



A COMPLETE

explanation of your plan

Health Net Individual and Family
Plan Contract and Evidence of
Coverage
HMO 40

PLAN 51T 0P59
EOCID: 76060

Important benefit information – please read

Plan Contract and Evidence of Coverage (“Plan Contract”)



ISSUED BY
HEALTH NET OF CALIFORNIA, INC

LOS ANGELES, CALIFORNIA

To the extent herein limited and defined, this Plan Contract and Evidence of Coverage ("Plan Contract") provides for comprehensive health services provided through Health Net of California, Inc. (Health Net). Although, Health Net is a federally qualified Health Maintenance Organization and a California Health Care Service Plan, this health plan is not a federally qualified product. Upon payment of subscription charges in the manner provided for in this Plan Contract, Health Net hereby agrees to furnish services and benefits as defined in this Plan Contract to eligible Subscribers and their eligible Family Members according to the terms and conditions of this Plan Contract.

Plan Code: 51T

HEALTH NET

A handwritten signature in black ink, appearing to read 'B. Curtis Westin'.

B. Curtis Westin
Secretary

A handwritten signature in black ink, appearing to read 'Chris Wing'.

Chris Wing
President

Use of Special Words

Special words used in this Plan Contract to explain your Plan have their first letter capitalized and appear in "Definitions," Section 1100.

The following words are used frequently:

- "**You**" refers to anyone in your family who is covered; that is, anyone who is eligible for coverage in this Plan and who has been accepted for enrollment.
- "**We**" or "**Our**" refers to Health Net.
- "**Subscriber**" means the primary covered person.
- "**Member**" is the Subscriber or an enrolled family member.
- "**Physician Group**" or "Participating Physician Group (PPG)" means the Health Net contracting medical group the individual Member selected as the source of all covered medical care.
- "**Primary Care Physician**" is the individual physician each Member selected who will provide or authorize all covered medical care.
- "**Plan**" and "**Plan Contract**" have similar meanings. You may think of these as meaning your Health Net benefits.

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About This Booklet

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

Method of Provider Reimbursement

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

Section-100

TERM OF YOUR COVERAGE (SECTION 100)

For Subscribers and any of their Family Members whose application for enrollment is accepted by Health Net, this Plan Contract becomes effective on the date stated on your Notice of Acceptance, at 12:00 a.m., Pacific Time and will remain in effect, subject to the payment of subscription charges as set below. You may terminate this Plan Contract with a written notice to Health Net. In such event, termination will be effective on midnight of the first day of the month following our receipt of your written notice to cancel. Health Net may terminate or not renew this Plan Contract for causes as set forth in "Termination for Cause or Involuntary Transfer to Another Primary Care Physician or Contracting Physician Group," Section 600, Subsection F. If the terms of this Plan Contract are altered by Health Net, no resulting reduction in coverage will adversely affect a Member who is confined to a Hospital at the time of such change.

Section-200

SUBSCRIPTION CHARGES (SECTION 200)

Subscription charges are payable by the Subscriber and are based on the type of Family Unit and are set out on the Notice of Acceptance. Monthly subscription payment must be paid in full for each member receiving coverage for any portion of the month, including those members and newborn babies whose coverage commences during the month and those Members whose coverage terminates during the month. **This Plan Contract may be terminated by Health Net upon 15 days' written notice if Subscriber fails to pay the subscription charges as set out in this section.**

The first Subscription payment must be paid to Health Net on or before the Effective Date of this Plan Contract. After that, payment is due on or before the first day of each coverage month while the Plan Contract is in effect. If payment is not made by the due date, Health Net will send a written notice of termination effective on the last day of the month for which full subscription charges were paid. If the Subscriber pays the delinquent amount, including any late or returned item fees, within 15 days of the date of the notice, this Plan Contract will be reinstated. However, the Subscriber will be subject to a late fee of \$15.00 per month for all amounts unpaid. Returned checks or insufficient funds on the Automatic Bank Drafts will also be subject to a \$15.00 return fee. Amounts received after the termination date will be refunded to you by Health Net within 20 business days.

The Subscriber can pay the subscription charges by any one of the following options: monthly automatic deduction from a personal checking account or by submitting payments to monthly or quarterly billing. If the Subscriber chooses to pay his or her subscription charges by Automatic deduction or by quarterly billing, the Subscriber will be exempt from the administrative billing fee. If the Subscriber does not use the automatic deduction or quarterly billing, a \$5.00 monthly administrative fee will be charged each month to cover the expense of issuing a monthly bill.

Subscription payments should be mailed to:

NOTE: This address is for initial application submission:

Health Net Individual and Family Enrollment Unit
P.O. Box 1150
Rancho Cordova, CA 95741-1150

Retroactive adjustments for additions for any Family Members will be made in subsequent billings, but in no event will the effective date be more than 30 days prior to the date of receipt of the written request by Health Net.

subscription charges may be changed by Health Net with at least a 30 days written notice to the Subscriber prior to the date of such change. Payment of any installment of subscription charges as altered shall constitute acceptance of this change.

If this Plan Contract is terminated for any reason, the Subscriber shall be liable for all subscription charges for any time this Plan Contract is in force during any notice period.

Section-300

INTRODUCTION TO HEALTH NET (SECTION 300)

Subsection-A

How to Obtain Care

When you enroll in this Plan, you must select a Physician Group where you want to receive all of your medical care. That Physician Group will provide or authorize all medical care. See the Health Net Individual HMO Physician Directory or call the Member Services Department at the number on your Health Net ID Card for a listing of participating providers in the Health Net Individual HMO Service Area.

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

Some Hospitals and other providers do not provide one or more of the following services that may be covered under your *Plan Contract and Evidence of Coverage* and that you or your Family Member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic or call the Member Services Department at 1-800-839-2172 to ensure that you can obtain the health care services that you need.

Selecting a Physician Group

Family members may select different Physician Groups. However, each person must select a contracting Physician Group close enough to his or her residence or place of work to allow reasonable access to medical care. Please call the Member Services Department at the number shown on your Health Net ID Card if you need a provider directory or if you have questions involving reasonable access to care. The provider directory is also available on the Health Net website at www.health.net under "DocSearch."

Selecting a Primary Care Physician

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

Specialists and Referral Care

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

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

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

Standing Referral to Specialty Care

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

Changing Physician Groups

You may transfer to another Physician Group, but only according to the conditions explained in the "Transferring to Another Contracting Physician Group" portion of "Eligibility, Enrollment and Termination," Section 600, of this Plan Contract.

Your Financial Responsibility

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

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

Deductibles

For certain services and supplies under this Plan, a calendar year Deductible applies, which must be satisfied before these services and supplies are covered. Such services and supplies are only covered to the extent that the covered expenses exceed the Deductible. Refer to the "Schedule of Benefits and Copayments," Section 400, for specific information on Deductibles.

Questions

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

Subsection-B

Emergency and Urgently Needed Care

WHAT TO DO WHEN YOU NEED MEDICAL CARE IMMEDIATELY

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

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

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

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

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

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

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

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

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

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

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

Definitions Related To Emergency And Urgently Needed Care

The following terms are located in "Definitions," Section 1100, but they are being repeated here for your convenience.

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

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

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

Emergency Care also includes treatment of severe pain or active labor.

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

Health Net will make any final decisions about Emergency Care.

Urgently Needed Care is any otherwise covered medical service that a reasonable person with an average knowledge of health and medicine would seek for treatment of an injury or unexpected illness to prevent the

serious deterioration of his or her health, but which does not qualify as Emergency Care, as defined in this section. This may include services for which a person should reasonably have known an emergency did not exist.

Prescription Drugs

If you purchase a covered Prescription Drug for a medical Emergency or Urgently Needed Care from a non-participating pharmacy, this Plan will pay you the retail cost of the drug less any required Deductible and Copayment shown in "Schedule of Benefits and Copayments," Section 400. You will have to pay for the Prescription Drug when it is dispensed.

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

Note

The Prescription Drugs portion of "Exclusions and Limitations," Section 800 and the requirements of the Recommended Drug List also apply when drugs are dispensed by a Nonparticipating Pharmacy.

SCHEDULE OF BENEFITS AND COPAYMENTS (SECTION 400)

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

For certain services and supplies under this Plan, as set out in this schedule, a Calendar Year Deductible applies, which must be satisfied before these services and supplies are covered. Such services and supplies are only covered to the extent that Covered Expenses exceed the Deductible.

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

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

There is a limit to the amount you must pay in a Calendar Year. Refer to "Out-of-Pocket Maximum," Section 500, for more information.

Deductible

Combined Calendar Year Deductible for Inpatient Hospital Facility Services (per Member).....\$1,500

Note:

The Calendar Year Deductible is required for Inpatient Hospital Facility Services only and is applied to the Out-of-Pocket Maximum. You must pay an amount of covered expenses for these services equal to the Calendar Year Deductible shown above before the benefits are paid by your Plan. After the Deductible is satisfied, covered Inpatient Hospital Facility Services expenses are paid at 100% for the remainder of the calendar year. You remain financially responsible for paying any other applicable Copayments until you satisfy the Individual or Family Out-of-Pocket Maximum. Professional services are not subject to the Deductible.

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

Copayment

Use of emergency room (facility and professional services) \$100
 Use of urgent care center (facility and professional services) \$40

Exceptions

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

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

Office Visits

Copayment

(See "Non-severe Mental Disorders and Chemical Dependency Benefits" in this section for the applicable Copayments)

Visit to Physician, Physician Assistant or Nurse Practitioner at a Physician Group..... \$40
 Visit to Physician, Physician Assistant or Nurse Practitioner at a Physician Group for treatment of Severe Mental Illness or Serious Emotional Disturbances of a Child \$40
 Specialist consultation \$40
 Periodic health evaluation..... \$40
 OB/GYN self referral \$40
 Vision or hearing examination..... \$40

Physician to a Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net).....	\$80
Annual Routine Physical Examination (1 per Calendar Year)	\$40

Hospital Visits by Physician

Copayment

Physician visit to Hospital or Skilled Nursing Facility.....	\$0
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Allergy, Immunizations and Injections

Copayment

Allergy testing.....	\$40
Allergy serum	\$0
Allergy injection services	\$40
Immunizations for occupational purposes or foreign travel	20%
Other immunizations	\$40
Injections (excluding injections for Infertility)	\$0

Rehabilitation Therapy

Copayment

Physical therapy	\$40
Occupational therapy	\$40
Speech therapy	\$40
Pulmonary rehabilitation therapy	\$40
Cardiac rehabilitation therapy	\$40

Note:

These services will be covered when Medically Necessary.

Coverage for physical, occupational and speech rehabilitation therapy services is subject to certain limitations as described under the heading "Rehabilitation Therapy" of "Exclusions and Limitations," Section 800.

Care for Conditions of Pregnancy

Copayment

Prenatal or postnatal office visit	\$40
Specialist consultation regarding pregnancy	\$40
Newborn care office visit	\$40
Physician visit to the mother or newborn at a Hospital*.....	\$0
Professional Services for Normal delivery, including Cesarean section.....	\$0
Complications of pregnancy, including Medically Necessary abortions	See note
Normal delivery, including cesarean section	\$0
Elective abortion.....	\$150
Genetic testing of fetus.....	\$0
Circumcision of newborn	\$0

Note:

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

Care for complications of pregnancy require whatever Copayment would be required if the care was received for the treatment of any other illness or condition not related to pregnancy. For example, if the complication requires an office visit, the office visit Copayment will apply.

*One Copayment per visit.

Family Planning

Copayment

Sterilization of female.....	\$150
Sterilization of male.....	\$150
Family Planning Counseling.....	\$40
Injectable contraceptives (including but not limited to Depo Provera).....	\$0
Intrauterine (IUD).....	\$0

Other Professional Services

Copayment

Surgery.....	\$0
Assistance at surgery.....	\$0
Administration of anesthetics.....	\$0
Chemotherapy.....	\$0
Laboratory and X-ray services.....	\$0
Medical social services.....	\$0
Patient education.....	\$0
Nuclear medicine (use of radioactive materials).....	\$0
Renal dialysis.....	\$0
Organ, tissue or bone marrow transplants.....	\$0

Note:

Surgery includes surgical reconstruction of a breast incident to a mastectomy, including surgery to restore symmetry, also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema.

Medical Supplies

Copayment

Durable Medical Equipment and orthotics.....	50%
Diabetic equipment.....	\$25
Prosthetic devices (internal or external).....	\$0
Blood or blood products.....	\$0

Note:

Coverage for orthotics may be limited. Refer to "Exclusions and Limitations" section for limitations on covered orthotics. Diabetic equipment and orthotics which are covered under the medical benefit include blood glucose monitors, insulin pumps and podiatric devices.

Home Health Services

Copayment

Home Health Services (the Copayment starts on the 31 st day after the first visit).....	\$40
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Limitations

- Maximum of 3 visits per day
- 2 hours maximum per visit
- 100 visits maximum per Calendar Year

Hospice Services

Copayment

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

Copayment

Ground ambulance.....	\$80
Air ambulance.....	\$80

Inpatient Hospital Services (Subject to the Deductible)

Copayment

(See "Non-severe Mental Disorders and Chemical Dependency Benefits" in this section for the applicable Copayments)

Room and board in a semi private room or special care unit including ancillary (additional) services	\$0 after Calendar Year Deductible has been satisfied
Room and board in a semi private room or special care unit including ancillary (additional) services for the treatment of Severe Mental Illness or Serious Emotional Disturbances of a Child.....	\$0 after Calendar Year Deductible has been satisfied
Acute Inpatient Care for alcohol and drug abuse (detoxification)	\$100 per day

Outpatient Hospital Services

Copayment

Outpatient surgery (Hospital or Outpatient Surgery Center charges only).....	\$250
Outpatient hospital (other than surgery).....	See note

Note:

Other professional services performed in the outpatient department of a hospital, such as a visit to a Physician (office visit), lab and X-ray services, physical therapy, etc. are subject to the same Copayment which is required when these services are performed at your Physician Group. Look under the headings for the various services such as office visits, neuromuscular rehabilitation and other professional services to determine any additional Copayments that may apply.

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

Skilled Nursing Facility Services

Copayment

Room and board in a semiprivate room with ancillary (additional) services	\$50 per day
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Limitation

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

Non-severe Mental Disorders and Chemical Dependency

Professional Services

Copayment

Office visit (20-visit maximum each Calendar Year).....	\$40
Outpatient group therapy sessions	\$20
Physician inpatient visit	\$0

Note

Each group therapy session counts as one half of a private office visit for each Member participating in the session. In addition each group therapy session requires only one half of a private office visit Copayment.

Facility Services

Copayment

Inpatient Hospital Services (30-day maximum each Calendar Year)	\$0 after
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Calendar Year Deductible has been satisfied

Detoxification.....	\$100 per day
Outpatient Hospital Services.....	\$40

Note

This Plan does not cover treatment of chronic alcoholism, drug addiction or other Chemical Dependency problems, except detoxification.

Exceptions

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

The Mental Disorder Copayments and day or visit limits will not apply for Severe Mental Illness or Serious Emotional Disturbances of a Child. Services for these mental conditions, as defined in "Definitions," Section 1100, require whatever Copayment would be required if the services were provided for a medical condition. Look under the headings for the various services such as office visits, inpatient hospital services and outpatient hospital services to determine the applicable Copayment. All other Mental Disorders will be subject to the Copayments and limits shown above.

Prescription Drugs

Refer to the **Note** below for clarification of your financial responsibility regarding Deductible and Copayment.

Deductible and Copayment

Calendar Year Deductible (per Member).....	\$100
Level I Drugs (primarily generic) listed in the Health Net Recommended Drug List.....	\$15
Level II Drugs (primarily brand),insulin and diabetic supplies listed in the Health Net Recommended Drug List.....	\$25
Level III Drugs (Drugs not listed in the Health Net Recommended Drug List).....	\$50
Lancets.....	\$0
Smoking Cessation Drugs.....	50%
Contraceptive Devices.....	\$25

Notes:

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

Deductible:

Once your payment of Prescription Drug covered expenses equals the Calendar Year Deductible shown above, you are only responsible for the applicable retail pharmacy or mail order Copayment, as described herein, each time a covered Prescription Drug is dispensed to you. Prescription Drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's usual and customary charge for covered Prescription Drugs.

The Calendar Year Deductible does not apply to diabetic supplies and equipment dispensed through a Participating Pharmacy.

Copayment exceptions:

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

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

- the Level I Drug Copayment, plus

- the difference between the cost of the Generic Drug and the Brand Name Drug

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

Prior Authorization requirements and related Copayment exceptions are described in the "Prescription Drugs" portion of "Covered Services and Supplies," Section 700.

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

Mail Order:

The mail order Copayment is twice the applicable retail pharmacy Copayment, for up to a 90 consecutive-calendar-day supply of covered maintenance drugs. However, when the retail Copayment is a percentage, the mail order Copayment is the same percentage of the cost to Health Net as the retail Copayment.

Diabetic Supplies:

Diabetic supplies (blood glucose testing strips, lancets, needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (i.e., opened in order to dispense the product in quantities other than as packaged).

When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times your Physician has prescribed for a 30-day period

OUT-OF-POCKET MAXIMUM (SECTION 500)

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

Once the total amount of all Copayments and any Calendar Year Deductibles for Inpatient Hospital Facility Services you pay for Covered Services under this Plan Contract in any one Calendar Year equals the Out-of-Pocket Maximum amount, no payment for Covered Services and Benefits may be imposed on any Member, except as described in "Exceptions to OOPM" below.

The OOPM amounts per Calendar Year 2004 for this Plan are:

One Member.....	\$3,000
Family	\$6,000

Exceptions to OOPM

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

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

- Copayments made for Prescription Drug benefits. However, Copayments for diabetic supplies dispensed through a participating pharmacy will be applied to the OOPM amount.
- Deductible for Prescription Drug benefits.

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

How the OOPM Works

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

- If an individual Member pays amounts for covered services in a Calendar Year that equal the OOPM amount shown above for an individual Member, no further payment is required for that Member for the remainder of the Calendar Year.
- Once an individual Member in a Family satisfies the individual OOPM, the remaining enrolled Family Members must continue to pay the Copayments and the Calendar Year Deductible for Inpatient Hospital Facility Services until either (a) the aggregate of such Copayments and Deductibles paid by the Family reaches the Family OOPM or (b) each enrolled Family Member individually satisfies the individual OOPM.
- If amounts for covered services paid for all enrolled Members equal the OOPM amount shown for a family, no further payment is required from any enrolled Member of that family for the remainder of the Calendar Year for those services. (NOTE: In order for the Family Out-of-Pocket Maximum to apply, all Family Members must be enrolled under a single Subscriber. Family Members enrolled as separate Subscribers are each subject to the One Member Out-of-Pocket Maximum.)
- Only amounts that are applied to the individual Member's OOPM amount may be applied to the family's OOPM amount. Any amount you pay for covered services for yourself that would otherwise apply to your individual OOPM but exceeds the above stated OOPM amount for one Member will be refunded to you by Health Net and will not apply toward your family's OOPM. Individual members cannot contribute more than their individual OOPM amount to the Family OOPM.

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

ELIGIBILITY, ENROLLMENT AND TERMINATION (SECTION 600)

Subsection-A

Who Is Eligible and How to Enroll for Coverage

Health Net establishes the conditions of eligibility that must be met in order to be eligible for coverage under this health plan. In order to enroll in and receive coverage under this plan, Subscriber and each of the Subscriber's Family Members that apply for enrollment must either work or live in the Health Net Individual HMO Service Area and meet the additional eligibility requirements of this Plan Contract. Persons age 65 and older and persons who are eligible for Medicare benefits are not eligible to enroll under this plan. The Notice of Acceptance indicates the names of applicants who have been accepted for enrollment, the effective date thereof, the plan selected and the monthly subscription charge.

Subscribers who enroll in this plan may also apply to enroll Family Members who satisfy the eligibility requirements for enrollment. Except as otherwise indicated below, Health Net reserves the right to reject any Subscriber's or Dependent's application for enrollment. The following types of dependents describe those Family Members who may apply for enrollment in this plan:

- Spouse: The Subscriber's lawful spouse of the opposite sex (excluding common law marriages).
- Children: The unmarried dependent children of the Subscriber or his or her spouse (including legally adopted children and stepchildren).

Age Limit for Children

Each unmarried child is eligible to apply for enrollment as a Dependent until the age of 19.

Eligibility to apply for enrollment as a Dependent continues until age 23 for a child who remains unmarried and who is enrolled as a full-time student in a certified school and a dependent on the Subscriber's federal tax return in accordance with the requirements of the U.S. Internal Revenue Code.

A child loses eligibility as a Dependent if he or she marries or ceases to be a full-time student after age 19.

A full-time student is one taking at least nine semester units (or equivalent hours) in a qualified college, university or vocational school, as determined by Health Net.

Disabled Child

A child who is over the age limit shown above is eligible to apply for enrollment as a Dependent for coverage if **all** of the following conditions apply:

- The child cannot hold a full-time job because of a mental retardation or physical disability that began before the child reached the age limit;
- The child is not married; and
- The child has remained continuously dependent on the Subscriber for at least 50% of his or her economic support since he or she became disabled.

If you are applying to enroll a disabled child for new coverage as a Dependent, you must provide Health Net with proof of incapacity and dependency within 31 days of the date you apply for the child's coverage.

If you are *continuing* coverage for a disabled child, you must provide Health Net with proof of incapacity and dependency within 31 days of the date the child reaches the age limit.

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

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

Legal Separation or Final Decree of Dissolution of Marriage or Annulment

On midnight of the last day of the month in which legal separation occurs or entry of the final decree of dissolution of marriage or annulment occurs, a spouse shall cease to be an eligible Family Member. Children of the spouse who are not also the natural or legally adopted children of the Subscriber shall cease to be eligible Family Members at the same time.

Change in Eligibility

You must notify Health Net of changes that will affect your eligibility, including no longer working or residing in the Health Net Individual HMO Service Area. You should direct any such correspondence to us at: Health Net Individual Products, P.O. Box 1150, Rancho Cordova, CA 95670.

Subsection-B

Newly Acquired Dependents

You are entitled to enroll newly acquired dependents as follows:

Spouse: If you are the Subscriber and you marry while you are covered by this Plan, you may apply to enroll your new spouse (and your spouse's eligible children) within 30 days of the date of marriage by submitting a new Enrollment Application to Health Net. If your spouse is accepted for coverage, coverage begins on the date indicated on the Notice of Acceptance for the new enrollee.

Newborn Child: A child newly born to the Subscriber or his or her spouse is automatically covered from the moment of birth through the 30th day of life. In order for coverage to continue beyond the 30th day of life, you must enroll the child within the 30th day by submitting a Newborn Addition Form to Health Net and pay any applicable subscription charges. No evidence of Insurability is required if enrolling within first 30 days.

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

Adopted Child: A newly adopted child or a child who is being adopted becomes eligible on the date physical custody begins.

Coverage begins automatically and will continue for 30 days from the date of eligibility. No evidence of Insurability is required if enrolling within first 30 days. The child will be assigned to the Subscriber's Physician Group. You must enroll the child within the 30th day for coverage to continue beyond the first 30 days by submitting a Newborn Addition Form to Health Net and pay any applicable subscription charges. If you want to choose another Physician Group for that child, the transfer will take effect only as stated in the "Transferring to Another Contracting Physician Group" portion of this section.

Subsection-C

Transferring to Another Contracting Physician Group

As stated in the "Selecting a Physician Group" portion of "Introduction to Health Net," Section 300, each person must select a Physician Group close enough to his or her residence or place of work to allow reasonable access to care. Please call the Member Services Department at the telephone number on your Health Net ID card if you have questions involving reasonable access to care.

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

- When the Member moves to a new address (notify Health Net in writing within 30 days of the change).
- When determined necessary by Health Net.
- When the Member exercises the once-a-month transfer option.

Exceptions

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

Effective Date of Transfer

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

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

If your request for a transfer is not allowed because of a hospitalization and you still wish to transfer after the medical condition or treatment for it has ended, please call the Member Services Department at the telephone number on your Health Net ID Card to process the transfer request. The transfer in a case like this will take effect on the first day of the calendar month following the date the treatment for the condition causing the delay ends.

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

Subsection-D

Renewal Provisions

Subject to the termination provisions described below, coverage will remain in effect for each month subscription charges are received and accepted by Health Net.

Subsection-E

Re-enrollment

If you terminate coverage for yourself or any of your Family Members, you may apply for re-enrollment, but Health Net may decline enrollment at its discretion.

Subsection-F

Termination for Cause or Involuntary Transfer to Another Primary Care Physician or Contracting Physician Group

You may terminate this Plan Contract with a written notice to Health Net. You should direct any such correspondence to us at: Health Net Individual Products, P.O. Box 1150, Rancho Cordova, CA 95670. In such event, termination will be effective on midnight of the first day of the month following our receipt of your written notice to cancel. If the terms of this Plan Contract are altered by Health Net, no resulting reduction in coverage will adversely affect a Member who is confined to a Hospital at the time of such change.

Health Net may terminate this Plan Contract together with all like Plan Contracts by giving 90 days' written notice to the Subscriber and the California Department of Managed Health Care, in which case Health Net would offer replacement coverage in other available individual Plan Contracts. Health Net may individually terminate or not renew this Plan Contract or transfer you to another Primary Care Physician or contracting Physician Group under certain circumstances. The following are examples of circumstances that may result in a termination or involuntary transfer, as specified:

- Failure of the Subscriber to pay any subscription charges when due in the manner specified in "subscription charges," Section 200. This Plan Contract may be terminated by Health Net upon 15 days' written notice if Subscriber fails to pay the subscription charges. Said termination shall be effective on midnight of the last day of the month for which full subscription charges have last been paid. If the Subscriber brings current the de-

linquent amount, including any late or returned item fees, during this notice period this Plan Contract will be reinstated and said termination notice shall automatically rescind. In the event that the Subscriber does not pay the monthly subscription charges due within this notice period, Health Net may collect from the Subscriber or enrolled Family Members the amount expended by Health Net for health care services provided to Members after the effective date of termination of coverage. Amounts received after the termination date will be refunded to you by Health Net within 20 business days.

- Fraud or misrepresentation resulting from the Subscriber knowingly submitting to Health Net materially incorrect or incomplete information which is reasonably relied upon by Health Net in issuing or renewing this Plan Contract may result in termination immediately upon notice and Health Net may recoup any amounts paid for Covered Services obtained as a result of such fraud or misrepresentation. Also, if you fraudulently or deceptively use services or facilities of Health Net, its contracting Physician Group or other contracting providers, (or knowingly allow another person to do so), including altering a prescription, your coverage may be terminated.
- Termination of this Plan Contract or transfer to another Primary Care Physician or contracting Physician Group for good cause, including:
 - a. Subscriber ceases to be eligible according to the eligibility provisions of this health plan, in which case coverage will be terminated for Subscriber and any enrolled Family Members effective on midnight of the last day of the month for which loss of eligibility occurs.
 - b. Family Member ceases to be eligible according to the eligibility provisions of this health plan, in which case coverage will be terminated only for that person effective on midnight of the last day of the month in which loss of eligibility occurred.
 - c. Refusal to Follow Treatment: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you continually refuse to follow recommended treatment or established procedures of Health Net, the Primary Care Physician or the Physician Group. Health Net will offer you the opportunity to develop an acceptable relationship with another Primary Care Physician at the Physician Group or at another Physician Group, if available. A transfer to another Physician Group will be at Health Net's discretion.
 - d. Disruptive or Threatening Behavior: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you repeatedly disrupt the operations of the Physician Group or Health Net to the extent that the normal operations of either the Physician's office, the contracting Physician Group or Health Net are adversely impacted. Your coverage may be immediately terminated if you threaten the safety of the health care provider, his or her office staff, the contracting Physician Group or Health Net if such behavior does not arise from a diagnosed illness or condition. In addition, your coverage may be immediately terminated if you repeatedly or materially disrupt the operations of the Physician Group or Health Net to the extent that your behavior substantially impairs Health Net's ability to furnish or arrange services for you or other Health Net members or substantially impairs the Physician's office or contracting Physician Group's ability to provide services to other patients.
 - e. Abusive Behavior: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you exhibit behavior that is abusive or threatening in nature toward the health care provider, his or her office staff, the contracting Physician Group or Health Net personnel.
 - f. Inadequate Geographic Access to Care: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if it is determined that neither your residence nor place of work are within reasonable access to your current Primary Care Physician.

If coverage is terminated for any of the above reasons, you may lose the right to re-enroll in Health Net in the future. The termination is effective immediately on the date Health Net mails the notice of termination, unless Health Net has specified a later date in that notice.

Other circumstances for involuntarily being transferred to an alternate Primary Care Physician or Physician Group may exist where the treating Physician or Physicians have determined that there is an inability to continue to provide you care because the patient-physician relationship has been compromised to the extent that mutual trust and respect have been impacted. The treating Physicians and contracting Physician Group must always work within the code of ethics established through the American Medical Association (AMA). (For information on the AMA code of ethics, please refer to the American Medical Association website at <http://www.ama-assn.org>).

Under the code of ethics, the Physician will provide you with notice prior to discontinuing as your treating Physician that will enable you to contact Health Net and make alternate care arrangements.

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

Members are responsible for payment for any services received after termination of this Plan Contract at the provider's prevailing, non-Member rates. This is also applicable to Members who are hospitalized or undergoing treatment for an ongoing condition on the termination date of this Plan Contract.

If a Member's coverage is terminated under this health plan by Health Net and the Member has reason to believe that the termination was based upon the Member's health status or requirements for health care services, the Member may request a review of the termination by the Director of the California Department of Managed Health Care.

COVERED SERVICES AND SUPPLIES (SECTION 700)

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

Any covered service or supply may require a Copayment, be subject to a Deductible or have a benefit maximum. Please refer to "Schedule of Benefits and Copayments," Section 400, for details.

Certain limitations may apply. Be sure you read the section entitled "Exclusions and Limitations," Section 800, before obtaining care.

Subsection-A

Medical Services and Supplies

Office Visits

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

Health Evaluations

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

Vision and Hearing Examinations

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

Obstetrician and Gynecologist (OB/GYN) Self-Referral

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

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

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

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

Copayment requirements may differ depending on the service provided. Refer to "Schedule of Benefits and Copayments," Section 400.

Well-Woman Examinations

Well-woman examinations are covered for each female Member. The Member can select a gynecologist (GYN) from the Physician Group staff or from the Physician Group's available referral physicians.

Covered services include a medical history and diagnosis, physical examination (with breast and pelvic exams) and pap smear. The selected Physician Group will perform any additional examinations, tests or procedures that are Medically Necessary.

Immunizations and Injections

Immunizations and injections, professional services to inject the medications and the medications that are injected are covered. Allergy serum is included.

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

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

Surgical Services

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

Laboratory and X-ray Services

Laboratory and X-ray services and materials are covered.

Home Visit

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

Rehabilitation Therapy

Rehabilitation therapy services (physical, speech and occupational therapy) are covered when Medically Necessary, except as stated in "Exclusions and Limitations," Section 800.

Cardiac Rehabilitation Therapy

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

Clinical Trials

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

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

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

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

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

Pulmonary Rehabilitation Therapy

Rehabilitation therapy services provided in connection with the treatment of chronic respiratory impairment is covered Medically Necessary when continuous functional improvement in response to the treatment plan is demonstrated by objective evidence.

Pregnancy

Hospital and professional services for conditions of pregnancy are covered, including prenatal and postnatal care, delivery and newborn care. In cases of identified high risk pregnancy, prenatal diagnostic procedures and genetic testing of the fetus are also covered. Please refer to the "Schedule of Benefits and Copayments," Section 400 for Copayment requirements.

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

Your Physician will not be required to obtain authorization for a hospital stay that is equal to or less than 48 hours following vaginal delivery or 96 hours following cesarean section. Longer stays in the hospital will require authorization. Also the performance of cesarean sections must be authorized.

You may be discharged earlier only if you and your Physician agree to it.

If you are discharged earlier, your Physician may decide, at his or her discretion, that you should be seen at home or in the office, within 48 hours of the discharge, by a licensed health care provider whose scope of practice includes postpartum care and newborn care. Your Physician will not be required to obtain authorization for this visit.

Abortions

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

Copayment requirements may differ between the two. Refer to "Schedule of Benefits and Copayments," Section 400.

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

Medical Social Services

Hospital discharge planning and social service counseling are covered. In addition, if a Member needs services that this Plan does not cover and a medical social service worker refers that Member to providers or agencies for those services, the referral is covered even though the services are not.

Patient Education

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

Home Health Care

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

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

These services may include (but are not limited to) skilled nursing services, medical social services, infusion services, rehabilitation therapy (including physical, speech and occupational), pulmonary rehabilitation therapy and cardiac rehabilitation therapy. However, Custodial Care services, as described in "Definitions," Section 1100, are not covered. This treatment plan will be reviewed in the authorization process.

Ambulance Services

Air and ground ambulance services are covered.

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

Hospice Care

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

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

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

Durable Medical Equipment

Durable Medical Equipment, which includes but is not limited to wheelchairs, crutches and Hospital beds is covered and will be repaired or replaced when necessary. However, repair or replacement for loss or misuse is not covered. Health Net will decide whether to repair or replace an item.

Diabetic Equipment

Diabetic equipment is covered and may include (but are not limited to) blood glucose monitors, podiatric devices, insulin pumps and related supplies. In addition, diabetic supplies may be covered, please refer to the "Prescription Drugs" portion of this Section for additional information.

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

Organ, Tissue and Bone Marrow Transplants

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

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

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

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

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

Prosthetics and Corrective Appliances

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

Also covered are internally implanted devices such as heart pacemakers.

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

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

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

Blood

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

Inpatient Hospital Confinement

Care in a room of two or more beds or in a licensed special treatment unit is covered. Benefits for a private room are limited to the Hospital's most common charge for a two-bed room, unless a private room is determined to be Medically Necessary. Only acute detoxification and treatment of acute medical conditions relating to alcoholism, drug addiction or other chemical dependency problems are covered, if authorized by the Physician Group, in accordance with procedures established by the Physician Group and Health Net.

Reconstructive Surgery

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

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

This does not include cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance or dental services or supplies or treatment for disorders of the jaw except as set out under "Dental Services" and "Disorders of the Jaw" portions of "Exclusions and Limitations," Section 800.

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

Includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

Outpatient Hospital Services

Outpatient Hospital facility services are covered in the same manner as if they were performed at your Physician Group. Examples are the use of Hospital centers in which ambulatory patients receive the following services: surgery, rehabilitation therapy (including physical, occupational and speech therapy), pulmonary rehabilitation therapy and cardiac rehabilitation therapy, laboratory tests, X-rays and radiation therapy.

If your Physician Group refers you to a Physician who is located in the outpatient department of a Hospital, any Copayment that ordinarily applies to office visits will apply to these services.

Copayments for the other services will be the same as if they had been performed at your Physician Group.

Skilled Nursing Facility

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

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

Benefits are limited to the number of days of care stated in "Schedule of Benefits and Copayments," Section 400.

Phenylketonuria (PKU)

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

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

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

Second Opinion by a Physician

You have the right to request a second opinion when:

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

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

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

Surgically Implanted Drugs

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

Prescription Drugs

Please read the "Prescription Drugs" portion of "Exclusions and Limitations," Section 800.

You must satisfy the Prescription Drug Calendar Year Deductible shown in "Schedule of Benefits and Copayments," Section 400, before benefits for Prescription Drugs become payable by Health Net.

Covered Drugs and Supplies

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

Prescription Drugs in the Health Net Recommended Drug List include: Level I Drugs (primarily Generic) and Level II Drugs (primarily Brand)

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

Prescription Drugs NOT listed in the Health Net Recommended Drug List include: Level III Drugs

Prescription Drugs not listed in the Health Net Recommended Drug List that are not excluded or limited from coverage are covered. A Member requesting a Prescription Drug that is not listed is responsible for a higher Copayment as shown in "Schedule of Benefits and Copayments," Section 400. Some Prescription Drugs that are not on the List require Prior Authorization from Health Net to be covered.

In some cases a 30-consecutive-day supply of Medication may not be an appropriate drug treatment plan according to the Food and Drug Administration (FDA) or Health Net's usage guidelines. Medications taken on an "as-needed" basis may have a Copayment based on a standard package, vial, ampoule, tube or other standard 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.

Generic Equivalents to Brand Name Drugs

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

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

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

Off-Label Drugs

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

- Approved by the Food and Drug Administration.
- Prescribed or administered by a participating licensed health care professional for the treatment of :
 1. A life-threatening condition or

2. A chronic and seriously debilitating condition in which the drug is determined to be Medically Necessary to treat such condition.
- Recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following:
 1. The American Medical Association Drug Evaluations.
 2. The American Hospital Formulary Service Drug Information.
 3. The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional."
 4. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

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

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

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

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

Diabetic Drugs and Supplies

Prescription drugs for the treatment of diabetes are covered. Diabetic supplies are also covered including but not limited to insulin needles and syringes, reusable pen delivery systems, disposable insulin needles and syringes, disposable insulin pen needles, blood glucose monitors (specific brands only) and testing strips (specific brands only) and Ketone test strips and lancets when used in monitoring blood glucose levels. Additional supplies may be covered, please refer to the "Medical Services and Supplies" portion of this Section for additional information. Refer to "Schedule of Benefits and Copayments," Section 400 under "Diabetic Supplies," for details about the supply amounts that are covered and the applicable Copayment.

Smoking Cessation Coverage

Drugs that require a prescription in order to be dispensed for the relief of nicotine withdrawal symptoms are covered for the course of therapy stated in the "Prescription Drugs" portion of "Exclusions and Limitations," and if the member is concurrently enrolled in a comprehensive smoking cessation behavioral support program. The prescribing physician must request prior authorization for coverage. For information regarding smoking cessation behavioral support programs available through Health Net, contact Member Services at the telephone number on your Health Net ID card or visit the Health Net website at www.health.net (see "Wellsite").

Contraceptives

Oral contraceptives and emergency contraceptives are covered. Vaginal contraceptives are limited to diaphragms, cervical caps and IUDs and are only covered when a Member Physician performs a fitting examination and, in the case of diaphragms and cervical caps, prescribes the device. IUDs are only available through the Member Physician's office, are covered as a medical benefit and are limited to one fitting and device per Calendar Year unless additional fittings or devices are Medically Necessary. Diaphragms and cervical caps are only available through a prescription from a pharmacy and are limited to one fitting and prescription per Calendar Year unless additional fittings and devices are Medically Necessary. Injectable contraceptives which are administered by a Physician are covered as a medical benefit. Please refer to "Schedule of Benefits and Copayments," Section 400, under the heading "Family Planning" for information regarding contraceptives covered under the medical benefit. Additional contraceptive supplies and devices may be covered. Refer to the "Medical Services and Supplies" portion of this section under the heading "Family Planning" for more information.

The Recommended Drug List

What Is the Health Net Recommended Drug List?

The Health Net Recommended Drug List is the approved list of drugs which are covered. 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 Physicians and specialists that they refer to this List when choosing drugs for patients who are Health Net members. When your physician prescribes medications listed in the Recommended Drug List, it is ensured that you are receiving a high quality and high value prescription medication. In addition, the Recommended Drug List identifies whether a Generic version of a Brand Name Drug exists and whether Prior Authorization is required. If the Generic version exists, it will be dispensed instead of the Brand Name version.

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

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

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

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

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

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

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

Prior Authorization process

Prior Authorization status is included in the Recommended Drug List – The List identifies which drugs require Prior Authorization. A Physician must get approval from Health Net before writing a Prescription Drug Order for a drug that is listed as requiring Prior Authorization, in order for the drug to be covered by Health Net.

Urgent requests from Physicians are handled in a timely fashion, not to exceed 72 hours, as appropriate and Medically Necessary, for the nature of the Member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination. Routine requests from Physicians are processed in a timely fashion, not to exceed 5 days, as appropriate and Medically Necessary, for the nature of the Member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination. Requests may be submitted by telephone or facsimile. Health Net will evaluate the submitted information upon receiving your Physician's request for Prior Authorization and make a determination based on established clinical criteria for the particular medication. The criteria used for prior authorization are developed and based on input from the Health Net Pharmacy and Therapeutics Committee as

well as physician experts. Your physician may contact Health Net to obtain the usage guidelines for specific medications.

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

Retail Pharmacies and the Mail Order Program

Purchase Drugs at Participating Pharmacies

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

Health Net is contracted with many major pharmacies, supermarket-based pharmacies and privately owned pharmacies in California. For a complete and up-to-date list of Participating Pharmacies, please visit our website at www.health.net under the Pharmacy Info portal or call the Member Services Department at the telephone number on your Health Net ID card. Present your Health Net ID Card and pay the appropriate Copayment when the drug is dispensed.

If refills are stipulated on the Prescription Drug Order, a Participating Pharmacy may dispense up to a 30-consecutive-calendar-day supply for each Prescription Drug Order or for each refill at the appropriate time interval.

If your Health Net ID Card is not available: or eligibility cannot be determined

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

Health Net will reimburse you for the cost of the Prescription Drug, less any required Deductible and Copayment shown in "Schedule of Benefits and Copayments," Section 400.

Nonparticipating Pharmacies and Emergencies

During the first 30 days of your coverage, Prescription Drugs will be covered if dispensed by a Nonparticipating Pharmacy, but only if you are a new Member and have not yet received your Health Net ID Card. After 30 days, Prescription Drugs dispensed by a Nonparticipating Pharmacy will be covered only for Emergency Care or Urgently Needed Care, as defined in "Definitions," Section 1100 of this Plan Contract.

If the above situation applies to you:

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

Health Net will reimburse you for the cost of the Prescription Drug covered expenses, less any required Deductible and Copayment shown in "Schedule of Benefits and Copayments," Section 400.

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

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

Note

The Prescription Drug portion of "Exclusions and Limitations" in Section 800 and the requirements of the Recommended Drug List described above still apply when Prescription Drugs are dispensed by a Nonparticipating Pharmacy.

Claim forms will be provided by Health Net upon request or may be obtained from the Health Net website at www.health.net, under the pharmacy information.

Drugs Dispensed by Mail Order

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

- The completed Prescription Mail Order Form.

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

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

The mail order administrator may dispense up to a 90-consecutive calendar day supply of a covered Maintenance Drug and each refill allowed by that order. After you satisfy the Prescription Drug Calendar Year Deductible, the required Copayment applies each time a drug is dispensed.

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

Note

Schedule II drugs are not covered through mail order. Refer to the Prescription Drug portion of "Exclusions and Limitations" in Section 800 for more information.

Subsection-C

Mental Disorders and Chemical Dependency

Please read the "Mental Disorders and Chemical Dependency" portion of "Exclusions and Limitations," Section 800.

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

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

The Administrator will refer you to a nearby Participating Mental Health Professional. That professional will evaluate you to determine if additional treatment is necessary.

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

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

The following benefits are provided:

Outpatient Services

Outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy and rehabilitative care are covered up to the maximum number of visits shown in "Schedule of Benefits and Copayments," Section 400. Medication management care is also covered when appropriate.

Second Opinion

You may request a second opinion when:

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

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

Second opinions will only be authorized for Participating Mental Health Professionals, unless it is demonstrated that an appropriately qualified Participating Mental Health Professional is not available. The Administrator will ensure that the provider selected for the second opinion is appropriately licensed and has expertise in the specific clinical area in question.

Any service recommended by the second opinion must be authorized by the Administrator in order to be covered.

Inpatient Services

Inpatient treatment of Mental Disorders or Chemical Dependency is covered for up to the maximum number of days shown in "Schedule of Benefits and Copayments," Section 400 under "Inpatient Hospital Services."

Covered services and supplies include:

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

Detoxification

Inpatient services for acute detoxification are covered, except as stated in the "Mental Disorders and Chemical Dependency" portion of "Exclusion and Limitations," Section 800.

Serious Emotional Disturbances of a Child (SED)

The treatment and diagnosis of Serious Emotional Disturbances of a child under the age of 18 is covered as shown in "Schedule of Benefits and Copayments," Section 400. Look under the headings for office visits, outpatient services and inpatient hospital services to determine the applicable Copayment.

Severe Mental Illness

Treatment of Severe Mental Illness is covered as shown in "Schedule of Benefits and Copayments," Section 400.

Covered services include treatment of:

- schizophrenia
- schizoaffective disorder
- bipolar disorder (manic-depressive illness)
- major depressive disorders
- panic disorder
- obsessive-compulsive disorder
- pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition of the *Diagnostic and Statistical Manual for Mental Disorders*)
- autism
- anorexia nervosa
- bulimia nervosa

EXCLUSIONS AND LIMITATIONS (SECTION 800)

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

Subsection-A

Services and Supplies

The exclusions and limitations in this subsection apply to any category or classification of services and supplies described throughout this Plan Contract.

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

Custodial or Domiciliary Care

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

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

Disposable Supplies for Home Use

This Plan does not cover disposable supplies for home use.

Experimental or Investigational Services

Experimental or Investigational drugs, devices, procedures or other therapies are only covered when:

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

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

Home Birth

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

Ineligible Status

This Plan does not cover services or supplies provided before the Effective Date of coverage. Services or supplies provided after coverage through this Plan has ended are not covered.

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

No-Charge Items

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

Non-enrolled newborns

Any charges incurred by a baby beyond 30 days of its birth are excluded unless the baby is enrolled under this health plan within 30 days of its birth.

Nonparticipating

Services and supplies rendered by a nonparticipating physician without authorization from Health Net or the Physician Group.

Personal or Comfort Items

This Plan does not cover personal or comfort items.

Unlisted Services

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

Subsection-B

Medical Services and Supplies

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

Acupuncture

This Plan does not cover services for or incident to acupuncture.

Blood

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

Chiropractic Care

This Plan does not cover chiropractic care.

Clinical Trials

Although clinical trials are covered, as described in the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section of this Plan Contract, coverage for clinical trials does not include the following items:

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

Conception by Medical Procedures

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

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

Contraceptives

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

Cosmetic Services and Supplies

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

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

- Improve function, or
- Create a normal appearance to the extent possible, then,
- Surgery to remove or change the size (or appearance) of any part of the body.
- Surgery to reform or reshape skin or bone.
- Surgery to remove or reduce skin or tissue are covered.

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

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

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

Dental Services

Dental services or supplies are limited to the following situations, except as specified in Section III, "Individual and Family Plan Dental Coverage."

- When immediate emergency care to sound natural teeth as a result of an accidental injury is required. Please refer to the "Emergency and Urgently Needed Care" portion of "Introduction to Health Net," Section 300, for more information.
- General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the Member requires that an ordinarily non-covered dental service which would normally be treated in the dentist's office and without general anesthesia must instead be treated in a Hospital or Outpatient Surgical Center. The general anesthesia and associated facility services must be Medically Necessary

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

- When dental examinations and treatment of the gingival tissues (gums) are performed for the diagnosis or treatment of a tumor.

The following services are not covered under any circumstances.

- Routine care or treatment of teeth and gums including but not limited to dental abscesses, inflamed tissue or extraction of teeth.
- Spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, active splints or orthotics (whether custom fit or not), dental implants or other dental appliances and related surgeries to treat dental conditions.
- Follow-up treatment of an injury to sound natural teeth as a result of an accidental injury.

Disorders of the Jaw

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

- Surgical procedures to correct abnormally positioned or improperly developed bones of the upper or lower jaw are covered if the services are required due to injury, the existence of cysts, tumors or neoplasms or a functional disorder and they are Medically Necessary. However, spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, active splints or orthotics (whether custom fit or not), dental implants or other dental appliances and related surgeries to treat dental conditions are not covered under any circumstances.
- Surgical procedures and medical appliances to correct disorders of the temporomandibular (jaw) joint (also known as TMJ disorders) are covered if they are Medically Necessary. However, spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridge work, active splints or orthotics (whether custom fit or not), dental implants or other dental appliances to treat dental conditions related to TMJ disorders are not covered.

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

Durable Medical Equipment

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

- Exercise equipment.
- Hygienic equipment and supplies (to achieve cleanliness even when related to other covered medical services).
- Stockings, corrective shoes and arch supports.
- Surgical dressings other than primary dressings that are applied by your Physician Group or a Hospital to lesions of the skin or surgical incisions.
- Jacuzzis and whirlpools.
- Orthotics, unless custom made to fit the Member's body (orthotics are supports or braces for weak or ineffective joints or muscles)
- Orthotics, whether or not custom fit, to treat dental conditions related to TMJ disorder.
- Foot orthotics (whether or not custom fit) that are not incorporated into a cast, splint, brace or strapping of the foot.

However, the Plan does cover Medically Necessary diabetic supplies as shown in the "Medical Supplies" portion of "Schedule of Benefits and Copayments" and the "Diabetic Supplies" portion of "Covered Services and Supplies."

Genetic Testing and Diagnostic Procedures

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

Hearing Aids

This Plan does not cover any device inserted in or affixed to the outer ear to improve hearing.

Home Birth

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

Infertility services

This Plan does not cover infertility services (including artificial insemination), including professional services, inpatient and outpatient care, treatment by injection and prescription drugs prescribed for infertility.

Non-eligible Institutions

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

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

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

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 for such drug, equipment or supply.

Physician Self-Treatment

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

Physicians Treating Immediate Family Members

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

Prescribed Drugs and Medications

This Plan only covers outpatient Prescription Drugs or medications as described in the "Prescription Drug Benefits" portion of "Covered Services and Supplies, Section 700.

Private Duty Nursing

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

Refractive Eye Surgery

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

Rehabilitation Therapy

Coverage for rehabilitation therapy is limited to Medically Necessary services provided by a licensed physical, speech or occupational therapist for treatment of conditions resulting from a defined disease, injury or surgical procedure. The services must be at a level of complexity that requires the judgment, knowledge and skills of a licensed physical, speech or occupational therapist, be based on a treatment plan and be provided by such therapist or under the therapist's direct supervision. Such services are not covered when medical documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals or when a Member has already met the treatment goals. See Section 900(l) for the procedure to request Independent Medical Review of a Plan denial of coverage on the basis of Medical Necessity.

Reversal of Surgical Sterilization

This Plan does not cover services to reverse voluntary, surgically induced sterility.

Routine foot care

Routine foot care including callus treatment, corn paring or excision, toenail trimming, massage of any type and treatment for fallen arches, flat or pronated feet are excluded unless Medically Necessary for a diabetic condition. Additionally, treatment for cramping of the feet, bunions and muscle trauma are excluded, unless Medically Necessary.

Routine Physical Examinations

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

Services Not Related To Covered Condition, Illness Or Injury

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

Sex Change

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

Chemical Dependency

This Plan does not cover treatment of chronic alcoholism, drug addiction or other Chemical Dependency problems, except detoxification.

Surrogate Pregnancy

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

Treatment for obesity

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

Unauthorized Services and Supplies

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

Vision Therapy, Eyeglasses and Contact Lenses

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

Prescription Drugs

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

Note: Services or supplies excluded under the Prescription Drug benefits may be covered under your medical benefits portion of this Plan Contract. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 700, for more information.

Additional exclusions and limitations:

Allergy Serum

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

Appetite Suppressants or Drugs for Body Weight Reduction

Drugs prescribed for the treatment of obesity, except when Medically Necessary for the treatment of morbid obesity. In such case the drug will be subject to Prior Authorization from Health Net.

Compounded Drugs

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

Contraceptives

Oral contraceptives and emergency contraceptives are covered, as described in the Prescription Drug Benefits portion of "Covered Services and Supplies" section. Vaginal contraceptives are limited to diaphragms, cervical caps and IUDs and are only covered when a Member Physician performs a fitting examination and, in the case of diaphragms and cervical caps, prescribes the device. IUDs are only available through the Member Physician's office, are covered as a medical benefit and are limited to one fitting and device per Calendar Year unless additional fittings or devices are Medically Necessary. Diaphragms and cervical caps are only available through a prescription from a pharmacy and are limited to one fitting and prescription per Calendar Year unless additional fittings or devices are Medically Necessary. Injectable contraceptives are covered as a medical benefit when administered by a physician. If your Physician determines that none of the methods specified as covered by the Plan are medically appropriate then the Plan will provide coverage for another FDA approved prescription or contraceptive method as prescribed by your Physician.

Devices

Coverage is limited to vaginal contraceptive devices and those devices listed under the "Diabetic Drugs and Supplies" section of the "Prescription Drugs" portion of "Covered Services and Supplies." No other devices are covered even if prescribed by a Member Physician.

Dietary or Nutritional Supplements

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

Drugs Prescribed for Common Cold

Drugs when prescribed to shorten the duration of the common cold are not covered.

Drugs Prescribed for Cosmetic Purposes

Drugs that are prescribed to enhance or maintain appearance, including but not limited to those intended to treat wrinkles or hair loss, are not covered.

Food and Drug Administration (FDA)

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.

Hypodermic Syringes and Needles

Hypodermic syringes and needles are limited to insulin needles, syringes, devices and reusable pen devices. Needles and syringes required to administer self-injected medications will be provided when obtained through Health Net's Specialty Pharmacy Vendor. All other syringes and needles are not covered.

Infertility Services

This Plan does not cover prescription drugs prescribed for infertility.

Injectable Drugs

Injectable drugs obtained through a prescription are limited to insulin when prescribed by a Physician. Other injectable medications are covered under the medical benefit (see the "Immunizations and Injections" portion of "Covered Services and Supplies (Section 700)." Surgically implanted drugs are covered under the medical benefit (see the "Surgically Implanted Drugs" portion of "Covered Services and Supplies."

Lost, Stolen or Damaged Drugs

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

Nonapproved Uses

Drugs prescribed for indications approved by the Food and Drug Administration are covered. Off-label use of drugs is only covered when prescribed or administered by a licensed health care professional for treatment of a life-threatening or chronic and seriously debilitating condition as described herein (see the "Off-Label Drugs" provision in the "Prescription Drugs" portion of "Covered Services and Supplies," Section 700) or if otherwise Medically Necessary.

Noncovered Services

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

Nonparticipating Pharmacies

Drugs dispensed by Nonparticipating Pharmacies are not covered, except as specified in the " Nonparticipating Pharmacies and Emergencies" provision of "Covered Services and Supplies," Section 700.

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

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

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

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

Physician Is Not a Member Physician

Drugs prescribed by a Physician who is not a Member Physician or an authorized Specialist are not covered, except when the Physician's services have been authorized or because of a medical Emergency condition, illness or injury or as specifically stated.

Quantity Limitations

Some drugs are subject to specific quantity limitations per Copayment. Medications taken on an "as-needed" basis may have a Copayment based on a standard package, vial, ampoule, tube or other standard unit. In such a

case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If Medically Necessary, your Physician may request a larger quantity from Health Net.

Schedule II Drugs

Schedule II drugs are not covered through mail order. Schedule II drugs are drugs classified by the Federal Drug Enforcement Administration as having a high abuse risk but also safe and accepted for medical uses in the United States. Schedule II drugs include certain narcotic, stimulant and depressant drugs.

Sexual Dysfunction Drugs

Drugs (including injectable medications) for treatment of sexual dysfunction, when prescribed for treatment of sexual dysfunction, are not covered.

Smoking Cessation Coverage

Drugs that require a prescription in order to be dispensed for the relief of nicotine withdrawal symptoms are covered up to a twelve week course of therapy per calendar year if the member is concurrently enrolled in a comprehensive smoking cessation behavioral support program. The prescribing physician must request prior authorization for coverage. For information regarding smoking cessation behavioral support programs available through Health Net, contact Member Services at the telephone number on your Health Net ID Card or visit the Health Net website at www.health.net (see "Wellsite").

Unit Dose or "Bubble" Packaging

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

Subsection-D

Mental Disorders and Chemical Dependency

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

Note: Services or supplies excluded under the Mental Disorders and Chemical Dependency benefits may be covered under your medical benefits portion of this Plan Contract. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 700, for more information.

Mental health care as a condition of parole, probation or court-ordered testing for Mental Disorders is limited to Medically Necessary services and subject to this plan's day or visit limits as shown in "Schedule of Benefits and Copayments," Section 400.

Services and supplies for treating Mental Disorders and Chemical Dependency are covered only as specified in the "Mental Disorders and Chemical Dependency" portion of "Covered Services and Supplies," Section 700. The treatment and diagnosis of Serious Emotional Disturbances of a Child under the age of 18 is covered as shown in the "Schedule of Benefits and Copayments" section. Look under the headings for office visits, outpatient services and inpatient Hospital services to determine the applicable Copayment.

Additional exclusions and limitations:

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

Aversion Therapy

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

For Insurance

Services for obtaining or maintaining insurance are not covered.

Educational Employment Services

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

- Vocational rehabilitation.

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

Nonabstinence-Based Treatment

Chemical Dependency treatment not based on abstinence is not covered.

Noncontracting Providers of Facilities

Services, treatment or supplies rendered in a non-emergency by a non-participating provider or non-participating facility, are only covered when authorized by the Administrator's Medical Director or his/her designee or otherwise provided by the Plan.

Exceptions are those cases where the Administrator refers a Member to a noncontracting provider or authorizes Emergency Care or Urgently Needed Care or a second opinion.

Noncovered Treatments

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

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

Treatment for smoking cessation, weight reduction, obesity, stammering, sleeping disorders, stuttering or sexual addiction is not covered under the Mental Disorders and Chemical Dependency benefits of this Plan. Treatment related to judicial or administrative proceedings that is not Medically Necessary is also not covered.

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

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

Nonstandard Therapies

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

Nontreatable Disorders

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

Prescription Drugs

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

Private Duty Nursing

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

State Hospital Treatment

Services in a state Hospital are limited to treatment or confinement as the result of an emergency or Urgently Needed Care as defined in "Definitions," Section 1100.

Telephone Consultations

Treatment or consultations provided by telephone are not covered.

Psychological Testing

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

Treatment by a Relative

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

Congenital and Organic Disorders

Treatment of physiological diseases or defects, including but not limited to organic brain disease is not covered. However, some conditions shall be covered as shown in the "Schedule of Benefits and Copayments," Section 400, provided that their level of severity meets the criteria described in the definitions of "Serious Emotional Disturbances of a Child" and/or "Severe Mental Illness."

Learning Disabilities

Testing, screening or treatment for learning disabilities are not covered. However, some conditions shall be covered as shown in the "Schedule of Benefits and Copayments," Section 400, provided that their level of severity meets the criteria described in the definitions of "Serious Emotional Disturbances of a Child" and/or "Severe Mental Illness" and the conditions are treated by Participating Mental Health Professionals.

Detoxification in Newborns

Treatment of detoxification in newborns is not covered. However, these services are covered under the medical benefit (see "Covered Services and Supplies," "Inpatient Hospital Confinement.")

Excess Services

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

GENERAL PROVISIONS (SECTION 900)

Subsection-A

Form or Content of the Plan Contract

Only a Health Net officer can make changes to this Plan Contract. Any changes will be made through an endorsement signed and authorized by a Health Net officer. No agent or other employee of Health Net is authorized to change the terms, conditions or benefits of this Plan Contract.

Subsection-B

Entire Agreement

This Plan Contract, the Notice of Acceptance and the application shall constitute the entire agreement between Health Net and the Member.

Subsection-C

Right to Receive and Release Information

As a condition of enrollment in this health plan and a condition precedent to the provisions of benefits under this health plan, Health Net, its agents, independent contractors and participating physicians shall be entitled to release to or obtain from, any person, organization or government agency, any information and records, including patient records of Members, which Health Net requires or is obligated to provide pursuant to legal process, federal, state or local law or as otherwise required in the administration of this health plan.

Subsection-D

Regulation

Health Net is subject to the requirements and the implementing regulations of the California Knox-Keene Health Care Service Plan Act of 1975, as amended, as set forth at Chapter 2.2 of Division 2 of the California Health and Safety Code (beginning with Section 1340) and its implementing regulations, as set forth at Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations (beginning with Section 1300.43). Any provisions required to be in this Plan Contract by either of the above sources of law shall bind Health Net whether or not provided in this Plan Contract.

Subsection-E

Notice of Certain Events

Any notices required hereunder shall be deemed to be sufficient if mailed to the Subscriber at the address appearing on the records of Health Net. The Subscriber can meet any notice requirements by mailing the notice to: Health Net Individual Products, P.O. Box 2066, Rancho Cordova, CA 95741-2066.

Subsection-F

Benefit Changes

Health Net will provide Subscriber at least 30 days' notice of any changes in benefits or Plan Contract provisions. There is no vested right to receive the benefits of this health plan.

Subsection-G

Non-Discrimination

Health Net hereby agrees that no person who is otherwise eligible and accepted for enrollment under this Plan Contract shall be refused enrollment nor shall their coverage be terminated solely because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation or age.

Subsection-H

Interpretation of Plan Contract

The laws of the State of California shall be applied to interpretations of this Plan Contract. Where applicable, the interpretation of this Plan Contract shall be guided by the direct service, group practice nature of Health Net's operations as opposed to a fee for service indemnity basis.

Subsection-I

Grievance, Appeals, Independent Medical Review and Arbitration

Grievance Procedures

If you are not satisfied with efforts to solve a problem with Health Net or your Provider, you must first file a grievance or appeal against Health Net by calling the Member Services Department at **1-800-839-2172** or by submitting a Member Grievance Form through the Health Net website at www.health.net.

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

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

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

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

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

We will:

- Confirm in writing within five calendar days that we received your request.
- Review your complaint and inform you of our decision in writing within 30 days from the receipt of the Grievance. For conditions where there is an immediate and serious threat to your health, including severe pain or the potential for loss of life, limb or major bodily function exists, Health Net must notify you of the status of your grievance no later than three days from receipt of the grievance. For urgent grievances, Health Net will immediately notify you of the right to contact the Department of Managed Health Care. There is no requirement that you participate in Health Net's grievance process prior to applying to the Department of Managed Health Care for review of an urgent grievance.

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

Independent Medical Review of Grievances Involving a Disputed Health Care Service

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

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

Eligibility

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

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

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

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

For more information regarding the IMR process or to request an application form, please call the Member Services Department at **1-(800)-839-2172**.

Independent Medical Review of Investigational or Experimental Therapies

Health Net does not cover Experimental or Investigational drugs, devices, procedures or therapies. However, if Health Net denies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational and you meet the eligibility criteria set out below, you may request an independent medical review ("IMR") of Health Net's decision from the Department of Managed Health Care. The Department does not require you to participate in Health Net's grievance system prior to seeking an IMR of a decision to deny treatment on the basis that it is experimental or investigational.

Eligibility

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

If Health Net denies coverage of the recommended or requested therapy and you meet the eligibility requirements, Health Net will notify you within five business days of its decision and your opportunity to request external review of Health Net's decision through IMR. Health Net will provide you with an application form to request an IMR of Health Net's decision. The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of your request for IMR. If your Physician determines that the proposed therapy should begin promptly, you may request expedited review and the experts on the IMR panel will render a decision within seven days of your request. If the IMR panel recommends that Health Net cover the recommended or requested therapy, coverage for the services will be subject to the terms and conditions generally applicable to other benefits you are entitled to. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Health Net regarding the denial of the recommended or requested therapy. For more information, please call the Member Services Department at **1-800-839-2172**.

Binding Arbitration

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

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

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

appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

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

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

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

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this *Plan Contract*, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that State or Federal law provide for judicial review of Arbitration proceedings.

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

Subsection-J

Department of Managed Health Care

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

If you have a grievance against Health Net, you should first telephone Health Net at **1-800-839-2172** and use our grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

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

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

Medical Malpractice Disputes

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

Subsection-K

When A Third Party Causes A Member's Injuries

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

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

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

STEPS YOU MUST TAKE

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

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

- Telling Health Net and the medical providers the name and address of the third party, if you know it, the name and address of your lawyer, if you are using a lawyer and describing how the injuries were caused;
- Completing any paperwork that Health Net or the medical providers may reasonably require to assist in enforcing the lien;
- Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions;
- Notifying the lienholders immediately upon you or your lawyer receiving any money from the third parties or their insurance companies; and
- Holding any money that you or your lawyer receive from the third parties or their insurance companies in trust and reimbursing Health Net and the medical providers for the amount of the lien as soon as you are paid by the third party.

HOW THE AMOUNT OF YOUR REIMBURSEMENT IS DETERMINED

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

- The amount of the reimbursement that you owe Health Net or the Physician Group will be reduced by the percentage that your recovery is reduced if a judge, jury or arbitrator determines that you were responsible for some portion of your injuries.
- The amount of the reimbursement that you owe Health Net or the Physician Group will also be reduced a pro rata share for any legal fees or costs that you paid from the money you received.
- The amount that you will be required to reimburse Health Net or the Physician Group for services you receive under this Plan will not exceed one-third of the money that you receive if you do engage a lawyer or one-half of the money you receive if you do not engage a lawyer.

Relationship of Parties

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

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

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

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

Provider/Patient Relationship

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

Liability for Charges

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

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

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

Prescription Drug Liability

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

Transition of Care Upon Termination of Provider Contract

If Health Net's contract with a Physician Group or other provider is terminated, Health Net will transfer any affected Members to another contracting Physician Group or provider and make every effort to ensure the continuity of care. At least 60-days prior to termination of a contract with a Physician Group or acute care Hospital, Health Net will provide a written notice to affected Members.

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

- An acute condition
- A serious chronic condition
- A pregnancy (including the duration of the pregnancy and immediate postpartum care)
- A newborn (up to age 36 months)
- A terminal illness
- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment

For definitions of acute condition, serious chronic condition and terminal illness see the "Definitions" section of this Plan Contract.

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable Copayments and any other exclusions and limitations of this Plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider's contract termination.

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

Contracting Administrators

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

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

Decision-Making Authority

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

Subsection-M

Government Coverage

Medicare

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

Medi-Cal

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

Veterans' Administration

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

Subsection-N

Coverage Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

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

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

MISCELLANEOUS PROVISIONS (SECTION 1000)

Subsection-A

Cash Benefits

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

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

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

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

Subsection-B

Benefits Not Transferable

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

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

Subsection-C

Notice of Claim

In most instances, you will not need to file a claim to receive benefits this Plan provides. However, if you need to file a claim (for example, for Emergency or Urgently Needed Care from a non-Health Net provider), you must do so within 90 days from the date you receive the services or supplies. If you cannot do so within 90 days, you must show that it was not reasonably possible to file within that time limit and that you have filed as soon as was reasonably possible. Any claim filed more than one year from the date the expense was incurred will not be paid.

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

If you need to file a claim for Emergency Mental Disorders and Chemical Dependency or for other covered Mental Disorders and Chemical Dependency Services provided upon referral by Managed Health Network (MHN), you must file the claim with (MHN) after receiving those services. You must use MHN's forms in filing the claim and you should send the claim to MHN at the address listed in the claim form or to MHN at:

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

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

Health Care Plan Fraud

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

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

Subsection-D

Disruption of Care

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

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

Subsection-E

Confidentiality of Medical Records

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

Subsection-F

Notice Of Privacy Practices

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

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

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

How We May Use And Disclose Your Protected Health Information

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

- **Payment.** We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment.

- **Health Care Operations.** We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or customer service. In some cases, we may use or disclose the information for underwriting or determining premiums.
- **Treatment.** We may use and disclose your protected health information to assist your health care providers (doctors, dentists, pharmacies, Hospitals and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.
- **Plan Sponsor.** If you are enrolled through a group health plan, we may provide summaries of claims and expenses for enrollees in a group health plan to the plan sponsor, which is usually the employer.
- **Enrolled Dependents and Family Members.** We will mail explanation of benefits forms and other mailings containing protected health information to the address we have on record for the subscriber of the health plan.

Other Permitted Or Required Disclosures

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

Other Uses Or Disclosures With An Authorization

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

Your Rights Regarding Your Protected Health Information

You have certain rights regarding protected health information that the Plan maintains about you.

- **Right To Access Your Protected Health Information.** You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment,

billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.

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

Health Information Security

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

Changes To This Notice

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

Complaints

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

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

Contact The Plan

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

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

You may also contact us at:

Telephone: **1-800-839-2172**
Fax: **1-818-676-8981**
Email: **Privacy@health.net**

DEFINITIONS (SECTION 1100)

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

Acute Condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

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

Brand Name Drug is a Prescription Drug or medicine that has been registered under a brand or trade name by its manufacturer and is advertised and sold under that name and indicated as a brand in the Medi-Span Database.

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

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

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

Copayment is a fee charged to you for covered services when you receive them. The Copayment is due and payable to the provider of care at the time the service is received. The Copayment for each covered service is shown in "Schedule of Benefits and Copayments," Section 400.

Covered Expenses/Services are Medically Necessary medical, surgical, hospital and other services and supplies rendered by participating providers and emergency care and supplies provided by non-participating providers, which are specified as being covered in the Plan Contract.

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

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

Deductible is a set amount you pay each calendar year for specified covered expenses before Health Net pays any benefits for those covered expenses.

Dependents are those individuals in a Subscriber's Family Unit who meet the criteria of the definition of "Dependent" as used in the Internal Revenue Code and Regulations of the United States, subject to any eligibility prerequisites to the contrary described in this Plan Contract.

Durable Medical Equipment

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

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

Emergency Care is any otherwise covered service that a reasonable person with an average knowledge of health and medicine would seek if he or she was having serious symptoms and believed that without immediate treatment, any of the following would occur:

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

Emergency Care also includes treatment of severe pain or active labor.

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

Health Net will make any final decisions about Emergency Care.

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

Please refer to "Independent Medical Review of Investigational or Experimental Therapies," "General Provisions," Section 900, as well as the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section for additional information.

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

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

Generic Drug is the pharmaceutical equivalent of a Brand Name Drug whose patent has expired and is available from multiple manufacturers as set out in the Medi-Span or similar third party database used by Health Net. The Food and Drug Administration must approve the Generic Drug as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

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

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

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

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

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

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

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

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

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

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

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

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

Medically Necessary (or Medical Necessity) A Medically Necessary service or supply is one that meets the following criteria: it is an otherwise covered category of services, not specifically excluded and is recommended by the treating Physician and determined by Health Net's Medical Director or Physician designee to be:

Purpose

- For the purpose of treating a medical condition;

Scope

- The most appropriate supply or level of service, considering potential benefits and harm to the Member; not furnished primarily for the convenience of the Member or provider; not required solely for custodial, comfort or maintenance reasons; consistent with Health Net medical guidelines and furnished in the most economically efficient manner that may be provided safely and effectively for the Member; and

Evidence

- Known to be effective and safe in improving health outcomes. For new treatments, services or supplies, effectiveness is determined by scientific evidence. For existing treatments, services or supplies, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.

The fact that a Physician or other provider may prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary or make it a covered service.

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

Member is the Subscriber or an enrolled family member.

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

Mental Disorders is a nervous or mental condition that meets all of the following conditions:

- It is a clinically significant behavioral or psychological syndrome or pattern;
- It is associated with a painful symptom, such as distress;
- It impairs a patient's ability to function in one or more major life activities; or
- It is a condition listed as an Axis I Disorder (excluding V Codes) in the most recent edition of the DSM by the American Psychiatric Association.

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

Nonparticipating Pharmacy is a pharmacy that does not have an agreement with Health Net to provide Prescription Drugs to Members.

Nurse Practitioner (NP) is a registered nurse certified as a Nurse Practitioner by the California Board of Registered Nursing. The NP, through consultation and collaboration with Physicians and other health providers, may provide and make decisions about, health care.

Out-of-Pocket Maximum is the maximum amount of Copayments and Inpatient Hospital Facility Services Deductibles you must pay for Covered Services for each calendar year. It is your responsibility to inform Health Net when you have satisfied the Out-of-Pocket Maximum, so it is important to keep all receipts for Deductibles and Copayments that were actually paid. Deductibles and Copayments, which are paid toward certain covered services, are not applicable to your Out-of-Pocket Maximum and these exceptions are specified in the "Out-of-Pocket Maximum" section of this EOC.

Outpatient Surgical Center is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services.

Pain means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder or condition. Pain includes low back Pain, post-operative Pain and post-operative dental Pain.

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

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

Participating Mental Health Professional is a Physician or other professional who is licensed by the state of California to provide mental health care. The Participating Mental Health Professional must have a service contract with the Administrator to provide Mental Disorder and Chemical Dependency services.

Participating Pharmacy is a licensed pharmacy that has a contract with Health Net to provide Prescription Drugs to Members of this Plan.

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

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

Physician Group is the Health Net contracting medical group the individual Member selected as the source of all covered medical care. They are sometimes referred to as a "contracting Physician Group" or "Participating Physician Group (PPG)." Another common term is "a medical group." An individual practice association may also be a Physician Group.

Plan is the health benefits purchased by you and described in this Plan Contract.

Plan Contract is the booklet that Health Net has issued to the enrolled Subscriber, describing the coverage to which you are entitled.

Prescription Drug is a drug or medicine that can be obtained only by a Prescription Drug Order. All Prescription Drugs are required to be labeled "Caution, Federal Law Prohibits Dispensing Without a Prescription." An exception is insulin and other diabetic supplies, which are considered to be a covered Prescription Drug.

Prescription Drug Order is a written or verbal order or refill notice for Prescription Drugs or medicines issued by a Member Physician.

Primary Care Physician is a Member Physician who coordinates and controls the delivery of covered services and supplies to the Member. Primary Care Physicians include general and family practitioners, internists, pediatricians and obstetricians/gynecologists.

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

Qualifying Prior Coverage includes any health care benefit plan, including but not limited to, Medicare, Medicaid or other publicly sponsored program, that arranges or provides medical, hospital and surgical coverage and that is not designed to supplement other private or governmental plans.

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

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

Serious Emotional Disturbances of a Child is when a child under the age of 18 has one or more mental disorders identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance use disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following: (a) as a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home or (ii) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year; (b) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; and/or (c) the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Severe Mental Illness include schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition of the *Diagnostic and Statistical Manual for Mental Disorders*), autism, anorexia nervosa and bulimia nervosa.

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

Specialty Pharmacy Vendor is a pharmacy contracted with Health Net specifically to provide injectable medications.

Subscriber is the person enrolled under this Plan Contract who is responsible for payment of premiums to Health Net and whose status is the basis for family member eligibility under this Plan Contract.

Terminal Illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness

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

For more information, please contact us at:

Health Net Individual & Family Sales Enrollment Unit
Post Office Box 1150
Rancho Cordova, CA 95741-1150

Member Services
1.800.839.2172

www.health.net