Fork (Hospital: 39 miles), **93644** – Oakhurst (Hospital: 42 miles), **93653** – Raymond (Hospital: 35 miles), **93669** – Wishon (Hospital: 35 miles)

Merced County .....**93620** – Dos Palos (Hospital: 32 miles), **93635** – Los Banos (Hospital: 39 miles), **95322** – Gustine (Hospital: 33 miles)

Nevada County .....**95959** – Nevada City (Hospital: 31 miles)

Riverside County .....**92254** – Mecca (Hospital: 32 miles)

San Bernardino County ...**92277** – Twentynine Palms (Hospital: 30 miles), **92278** – Twentynine Palms (PCP: 40 miles and Hospital: 44 miles), **92309** – Baker (PCP: 105 miles and Hospital: 106 miles), **92310** – Fort Irwin (PCP: 40 miles and Hospital: 41 miles), San Diego County: **91905** – Boulevard (Hospital: 46 miles), **91906** – Campo (Hospital: 40 miles), **91934** – Jacumba (Hospital: 55 miles), **91948** – Mt. Laguna (Hospital: 37 miles), **91962** – Pine Valley (Hospital: 40 miles), **91980** – Tecate (Hospital: 37 miles), **92004** – Borrego Springs (Hospital: 47 miles), **92036** – Julian (Hospital: 48 miles), **92066** – Ranchita (Hospital: 38 miles), **92086** – Warner Springs (Hospital: 37 miles)

Santa Barbara County .....**93254** – New Cuyama (PCP: 32 miles and Hospital: 37 miles)

Sonoma County .....**95412** – Annapolis (Hospital: 34 miles), **95497** – Gualala (Hospital: 39 miles)

Tulare County .....**93262** – Sequoia National Park (Hospital: 41 miles), **93271** – Three Rivers (Hospital: 32 miles)

Yolo County .....**95606** – Brooks (PCP and Hospital: 33 miles), **95637** – Guinda (PCP 32 miles and Hospital: 33 miles), **95679** - Rumsey (PCP and Hospital: 33 miles), **95937** – Dunnigan (PCP: 34 miles and Hospital: 35 miles)

If you have any questions about the PureCare Network service area, how to choose a primary care physician, or how to access care or your benefits, please contact the Health Net Customer Contact Center at **1-800-522-0088**.

Health Net HSP PureCare Network Alternative Access Standards

The HSP PureCare Network includes participating ancillary providers, including acupuncture, vision and dental services providers, in the PureCare service area. However, in the rural zip codes within the service area identified below, Health Net may not have a contracted provider for acupuncture, vision and/or dental services. If you require medically necessary services from an acupuncture, vision and/or dental services provider in these areas where Health Net does not have a contracted provider for acupuncture, vision and/or dental services, and there are nonparticipating acupuncture, vision and/or dental providers offices located within access standards, Health Net's applicable ancillary provider networks will make arrangements with a nonparticipating acupuncture, vision and/or dental services provider within the access standards who will provide the services to you at the Copayment levels described in the *Evidence of Coverage*.

Acupuncture

Fresno County .....93210 (Coalinga), 93234 (Huron), 93640 (Mendota), 93642 (Mono Hot Springs) and 93664 (Shaver Lake)

Kern County .....93205 (Bodfish), 93240 (Lake Isabella), 93283 (Weldon), 93505 (California City), 93519 (Cantil), 93523 (Edwards) and 93561 (Tehachapi)

Kings County .....All Zip Codes in the Kings County service area.

Los Angeles County .....90704 (Avalon)

Madera County .....93644 (Oakhurst)

San Bernardino County ....92277 (Twentynine Palms), 92309 (Baker), 92310 (Fort Irwin), 92327 (Daggett) and 92365 (Newberry Springs)

Tulare County All Zip Codes in the Tulare County service area

Vision

Fresno County .....93628 (Hume)

Kern County .....93243 (Lebec), 93505 (California City), 93516 (Boron), 93519 (Cantil), 93523 (Edwards), 93524 (Edwards) and 93596 (Boron)

Los Angeles County .....90704 (Avalon) and 93243 (Lebec)

San Bernardino County ....92277 (Twenty-Nine Palms), 92309 (Baker), 92310 (Fort Irwin) and 93516 (Boran)

San Diego County .....91905 (Boulevard) and 92004 (Borrego Springs)

Tulare County .....93262 (Sequoia National Park)

Dental

Primary Care Dentists and General Dentists

Contra Costa County .....94513 (Brentwood)

El Dorado County .....95619 (Diamond Springs), 95633 (Garden Valley), 95634 (Georgetown), 95635 (Greenwood), 95636 (Grizzly Flats), 95667 (Placerville), 95684 (Somerset), 95709 (Camino) and 95726 (Pollock Pines)

Fresno County .....93210 (Coalinga), 93234 (Huron), 93242 (Laton), 93602 (Auberry), 93603 (Badger), 93605 (Big Creek), 93607 (Burrel), 93608 (Cantua Creek), 93609 (Caruthers), 93619 (Clovis), 93620 (Dos Palos), 93621 (Dunlap), 93622 (Firebaugh), 93624 (Five Points), 93627 (Helm), 93628 (Hume), 93630 (Kerman), 93631 (Kingsburg), 93634 (Lakeshore), 93640 (Mendota), 93641 (Miramonte), 93642 (Mono Hot Springs), 93646 (Orange Cove), 93648 (Parlier), 93649 (Piedra), 93651 (Prather), 93654 (Reedley), 93656 (Riverdale), 93657 (Sanger), 93660 (San Joaquin), 93662 (Selma), 93664 (Shaver Lake), 93667 (Tollhouse), 93668 (Tranquillity), 93675 (Squaw Valley), 93706 (Fresno) and 93725 (Fresno)

Kern County .....93203 (Arvin), 93205 (Bodfish), 93206 (Buttonwillow), 93215 (Delano), 93216 (Delano), 93222 (Pine Mountain Club), 93224 (Fellows), 93225 (Frazier Park), 93226 (Glennville), 93238 (Kernville), 93240 (Lake Isabella), 93243 (Lebec), 93249 (Lost Hills), 93250 (Mc Farland), 93251 (Mc Kittrick), 93252 (Maricopa), 93255 (Onyx), 93263 (Shafter), 93268 (Taft), 93276 (Tupman), 93280 (Wasco), 93283 (Weldon), 93285 (Wofford Heights), 93287 (Woody), 93307 (Bakersfield), 93308 (Bakersfield), 93311 (Bakersfield), 93313 (Bakersfield), 93314 (Bakersfield), 93501 (Mojave), 93502 (Mojave), 93504 (California City), 93505 (California City), 93516 (Boron), 93518 (Caliente), 93519 (Cantil), 93523 (Edwards), 93524 (Edwards), 93531 (Keene), 93536 (Lancaster), 93560 (Rosamond), 93561 (Tehachapi), 93581 (Tehachapi) and 93596 (Boron)

Kings County .....93202 (Armona), 93204 (Avenal), 93212 (Corcoran), 93230 (Hanford), 93631 (Kingsburg), 93232 (Hanford), 93239 (Kettleman City), 93242 (Laton), 93245 (Lemoore), 93266 (Stratford) and 93656 (Riverdale)

Los Angeles County .....90704 (Avalon), 91390 (Santa Clarita), 93243 (Lebec), 93532 (Lake Hughes), 93535 (Lancaster), 93536 (Lancaster), 93543 (Littlerock), 93544 (Llano), 93553 (Pearblossom), 93563 (Valyermo), 93591 (Palmdale)

Madera County .....93601 (Ahwahnee), 93604 (Bass Lake), 93610 (Chowchilla), 93614 (Coarsegold), 93622 (Firebaugh), 93626 (Friant), 93636 (Madera), 93637 (Madera), 93638 (Madera), 93639 (Madera), 93643 (North Fork), 93644 (Oakhurst), 93645 (O Neals), 93653 (Raymond) and 93669 (Wishon)

Marin County .....94901 (San Rafael), 94903 (San Rafael), 94904 (Greenbrae), 94912 (San Rafael), 94913 (San Rafael), 94914 (Kentfield), 94924 (Bolinas),

94929 (Dillon Beach), 94930 (Fairfax), 94933 (Forest Knolls), 94937 (Inverness), 94938 (Lagunitas), 94939 (Larkspur), 94940 (Marshall), 94945 (Novato), 94946 (Nicasio), 94947 (Novato), 94948 (Novato), 94949 (Novato), 94950 (Olema), 94952 (Petaluma), 94956 (Point Reyes Station), 94957 (Ross), 94960 (San Anselmo), 94963 (San Geronimo), 94970 (Stinson Beach), 94971 (Tomales), 94973 (Woodacre), 94978 (Fairfax), 94979 (San Anselmo) and 94998 (Novato)

Merced County .....93610 (Chowchilla), 93620 (Dos Palos), 93622 (Firebaugh), 93635 (Los Banos), 93661 (Santa Rita Park), 93665 (South Dos Palos), 95301 (Atwater), 95303 (Ballico), 95312 (Cressey), 95315 (Delhi), 95317 (El Nido), 95322 (Gustine), 95324 (Hilmar), 95333 (Le Grand), 95334 (Livingston), 95340 (Merced), 95341 (Merced), 95343 (Merced), 95344 (Merced), 95348 (Merced), 95360 (Newman), 95365 (Planada), 95369 (Snelling), 95374 (Stevinson), 95380 (Turlock) and 95388 (Winton)

Napa County .....94508 (Angwin), 94515 (Calistoga), 94558 (Napa), 94567 (Pope Valley), 94574 (Saint Helena) and 94576 (Deer Park)

Nevada County.....All Zip Codes in the Nevada County service Aaea.

Placer County .....95603 (Auburn), 95631 (Foresthill), 95701 (Alta), 95703 (Applegate), 95713 (Colfax), 95714 (Dutch Flat), 95722 (Meadow Vista), 95736 (Weimar)

Riverside County .....92220 (Banning), 92223 (Beaumont), 92230 (Cabazon), 92234 (Cathedral City), 92235 (Cathedral City), 92240 (Desert Hot Springs), 92241 (Desert Hot Springs), 92254 (Mecca), 92258 (North Palm Springs), 92262 (Palm Springs), 92263 (Palm Springs), 92264 (Palm Springs), 92274 (Thermal), 92282 (Whitewater), 92539 (Anza) and 92561 (Mountain Center)

Sacramento County.....95632 (Galt), 95638 (Herald), 95641 (Isleton) and 95690 (Walnut Grove)

San Bernardino County ....92252 (Joshua Tree), 92256 (Morongo Valley), 92268 (Pioneertown), 92277 (Twentynine Palms), 92278 (Twentynine Palms), 92284 (Yucca Valley), 92285 (Lander), 92286 (Yucca Valley), 92301 (Adelanto), 92305 (Angelus Oaks), 92309 (Baker), 92310 (Fort Irwin), 92311 (Barstow), 92312 (Barstow), 92314 (Big Bear City), 92315 (Big Bear Lake), 92327 (Daggett), 92333 (Fawnskin), 92347 (Hinkley), 92356 (Lucerne Valley), 92365 (Newberry Springs), 92386 (Sugarloaf), 92398 (Yermo), 93516 (Boron)

San Diego County.....91901 (Alpine), 91905 (Boulevard), 91906 (Campo), 91916 (Descanso), 91917 (Dulzura), 91931 (Guatay), 91934 (Jacumba), 91948 (Mount Laguna), 91962 (Pine Valley), 91963 (Potrero), 91980 (Tecate), 92004 (Borrego Springs), 92036 (Julian), 92061 (Pauma Valley), 92065 (Ramona), 92066 (Ranchita), 92070 (Santa Ysabel) and 92086 (Warner Springs)

San Joaquin County.....95215 (Stockton), 95220 (Acampo), 95227 (Clements), 95230 (Farmington), 95236 (Linden), 95237 (Lockeford), 95240 (Lodi), 95632 (Galt), and 95638 (Herald)

San Mateo County .....94010 (Burlingame), 94060 (Pescadero) and 94062 (Redwood City), 94401 (San Mateo), and 94402 (San Mateo)

Santa Barbara County .....93013 (Carpinteria), 93014 (Carpinteria), 93067 (Summerland), 93101 (Santa Barbara), 93102 (Santa Barbara), 93103 (Santa Barbara), 93105 (Santa Barbara), 93106 (Santa Barbara), 93107 (Santa Barbara), 93108 (Santa Barbara), 93109 (Santa Barbara), 93110 (Santa Barbara), 93111 (Santa Barbara), 93116 (Goleta), 93117 (Goleta), 93118 (Goleta), 93120 (Santa Barbara), 93121 (Santa Barbara), 93130 (Santa Barbara), 93140 (Santa Barbara), 93150 (Santa Barbara), 93160 (Santa Barbara), 93190 (Santa Barbara), 93199 (Goleta), 93252 (Maricopa), 93254 (New Cuyama), 93427 (Buellton), 93429 (Casmalia), 93434 (Guadalupe), 93436 (Lompoc), 93437 (Lompoc), 93438 (Lompoc), 93440 (Los Alamos), 93441 (Los Olivos), 93454 (Santa Maria), 93455 (Santa Maria), 93456 (Santa Maria), 93457 (Santa Maria), 93458 (Santa Maria), 93460 (Santa Ynez), 93463 (Solvang) and 93464 (Solvang)

Santa Clara County.....95020 (Gilroy)

Santa Cruz County.....94060 (Pescadero), 95001 (Aptos), 95003 (Aptos), 95005 (Ben Lomond), 95010 (Capitola), 95017 (Davenport), 95018 (Felton), 95019 (Freedom), 95041 (Mount Hermon), 95060 (Santa Cruz), 95061 (Santa Cruz), 95062 (Santa Cruz), 95063 (Santa Cruz), 95064 (Santa Cruz), 95065 (Santa Cruz), 95066 (Scotts Valley), 95067 (Scotts Valley), 95073 (Soquel), 95076 (Watsonville) and 95077 (Watsonville)

Solano County .....94571 (Rio Vista), 95620 (Dixon) and 95690 (Walnut Grove)

Sonoma County.....94923 (Bodega Bay), 94952 (Petaluma), 94953 (Petaluma), 94954 (Petaluma), 94955 (Petaluma), 94975 (Petaluma), 94999 (Petaluma), 95412 (Annapolis), 95421 (Cazadero), 95425 (Cloverdale), 95441 (Geyserville), 95446 (Guerneville), 95448 (Healdsburg), 95450 (Jenner), 95480 (Stewarts Point) and 95497 (The Sea Ranch)

Stanislaus County.....95230 (Farmington), 95307 (Ceres), 95313 (Crows Landing), 95316 (Denair), 95322 (Gustine), 95323 (Hickman), 95324 (Hilmar), 95328 (Keyes), 95329 (La Grange), 95360 (Newman), 95361 (Oakdale), 95363 (Patterson), 95380 (Turlock), 95381 (Turlock), 95382 (Turlock) and 95386 (Waterford)

Tulare County .....93201 (Alpaugh), 93207 (California Hot Springs), 93208 (Camp Nelson), 93212 (Corcoran), 93215 (Delano), 93218 (Ducor), 93219 (Earlimart), 93221 (Exeter), 93223 (Farmersville), 93227 (Goshen), 93235 (Ivanhoe), 93237 (Kaweah), 93244 (Lemon Cove), 93247 (Lindsay), 93256 (Pixley), 93257 (Porterville), 93258 (Porterville), 93260 (Posey), 93261(Richgrove), 93262 (Sequoia National Park), 93265 (Springville), 93267 (Strathmore), 93270 (Terra Bella), 93271 (Three Rivers), 93272 (Tipton), 93274 (Tulare), 93275 (Tulare), 93277 (Visalia), 93278 (Visalia), 93279 (Visalia), 93282 (Waukena), 93286 (Woodlake), 93290 (Visalia), 93291 (Visalia), 93292 (Visalia), 93603 (Badger), 93615 (Cutler), 93618 (Dinuba), 93631 (Kingsburg), 93646 (Orange Cove), 93647 (Orosi), 93654 (Reedley), 93666 (Sultana), 93673 (Traver) and 93670 (Yettem)

Ventura County.....93001 (Ventura), 93022 (Oak View), 93023 (Ojai), 93024 (Ojai), and 93252 (Maricopa)

Yolo County .....95606 (Brooks), 95607 (Capay), 95637 (Guinda), 95679 (Rumsey) and 95937 (Dunnigan)

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How the Plan Works

Please read the following information so you will know from whom health care may be obtained, or what group of providers to use. If any network rider has been issued with this document, refer to the rider for additional information.

CHOICE OF PARTICIPATING PROVIDERS

- When you enroll in the Health Net HSP plan, you may go directly to any HSP PureCare participating provider. Simply find the provider you wish to see in the *Health Net HSP PureCare Participating Provider Directory* and schedule an appointment.
- Participating providers accept a special rate, called the contracted rate, as payment in full. Your share of costs is based on that contracted rate. All benefits of an HSP plan (except emergency and urgently needed care) must be provided by a participating provider in order to be covered.
- Health Net requires the designation of a PCP. A PCP provides and coordinates your medical care. You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For children, a pediatrician may be designated as the PCP. Until you make this PCP designation, Health Net designates one for you. For information on how to select a PCP and for a list of the participating PCPs in the Health Net service area, refer to your Health Net Group HSP Directory (*Health Net HSP PureCare Participating Provider Directory*). The *Health Net HSP Participating Provider Directory* is also available on the Health Net website at www.healthnet.com. You can also call the Customer Contact Center at the number shown on your Health Net ID card to request provider information.
- Whenever you or a covered family member needs health care, your PCP may provide the medically necessary care or you may go directly to any HSP PureCare participating provider.
- You do not have to choose the same PCP for all members of your family. Participating providers, with names of physicians, are listed in the *Health Net HSP PureCare Participating Provider Directory*.

*In some instances, **certification** (also known as preauthorization or treatment review) is required for full benefits to be paid. Refer to the "Certification Requirements" section of this Disclosure Form to find out which services or supplies require certification.*

SPECIALISTS CARE

If you need specialty care, you are free to see any specialist without a referral from a participating provider in the *Health Net HSP PureCare Participating Provider Directory*. Simply call and schedule an appointment.

You do not need prior authorization from Health Net or from any other person (including a primary Care Physician) in order to obtain access to obstetrical, gynecological, reproductive or sexual health care from an in-network health care professional who specializes in obstetrics, gynecology or

reproductive and sexual health. The health care professional, however, may be required to comply with certain procedures, including obtaining prior certification for certain services, or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics, gynecology or reproductive and sexual health, refer to your *Health Net HSP PureCare Participating Provider Directory* on the Health Net website at www.healthnet.com. A copy of the *Health Net HSP PureCare Participating Provider Directory* may also be ordered online or by calling Health Net Customer Contact Center at **1-800 522-0088**.

MENTAL HEALTH AND SUBSTANCE USE DISORDERS

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

HOW TO ENROLL

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

Some hospitals and other providers do not provide one or more of the following services that may be covered under the plan's Evidence of Coverage and that you or your family member might need:

- **Family planning**
- **Contraceptive services; including emergency contraception**
- **Sterilization, including tubal ligation at the time of labor and delivery**
- **Infertility treatments**
- **Abortion**

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

Benefits Matrix

The matrix below lists examples of services that are provided under this plan. Refer to the SBC, which is issued in conjunction with this Disclosure Form, for the amount you will pay for covered services and supplies.

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

Principal Benefits	What You Pay
Deductible	The *SBC* shows if your plan has a deductible that has to be met before we begin to pay the benefits.
Lifetime maximums	This plan does not have a lifetime maximum.
Professional services	Refer to the *SBC* under "If you visit a health care provider's office or clinic."
Outpatient services	Refer to the *SBC* under "If you have outpatient surgery."
Hospitalization services	Refer to the *SBC* under "If you have a hospital stay."
Emergency health coverage	Refer to the *SBC* under "If you need immediate medical attention."
Ambulance services	Refer to the *SBC* under "If you need immediate medical attention."
Prescription drug coverage	Refer to the *SBC* under "If you need drugs to treat your illness or condition."
Durable medical equipment	Refer to the *SBC* under "If you need help recovering or have other special health needs."
Mental health services	Refer to the *SBC* under "If you need mental health, behavioral health, or substance abuse services."
Substance use disorder services	Refer to the *SBC* under "If you need mental health, behavioral health, or substance abuse services."
Home health services	Refer to the *SBC* under "If you need help recovering or have other special health needs."
Other services	Refer to the *SBC* under "If you have a test" and "If you need help recovering or have other special health needs."
Pediatric vision care	Pediatric vision benefits are administered by Envolve Vision, Inc. Refer to the "Pediatric Vision Care Program" section later in this *Disclosure Form* for the benefit information which includes the eyewear schedule.
Pediatric dental services	Pediatric dental benefits are offered and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is not affiliated with Health Net. Refer to the "Pediatric Dental Program" section later in this *Disclosure Form* for the benefit information. See the *EOC* for additional details.

Certification Requirements

Certain covered services require Health Net's review and approval, called certification, before they are obtained. If these services are not certified before they are received, you will be responsible for paying a $250 noncertification penalty. These penalties do not apply to your out-of-pocket maximum. If you incur noncertification penalties after your out-of-pocket maximum has been met, you will still be responsible for paying the noncertification penalties. Services provided as the result of an emergency do not require certification.

We may revise the certification list from time to time. Any such changes, including additions and deletions from the list will be communicated to participating providers and posted on the www.healthnet.com website.

Certification is NOT a determination of benefits. Some of these services or supplies may not be covered under your plan. Even if a service or supply is certified, eligibility rules, and benefit limitations will still apply.

SERVICES REQUIRING CERTIFICATION

Inpatient facility admissions

Any type of facility, including but not limited to:

- Acute rehabilitation center
- Mental health facility
- Hospice
- Hospital
- Skilled nursing facility
- Substance use disorder facility

Outpatient procedures, services or equipment

- Ablative techniques for treating Barrett's esophagus and for treatment of primary & metastatic liver malignancies
- Acupuncture (after the initial consultation)
- Ambulance: non-emergency, air or ground ambulance services
- Balloon sinuplasty
- Bariatric procedures
- Bronchial thermoplasty
- Capsule endoscopy
- Chiropractic care (after the initial consultation)
- Clinical trials
- Cochlear implants

- Diagnostic procedures including:
  1. Advanced imaging
     - Computerized Tomography (CT)
     - Computed Tomography Angiography (CTA)
     - Magnetic Resonance Angiography (MRA)
     - Magnetic Resonance Imaging (MRI)
     - Positron Emission Tomography (PET)
  2. Cardiac Imaging
     - Coronary Computed Tomography Angiography (CCTA)
     - Echocardiography
     - Myocardial Perfusion Imaging (MPI)
     - Multigated Acquisition (MUGA) scan
  3. Sleep studies
- Durable Medical Equipment (DME)
- Ear, Nose and Throat (ENT) procedures
- Enhanced External Counterpulsation (EECP)
- Experimental/Investigational services and new technologies
- Gender affirming services
- Genetic testing
- Implantable pain pumps including insertion or removal
- Injections, including trigger point, and sacroiliac (SI) joint injections
- Joint surgeries
- Mental health and substance use disorder services other than office visits including:
  - Applied Behavioral Analysis (ABA) and other forms of Behavioral Health Treatment (BHT) for autism and pervasive developmental disorders
  - Outpatient detoxification
  - Psychological testing
  - Neuropsychological testing
  - Outpatient Electroconvulsive Therapy (ECT)
  - Outpatient Transcranial Magnetic Stimulation (TMS)
  - Partial Hospital Program or Day Hospital (PHP)
  - Half-day partial Hospitalization

  - Intensive Outpatient Program (IOP)
- Neuro or spinal cord stimulator
- Neuropsychological testing
- Occupational and speech therapy (includes home setting)
- Orthognathic procedures (includes TMJ treatment)
- Orthotics (custom made items)
- Pharmaceuticals
- Outpatient Prescription Drugs
  - Most specialty drugs, including self-injectable drugs and hemophilia factors, must have prior authorization through the outpatient prescription drug benefit and may need to be dispensed through the specialty pharmacy vendor. Please refer to Essential RX Drug List to identify which drugs require prior authorization. Urgent or emergent drugs that are medically necessary to begin immediately may be obtained at a retail pharmacy.
  - Other prescription drugs, as indicated in the Essential RX Drug List, may require prior authorization. Refer to the Essential RX Drug List to identify which drugs require prior authorization.
  - Certain physician-administered drugs, including newly approved drugs, whether administered in a Physician office, free-standing infusion center, home infusion, Outpatient surgical center, outpatient dialysis center, or outpatient hospital. Refer to the Health Net website, www.healthnet.com, for a list of physician-administered drugs that require certification. Biosimilars are required in lieu of branded drugs, unless medically necessary.
- Physical therapy (includes home setting)
- Prosthesis
- Quantitative drug testing
- Radiation therapy
- Reconstructive and cosmetic surgery, services and supplies such as:
  - Bone alteration or reshaping such as osteoplasty
  - Breast reductions and augmentations except when following a mastectomy (includes mastectomy for gynecomastia)
  - Dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
  - Dermatology such as chemical exfoliation, electrolysis, dermabrasion, chemical peel, laser treatment, skin injections or implants

  - Excision, excessive skin and subcutaneous tissue (including lipectomy and panniculectomy) of the abdomen, thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad, and other areas
  - Eye or brow procedures such as blepharoplasty, brow ptosis or canthoplasty
  - Gynecologic or urology procedures such as clitoroplasty, labioplasty, vaginal rejuvenation, scrotoplasty, testicular prosthesis, and vulvectomy
  - Hair electrolysis, transplantation or laser removal
  - Lift such as arm, body, face, neck, thigh
  - Liposuction
  - Nasal surgery such as rhinoplasty or septoplasty
  - Otoplasty
  - Penile implant
  - Treatment of varicose veins
  - Vermilionectomy with mucosal advancement
- Referrals to nonparticipating providers
- Spinal surgery including but not limited to, laminotomy, fusion, discectomy, vertebroplasty, nucleoplasty, stabilization and X-Stop
- Testosterone therapy
- Transplant related services
- Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
- Vestibuloplasty

Exceptions: *Certification is not required for the length of a hospital stay for reconstructive surgery incident to a mastectomy (including lumpectomy) or for renal dialysis. Certification is also not required for the length of stay for the first 48 hours following a normal delivery or 96 hours following cesarean delivery or for behavioral health treatment for pervasive developmental disorder or autism.*

Limits of Coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- Ambulance and paramedic services that do not result in transportation or that do not meet the criteria for emergency care, unless such services are medically necessary and prior authorization has been obtained;
- Biofeedback therapy is limited to medically necessary treatment of certain physical disorders (such as incontinence and chronic pain) and mental health and substance use disorders;
- Care for mental health care as a condition of parole or probation, or court-ordered testing for mental health and substance use disorders, except when such services are medically necessary;
- Chiropractic services, unless shown as covered on your plan's *SBC*;
- Corrective footwear is limited to medically necessary footwear that is custom made for the member and permanently attached to a medically necessary orthotic device that is also a covered benefit under this plan, or is a podiatric device to prevent or treat diabetes-related complications. Other corrective footwear is not covered unless specifically described in your plan's *EOC*;
- Cosmetic services and supplies;
- Custodial or live-in care;
- Dental services for members age 19 and over in California. However, medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures are covered. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate;
- Disposable supplies for home use; except certain disposable ostomy or urological supplies
- Experimental or investigational procedures, except as set out under the "Clinical Trials" and "If You Have a Disagreement with Our Plan" sections of this *Disclosure Form*;
- Fertility preservation coverage does not include the following: follow-up assisted reproductive technologies (ART) to achieve future pregnancy such as artificial insemination, in vitro fertilization and/or embryo transfer; pre-implantation genetic diagnosis; donor eggs, sperm or embryos; or gestational carriers (surrogates);
- Genetic testing is not covered except when determined by Health Net to be medically necessary. The prescribing physician must request prior authorization for coverage;
- Hearing aids;
- Immunizations and injections for foreign travel/occupational purposes;
- Infertility services and supplies, unless shown as covered on your plan's *SBC*;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental health or substance use disorder;

- Noneligible institutions. This plan only covers medically necessary services or supplies provided by a licensed hospital, hospice, Medicare-approved skilled nursing facility, residential treatment center or other properly licensed medical facility as specified in the plan's *EOC*. Any institution that is not licensed to provide medical services and supplies, regardless of how it is designated, is not an eligible institution;
- Orthoptics (eye exercises);
- Orthotics (such as bracing, supports and casts) that are not custom made to fit the member's body. Refer to the "corrective footwear" bullet above for additional foot orthotic limitations;
- Outpatient prescription drugs (except as noted under "Prescription Drug Program");
- Personal or comfort items;
- Physician self-treatment;
- Physician treating immediate family members;
- Private rooms when hospitalized, unless medically necessary;
- Private-duty nursing;
- Refractive eye surgery unless medically necessary, recommended by the member's treating physician and authorized by Health Net;
- Reversal of surgical sterilization;
- Routine foot care for treatment of corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes;
- Routine physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp or other nonpreventive purposes;
- Services and supplies not authorized by Health Net, a participating provider (medical), or the Behavioral Health Administrator according to Health Net's procedures;
- Services for a surrogate pregnancy are covered when the surrogate is a Health Net member. However, when compensation is obtained for the surrogacy, Health Net shall have a lien on such compensation to recover its medical expense;
- Services or supplies that are rendered by a non-contracting provider or facility are only covered when authorized by Health Net (medical), the Behavioral Health Administrator (mental health or substance use disorders) or when you require emergency or urgently needed care.
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the plan's *EOC*;
- Services related to education or training, including for employment or professional purposes, except for behavioral health treatment for pervasive developmental disorder or autism;
- State hospital treatment, except as the result of an emergency or urgently needed care;
- Stress, except when rendered in connection with services provided for a treatable mental health or substance use disorder;
- Telehealth consultations through a select telehealth services provider do not cover specialist services; and prescriptions for substances controlled by the DEA, non-therapeutic drugs or certain other drugs which may be harmful because of potential for abuse;

- Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary; and
- Treatment of obesity, weight reduction or weight management, except for treatment of morbid obesity. Certain services may be covered as preventive care services as described in the plan's *EOC*.

The above is a partial list of the principal exclusions and limitations applicable to the medical portion of your Health Net plan. The *EOC*, which you will receive if you enroll in this plan, will contain the full list.

Benefits and Coverage

MEDICALLY NECESSARY CARE

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

EMERGENCIES

Health Net covers emergency and urgently needed care throughout the world. If you need emergency or urgently needed care, seek care where it is immediately available. Depending on your circumstances, you may call a participating provider (medical) or the Behavioral Health Administrator (mental health and substance use disorders) or go to the nearest emergency facility or call **911**.

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

All follow-up care (including mental health and substance use disorders) after the urgency has passed and your condition is stable, must be provided or authorized by a participating provider (medical) or the Behavioral Health Administrator (mental health and substance use disorders); otherwise, it will not be covered by Health Net.

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

child. Emergency care will also include additional screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, either within the capability of the facility or by transferring the member to a psychiatric unit within a general acute hospital or to an acute psychiatric hospital as medically necessary.

All air and ground ambulance and ambulance transport services provided as a result of a 911 call will be covered, if the request is made for an emergency medical condition (including mental health and substance use disorders).

***Emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) Placing the patient's health in serious jeopardy, (2) Serious impairment to bodily functions, or (3) Serious dysfunction of any bodily organ or part.*

***Psychiatric emergency medical condition** means a mental health and substance use disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: (1) An immediate danger to himself or herself or to others, or (2) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental health and substance use disorder.*

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

NOTICE OF REQUIRED COVERAGE

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

The Newborns' and Mothers' Health Protection Act of 1996 sets requirements for a minimum hospital length of stay following delivery. Specifically, group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

TIMELY ACCESS TO CARE

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

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

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

CLINICAL TRIALS

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

COVERAGE FOR NEWBORNS

Children born after your date of enrollment are automatically covered for 31 days (including the date of birth). To continue coverage, the child must be enrolled through your employer before the 60th day of the child's life. If the child is not enrolled within 60 days (including the date of birth):

- Coverage will end after 31 days (including the date of birth); and
- You will have to pay for all medical care provided after 31 days (including the date of birth).

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

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

EXTENSION OF BENEFITS

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

- A maximum of 12 consecutive months elapses from the termination date;
- Available benefits are exhausted;
- The disability ends; or

- The member becomes enrolled in another plan that covers the disability.

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

CONFIDENTIALITY AND RELEASE OF MEMBER INFORMATION

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

PRIVACY PRACTICES

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

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

Utilization Management

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

PRE-AUTHORIZATION

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

CONCURRENT REVIEW

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

DISCHARGE PLANNING

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

RETROSPECTIVE REVIEW

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

CARE OR CASE MANAGEMENT

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

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

Payment of Fees and Charges

PREPAYMENT FEES

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

YOUR, DEDUCTIBLES, COPAYMENTS, AND OUT-OF-POCKET MAXIMUMS

The *SBC* explains your coverage and payment for services. Please take a moment to look it over.

Some of the covered expenses under the PureCare HSP plan are subject to a requirement of certification in order for a noncertification penalty to not apply. See the "Certification Requirements" section for more information. Covered expenses for services provided by a participating provider will be based on the contracted rate.

You are responsible for payment of your share of the cost of services covered by this plan. Amounts paid by you are called deductibles and copayments, which are described in the *SBC*. Beyond these charges, the remainder of the cost of covered services will be paid by Health Net.

If your benefits are subject to a deductible, you must pay the deductible before we begin to pay for those benefits. When the total amount of copayments you pay equals the out-of-pocket maximum shown in the *SBC*, you will not have to pay additional copayments for the rest of the year for most services provided or authorized by Health Net.

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

LIABILITY OF SUBSCRIBER OR ENROLLEE FOR PAYMENT

If you receive health care services from an out-of-network provider for care other than emergency or urgently needed care, or the Behavioral Health Administrator (mental health and substance use disorders), you are responsible for the cost of these services.

Remember, this plan only covers services that are provided or authorized by a participating provider, or the Behavioral Health Administrator, except for emergency or out-of-area urgent care. Consult the HSP PureCare Participating Provider Directory for a full listing of Health Net-contracted physicians.

REIMBURSEMENT PROVISIONS

Payments that are owed by Health Net for services provided by your participating provider (medical), or the Behavioral Health Administrator (mental health and substance use disorders) will never be your responsibility.

Health Net is responsible for paying participating providers for covered services. Except for copayments and deductibles, participating providers may not bill you for charges in excess of our payment. You are financially responsible for: (a) services beyond the benefit limitations stated in the plan's EOC; and (b) services not covered by the plan. The plan does not cover: prepayment fees, copayments, deductibles, services and supplies not covered by the plan, or non-emergency care rendered by a nonparticipating provider.

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

If you receive emergency or urgent care services not provided by a participating provider (medical), or the Behavioral Health Administrator (mental health and substance use disorders), you may have to pay at the time you receive services. To be reimbursed for these charges, you should get a complete statement of the services received and, if possible, a copy of the emergency room or urgent care center report.

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

How to File a Claim

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

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

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

For outpatient prescription drugs, please send a completed prescription drug claim form to:

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

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

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

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

Please call MHN Claims at 1-800-444-4281 to obtain a claim form.

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

PROVIDER REIMBURSEMENT DISCLOSURE

Health Net pays participating physicians and other professional providers on a fee-for-service basis, according to an agreed contracted rate. Members may request more information about our payment methods by contacting Health Net's Customer Contact Center at the telephone number on the back of their Health Net ID card.

Facilities

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

- The facilities of the participating provider; or
- A nearby Health Net-contracted hospital, if hospitalization is required.

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

CONTINUITY OF CARE

Transition of Care for New Enrollees

You may request continued care from a provider who does not contract with Health Net if at the time of your enrollment with Health Net you were receiving care for the conditions listed in the "Continuity of Care upon Termination of Provider Contract" provision immediately below.

Health Net may provide coverage for completion of services from a nonparticipating provider, subject to applicable copayments and any exclusions and limitations of your plan. You must request the coverage within 60 days of your group's effective date unless you can show that it was not reasonably possible to make the request within 60 days of the group's effective date and you make the request as

soon as reasonably possible. The 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.

Continuity of Care upon Termination of Provider Contract

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

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

You may request continued care from a provider whose contract is terminated if at the time of termination the member was receiving care from such a provider for the conditions listed below.

The following conditions are eligible for continuation of care:

- an acute condition;
- a serious chronic condition not to exceed twelve months;
- a pregnancy (including the duration of the pregnancy and immediate postpartum care);
- maternal mental health, not to exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later;
- a newborn (up to 36 months of age, not to exceed twelve months);
- a terminal illness (through the duration of the terminal illness);
- a surgery or other procedure that has been authorized by Health Net (or by the member's prior health plan for a new enrollee) as part of a documented course of treatment.

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

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

To request continued care, you will need to complete a Continuity of Care Request Form. If you would like more information on how to request continued care or to request a copy of the Continuity of Care

Request Form or of Health Net's continuity of care policy, please call the Health Net Customer Contact Center at the phone number on the back cover.

Renewing, Continuing or Ending Coverage

RENEWAL PROVISIONS

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

INDIVIDUAL CONTINUATION OF BENEFITS

Please examine your options carefully before declining coverage.

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

- **COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985):** For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside of California. Please check with your group to determine if you and your covered dependents are eligible.
- **Small Employer Cal-COBRA Continuation Coverage:** For employers with fewer than 20 employees who were eligible to enroll in the employer's health plan on 50% of the employer's business days in the preceding year, Health Net is required by state law to offer continuation coverage. More information regarding eligibility for this coverage is provided in your *EOC*.
- **Cal-COBRA Continuation Coverage:** If you have exhausted COBRA and you live in the Health Net service area, you may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if you have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage, and you are not entitled to Medicare. If you are eligible, you have the opportunity to continue group coverage under this plan through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.
- **USERRA Coverage:** Under a federal law known as the Uniformed Services Employment and Reemployment Rights Act (USERRA), employers are required to provide employees who are absent from employment to serve in the uniformed services and their dependents who would lose their group health coverage the opportunity to elect continuation coverage for a period of up to 24 months. Please check with your group to determine if you are eligible.

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

TERMINATION OF BENEFITS

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

Termination for Nonpayment of Subscription Charges

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

Termination for Loss of Eligibility

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

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

Termination for Cause

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

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

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

How to Appeal Your Termination

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

If your coverage is terminated based on any reason other than for nonpayment of subscription charges and your coverage is still in effect when you submit your complaint, Health Net will continue your coverage until the review process is completed, subject to Health Net's receipt of the applicable subscription charges. You must also continue to pay any applicable deductible and copayments for any services and supplies received while your coverage is continued during the review process.

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

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

If You Have a Disagreement with Our Plan

The provisions referenced under this title as described below are applicable to services and supplies covered under this *Disclosure Form*. The California Department of Managed Health Care is responsible for regulating health care service plans.
If you have a grievance against Health Net, you should first telephone Health Net at the phone number on the back cover and use the plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, or a grievance that has not been satisfactorily resolved by Health Net, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.
You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-466-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's internet website http://www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

MEMBER GRIEVANCE AND APPEALS PROCESS

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

How to file a grievance or appeal

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

You may also write to:

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

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

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

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

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

ARBITRATION

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

Additional Plan Benefit Information

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

Behavioral Health Services

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

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

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

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

TRANSITION OF CARE FOR NEW ENROLLEES

If you are receiving ongoing care for an acute, serious, or chronic mental health or substance use disorder from a provider not affiliated with the Behavioral Health Administrator when you enroll with Health Net, we may temporarily cover services provided by that provider, subject to applicable copayments and any other exclusions and limitations of this plan.

Your nonparticipating mental health professional must be willing to accept the Behavioral Health Administrator's standard mental health provider contract terms and conditions and be located in the plan's service area.

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

MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Mental health and substance use disorders means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this definition as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

CONTINUATION OF TREATMENT

If you are in treatment for a mental health or substance use disorder, call the telephone number shown on your Health Net ID card to receive assistance in transferring your care to a participating provider.

WHAT'S COVERED

Please refer to the *SBC* for the explanation of covered services and copayments.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

Services or supplies for the treatment of mental health and substance use disorders are subject to the plan's general exclusions and limitations. Please refer to the "Limits of Coverage" section of this *Disclosure Form* for a list of what's not covered under this plan.

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

Prescription Drug Program

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

THE HEALTH NET ESSENTIAL RX DRUG LIST

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

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

The Essential Rx Drug List is updated regularly, based on input from the Health Net Pharmacy and Therapeutics (P&T) Committee. The Committee members are actively practicing physicians of various medical specialties and clinical pharmacists. Voting members are recruited from contracting physician groups throughout California based on their experience, knowledge and expertise. In addition, the P&T Committee frequently consults with other medical experts to provide additional input to the Committee. Updates to the Essential Rx Drug List and drug usage guidelines are made as new clinical

information and new drugs become available. In order to keep the Formulary current, the P&T Committee evaluates clinical effectiveness, safety and overall value through:

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

To obtain a copy of Health Net's most current Essential Rx Drug List, please visit our website at www.healthnet.com or call the Health Net Customer Contact Center at the phone number on the back cover.

The Health Net Essential Rx Drug List is applicable to drugs (1) prescribed for members enrolled with Health Net who reside or work in California and (2) purchased at Health Net participating pharmacies.

WHAT IS "PRIOR AUTHORIZATION"?

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

How to Request Prior Authorization

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

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

The appeal may be submitted in writing, by telephone or through e-mail. We must receive the appeal within 365 days of the date of the denial notice. Please refer to the plan's *EOC* for details regarding your right to appeal.

To submit an appeal:

- Call the Health Net Customer Contact Center at the phone number on the back cover;
- Visit www.healthnet.com for information on e-mailing the Customer Contact Center; or
- Write to:

  Health Net Customer Contact Center
  P.O. Box 10348
  Van Nuys, CA 91410-0348

PRESCRIPTIONS BY MAIL PROGRAM

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period), you may fill it through our convenient prescriptions by mail program. This program allows you to receive up to a 90-consecutive-calendar-day supply of maintenance drugs from our network mail-order pharmacy. For complete information, visit www.healthnet.com or call the Health Net Customer Contact Center at the phone number on the back cover.

Tier 4 (specialty drugs) and Schedule II narcotic drugs (which are drugs that have a high abuse risk as classified by the Federal Drug Enforcement Administration) are not covered through mail order.

WHAT'S COVERED

Please refer to the SBC for the explanation of covered services and copayments.

This plan covers the following:

- Tier 1 drugs - Drugs listed as Tier 1 on the Essential Rx Drug List that are not excluded from coverage (include most generic drugs and some low-cost preferred brand name drugs when listed on the Essential Rx Drug List)
- Tier 2 drugs - Drugs listed as Tier 2 on the Essential Rx Drug List that are not excluded from coverage (include non-preferred generic drugs, preferred brand name drugs, peak flow meters, inhaler spacers, insulin and diabetic supplies when listed in the Essential Rx Drug List and certain brand name drugs with a generic equivalent when listed in the Essential Rx Drug List)
- Tier 3 drugs - Drugs listed on the Essential Rx Drug List as Tier 3 (include non-preferred brand name drugs, brand name drugs with a generic equivalent when medically necessary, drugs listed as Tier 3 Drugs, drugs indicated as "NF", if approved, or drugs not listed in the Essential Rx Drug List)
- Tier 4 (specialty drugs) - may be provided through a specialty pharmacy vendor (include specialty, self-administered injectable drugs (excluding insulin); high-cost drugs used to treat complex or chronic conditions when listed in the Essential Rx Drug List); and specialty drugs that are not listed on the Essential Rx Drug List and that are covered as an exception
- Preventive drugs and women's contraceptives

MORE INFORMATION ABOUT DRUGS THAT WE COVER

- Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.
- If a prescription drug deductible (per member each calendar year) applies, you must pay this amount for prescription drug covered expenses before Health Net begins to pay. Diabetic supplies, preventive drugs and women's contraceptives are not subject to the deductible. After the deductible is met, the copayment amounts will apply.

- Prescription drug refills are covered, up to a 30-consecutive-day supply per prescription at a Health Net contracted pharmacy for one copayment. A copayment is required for each prescription. In some cases, a 30-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan according to the Food and Drug Administration (FDA) or Health Net's usage guidelines. If this is the case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply.
- Percentage copayments will be based on Health Net's contracted pharmacy rate.
- Mail order drugs are covered up to a 90-consecutive-calendar-day supply. When the retail pharmacy copayment is a percentage, the mail order copayment is the same percentage of the cost to Health Net as the retail pharmacy copayment.
- Prescription drugs for the treatment of asthma are covered as stated in the Essential Rx Drug List. Inhaler spacers and peak flow meters are covered through the pharmacy benefit when medically necessary. Nebulizers (including face masks and tubing) are covered under "Durable Medical Equipment" and educational programs for the management of asthma are covered under "Patient Education" through the medical benefit.
- Preventive drugs, including smoking cessation drugs, are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Covered contraceptives are FDA-approved contraceptives for women that are either available over-the-counter or are only available with a prescription. Vaginal, oral, transdermal and emergency contraceptives are covered under this pharmacy benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit. Refer to the plan's *EOC* for more information.
- Diabetic supplies (blood glucose testing strips, lancets, needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (that is, opened in order to dispense the product in quantities other than those packaged). When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times your physician has prescribed for up to a 30-day period.
- Self-injectable drugs (other than insulin), including drugs for the treatment of hemophilia, and needles and syringes used with these self-injectable drugs are included under Tier 4 (specialty drugs), which are subject to prior authorization and must be obtained through Health Net's contracted specialty pharmacy vendor. Your PCP or treating physician will coordinate the authorization and upon approval the specialty pharmacy vendor will arrange for the dispensing of the drugs, needles and syringes. The specialty pharmacy vendor may contact you directly to coordinate the delivery of your medications.
- Tier 4 (specialty drugs) are identified in the Essential Rx Drug List with "SP", and require prior authorization from Health Net. We may require you to obtain your Tier 4 (specialty drug) through the specialty pharmacy vendor. Tier 4 (specialty drugs) are not available through mail order. Please refer to the plan's *EOC* for additional information.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

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

- Allergy serum is covered as a medical benefit;
- Coverage for devices is limited to FDA-approved vaginal contraceptive devices, peak flow meters, inhaler spacers and diabetic supplies. No other devices are covered even if prescribed by a participating physician;
- Drugs prescribed for the treatment of obesity are covered, when medically necessary for the treatment of morbid obesity or when you meet Health Net prior authorization coverage requirements. In such cases, the drugs will be subject to prior authorization from Health Net;
- Drugs or medicines administered by a physician or physician's staff member;
- Drugs prescribed for routine dental treatment;
- Drugs prescribed to shorten the duration of the common cold;
- Drugs (including injectable medications) when medically necessary for treating sexual dysfunction are limited to a maximum of 8 doses in any 30 day period. Sexual dysfunction drugs are not available through the mail order program;
- Experimental drugs (those that are labeled "Caution - Limited by federal Law to investigational use only"). If you are denied coverage of a drug because the drug is investigational or experimental, you will have a right to independent medical review. See "If You Have a Disagreement with Our Plan" section of this *Disclosure Form* for additional information;
- Hypodermic needles or syringes, except for insulin needles, syringes and specific brands of pen devices;
- Immunizing agents, injections (except for insulin), agents for surgical implantation, biological sera, blood, blood derivatives or blood plasma obtained through a prescription;
- Individual doses of medication dispensed in plastic, unit dose or foil packages unless medically necessary or only available in that form;
- Limits on quantity, dosage and treatment duration may apply to some drugs. Medications taken on an "as-needed" basis may have a copayment based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If medically necessary, your physician may request a larger quantity from Health Net;

- Medical equipment and supplies (including insulin), that are available without a prescription are covered when prescribed by a physician for the management and treatment of diabetes, or for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations or for female contraception as approved by the FDA. Any other nonprescription drug, medical equipment or supply that can be purchased without a prescription drug order is not covered even if a physician writes a prescription drug order for such drug, equipment or supply. However, if a higher dosage form of a prescription drug or over-the-counter (OTC) drug is only available by prescription, that higher dosage drug will be covered;
- Prescription drugs filled at pharmacies that are not in the Health Net pharmacy network or are not in California except in emergency or urgent care situations;
- Prescription drugs prescribed by a physician who is not a member physician or an authorized specialist are not covered, except when the physician's services have been authorized, or because of a medical emergency condition, illness or injury, for urgently needed care or as specifically stated;
- Once you have taken possession of medications, replacement of lost, stolen or damaged medications is not covered;
- Supply amounts for prescriptions that exceed the FDA's or Health Net's indicated usage recommendation are not covered unless medically necessary and prior authorization is obtained from Health Net. Drugs that are not approved by the FDA are not covered, except as described in the plan's *EOC*; and
- Drugs prescribed for a condition or treatment not covered by this plan are not covered. However, the plan does cover drugs for medical conditions that result from nonroutine complications of a noncovered service.

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

Acupuncture Care Program

Acupuncture services, typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain, are provided by Health Net. Health Net has partnered with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage. Although you are always welcome to consult your PCP, you will not need a referral to see a contracted acupuncturist.

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

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

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

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

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

- Diagnostic scanning, MRI, CT scans or thermography;
- X-rays, laboratory tests, and x-ray second opinions;
- Hypnotherapy, behavioral training, sleep therapy, weight programs, educational programs, self-help items or services, or physical exercise training;
- Physical therapy services classified as experimental or investigational;
- Experimental or investigational acupuncture services. Only acupuncture services that are non-investigational, proven and meet professionally recognized standards of practice in the acupuncture provider community are covered. ASH Plans will determine what will be considered experimental or investigational;
- Charges for hospital confinement and related services;
- Charges for anesthesia; and
- Treatment or services not authorized by ASH Plans or not delivered by a contracted acupuncturist when authorization is required; treatment not delivered by a contracted acupuncturist (except upon referral to a non-contracted acupuncturist approved by ASH Plans).
- Only services that are within the scope of licensure of a licensed acupuncturist in California are covered.

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

Pediatric Vision Care Program

The pediatric vision services benefits are provided by Health Net. Health Net contracts with Envolve Vision, Inc., to administer the pediatric vision services benefits.

Pediatric vision services are covered until the last day of the month in which the individual turns nineteen years of age.

WHAT'S COVERED

The pediatric vision services and supplies, as shown below, must be provided by a participating vision provider in order to be covered. To find a participating eyewear dispenser, call the Health Net Vision Program at **1-866-392-6058** or visit our website at www.healthnet.com.

Eyewear Schedule

Professional Services	What you pay
Routine eye examination with dilation, as medically necessary	$0
Examination for contact lenses	
Standard contact lens fit and follow-up	$0*
Premium contact lens fit and follow-up	$0*

Limitation:

* In accordance with professionally recognized standards of practice, this plan covers one complete vision examination once every 12 months.

Materials (including frames and lenses)	What you pay
Provider selected Frames (one every 12 months)	$0
Standard Plastic Eyeglass Lenses (one pair every 12 months)	$0

- Single vision, bifocal, trifocal, lenticular
- Glass or plastic

Optional Lenses and Treatments including: $0

- UV Treatment
- Tint (Fashion & Gradient & Glass-Grey)
- Standard Plastic Scratch Coating
- Standard Polycarbonate
- Photochromic / Transitions Plastic
- Standard Anti-Reflective Coating
- Polarized
- Standard Progressive Lens
- Hi-Index Lenses
- Blended segment Lenses
- Intermediate vision Lenses
- Select or ultra-progressive lenses

Premium Progressive Lenses $0

Provider selected contact lenses (In lieu of eyeglass lenses) $0

- Extended Wear Disposables: Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
- Daily Wear/Disposables: Up to 3 month supply of daily disposables, single vision spherical contact lenses
- Conventional: 1 pair from selection of provider designated contact lenses
- Must be medically necessary

Medically Necessary Contact Lenses

Coverage of medically necessary contact lenses is subject to medical necessity and all applicable exclusions and limitations. Contact lenses are defined as medically necessary if the individual is diagnosed with one of the following conditions:

- High Ametropia exceeding -10D or +10D in meridian powers
- Anisometropia of 3D in meridian powers
- Keratoconus when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses
- Vision improvement for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to the best corrected standard spectacle lenses

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

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

In addition to the limitations described above, the plan does not cover the following:

- Services and supplies provided by a provider who is not a participating vision provider are not covered.
- Charges for services and materials that Health Net determines to be non-medically necessary are excluded. One routine eye exam with dilation is covered every calendar year and is not subject to medical necessity.
- Plano (non-prescription) lenses are excluded.
- Coverage for prescriptions for contact lenses is subject to medical necessity and all applicable exclusions and limitations. When covered, contact lenses are furnished at the same coverage interval as eyeglass lenses under this vision benefit. They are in lieu of all eyeglasses lenses and frames.
- Hospital and medical charges of any kind, vision services rendered in a hospital and medical or surgical treatment of the eyes, are not covered.
- A second pair of glasses in lieu of bifocals is excluded from the basic benefit. However, Health Net Participating Vision Providers offer discounts up to 40 percent off their normal fees for secondary purchases once the initial benefit has been exhausted.

LIABILITY FOR PAYMENT

If you go to a care provider not affiliated with Health Net, you will be responsible for payment of your eye exam, glasses or contact lenses.

You may also have to pay additional fees when you use an affiliated provider if you choose lenses, frames or contact lenses that cost more than the covered expense. Health Net will seek reimbursement for vision and eyewear services that are covered under Workers' Compensation or required by occupational disease law.

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

Pediatric Dental Services

All of the following services must be provided by your selected Health Net Participating Primary Dental Provider in order to be covered. Refer to the "Pediatric Dental Care Program Exclusions and Limitations" later in this section for limitations on covered pediatric dental services.

Pediatric dental services are covered until the last day of the month in which the individual turns nineteen years of age.

HOW TO CHOOSE A PRIMARY DENTIST

Subscribers must select a single primary dentist from the *Participating Dentist Directory* for their area for themselves and their enrolled family members (i.e., enrolled family members must use the same primary dentist). Call the Customer Contact Center at the number on your Health Net ID card for a listing of participating dental providers. Each member's primary dentist is responsible for the provision, direction and coordination of the member's complete dental care. Members are required to select a primary dentist at the time of enrollment. If you do not make this selection and notify Health Net, Health Net will assign a primary dentist within close proximity to the Subscriber's primary residence. The assignment will be made within 31 days from the member's commencement of coverage or 31 days after receiving complete enrollment information, whichever is later.

WHAT'S COVERED

When you receive benefits from your selected primary dentist you only pay the applicable Copayment amount noted below. You do not need to submit a claim. Health Net arranges for the provision of dental services by contracting with participating dentists to serve you in an organized and cost-effective manner.

If you have purchased a supplemental pediatric dental benefit plan, pediatric dental benefits covered under this plan will be paid first, with the supplemental pediatric dental benefit plan covering non-covered services and or cost sharing as described in your supplemental pediatric dental benefit plan coverage document.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call the Customer Contact Center at the telephone number on your Health Net dental ID card or your insurance broker. To fully understand your coverage, you may wish to carefully review the *EOC* document.

Administration of these pediatric dental plan designs comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for pediatric dental services.

Summary of Pediatric Dental Benefits

Copayments range by category of services. Refer to the *EOC* for a complete listing of covered pediatric dental services, copayments, benefit limitations and exclusion.

Dental Benefit	What you pay
Diagnostic and Preventive Services Includes services such as oral exam, preventive x-ray and cleaning, sealants per tooth, topical fluoride application and space maintainers	$0
Restorative Procedures Medically necessary dental services to repair or restore the natural teeth to healthy condition	Copayments range from $25 - $310
Endodontics Medically necessary dental services that involve treatment of the tooth pulp, canals and roots	Copayments range from $20 - $365
Periodontics Medically necessary dental services that involve the treatment of the gums and bone supporting the teeth and the management of gingivitis (gum inflammation) and periodontitis (gum disease)	Copayments range from $10 - $350
Prosthodontics Services Removable prosthodontics (removal denture), fixed prosthodontics (fixed bridge), maxillofacial prosthetics, and implant services	Copayments range from $20 - $350
Oral Maxillofacial Surgery Medically necessary dental services that involve the extraction of teeth and other surgical procedures	Copayments range from $30 - $350
Adjunctive General Services	Copayments range from $0 - $210
Medically necessary Orthodontics	$1,000

Orthodontic Benefits

This dental plan covers orthodontic benefits as described above. Extractions and initial diagnostic x-rays are not included in these fees. Orthodontic treatment must be provided by a participating dentist.

Referrals to Specialists for Orthodontic Care

Each member's primary dentist is responsible for the direction and coordination of the member's complete dental care for benefits. If your primary dentist recommends orthodontic care and you wish to receive Benefits for such care under this dental plan, Health Net's Customer Contact Center will assist you in selecting a participating orthodontist from the Participating Orthodontist Directory.

Medically Necessary Dental Services

Medically necessary dental services are dental benefits which are necessary and appropriate for treatment of a member's teeth, gums and supporting structures according to professionally recognized standards of practice and are:

- Necessary to treat decay, disease or injury of the teeth; or
- Essential for the care of the teeth and supporting tissues of the teeth

Emergency Dental Services

Emergency dental services are dental procedures administered in a dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that a person could reasonably expect that immediate dental care is needed.

All selected general dentists provide emergency dental services twenty-four (24) hours a day, seven (7) days a week and we encourage you to seek care from your selected general dentist. **If you require emergency dental services, you may go to any dental provider, go to the closest emergency room, or call 911 for assistance, as necessary. Prior authorization for emergency dental services is not required.**

PEDIATRIC DENTAL CARE PROGRAM EXCLUSIONS AND LIMITATIONS:

Dental Procedures Limitations

The covered dental procedures are subject to the limits shown below. Refer to the *EOC* for a complete listing of covered pediatric dental services, copayments, benefit limitations and exclusion.

Periodic oral evaluations: Limited to 1 every 6 months.

Prophylaxis services (cleanings): Limited to 1 every 6 months.

Fluoride treatment: Covered once 1 every 6 months.

Intraoral radiographic images: Complete series of radiographic images are limited to once every 36 months. Occlusal radiographic image are limited to 2 every 6 months.

Bitewing x-rays: Bitewing x-rays that are provided in conjunction with periodic examinations are limited to one series of 4 films in any 6-month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.

Full mouth x-rays: Full mouth x-rays that are provided in conjunction with periodic examinations are limited to once every 24 months.

Panoramic film x-rays: Limited to once every 36 months.

Dental sealant treatments: Limited to the first, second and third permanent molars that occupy the second molar position.

Replacement of a restoration: Covered only when it is defective, as evidenced by conditions such a recurrent caries or fracture, and replacement is medically necessary.

Crowns:

Prefabricated Crowns – primary teeth are covered once every 12 months.

Prefabricated Crowns – permanent teeth are covered once every 36 months.

Replacement prefabricated crowns necessary in primary teeth within the first 12 months and permanent teeth within the first 36 months are covered.

Only acrylic crowns and stainless crowns are benefit for children under 12 years of age. If other types of crowns are chosen the member will pay the difference in cost for children under 12 years of age. The covered dental benefit level will be that of an acrylic crown.

Gingivectomy or gingivoplasty and osseous surgery: Limited to once per quadrant every 36 months.

Periodontics (other than Maintenance): Periodontal scaling and root planing, and subgingival curettage are limited to once per quadrant every 24 months.

Periodontal maintenance: Covered once every 12 months per quadrant.

Dental Services Exclusions and Limitations

Services or supplies excluded under pediatric dental services may be covered under the medical benefits portion of your plan. Consult the plan's EOC for more information.

The following are the limitation of benefits, unless otherwise specifically listed as a covered benefit on this plan's schedule of benefits:

- Any procedure that in the professional opinion of the attending dentist: (a) has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or (b) is inconsistent with generally accepted standards for dentistry.
- Implant Services (D6000-D6199): Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity.
- Medically necessary orthodontia (D8000-D8999): Benefits for medically necessary comprehensive orthodontic treatment must be approved by Health Net dental consultants for a member who has one of the medical conditions handicapping malocclusion, cleft palate and facial growth management cases. Orthodontic care is covered when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.
    - Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
    - All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.

- Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.

  The automatic qualifying conditions are:
  - cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
  - craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
  - a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
  - a crossbite of individual anterior teeth causing destruction of soft tissue,
  - an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
  - a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

  If a member does not score 26 or above nor meets one of the six automatic qualifying conditions, he/she may be eligible under the Early and Periodic Screening, Diagnosis and Treatment – Supplemental Services (EPSDT-SS) exception if medical necessity is documented.

- Adjunctive Services (D9000-D9999); Adjunctive services including anesthesia, professional visits and consults, behavior management, post-surgical complications, and occlusal guards;
  - Palliative treatment (relief of pain)
  - Palliative (emergency) treatment, for treatment of dental pain, limited to once per day, per member.
  - House/extended care facility calls, once per member per date of service.
  - One hospital or ambulatory surgical center call per day per provider per member.
  - Anesthesia for members under 19 years of age, deep sedation or general anesthesia services are covered on a case-by-case basis and when prior authorized, except for oral surgery services. For oral, surgery services, deep sedation or general anesthesia services do not require prior authorization.
  - Occlusal guards when medically necessary and prior authorized, for members from 12 to 19 years of age when member has permanent dentition.
  - Teledentistry benefits are limited to twice in a 12 month period. This plan does not cover Teledentistry beyond the two sessions in a 12 month period.
- The following services, if in the opinion of the attending dentist or Health Net are not medically necessary, will not be covered:
  - Temporomandibular joint treatment (aka "TMJ").

- Elective Dentistry and cosmetic dentistry.
- Oral surgery requiring the setting of fractures or dislocations, orthognathic surgery and extraction solely for orthodontic purposes (does not apply to fractured or dislocated (knocked out) teeth).
- Treatment of malignancies, cysts, neoplasms or congenital malformations.
- Prescription medications.
- Hospital charges of any kind.
- Loss or theft of full or partial dentures.
- Any procedure of implantation.
- Any experimental procedure.
- General anesthesia or intravenous/conscious sedation, except as specified in the medical benefits section.
- Services that cannot be performed because of the physical or behavioral limitations of the patient.
- Fees incurred for broken or missed appointments (without 24 hours' notice) are the member's responsibility. However, the copayment for missed appointments may not apply if: (1) the member canceled at least 24 hours in advance; or (2) the member missed the appointment because of an emergency or circumstances beyond the control of the member.
- Any procedure performed for the purpose of correcting contour, contact or occlusion.
- Any procedure that is not specifically listed as a covered service.
- Services that were provided without cost to the member by state government or an agency thereof, or any municipality, county or other subdivisions.
- The cost of precious metals used in any form of dental benefits.
- Services of a pedodontist/pediatric dentist, except when the member is unable to be treated by his or her panel provider, or treatment by a pedodontist/pediatric dentist is medically necessary, or his or her plan provider is a pedodontist/pediatric dentist. Pediatric dental services that are received in an emergency care setting for conditions that are not emergencies if the subscriber reasonable should have known that an emergency care situation did not exist.

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

Nondiscrimination Notice

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

Health Net:

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

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

Individual & Family Plan (IFP) Members On Exchange/Covered California 1-888-926-4988 (TTY: 711)

Individual & Family Plan (IFP) Members Off Exchange 1-800-839-2172 (TTY: 711)

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

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

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

Health Net of California, Inc.
Company Appeals & Grievances
PO Box 10348,
Van Nuys, CA 91410-0348

Fax: 1-877-831-6019
Email: Member.Discrimination.Complaints@healthnet.com (Members) or
Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

If your health problem is urgent, if you already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at **1-888-466-2219 (TDD: 1-877-688-9891)** or online at www.dmhc.ca.gov/FileaComplaint.

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

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

Notice of Language Services

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

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

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

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

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

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

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

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

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

Navajo
Doo bą́ąh ílínígóó saad bee háká ada'iiyeed. Ata' halne'ígíí da ła' ná hádídóot'įįł. Naaltsoos da t'áá shí shizaad k'ehjí shichį' yídooltah nínízingo t'áá ná ákódoolníił. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíjį' hodíílnih ninaaltsoos nanitingo bee néého'dolzinígíí hodoonihjį' bikáá' éí doodago kojį' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojį' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí kojį' hólne' 1-888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí kojį' hólne' 1-800-522-0088 (TTY: 711).

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

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

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

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

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

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

Vietnamese

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

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

FLY017549EH00 (12/17)

Contact Us

1-800-522-0088 (English) TTY: 711
1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

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