Health Net Health Plan of Oregon, Inc.

WASHINGTON
PPO GROUP AGREEMENT

2019

Health Net®

Health Net Health Plan of Oregon, Inc.
13221 SW 68th Parkway
Tigard, Oregon 97223
Phone 888.802.7001
www.healthnet.com

Dear Group Administrator,

We are pleased to provide the enclosed Group Service Agreement. The agreement includes your rates, benefit schedules, and contract.

Please call your Health Net Health Plan of Oregon account representative toll-free at 1-888-802-7001 with any questions regarding the agreement or your plan.

We look forward to a successful partnership.

Sincerely,

Sales Department

Health Net Health Plan of Oregon, Inc.

Health Net®

Dear Health Net Member:

Thank you for choosing Health Net to provide your health care benefits. We look forward to ensuring a positive experience and your continued satisfaction with the services we provide.

Enclosed you will find information about your new Plan Contract. This document is the most up-to-date version. To avoid confusion, please discard any versions you may have previously received.

If you've got a web-enabled smartphone, you've got everything you need to track your health plan details. Take the time to download Health Net Mobile. You'll be able to carry your ID card with you, easily find details about your plan, store provider information for easy access, search for doctors and hospitals, or contact us at any time. It's everything you need to track your health plan details – no matter where you are as long as you have your smartphone handy.

We look forward to serving you. Contact us at www.healthnet.com 24 hours a day, seven days a week for information about our plans, your benefits and more. You can even submit questions to us through the website, or contact us at one of the numbers below. Our Customer Contact Center is available from 7:00 a.m. to 6:00 p.m., Monday through Friday, except holidays. You'll find the number to call on the back of you member ID card.

Our goal is to help you get the greatest benefit from your health care while fully and efficiently addressing your needs and concerns.

Thank you for choosing Health Net Health Plan of Oregon, Inc.

Health Net®

Basic Benefit Copayment and Coinsurance Schedule
PPO Advantage
PPO Standard Plan

PPO: In health coverage, PPO stands for Preferred Provider Organization. For you, PPO means that you have flexibility and choice in deciding who will provide your health care. That's because this plan lets you receive services from Providers in our PPO network or Providers out of our network. Who performs the services determines which benefit level applies to Covered Services and how much you will pay out-of-pocket. To confirm whether a Provider participates in our PPO network and to verify which benefit level will apply to a covered service, please contact one of our Customer Contact Center representatives.

PPO Benefits: When you receive Covered Services from Providers in our PPO network, your expenses include a Calendar Year Deductible (if any), fixed dollar amounts for certain services or a fixed percentage that is applied to our contracted rates with PPO Providers. The percentage of our contracted rate that is your responsibility is shown on this Schedule as **% contract rate**.

When you receive Covered Services from Providers in our PPO network, you are not responsible for charges that are above our contracted rates. We recommend that you contact your treating Provider to discuss the other types of Providers that may be used for your services, as Out-of-Network Provider charges will be reimbursed at the Out-of-Network level. **Certain services including but not limited to Home Health Care, infusion services that can be safely administered in the home or infusion suite, organ and tissue transplant services, and Durable Medical Equipment are covered only if provided by a designated Specialty Care Provider. See "Specialty Care Providers" under the "General Terms Under Which Benefits Are Provided" section of the Group Plan Benefits.**

Out-of-Network Benefits unless noted as not a covered benefit: When services are performed by a Provider who is not in our PPO network, your expenses include a Calendar Year Deductible, fixed dollar amounts for certain services and a fixed percentage of Maximum Allowable Amount (MAA) for other services. We pay Out-of-Network Providers based on MAA rates, not on billed amounts. MAA rates may often be less than the amount a Provider bills for a service. Out-of-Network Providers may therefore hold you responsible for amounts they charge that exceed the MAA rates we pay. Amounts that exceed our MAA rates are not covered and do not apply to your annual Out-of-Pocket Maximum. *Your responsibility for any amounts that exceed our MAA payment is shown on this Schedule as **MAA***. See the definition of "MAA" in your Plan Contract for more information on how MAA rates are calculated.

Prior authorization: Some services must be authorized by us before you get them. See "Prior Authorization" in the Group Plan Benefits of the Plan Contract for details.

This Schedule is an amending attachment to the Group Plan Benefits. Subject to all terms, conditions, exclusions and definitions in the Group Medical and Hospital Service Agreement and its attachments, except as expressly amended by benefits provision of this Schedule, you are entitled to receive benefits set forth in this Schedule upon payment of the relevant premiums and Copayments.

Professional Medical Services and Supplies

Your benefits are subject to Deductibles, Copayments and Coinsurance amounts listed in this Schedule.

For Covered Services, you are responsible for:

Calendar Year Deductible	PPO Network	Out-of-Network

You must meet the specified Deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims. All amounts applied toward the Individual Deductible for each Member in a family unit will accumulate to satisfy the Family Deductible. Once the Family Deductible is met, no further individual Deductibles for covered Members in the Family Unit will have to be satisfied during the Year.

Annual Deductible per person .....$[ ]PPO Network and Out-of-Network combined
Annual Deductible per family.....$[ ]PPO Network and Out-of-Network combined

Physician/Professional/Outpatient Care

Physician services, office visit, and preventive care Copayment or Coinsurance shown below includes Physician services only. Other services may be subject to Copayments or Coinsurance as listed. For example, if Physician services are provided in a hospital-based facility or in an emergency room, the hospital-based facility or emergency room Deductible and Copayments or Coinsurance will also apply.

	PPO Network	Out-of-Network
Physician services, office visit	$[ ] per visit, after Deductible	[ ]% MAA
Preventive care and preventive screenings	No charge, Deductible is waived	[ ]% MAA
Diagnostic X-ray /mammography/EKG/Ultrasound	[ ]% contract rate	[ ]% MAA
Diagnostic laboratory tests, including PAP/PSA test	[ ]% contract rate	[ ]% MAA
Diagnostic Imaging, including CT/MRI/PET/SPECT/EEG/Holter monitor/Stress test	[ ]% contract rate	[ ]% MAA
Allergy and therapeutic injections	[ ]% contract rate	[ ]% MAA
Prenatal and postnatal care	[ ]% contract rate	[ ]% MAA
Maternity delivery care (professional services only)	[ ]% contract rate	[ ]% MAA
Outpatient rehabilitation therapy- 25 days/year max	[ ]% contract rate	[ ]% MAA
Outpatient habilitative therapy 25 days/year max	[ ]% contract rate	[ ]% MAA
Outpatient Surgery Services at Ambulatory Surgery Center	[ ]% contract rate	[ ]% MAA

	PPO Network	Out-of-Network
Outpatient Surgery Services at Hospital-based facility	[ ]% contract rate	[ ]% MAA
Physician Hospital visits	[ ]% contract rate	[ ]% MAA

Hospital Care	PPO Network	Out-of-Network
Inpatient services	[ ]% contract rate	[ ]% MAA
Inpatient rehabilitation therapy - 30 days/year max	[ ]% contract rate	[ ]% MAA
Inpatient habilitative therapy 30 days/year max	[ ]% contract rate	[ ]% MAA

Emergency Services	PPO Network	Out-of-Network
Outpatient emergency room services	[ ]% contract after In-net deductible Copayment or Coinsurance is waived if you are admitted	[ ]% contract after In-net deductible Copayment or Coinsurance is waived if you are admitted
Urgent care center	[ ]% after deductible	[ ]% after deductible then billed over MAA
Inpatient admission from emergency room	[ ]% contract rate	[ ]% contract rate
Emergency ground and air ambulance transport	[ ]% of the amount billed by the ambulance company after In-net deductible	[ ]% of the amount billed by the ambulance company after In-net deductible

Mental/Behavioral Health/Substance Use Disorder Services	PPO Network	Out-of-Network
Outpatient, office visit	$[ ] after Deductible	[ ]% MAA
Outpatient services, other	[ ]% contract rate	[ ]% MAA
Inpatient services	[ ]% contract rate	[ ]% MAA

Other Services	PPO Network	Out-of-Network
Diabetes care management (includes routine foot care)	$[ ] after Deductible	[ ]% MAA
Durable Medical Equipment and Prosthetic Devices/Orthotic Devices	[ ]% contract rate	[ ]% MAA

Other Services	PPO Network	Out-of-Network
Home infusion therapy	[ ]% contract rate	[ ]% MAA
Home health visits – 130 visits/year max	[ ]% contract rate	[ ]% MAA
Hospice services	[ ]% contract rate	[ ]% MAA
Medical foods. Nutrition and associated treatment for newborn PKU or inborn errors of metabolism	[ ]% contract rate	[ ]% MAA
Medical supplies (including allergy serum and injected substances)	[ ]% contract rate	[ ]% MAA
Outpatient chemotherapy (non-self administered anticancer medications and administration)	[ ]% contract rate	[ ]% MAA
Respite care – inpatient or outpatient, 14 days per member limit, per lifetime, for hospice care patients	[ ]% contract rate	[ ]% MAA
Skilled Nursing Facility care- 60 days/year max	[ ]% contract rate	[ ]% MAA
Telemedical Services	$[ ] after Deductible	[ ]% MAA
TMJ services	[ ] % contract rate	[ ]% MAA
Spinal and other manipulations (any provider: MD, DO, chiropractor)- 15 manipulations/year max	$[ ] after Deductible	[ ]% MAA
Acupuncture Care - 15 visits/year max	$[ ] after Deductible	[ ]% MAA
Naturopathic Care	$[ ] after Deductible	[ ]% MAA
Massage Therapy - 15 visits/year max	$[ ] after Deductible	[ ]% MAA
Pediatric Vision	(See Pediatric Vision Benefits section below for more details)	(See Pediatric Vision Benefits section below for more details)
Pediatric Dental	(See Pediatric Dental Benefits section below for more details)	(See Pediatric Dental Benefits section below for more details)
Prescription Drugs	(See Outpatient Prescription Drug Benefits section below for more details)	(See Outpatient Prescription Drug Benefits section below for more details)

Benefit Maximum	PPO Network	Out-of-Network

The annual Out-of-Pocket Maximum includes the annual Deductible. After you reach the Out-of-Pocket Maximum in a Calendar Year, we will pay your Covered Services during the rest of that Calendar Year at 100% of our contract rates for PPO services and at 100% of MAA for Out-of-Network (OON) services. You are still responsible for OON billed charges that exceed MAA.

Annual Out-of-Pocket Maximum per person .....$[ ] PPO Network and Out-of-Network combined
Annual Out-of-Pocket Maximum per family.....$[ ] PPO Network and Out-of-Network combined

Outpatient Prescription Drug Benefits

Calendar Year Deductible for Prescription Drug Benefits: $500

Copayments, Coinsurance and other amounts you pay for prescription drugs apply toward your plan's Out-of-Pocket Maximum as shown in the "Benefit Maximums" section above.

Prescription Drugs	In Pharmacy (Per Fill Up to a 30-Day Supply)	Mail Order (Per Fill Up to a 90-day supply)
Tier 1	$[ ] deductible waived	$[ ] deductible waived
Tier 2	[ ] % after Deductible	[ ] % after Deductible
Tier 3	[ ] % after Deductible	[ ] % after Deductible
Preventive Pharmacy, Tobacco Cessation Medications, and Contraceptive Methods	No Copayment and/or Coinsurance	No Copayment and/or Coinsurance
Specialty Pharmacy	[ ] % after Deductible	Mail order not available
Prescribed, self-administered anticancer medications	[ ] % after Deductible	Mail order not available

This pharmacy plan provides Creditable Coverage for Medicare Part D.

Pediatric Vision Benefits

This plan covers Medically Necessary vision services and supplies for Enrolled children under age 19 as described below. These services are not subject to the Calendar Year Deductible. You must utilize Participating Providers. A list of Participating Providers is available at www.healthnet.com or by calling our Customer Contact Center at the phone number listed at the bottom of this Schedule.

Routine vision screening limit: 1 per Calendar Year ..... $[ ] Copayment
Comprehensive eye exam, including dilation if professionally indicated and with refraction limit: 1 per Calendar Year ..... $[ ] Copayment
Lenses limit: 1 pair per Calendar Year, including Single vision, bifocal, trifocal, lenticular, Glass or Plastic ..... $[ ] Copayment
Provider selected frames limit: 1 per Calendar Year ..... $[ ] Copayment
Optional Lenses and Treatments including: UV Treatment, Tint (Fashion & Gradient & Glass-Grey), Standard Plastic Scratch Coating, Standard Polycarbonate, Photocromatic / Transitions Plastic, Standard Anti-Reflective Coating, Polarized, Standard Progressive Lens, Hi-Index Lenses, Blended segment Lenses, Intermediate vision Lenses, Select or ultra progressive lenses ..... $[ ] Copayment
Provider selected contact lenses, a one year supply is covered every Calendar Year (in lieu of eyeglass lenses): Disposables, Conventional, Medically Necessary ..... $[ ] Copayment
Subnormal or Low Vision Aids including: One comprehensive low vision evaluation is covered every 5 years; follow up care of four visits every 5 years, low vision aids, including high-power spectacles, magnifiers or telescopes (limited to one aid per year). ..... $[ ] Copayment

Pediatric Dental Benefits

Necessary Dental Care for Enrolled children under age 19 is covered. This plan covers limited pediatric Dental Services as described below. You can see any licensed dentist and receive benefits for Covered Services and Supplies. However, if you do see a Participating Provider, charges for Covered Services will be limited to Health Net's contracted amount with the Provider. You can obtain a list of Participating Providers by calling our Customer Contact Center at the phone number at the bottom of this Schedule.

Your Group Plan Benefits are based on who provides your Dental Services. For more information on what services are covered and how much your plan pays, please see the "Pediatric Dental" subsection of the Group Plan Benefits section, and the definition of "Dental Services" in the Group Medical and Hospital Service Agreement of your PPO Plan Contract or call our Customer Contact Center at the phone number listed at the bottom of this Schedule.

Coverage is as follows:

Deductible

The Deductible is the amount you pay before your plan begins paying benefits for Covered Services. The Deductible applies to all services.

Deductible per Member .....$[ ] per Calendar Year

Diagnostic and Preventive Services	Plan Pays:	Benefit Limitations
Periodic Oral Evaluations	[ ]%	Once every 6 months, beginning before one year of age
Dental Prophylaxis (cleaning)	[ ]%	Once every 6 months
X-Rays (Radiographs)	[ ]%	Intraoral complete series one in a 3 year period unless a panoramic X-ray for the same member has been performed in the same 3 year period; Medically Necessary periapical X-rays that are not included in a complete series for diagnosis in conjunction with definitive treatment: an occlusal intraoral X-ray once in a 2 year period; a maximum of 4 bitewing X-rays (once per quadrant) once every twelve months; panoramic X-rays in conjunction with 4 bitewings, once in a 3 year period, only when an intraoral complete series for the same enrollee has not been paid in the same 3 year period. Cephalometric films once in a 2 year period; X-rays not listed above on a case by case basis when Medically Necessary; oral and facial photographic images on a case by case basis.
Topical Fluoride Treatments	[ ]%	3 times in a 12 month period for ages six and under; 2 times in a 12 month period for ages 7 to 18 years of age; up to 3 times in a 12 month period per child during orthodontic treatment. Additional applications on a case by case basis as Medically Necessary.
Oral Hygiene Instruction – includes tooth brushing techniques, flossing, and use of oral hygiene aids	[ ]%	Once every 6 months, up to 2 times in a 12 month period for those 8 and younger if not billed on the same day as a prophylaxis treatment.

Diagnostic and Preventive Services	Plan Pays:	Benefit Limitations
Sealants	[ ]%	Once every three years for permanent bicuspids and molars only.
Tests and Examinations	[ ]%	One pulp vitality test per visit. Diagnostic casts other than those included in an orthodontic case study.
Space Maintainers	[ ]%	Space maintainer for 12 years and younger for fixed unilateral or bilateral space maintenance subject to one space maintainer per quadrant for primary molars A, B, I, J, K, L, S, and T. Covers replacement space maintainers on a case by case basis.

Basic Services	Plan Pays:	Benefit Limitations
Minor Restorative Services (fillings)	[ ]%	Covers two occlusal restorations for the upper molars on teeth one, two three, fourteen, fifteen and sixteen if, the restorations are anatomically separated by sound tooth structure; a maximum of five surfaces per tooth for permanent posterior teeth, except for upper molars and a maximum of six surfaces per tooth for teeth one, two, three, fourteen, fifteen and sixteen; a maximum of six surfaces per tooth for resin-based composite restorations for permanent anterior teeth.

Basic Services	Plan Pays:	Benefit Limitations
Endodontic Services	[ ]%	Covered for therapeutic pulpotomy on primary teeth and pulpal debridement on permanent teeth only (excluding teeth 1, 16, 17 and 32; treatment with resorbable material for primary maxillary incisor teeth D, E, F, and G, if the entire root is present at treatment; treatment on primary posterior teeth only; treatment for permanent anterior, bicuspid, and molar teeth (excluding teeth 1, 16, 17, and 32). Retreatment for the removal of post, pin, old root canal filling material, and all procedures necessary to prepare the canal with placement of new filling material. Apexification for apical closures of anterior permanent teeth. Apicoectomy and retrograde filling for anterior teeth
Palliative Treatment (relief of pain)	[ ]%	
General Anesthesia	[ ]%	Deep sedation/general anesthesia – first 30 minutes and each additional 15 minutes.
Nonsurgical Periodontal Scaling and Root Planing	[ ]%	Once per quadrant in a 2 year period for ages 13 and older, with prior authorization and evidenced by X-ray
Surgical Periodontal	[ ]%	1 time per consecutive 36 months per surgical area
Periodontal Maintenance	[ ]%	Once per quadrant in a 12 month period for ages 13 and older with prior authorization
Simple Extraction	[ ]%	Covers surgical extraction of unerupted teeth.
Surgical Extraction, including impacted wisdom teeth	[ ]%	Covers surgical extraction of unerupted teeth.

Basic Services	Plan Pays:	Benefit Limitations
Oral Surgery	[ ]%	Frenulectomy or Frenuloplasty covered for ages 6 and under without prior authorization

Major Services	Plan Pays:	Benefit Limitations
Inlays/Onlays/Crowns	[ ]%	Covers an indirect crown once every 5 years, per tooth, for permanent anterior teeth for 12 through 18 years of age with prior authorization; all recementations of permanent indirect crowns for 12 through 18 years of age; prefabricated stainless steel crowns for primary posterior teeth once every 3 years; prefabricated stainless steel crowns for permanent posterior teeth excluding 1, 16, 17, and 32 once every 3 years; metal/porcelain crowns and porcelain crowns on anterior teeth only, with prior authorization; core buildup, including pins, only on permanent teeth, when performed in conjunction with a crown; cast post and core or prefabricated post and core, on permanent teeth when performed in conjunction with a crown and with prior authorization.
Prosthodontic Services (Removable)	[ ]%	One resin based partial denture, replaced once within a 3 year period; one complete denture upper and lower, and one replacement denture per lifetime after at least 5 years from the seat date; rebasing and relining of complete or partial dentures one in a 3 year period, if performed at least 6 months from the seating date.

Major Services	Plan Pays:	Benefit Limitations
Prosthodontics, Fixed (Bridges)	[ ]%	Covers fixed partial denture pontics; retainers – inlays/onlays/crowns; other fixed partial denture services with prior authorization
Occlusal Guard, by report	[ ]%	Medically necessary for those 12 to 19 years of age only.

Orthodontic Services	Plan Pays:	Benefit Limitations
Medically Necessary orthodontia	[ ]%	Covered with Prior Authorization

This schedule presents general information only. Certain services require Prior Authorization or must be performed by a Specialty Care Provider. Refer to your Plan contract for details, limitations and exclusions.

Health Net Health Plc an of Oregon, Inc. • 1-888-802-7001 • www.healthnet.com

HEALTH NET HEALTH PLAN OF OREGON, INC.

Washington Small Group

PPO PLAN CONTRACT

Group Plan Benefits and Group Medical and Hospital Service Agreement

2019

Health Net®

Health Net Health Plan of Oregon, Inc.
Washington PPO Plan
Policy Disclosures

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 DISCLOSURE

Health plans that provide medical and surgical benefits with respect to mastectomy shall provide, in a case of a Member who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for the following services in a manner determined in consultation with the physician and the Member:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications in all stages of mastectomy, including lymphedemas.

Benefits for reconstructive surgery are subject to applicable annual Deductibles, if any, and Coinsurance consistent with those established for other benefits. Health plans and Employers may not deny a person eligibility to Enroll in or to renew coverage solely for the purpose of avoiding coverage of breast reconstruction following a mastectomy.

SECOND MEDICAL OPINION

At the request of a Member, we will provide access to a second medical opinion from a Participating Provider of his or her choice, subject to maximum benefit limits and applicable Deductible and Coinsurance or Copayment amounts.

SELF-REFERRAL FOR WOMEN'S HEALTH CARE SERVICES

Female Members may seek care for Women's Health Care Services without Prior Authorization. You may seek these services from any Women's Health Care Provider. Facility services such as those provided by Hospitals or Outpatient Surgical Centers require Prior Authorization.

THE RIGHT TO EXERCISE CONSCIENCE

Health care Providers or Employers have the right not to provide termination of pregnancy or other services to which they object because of religious belief or issues of conscience. If your Employer objects to providing a specific service that is normally provided, you will be told how to receive this particular service from another Provider, with no added cost to you. For more information, please call the Customer Contact Center at the number listed at the back of your Agreement.

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Health Net

Health Net Health Plan of Oregon, Inc.
Washington PPO Plan

GROUP PLAN BENEFITS

General Terms Under Which Benefits Are Provided

Throughout this Group Plan Benefits section, the terms "we," "our" and "us" refer to Health Net Health Plan of Oregon, Inc. (Health Net) and the terms "you" and "your" refer to the Subscriber and to each Enrolled Dependent unless otherwise specified.

If you have any questions about your coverage or any other plan that We offer, please call to talk with one of our Customer Contact Center representatives at the phone number listed at the back of the this Agreement. You may also visit our web site at: www.healthnet.com.

You are entitled to receive the benefits set forth in this Group Plan Benefits section subject to the following conditions:

- All benefits are subject to the terms, conditions and definitions in the Group Medical and Hospital Service Agreement and the exclusions and limitations in the "Exclusions and Limitations" section of this Group Plan Benefits section, including payment of any applicable Copayments and/or Coinsurance identified in the attached Copayment and Coinsurance Schedule. Health Net's obligation to pay benefits for Covered Services and Supplies is subject to Your payment of any required Copayment, Coinsurance and Deductibles.
- All services, other than the preventive care services outlined in the Agreement, are covered only if Medically Necessary and required in accordance with accepted standards of medical practice.
- The fact that a Provider may provide, prescribe, order, recommend, approve, refer or direct a service or supply does not, in and of itself, make the service or supply a covered benefit.
- Subject to the Specialty Care Provider requirements, you may choose to obtain covered Medical Services and supplies from a Nonparticipating Provider. You may incur higher out-of-pocket expenses if you receive services or supplies from a Nonparticipating Provider.
- When services are performed by or received from a Nonparticipating Provider, your expenses may include a Calendar Year Deductible, fixed dollar amounts for certain services and the amount by which billed charges exceed the Maximum Allowable Amount (MAA) for other services. The definition of MAA is set forth in the "Definitions" section of the Group Medical and Hospital Service Agreement. The MAA for covered Medical Services and supplies may not be the same as what the Nonparticipating Provider bills.

- When you receive care from or stay in, a Participating Provider Hospital (or facility), and if you receive Covered Services or Supplies from Nonparticipating Providers, you will be reimbursed at the Out-of-Network level for Covered Services performed by such Nonparticipating Providers. These Providers include, but are not limited to, those who provide anesthesia services, emergency room physician services, radiology (X-ray), pathology or laboratory services.
- For Covered Services, Health Net uses available guidelines of Medicare, including billing and coding requirements, to assist in its determination as to which services and procedures are eligible for reimbursement, and in determining the Maximum Allowable Amount (MAA). The definition of MAA is set forth in the "Definitions" section of the Group Medical and Hospital Service Agreement.
- Members who believe they do not have sufficient access to Participating Providers for Covered Services within the Service Area may contact the Customer Contact Center at the phone number listed at the back of the Agreement, prior to receiving care, to request a benefit exception. The Member's request will be evaluated by the Customer Contact Center representative to determine if the existing Participating Providers meet the access standards, as they apply to the Member's specific circumstance. If the requested Covered Service is determined to be available in-network, as per the applicable access standard, the Member will be informe78uyd accordingly and the relevant Participating Providers will be communicated to the Member at that time. If it is determined that the Member does not have sufficient access to Participating Providers within the Service Area, as determined by the access standard, a benefit exception will be processed internally such that the Member's cost will not exceed what the Member's cost would have been if the services were provided by a Participating Provider. Under such exceptions, applicable requirements for Medical Necessity, Prior Authorization and all other plan provisions remain in force.
- **Specialty Care Providers.** Medical Services for certain conditions or certain treatment procedures may be provided only at Participating Providers that we designate as Specialty Care Providers. Services which require use of a Specialty Care Provider include but are not limited to: 1) Home Health Care; 2) infusion services that can be safely administered in the home or in a home infusion suite; 3) organ and tissue transplant services; and 4) Durable Medical Equipment. We shall have the right to require a Member to use a designated Specialty Care Provider as a condition to receive coverage under this Agreement.

  We may authorize Members to travel out of the Service Area to receive care. If we authorize the Members to use a Specialty Care Provider outside the Service Area, we will pay reasonable transportation, board and lodging expenses for the Member, to be determined by us based upon individual circumstances, including without limitation the distance between the Member's home and the Specialty Care Provider, and the Member's medical condition.
- The coverage described in this Group Plan Benefits section shall be consistent with the Essential Health Benefits coverage requirements in accordance with the Affordable Care Act (ACA). The Essential Health Benefits are not subject to any annual dollar limits.
- The benefits described under this Agreement do not discriminate on the basis of race, ethnicity, nationality, gender, age, disability, sexual orientation, genetic information, or religion, and are not subject to any pre-existing condition exclusion period. Please refer to the Notice of Nondiscrimination enclosed in this Plan Contract.

Physician Services

Medically Necessary Physician services are covered as follows:

- **Allergy Injections.** Administration of treatment compounds, solutions and medications for allergy care is covered.
- **Diagnostic Services.** Diagnostic services, including radiology (X-ray), pathology, laboratory services, supplies and tests, and other imaging and diagnostic services are covered. Diagnostic services, including, MRIs, MRAs, CT, PET, echocardiography and nuclear cardiac imaging, require Prior Authorization. Hearing tests in support of a diagnosis are covered.

  Exclusions and Limitations:

  Screening audiometry and tympanograms not in support of a diagnosis are not covered.
- **Radiation.** Radiation therapy is covered.
- **Chemotherapy.** Chemotherapy and chemotherapy self-injectables are covered. Chemotherapy is the use of anticancer drugs to treat conditions including, but not limited to cancer. The chemotherapy benefit covers anticancer drugs and drugs used to treat the side effects of chemotherapy. It also includes administration of the drugs in the Provider's office, and medical supplies related to the mixing and administration of the drugs. Prescribed, self-administered anticancer medications are covered as a prescription benefit. See the "Prescription Drug Benefit" section in this Group Plan Benefits section for information on how to obtain self-administered anticancer medications.
- **Office Visits**. Your office visits, including diagnostic examination and treatment of illness or injury, are covered. Certain services may require Prior Authorization. Please refer to the "Prior Authorization" section for a list of services that require Prior Authorization.
- **Physician Services** While Hospitalized. The services of Physicians during a covered hospitalization, including services of primary care Providers, specialist surgeons, assistant surgeons, anesthesiologists, pediatrician visits to an Enrolled newborn Child, and other appropriate medical personnel, are covered.
- **Home Visits**. Visits to your home are covered.
- **Specialty Physician Services.** Services of specialty Physicians and other specialty Providers are covered.
- **Surgery.** Inpatient or outpatient surgical procedures are covered only when Prior Authorized or as Emergency Medical Care.
- **Primary Care Provider Designation.** Health Net allows the designation of a primary care Provider. You have the right to designate any primary care Provider who participates in our Health Net PPO DV Network and who is available to accept you or your family members. Members have the ability to select a licensed naturopathic physician (ND) as their primary care provider and receive primary care services within the scope of the ND's license. For children, you may designate a pediatrician as the primary care Provider. For information on how to select a primary care Provider, and for a list of the participating primary care Providers, you may contact us at:

Health Net Health Plan of Oregon, Inc.
13221 SW 68th Parkway
Tigard, Oregon 97223

Customer Contact Center
Monday - Friday 7:30 a.m. to 5:00 p.m.
1-888-802-7001
www.healthnet.com

Hearing and Speech Assistance
Monday - Friday 7:30 a.m. to 5:00 p.m.
TTY 1-888-802-7122 TTY: 711

- **Obstetrical and Gynecological Care.** You do not need Prior Authorization from us or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our Health Net PPO DV Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of Participating health care professionals who specialize in obstetrics or gynecology, you may contact us at:

  Health Net Health Plan of Oregon, Inc.
  13221 SW 68th Parkway
  Tigard, Oregon 97223

  Customer Contact Center
  Monday - Friday 7:30 a.m. to 5:00 p.m.
  1-888-802-7001
  www.healthnet.com

  Hearing and Speech Assistance
  Monday - Friday 7:30 a.m. to 5:00 p.m.
  TTY 1-888-802-7122 TTY: 711

Hospital Inpatient Services

Medically Necessary Hospital inpatient services are covered as follows:

- **Hospital Inpatient.** Inpatient services are covered only when Prior Authorized or as Emergency Medical Care. Coverage includes Hospital visits, facility costs, provider and staff services and treatments delivered during an inpatient Hospital stay, including inpatient pharmacy services.

- **Hospital Room and Board.** While you are a patient in a Hospital, an average two-bed accommodation; general nursing care; meals; special diets; use of operating room and related facilities; intensive care unit and services; respite care; X-ray, laboratory, and other diagnostic tests; drugs; medications; biologicals; anesthesia and oxygen services; radiation therapy; chemotherapy; inhalation therapy; internal Prosthetic Devices, such as pacemakers and hip joints, approved by the Food and Drug Administration and implanted during a surgery pursuant to a Prior Authorization. Single occupancy rooms are covered at those facilities which only offer single occupancy accommodations, but are not covered merely for patient convenience or preference.
- **Maternity Hospitalization.** Refer to the "Maternity Benefits" section of this Group Plan Benefits section.
- **Newborn Nursery Care.** Routine care in the Hospital nursery is covered for the newborn Child. See the "Enrollment and Effective Date" section of the Group Medical and Hospital Service Agreement for newborn Child Enrollment guidelines. (Please note the newborn nursery care is included with the hospitalization of the mother. However, if the newborn patient requires admission to an intermediate or intensive care nursery, a separate Copayment or Coinsurance for inpatient services, as shown on the Copayment and Coinsurance Schedule, will apply to the newborn patient.)
- **Dental Hospitalization.** Inpatient and outpatient services and supplies for hospitalization for Dental Services are covered, including anesthesia as provided in the "Dental Anesthesia" section and, if hospitalization in an Ambulatory Surgical Center or Hospital is necessary to safeguard your health. Benefits are not available for the charges of a dentist or for services received in a dentist's office.

Exclusions and Limitations:

A private room or services of private or special duty nurses other than as Medically Necessary or when the only accommodation offered when you are an inpatient in a Hospital. Personal comfort items, such as television, telephone, lotions, shampoos, guest meals, housekeeping services, etc. Prescriptions relating to an inpatient confinement filled at a Hospital pharmacy prior to discharge for use at home (take-home medications).

When multiple procedures are performed at the same time, we will use Medicare guidelines to determine the circumstances under which claims for multiple surgeries will be eligible for reimbursement, in accordance with our normal claims filing requirements. Per Medicare guidelines, no benefits are payable for incidental surgical procedures, such as an appendectomy performed during gall bladder surgery.

We use Medicare guidelines to determine which procedures are eligible for separate professional and technical components.

We use Medicare guidelines to determine the circumstances under which claims for Assistant Surgeons, Co-Surgeons and Team Surgeons will be eligible for reimbursement, in accordance with our normal claims filing requirements.

We use Medicare guidelines to determine coverage during a post-operative global period for surgical procedures.

Outpatient Services

Medically Necessary outpatient services are covered as follows:

- **Diagnostic Services.** Diagnostic services, including radiology (X-ray), pathology, laboratory services, supplies and tests, and other imaging and diagnostic services are covered. Diagnostic services, including MRI, MRA, CT, PET, echocardiography and nuclear cardiac imaging require Prior Authorization. Outpatient services may be provided in a non-Hospital based health care facility or at a Hospital.

  The Copayment or Coinsurance for Laboratory and X-ray services may be different depending on whether the services are received at a Physician's office, a free-standing X-ray or laboratory facility, an Ambulatory Surgery Center or on an outpatient basis at a Hospital-based facility. Refer to the Copayment and Coinsurance Schedule under "Physician/Professional/Outpatient Care" for the applicable Copayment or Coinsurance.

  - **Basic Diagnostic X-ray, Lab and Imaging**
    Basic diagnostic x-ray, lab and imaging services that do not meet the preventive guidelines include but are not limited to:
    - Barium enema
    - Blood and blood services (storage and procurement, including blood banks), when Medically Necessary
    - Bone density screening for osteoporosis
    - Cardiac testing, including pulmonary function studies
    - Colonoscopies for a medical condition
    - 2-D and 3-D Mammograms for a medical condition
    - Neurological and neuromuscular tests
    - Pathology tests
  - **Major Diagnostic X-ray and Imaging**
    - Major diagnostic x-ray and imaging services include:
    - Computed Tomography (CT) scan
    - High technology ultrasounds
    - Nuclear cardiology
    - Magnetic Resonance Imaging (MRI)
    - Magnetic Resonance Angiography (MRA)
    - Positron Emission Tomography (PET) scan
  - **Sleep Studies**
    - Sleep studies include professional services, office visit or facility fees, and supplies for:
    - Home sleep studies
    - Sleep studies performed in an office or medical facility

Exclusions and Limitations:

- Diagnostic services from an inpatient facility, an outpatient facility, or emergency room that are billed with other Hospital or emergency room services. These services are covered under inpatient, outpatient or emergency room benefits.
- Allergy tests. These services are covered under the "Physician Services" and "Medical Supplies" sections of this Group Plan Benefits section.

- **Radiation Therapy**. Radiation therapy is covered.
- **Chemotherapy.** Chemotherapy and chemotherapy self-injectables are covered. Chemotherapy is the use of anticancer drugs to treat conditions including, but not limited to cancer. The chemotherapy benefit covers anticancer drugs and drugs used to treat the side effects of chemotherapy. It also includes administration of the drugs in the Provider's office, and medical supplies related to the mixing and administration of the drugs. Prescribed, self-administered anticancer medications are covered as a prescription benefit. See the "Prescription Drug Benefit" section in this Group Plan Benefits section for information on how to obtain self-administered anticancer medications.
- **Outpatient Surgery.** Outpatient surgery is covered only when Prior Authorized, if required, or as Emergency Medical Care. See the "Prior Authorization" subsection of this Group Plan Benefits section for a list of surgeries requiring Prior Authorization.
- **Dental Hospitalization.** Inpatient and outpatient services and supplies for hospitalization for Dental Services are covered including anesthesia as provided in the "Dental Anesthesia" section and, if hospitalization in an Ambulatory Surgical Center or Hospital is necessary to safeguard your health. Benefits are not available for the charges of a dentist or for services received in a dentist's office.

When multiple procedures are performed at the same time, we will use Medicare guidelines to determine the circumstances under which claims for multiple surgeries will be eligible for reimbursement, in accordance with our normal claims filing requirements. Per Medicare guidelines, no benefits are payable for incidental surgical procedures, such as an appendectomy performed during gall bladder surgery.

We use Medicare guidelines to determine which procedures are eligible for separate professional and technical components.

We use Medicare guidelines to determine the circumstances under which claims for Assistant Surgeons, Co-Surgeons and Team Surgeons will be eligible for reimbursement, in accordance with our normal claims filing requirements.

We use Medicare guidelines to determine coverage during a post-operative global period for surgical procedures.

Surgery Services

Inpatient or outpatient surgical procedures are covered. Services require Prior Authorization as outlined in the "Prior Authorization" section. Emergency Medical Care is covered without Prior Authorization.

Covered Services include:

- Anesthesia and postoperative care
- Cornea transplants and skin grafts
- Cochlear implants
- Blood transfusion, including blood derivatives
- Biopsies and scope insertion procedures such as endoscopies
- Colonoscopy and sigmoidoscopy services that do not meet the preventive guidelines. For more information about what services are covered as preventive see the "Preventive Care Services" section of this Group Plan Benefits section.
- Facility fees
- Surgical supplies
- Lawful termination of pregnancy
- Reconstructive surgery that is needed because of an injury, infection or other illness.
- The repair of a congenital anomaly

For the purposes of this section:

"Lawful termination of a pregnancy" means an abortion, with the woman's consent, prior to viability of the fetus, or to protect the woman's life or health. For the purpose of this definition, "viability" means the point in the pregnancy when, in the judgement of the physician on the particular facts of the case before such physician, there is a reasonable likelihood of the fetus's sustained survival outside the uterus without the application of extraordinary medical measures.

"Unlawful abortion" means pregnancy termination that is not a lawful termination of pregnancy.

Exclusions and Limitations:

- Routine colonoscopy, sigmoidoscopy and barium enema screening. See the "Preventive Care" section for details.
- Breast reconstruction. See the "Reconstruction Services" section for those Covered Services.
- Unlawful abortions

Emergency Services

Emergency service(s) include "Emergency Medical Care" and "Emergency Medical Screening Exam" for evaluation, treatment and "Stabilization" of an "Emergency Medical Condition."

Emergency services are covered inside or outside the Service Area without Prior Authorization. Refer to the "Definitions" section of the Group Medical and Hospital Service Agreement for the definitions of "Emergency Medical Care," "Emergency Medical Condition," and "Emergency Medical Screening Exam."

Emergency Inside the Service Area. If you have an Emergency Medical Condition inside the Service Area, medical care should be sought from the nearest Provider appropriate for the severity of your condition (Physician's office or clinic, Urgent Care center, or Hospital emergency room) or call 911.

Emergency Outside the Service Area. If you have an Emergency Medical Condition outside the Service Area, medical care should be sought from the nearest Provider appropriate for the severity of your condition (Physician's office or clinic, Urgent Care center, or Hospital emergency room) or call

911. Prescription medications associated with an Emergency Medical Condition, including those purchased in a foreign country are covered. See the "Prescription Drug benefits" subsection in this Group Plan Benefits section for more information.

Emergency Room. Services of a Hospital emergency room are limited to treatment of an Emergency Medical Condition and are not covered if merely for your convenience. Emergency Medical Condition means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, would place the person's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child. Covered Services include emergency room and department based services, supplies and treatment, including professional charges, facility costs, and outpatient charges for patient observation and medical screening exams required to stabilize a patient experiencing an Emergency Medical Condition.

Urgent Care Center. Medically Necessary services (including provider services, facility costs and supplies) provided in an Urgent Care center are covered.

Notification. If you are hospitalized for an Emergency Medical Condition, notice of the admission sufficient to establish your identity and the institution to which you were admitted must be given to us as soon as possible, but no later than 24 hours or by the next business day after admission.

Follow-up and Continued Care. To ensure the maximum available benefits under this Agreement, you should obtain your follow-up care after Stabilization of an Emergency Medical Condition from Participating Providers and in accordance with any Prior Authorization requirements. If you are hospitalized in a Nonparticipating Provider Hospital and require continuous care, we will arrange to have you transferred to a Participating Provider as soon as Stabilization has occurred.

Ambulance Transport. Licensed ground or air ambulance services are covered in the event of an Emergency Medical Condition. Medically Necessary ambulance transport for facility to facility transfers are also covered.

Exclusions and Limitations:

Ambulance transport that is not Emergency Medical Care or Medically Necessary is not covered.

We use a prudent layperson standard to determine whether the criteria for Emergency Care have been met. Under this Agreement, the prudent layperson standard is outlined in the definition of "Emergency Medical Condition" in the "Definitions" section of the Group Medical and Hospital Service Agreement.

Autism Spectrum and Pervasive Developmental Disorder

- Outpatient behavioral health treatment for Pervasive Developmental Disorder or Autism. Professional services for behavioral health treatment, including Applied Behavior Analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member diagnosed with the severe mental illnesses of Pervasive Developmental Disorder or Autism, are as shown in the Copayment and Coinsurance Schedule.

- The treatment must be prescribed by a licensed Physician or developed by a licensed psychologist, and must be provided under a documented treatment plan prescribed, developed and approved by a Qualified Autism Service Provider, as defined in this section, providing treatment to the Member for whom the treatment plan was developed. The treatment must be administered by the Qualified Autism Service Provider, or by qualified Autism service professionals or paraprofessionals who are supervised and employed by the treating Qualified Autism Service Provider.
- A licensed Physician or licensed psychologist must establish the diagnosis of Pervasive Developmental Disorder or Autism. In addition, the Qualified Autism Service Provider must submit the initial treatment plan to the Behavioral Health Administrator.
- The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated, and must be reviewed by the Qualified Autism Service Provider at least once every six months and modified whenever appropriate. The treatment plan must not be used for purposes of providing or for the reimbursement of respite, day care or educational services, or to reimburse a parent for participating in a treatment program.
- The Qualified Autism Service Provider must submit updated treatment plans to Health Net for continued behavioral health treatment beyond the initial six months and at ongoing intervals of no less than six-months thereafter. The updated treatment plan must include documented evidence that progress is being made toward the goals set forth in the initial treatment plan.
- We may deny coverage for continued treatment if the requirements above are not met or if ongoing efficacy of the treatment is not demonstrated.

Qualified Autism Service Provider means either of the following: (1) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive Developmental Disorder or Autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified. (2) A person licensed as a Physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist and who designs, supervises, or provides treatment for Pervasive Developmental Disorder or Autism, provided the services are within the experience and competence of the licensee.

Qualified Autism Service Providers employ and supervise qualified Autism service professionals and paraprofessionals who provide behavioral health treatment and implement services for Pervasive Developmental Disorder or Autism pursuant to the treatment plan developed and approved by the Qualified Autism Service Provider.

Exclusions and Limitations:

Applied Behavioral Analysis and other forms of behavioral health treatment for Autism and Pervasive Developmental Disorder require Prior Authorization.

Blood

Blood transfusions, including blood processing, the cost of blood, unreplaced blood, blood products, and blood storage, including the services and supplies of a blood bank, are covered.

Exclusions and Limitations:

Extraction and storage of self-donated (autologous) or family member or friend blood and derivatives.

Chemical Dependency Treatment (Substance Use Disorder Services)

Mental health care and treatment for alcohol and drug dependence is covered. Alcohol and drug services from a state-approved treatment program will also be covered. You must also get these services in the lowest cost type of setting that can give you the care you need.

Inpatient, outpatient, residential, Partial Hospitalization Program, Intensive Outpatient Program, and professional services benefits are available for covered Chemical Dependency conditions. Prior Authorization is required for non-emergent services.

For the purpose of this section:

Partial Hospitalization Program is a treatment program that may be free-standing or Hospital-based and provides services at least four (4) hours per day and at least four (4) days per week.

Intensive Outpatient Program is a treatment program that is utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week.

Chemical dependency means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

Coverage for Chemical Dependency treatment includes:

Medically Necessary services and supplies of a Provider, facility, an approved treatment program under RCW 70.96A.020 is provided for inpatient, residential and outpatient care. An approved treatment program under RCW 70.96A.020 is a program for persons with a substance use disorder provided by a treatment program certified by the department of social and health services as meeting the standards of Chapter 70.96A of RCW.

Preadmission Authorization and continued stay Authorization is required for both rehabilitation and non-emergent detoxification services. All admissions for rehabilitation and considered non-emergent and must be certified as Medically Necessary prior to admission. Detoxification services are covered only when Prior Authorized or as Emergency Medical Care. The Prior Authorization criteria shall not be considered satisfied unless the patient has been personally evaluated by a Physician or other licensed

health care professional with admitting privileges to the facility to which the patient is being admitted prior to the admission.

- Individual, family or group therapy;
- Lab and testing;
- Take-home drugs you get in a facility;
- Unlimited acupuncture visits for Chemical Dependency;
- Medically Necessary services in a Residential Treatment Center are covered except as stated in the "Exclusions and Limitations" portion of this Group Plan Benefits section.
- Services received in a home health setting;
- Detoxification, supportive services, and approved prescription drugs prescribed by the Provider or facility, licensed by the state. Medically Necessary detoxification services are covered as an Emergency Medical Condition so long as the patient is not yet enrolled in other Chemical Dependency treatment. Charges incurred for detoxification services will be paid as any other medical benefit.
- Court-ordered mental health treatment which is Medically Necessary.

Exclusions and Limitations:

Coverage under this provision is limited to the specific services listed above and does not include:

- Alcoholics Anonymous or other similar Chemical Dependency programs or support groups;
- Court ordered assessments or other assessments to determine the Medical Necessity of court ordered treatments;
- Court ordered treatment and/or treatment related to the deferral of prosecution, deferral of sentencing or suspended sentencing, or treatment ordered as a condition of retaining motor vehicle driving rights, when no Medical Necessity exists;
- Emergency patrol services;
- Information and referral authorization services;
- Information schools;
- Long term or residential Custodial Care; or
- Expenses related to a stay at a sober living facility.

Circumcisions

Circumcisions for newborn male children are covered.

Clinical Trials

We will provide coverage for the routine patient costs of the care of a Qualified Individual enrolled in and participating in an approved clinical trial. We will not exclude, limit or impose special conditions on the coverage of the routine patient costs for items and services furnished in connection with participation

in an approved clinical trial; and we will not include provisions that discriminate against an individual on the basis of the individual's participation in an approved clinical trial. Prior Authorization is required.

The following provisions apply:

- A Qualified Individual is a Member who is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition, and either;
  a. the referring Provider has concluded that the Member's participation in such trial is appropriate; or
  b. the Member provides medical and scientific information establishing that his or her participation in such trial is appropriate
- Routine patient costs are defined as all Medically Necessary conventional care, items or services that would be covered if typically provided to a Member who is not enrolled in a clinical trial.

  Routine patient costs do not include:
  a. The drug, device or service being tested in the approved clinical trial unless the drug, device or service would be covered for that medical condition by the Health Benefit Plan if provided outside of an approved clinical trial;
  b. Items or services required solely for the provision of the study drug, device, or service being tested in the clinical trial;
  c. Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
  d. Items or services customarily provided by a clinical trial sponsor free of charge to any participant in the clinical trial;
  e. Items or services that are not covered by the Health Benefit Plan if provided outside of the clinical trial; or
  f. Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Approved Clinical Trial is defined as a clinical trial that is:
  a. A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:
  b. Funded or approved by the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs;

c. Supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs;

d. Conducted as an Investigational New Drug Application (INDA), an Investigational device exemption or a Biologics License Application (BLA) subject to approval by the United States Food and Drug Administration; or

e. An institutional review board of an institution in this state that has a multiple project assurance contract approval by the Office of Protection for the Research Risks of the NIH;

f. A qualified research entity that meets the criteria for NIH Center Support Grant eligibility; or

g. Exempt by federal law from the requirement to submit an Investigational New Drug Application to the United States Food and Drug Administration.

- Under this section, life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Qualified Individuals may be required to participate in an approved clinical trial through a Participating Provider if such a Participating Provider is available and will accept the individual as a participant in the trial.
- You must pay any Deductibles, Copayments or Coinsurance that apply to the drug, device or service being tested in the absence of an approved clinical trial.

Dental Anesthesia

General anesthesia services and related facility charges will be covered in relation to a dental procedure, or dental hospitalization, if such services and related facility charges are Medically Necessary because the Member:

- Is under the age of nine, or physically or developmentally Disabled with a dental condition that cannot be safely and effectively treated in a dental office; or
- Has a medical condition that the Member's Physician determines would place the Member at an undue risk if performed in a dental office. The procedure must be approved by the Member's Physician.

Exclusions and Limitations:

The services must be Prior Authorized and must be performed in a Hospital or in an Ambulatory Surgery Center.

The dental procedures performed are only covered as specifically outlined in this Agreement.

Dental Injury

Dental services required because of an injury by external force or trauma is covered provided that the services are furnished within 12 months after an injury or accident.

Dental services or appliances necessary for or resulting from medical treatment if the service is either emergency in nature or requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease.

Exclusions and Limitations:

Damage to teeth caused by chewing or biting is not considered a dental injury. Covered Services include only that dental treatment required to restore function and appearance to a pre-injury level, and are limited to the least costly alternative which achieves a medically acceptable and effective result. If you are also covered under a Health Net dental plan, benefits for services covered under this provision will be paid before any available benefits for those same services are paid under your dental plan.

Diabetes Management

The following is covered in relation to the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes:

- Outpatient diabetes self-management training and education, including medical nutrition therapy, as ordered by the health care Provider is covered. Diabetes outpatient self-management training and education may be provided only by health care Providers with expertise in diabetes.
- Supplies and equipment related to Diabetes Management including blood glucose test strips, lancets, insulin syringes and needles as described in the "Prescription Drug Benefits" and "Medical Supplies" provision of this section.
- Routine foot care in connection with the treatment of diabetes.
- Screening for gestational diabetes is covered as preventive care in the "Preventive Care" subsection of this Group Plan Benefits section.
- Nutritional counseling services are covered and not subject to the lifetime limit as shown in the "Nutritional Counseling Services" section.

Dialysis Services

Dialysis Services are covered in an office or at a facility. Coverage includes, but is not limited to, professional services, facility charges, and any supplies, drugs or solutions used for dialysis. Services include Medically Necessary in-home renal dialysis treatment.

If you receive dialysis services due to a diagnosis of end stage renal disease, you may be eligible to enroll in Medicare. If you enroll in Medicare, this plan will coordinate benefits per Medicare rules. Generally, this plan will be the primary payer for 30 months, and Medicare will be the primary payer after 30 months.

For more information about Medicare enrollment, contact Medicare at 1-800-MEDICARE or log onto their website at www.medicare.gov.

Durable Medical Equipment and Prosthetic Devices

Durable Medical Equipment and mobility enhancing equipment used to serve a medical purpose, including your initial rental or purchase, is covered if prescribed by your Physician, and is the least costly alternative that achieves a medically acceptable result. Coverage includes, but is not limited to, braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatus used to support, align, or correct deformities or to improve the function of moving parts. Prosthetic Devices are covered as Durable Medical Equipment. Prior Authorization is required. Medically Necessary lenses for the treatment of aphakia and keratoconus are covered as Durable Medical Equipment. We also cover sales tax under this benefit for Durable Medical Equipment and mobility enhancing equipment, that is a Covered Service and when such equipment is not otherwise tax exempt.

In assessing Medical Necessity for Durable Medical Equipment coverage, we apply nationally recognized Durable Medical Equipment coverage guidelines, such as those defined by InterQual (McKesson) and the Medicare Durable Medical Equipment Regional Administrative Contracts (DME MAC), Healthcare Common Procedure Coding System (HCPCS) Level II and Medicare National Coverage Determinations (NCD).

Breastfeeding devices and supplies are covered as preventive care listed under "Preventive Care" subsection in this Group Plan Benefits section.

Corrective shoes and arch supports including foot orthotics are covered when prescribed in the course of treatments for, or complications from, diabetes.

Exclusions and Limitations:

We may utilize a Specialty Care Provider of Durable Medical Equipment if you live in the Service Area. Prior Authorization is required. Repair of covered Medically Necessary equipment due to normal use, change in physical condition, or growth of a child is eligible for coverage. Duplicate items are not covered. Purchase (vs. rental) is at our discretion. Subject to benefits and review for Medical Necessity.

Family Planning

Covered Services and Supplies include, but are not limited to, the following: Counseling and assessment for birth control. Insertion and removal of diaphragms and non-hormonal contraceptive devices, IUDs, contraceptive implants, and contraceptive injectables are covered when provided in the doctor's office. The Deductible, if any, is waived for these services.

(Please refer to "Contraception Methods" under the "Prescription Drug Benefits" subsection of this Group Plan Benefits section for details on the coverage of prescribed and over-the-counter contraceptives that can be obtained through a participating pharmacy.)

Fertility Preservation

Medically Necessary services and supplies for established fertility preservation treatments are covered when treatment for cancer or gender dysphoria may directly or indirectly cause iatrogenic infertility. Iatrogenic infertility is infertility that is caused by a medical intervention, including reactions from prescribed drugs or from medical or surgical procedures. This benefit is subject to the applicable Deductibles, Copayments and/or Coinsurance (identified in the attached Copayment and Coinsurance Schedule) as would be required for Covered Services to treat any illness or condition under this plan.

Exclusions and Limitations:

Services and supplies for gamete or embryo storage, use of frozen gamete or embryos to achieve future conception, pre-implantation genetic diagnosis, donor egg, sperm or embryos and/or gestational carriers (surrogates) are not covered.

Genetic Testing and Diagnostic Procedures

Genetic testing is covered as a diagnostic service when determined to be Medically Necessary. The prescribing Physician must request Prior Authorization for coverage.

Exclusions and Limitations:

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.

Health Education Services

Instruction in the appropriate use of health services and the contribution you can make to the maintenance of your own health is covered. Health education services shall include instruction in personal health care measures and information about services, including recommendations on generally accepted medical standards for use and frequency of such service. Qualifying classes include: prenatal/child birthing, exercise, healthy heart, first aid/CPR, chronic disease management, weight management, stress management, and smoking cessation.

Hearing Care

Cochlear implants are covered under this Agreement and require Prior Authorization. Hearing screening tests are covered as required under preventive care in the "Preventive Care" subsection of this Group Plan Benefits section.

Home Health Care

Home Health Care for Skilled Nursing Services is covered in your home or place of residence which is not a Skilled Nursing Facility as an alternative to hospitalization.

Home Health Care services must be part of a Home Health Care treatment plan. These services are covered when a qualified Provider certifies that the services are provided or coordinated by a state-licensed or Medicare-certified home health agency or certified rehabilitation agency. Prior Authorization is required for physical, occupational and speech therapy performed in the home.

Covered Services provided and billed by a home health agency include:

- Home visits and acute nursing (short-term nursing care for illness or injury)
- Home medical equipment, medical supplies and devices
- Prescription drugs and insulin provided by and billed by a Home Health Care Provider or home health agency

Exclusions and Limitations:

- Home health care visits are limited to one hundred thirty (130) visits per Calendar Year as shown in the Basic Benefit Copayment and Coinsurance Schedule.
- We may utilize a Specialty Care Provider of home health services if you live in the Service Area.
- We do not cover Custodial Care or private duty nursing.
- Over-the-counter drugs, solutions and nutritional supplements
- Services provided to someone other than the ill or injured member
- Services provided by family members or volunteers
- Services or providers not in the written plan of care or not named as covered in this benefit
- Custodial care
- Nonmedical services, such as housekeeping
- Services that provide food, such as Meals on Wheels or advice about food
- Services will be provided in accordance to the "Case Management" subsection of this Group Plan Benefits section.

Home Infusion Services

Medically Necessary home infusion services that are safely administered in the home or in a home infusion suite are covered when provided in lieu of inpatient/outpatient hospitalization, Physician's office or Skilled Nursing Facility care.

Except for insulin, Prior Authorization is required for Medically Necessary injectable medications used at home.

Exclusions and Limitations:

We may utilize a Specialty Care Provider of home infusion services if you live in the Service Area.

Hospice Care

Hospice Care is covered if you are terminally ill (a patient considered to be within the last six months of life). Coverage will be provided for an initial period of no less than six months and for an additional six months where the patient is facing imminent death or is entering remission if certified in writing by the attending Physician. Coverage includes acute, respite, and home care services. Prior Authorization is required for inpatient services.

Inborn Errors of Metabolism

Clinical visits, biochemical analysis, treatment and medical foods are covered for inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage includes diagnosis, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. Phenylketonuria (PKU) screenings are covered as preventive care. See the "Preventive Care" and the "Nonprescription Elemental Enteral Formula" subsection in this Group Plan Benefits section for details

on Covered Services. Formulas necessary for the treatment of PKU are covered as shown on your Copayment and Coinsurance Schedule under "Medical Foods."

"Medical foods" are defined as those formulated to be consumed or administered enterally under the supervision of a Physician, that are specifically processed or formulated to be deficient in one or more of the nutrients present in typical nutritional counterparts, that are for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained therein or have other specific nutrient requirements as established by medical evaluation and that are essential to optimize growth, health and metabolic homeostasis.

Infertility Diagnosis

This plan does not cover infertility treatment, but services that lead to a diagnosis of Infertility are covered.

Infertility is the failure of a female Member during normal childbearing years to achieve conception after one or more years of regular sexual intercourse without practicing contraceptive measures. Sexual dysfunction that prevents successful intercourse may also be considered infertility. Infertility-related diagnosis includes, but is not limited to:

a. Evaluation of a female Member's inability to conceive.

b. Evaluation of a female Member's habitual abortion, including chromosomal analysis.

For a Member, semen analysis, documentation of normal ovulation function unless done as part of an endocrine evaluation for non-infertility indications, post-coital examination, and testing for patency of fallopian tubes is always considered infertility evaluation.

Maternity Benefits

Medically Necessary maternity care is covered as follows:

- **Availability.** Maternity benefits are available for all Members (Subscriber and his/her Enrolled Dependent(s)).
- **Prenatal and Postnatal Care.** Prenatal and postnatal care is covered. Coverage includes prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures and in utero treatment of a fetus during pregnancy. Prenatal, postnatal and newborn preventive care services are covered in full. See the "Preventive Care" section for details on Covered Services. If other non-preventive care services are received during the same office visit, the applicable Copayments and/or Coinsurance, as shown on your Copayment and Coinsurance Schedule, will apply.

  Breastfeeding support, supplies and counseling, and screening for gestational diabetes are covered as preventive care in the "Preventive Care" subsection of this Group Plan Benefits section.
- **Complications of pregnancy.** Complications of pregnancy are covered including, but not limited to, fetal distress, gestational diabetes, and toxemia.

- **Delivery and Nursing Care.** Delivery services and nursing care are covered in a Hospital, birthing center or at home including facility fees and Medically Necessary home birthing supplies. Charges from Providers offering delivery care under the scope of a professional license are covered.
- **Notification Required.** In order to assist in managing your maternity care, please notify Health Net at the time you attend your first prenatal visit.
- We will not restrict travel during pregnancy, including 3rd trimester.
- **Termination of pregnancy.** Lawful terminations of pregnancy (surgical or drug) are covered.
- **Hospital Room and Board.** Hospital room and board for the mother are covered the same as for any other covered illness or injury. The attending Provider (including Women's Health Care Providers), in consultation with the mother, is permitted to make decisions on the length of inpatient stay. These decisions must be based on accepted medical practice.

  We must be notified of admission within 24 hours or as soon as reasonably possible after admission. Once the Hospital notifies us of the maternity admission, we will contact the Hospital's Utilization Review department to discuss the case.

Medical Supplies

Medical supplies are covered as follows:

- Appropriate and Medically Necessary diabetic equipment and supplies dispensed in accordance with recognized Durable Medical Equipment coverage guidelines as defined by the Medicare Durable Medical Equipment Regional Administrative Contracts (DME MAC), Healthcare Common Procedure Coding System (HCPCS) Level II and Medicare National Coverage Determinations (NCD) in assessing Medical Necessity for coverage. Coverage includes syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, and foot care appliances for prevention of complications associated with diabetes. Insulin glucagon emergency kits and prescriptive oral agents are excluded except as covered under your Prescription Drug Benefit. Prescription drugs for the treatment of diabetes (including insulin) are covered. See the "Prescription Drug Benefits" subsection of the Group Plan Benefits section for more information.
- Ostomy supplies are covered, including flanges, pouches, irrigators, irrigator sleeves and drains, closed-end pouches, stoma caps, ostomy deodorant, belts, convex inserts, drain tube adapters, drainable pouch clamps, medical adhesive, replacement filters, security tape, and skin barriers.
- Non-durable supplies required for the function of Durable Medical Equipment are covered.
- The first pair of Medically Necessary eyeglasses or contact lenses following covered cataract surgery is covered. Contact our Customer Contact Center for benefit limitations.
- Allergy serums, treatment compounds, solutions, and medications are covered. Substances administered by therapeutic injection in a Provider's office are covered.
- Non-durable medical supplies provided in the Provider's office are covered.

Exclusions and Limitations:

Wound care products; incontinence products; blood pressure cuffs, thermometers, sensor alarms, and all other non-durable medical supplies.

Some Durable Medical Equipment may have specific quantity limits or may not be covered as they are considered primarily for non-medical use. Nebulizers (including face masks and tubing) and Orthotics are not subject to such quantity limits.

Mental or Nervous Conditions

Inpatient, outpatient, residential, and professional services and benefits for treatment of Mental Disorders included in the Diagnostic and Statistical Manual of Disorders (DSM) are provided. Prior Authorization is required for Inpatient, Partial Hospitalization Program, Intensive Outpatient Program, and Psych/Neuropsych testing. Prior authorization is not required in the case of a Member who is involuntarily committed to and subsequently treated in a state Hospital.

For the purpose of this section:

Mental or Nervous Conditions means all disorders listed in the most recent edition of the DSM published by the American Psychiatric Association except specified diagnosis related to developmental disability, learning disorders, paraphilias and some relationship-related diagnosis.

- Partial Hospitalization Program is a treatment program that may be free-standing or Hospital-based and provides services at least four (4) hours per day and at least four (4) days per week.
- Intensive Outpatient Program is a treatment program that is utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week.

Coverage for Mental or Nervous Conditions treatment includes:

- Medically Necessary services and supplies of a Provider, facility, including services received in a home health setting, or program approved for both Inpatient and outpatient care; and
- Approved prescription drugs prescribed by the Provider or facility, licensed in accordance with state law and practice or provide services within the scope of such license.
- Eating disorder treatment is covered when associated with a diagnosis of a DSM categorized mental health condition.
- Medically Necessary services for parent-child relational problems, neglect or abuse, and bereavement for a child or children five years of age or younger, and gender dysphoria.

Exclusions and Limitations:

Coverage under this provision is limited to the specific services listed above and does not include:

- Support groups;
- Court ordered assessments or other assessments to determine the Medical Necessity of court order treatments;

- Court ordered treatment and/or treatment related to the deferral of prosecution, deferral of sentencing or suspended sentencing, or treatment ordered as a condition of retaining motor vehicle driving rights, when no Medical Necessity exists;
- Emergency patrol services;
- Information and referral authorization services;
- Information schools;
- Long term or residential Custodial Care; or
- Expenses related to a stay at a sober living facility.
- Medically Necessary services in a Residential Treatment Center are covered except as stated in the "Exclusions and Limitations" portion of this Group Plan Benefits section.

Neurodevelopmental Therapy

Charges for Medically Necessary neurodevelopmental therapy (including physical, speech and occupational therapy) are covered when provided to Dependents by occupational, physical, and speech therapists. This includes services to restore and improve function, and services for maintenance care in cases where significant deterioration in the Dependent's condition would result without the service. Prior Authorization is required.

Nonprescription Elemental Enteral Formula

Nonprescription elemental enteral formula for home use is covered if the formula is Medically Necessary for the treatment of severe intestinal malabsorption phenylketonuria or eosinophilic gastrointestinal associated disorder, and a Participating Provider has issued a written order for the formula.

Nutritional Counseling Services

Services of a nutritionist are covered only for specific conditions such as diabetes, high blood pressure, and anemia, or as outlined in the "Inborn Errors of Metabolism" or as listed in the "Preventive Care" subsections of this Group Plan Benefits section.

Exclusions and Limitations:

Nutritional counseling services are covered up to three visits per lifetime (diabetic education/counseling is not subject to the lifetime limit).

Oral and Maxillofacial Services

The following oral and maxillofacial services are covered:

- Oral and surgical care for tumors and cysts (benign or malignant); and
- Treatment of cleft lip, cleft palate, or other maxillofacial congenital anomalies of a child.

Organ and Tissue Transplants

Organ, stem cell or tissue transplant services (that are not Experimental or Investigational) are covered for donors and recipients, including covered expenses incurred in a Hospital setting or outpatient setting. Prior Authorization is required for all organ, tissue and stem cell transplant services, including pre-evaluation and pre-treatment services and the transplant procedure.

Artificial organ transplants are covered based on your doctor's medical guidelines and the manufacturer recommendations.

The following organ and tissue transplants are covered when Medically Necessary:

- Kidney transplants
- Pancreas after kidney transplants
- Pancreas transplants.
- Cornea transplants
- Heart transplants
- Liver transplants
- Lung transplants
- Small bowel transplants
- Islet cell transplantation
- Multivisceral transplants
- Hematopoietic stem cell support (donor stem cells can be collected from either the bone marrow or the peripheral blood). Hematopoietic stem cell support may involve the following donors, i.e., either
- autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor) or
- umbilical cord blood (only covered for certain conditions).

Prior Authorization is required for transplant evaluation, services, and procedures related to a transplant. We will direct you to a designated Specialty Care Provider in accordance with the "General Terms Under Which Benefits Are Provided" portion of this Group Plan Benefits section. Services provided by other than the designated Specialty Care Provider will not be covered.

Exclusions and Limitations:

- No other organ or tissue transplants are covered. Organ or bone marrow search, selection, storage, and eye bank costs are not covered.
- All organ and tissue transplants or autologous stem cell rescue not explicitly listed as covered in this section.
- Services for an organ donor or prospective organ donor when the transplant recipient is not a Member.

- Organ and bone marrow search, selection, storage, and eye bank costs.
- Non-human organs and the related implantation services.
- Permanent or temporary implantation of artificial or mechanical devices to replace or assist human organ function until the time of organ transplant, except for dialysis to maintain a kidney and artificial pump bridge to approved cardiac transplants or based on your doctor's medical guidelines and the manufacturer recommendations.
- High dose chemotherapy which requires the support of a non-covered bone marrow transplant or autologous stem cell rescue.
- Bone marrow transplantation, autologous stem cell transplantation for acute myocardial infarction (ASTAMI) or heart failure stem cells for spinal fusion.
- Transplant services not Prior Authorized and/or not provided at the Specialty Care Provider designated by us are not covered.

Outpatient Pharmaceuticals

Certain outpatient pharmaceuticals, whether administered in a Physician's office, free-standing infusion center, Ambulatory Surgery Center, outpatient dialysis center or outpatient Hospital, are covered under your medical plan with Prior Authorization. See the "Prior Authorization" subsection of this Group Plan Benefits section for more details.

Pediatric Dental Services

Routine dental care for Enrolled children is covered through the last day of the month in which the Child turns 19 years of age. This plan covers limited pediatric Dental Services that are provided in Class I, II, and III including orthodontics as outlined in the Basic Benefit Copayment and Coinsurance Schedule.

You can see any licensed dentist and receive benefits for Covered Services and Supplies. However, in order to ensure the highest level of coverage, you should obtain services from a Participating Provider. Services performed by a denturist who practices within the scope of his or her license are covered if such services would have otherwise been covered under this plan when provided by a licensed dentist. You can obtain a list of Participating Provides by calling our Customer Contact Center at the phone number on the back of this Agreement.

Payments for Dental Services are based on whether you seek services from a Participating Provider or a Nonparticipating Provider. If you see a Participating Provider, your Group Plan Benefits are based on MAC. MAC stands for Maximum Allowable Charge, which is a discounted fee negotiated between us and a Participating Provider. There is usually a difference between the amount your Provider actually charges for a service, and how much of that billed charge the Provider has agreed to accept as payment in full for services under a Participating Provider contract. If you see a Participating Provider, your plan pays a percentage of MAC, and you are not responsible for any billed amounts above the MAC allowance.

If you see a Nonparticipating Provider, your Group Plan Benefits are based on MAA. MAA stands for Maximum Allowable Amount. The MAA is determined by us, based on data obtained regarding fees usually charged by Providers for the same service within the same geographic area. There is usually a

difference between the amount your Provider actually charges for a service, and how much of that billed charge we allow as the Maximum Allowable Amount. Your plan pays a percentage of the MAA amount rather than a percentage of the billed charge. If your Provider charges more than the MAA, you are responsible for the difference between the billed charge and the MAA.

Covered Services include:

- Clinical oral evaluations
  - Periodic oral evaluations are limited to two per enrollee per year, beginning before one year of age. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation;
- Limited oral evaluations when necessary to evaluate for a specific dental problem or oral health complaint, dental emergency or referral for treatment are limited to once every six months;
- Limited visual oral assessment or screening, up to two per member, per year
  - Covered only when the provider performing the limited oral evaluation is not providing routine scheduled Dental Services for the member;
- Problem focused oral examinations;
- Comprehensive oral evaluations are limited to two per enroller per year, beginning before one year of age, as an initial examination that must include,
  - A complete dental and medical history and general health assessment,
  - A complete thorough evaluation of extra-oral and intra-oral hard and soft tissue and
  - The evaluation and recording of dental caries, missing or unerupted teeth, restoration, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening;
- X-rays (Radiographs)
  - Bitewing X ray once a year;
  - Intraoral complete series, once in a three-year period only if the health plan has not paid for a panoramic X-ray for the same member in the same three-year period. The intraoral complete series includes 14-22 periapical and posterior bitewings;
  - An occlusal intraoral X-ray once in a two-year period;
  - A maximum of four bitewing X-rays (once per quadrant) once every twelve months;
  - Panoramic X-rays in conjunction with four bitewings, once in a three-year period, only if the health plan has not paid for an intraoral complete series for the same member in the same three-year period;
  - Cephalometric films once in a two-year period, only on a case-by-case basis, and when Prior Authorized. No Prior Authorization required for Orthodontics;
  - Periapical X-rays not included in a complete series for diagnosis in conjunction with definitive treatment;
  - Photographic images (oral and facial) when dentally appropriate
- Tests and examinations.
  - Diagnostic exams once every six months, beginning before one year of age;
  - One pulp vitality test per visit (not per tooth); for diagnosis only during limited oral evaluations;
  - Diagnostic casts other than those included in an orthodontic case study, on a case-by-case basis;

- Dental prophylaxis (cleaning)
  - Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on primary or permanent dentition;
  - Prophylaxis every six months beginning at age six months;
- Topical fluoride treatment
  - Fluoride rinse, foam or gel, including disposable trays, for members 6 years of age and younger, up to 3 times within a 12-month period per member per provider or clinic during orthodontic treatment.
  - Fluoride rinse, foam or gel, including disposable trays, for members from 7 to 19 years of age, up to 2 times within a 12-month period per member;
- Oral hygiene instruction
  - Oral hygiene instruction is covered no more than once every 6 months, up to 2 times within a 12-month period for children 8 and younger. Only when not performed on the same date of service as prophylaxis;
- Sealants once per tooth; In a 3-year period;
- Space maintenance
  - Space Maintenance covers fixed unilateral or fixed bilateral space maintainers for clients 12 years of age and younger, subject to the following:
  - Only one space maintainer is covered per quadrant for missing primary molars A, B, I, J, K, L, S, and T.
  - Covers recementation of space maintainers and the removal of fixed space maintainers for clients 18 years of age or younger;
  - Replacement of space maintainers when dentally appropriate;
- Amalgam and resin restorations (fillings) for primary and permanent teeth;
  - Every two years for the same restoration;
- Amalgam and resin restorations (filings) procedure description and limitations:
  - Amalgam - one surface, primary or permanent
  - Amalgam - two surfaces, primary or permanent
  - Amalgam - three surfaces, primary or permanent. Tooth and surface designations required. If billed on a primary first molar, the reimbursement will be at the rate for a two-surface restoration.
  - Amalgam - four or more surfaces, primary or permanent. Tooth and surface designations required. If billed on a primary first molar, the reimbursement will be at the rate for a two-surface restoration. If billed on a primary second molar, the reimbursement will be at the rate for a three-surface restoration.
  - Resin-based composite - one surface, anterior
  - Resin-based composite - two surfaces, anterior
  - Resin-based composite - four or more surfaces or involving incisal angle (anterior). Tooth and surface designations required. Not allowed on primary teeth.
  - Resin-based composite - three surfaces, posterior. Tooth and surface designations required. If billed on a primary first molar, the reimbursement will be at the rate for a two-surface restoration. If billed on a primary second molar, the reimbursement will be at the rate for a three-surface restoration.

- Resin-based composite - four or more surfaces, posterior. Tooth and surface designations required. If billed on a primary first molar, the reimbursement will be at the rate for a two-surface restoration. If billed on a primary second molar, the reimbursement will be at the rate for a three-surface restoration.

- Crowns and Fixed Bridge Services
  - Stainless steel crowns for primary anterior teeth once every three years; if age thirteen and older with Prior Authorization;
  - Stainless steel crowns for primary posterior teeth once in a three year period;
  - Stainless steel crowns for permanent posterior teeth (excluding teeth one, 16, 17 and 32) once every three years;
  - Metal/porcelain crowns and porcelain crowns on anterior teeth only, with Prior Authorization;
  - All recementations of permanent indirect crowns for members 12 years of age and older;
  - Resin-based composite crowns;
  - Prefabricated esthetic coated stainless steel crowns;
  - Fabricated resin crowns for primary anterior teeth once every three years;
  - Prefabricated stainless steel crowns for primary posterior teeth once every three years;
  - Crowns and crown build-ups, limited to the following:
    - An indirect crown in a five-year period, per tooth for permanent anterior teeth for enrollees 12 years of age and older;
    - Cast post and core or prefabricated post and core, on permanent teeth where performed in conjunction with a crown;
    - Core build-ups, including pins, only on permanent teeth when performed in conjunction with a crown;
    - Dental implant crown and abutment related procedures, one per member per tooth in a seven-year period;
    - Repair of crowns. May be limited to one per tooth per enrollee lifetime;
    - Repair of implant-supported prosthesis or abutment. May be limited to one per tooth per enrollee lifetime.

- Endodontic Services
  - Pulpotomy/pulpal debridement;
    - Therapeutic pulpotomy on primary teeth only;
    - Pulpal debridement on permanent teeth only, excluding teeth 1, 16, 17, and 32;
  - Endodontic treatment on primary teeth;
    - Endodontic treatment with resorbable material for primary maxillary incisor teeth D, E, F, and G, if the entire root is present at treatment;
    - Root canals on baby primary posterior teeth only;
  - Endodontic treatment on permanent teeth;
    - Endodontic treatment for permanent anterior, bicuspid, and molar teeth, excluding teeth 1, 16, 17, and 32;
    - Root canals on permanent anterior, bicuspid and molar teeth, excluding teeth 1, 16, 17 and 32;

- Endodontic retreatment on permanent anterior teeth, includes the removal of post(s), pin(s), old root canal filling material, and all procedures necessary to prepare the canals, placement of new filling material, retreatment for permanent anterior, bicuspid, and molar teeth, excluding teeth 1, 16, 17, and 32;
- Apexification/Apicoectomy
  - Apexification for apical closures for anterior permanent teeth only on a case-by-case basis and when prior authorized. Apexification is limited to the initial visit and three medication replacements, per tooth;
  - Apicoectomy and a retrograde filling for anterior teeth;

- Periodontic Services
  - Surgical periodontal services
    - Gingivectomy/gingivoplasty, only on a case-by-case basis and when prior authorized;
    - Surgical extraction of unerupted teeth;
    - Other Surgical Procedures, tooth reimplantation/Stabilization of accidentally evulsed or displaced teeth;
    - Frenulectomy or Frenuloplasty covered for ages six and under without Prior Authorization and 7 to 12 years of age only with Prior Authorization;
    - Surgical excision of soft tissue lesions;
    - Excision of bone tissue;
    - Surgical incision;
  - Other surgical procedures;
    - Tooth reimplantation and/or Stabilization of accidentally evulsed or displaced tooth. Clients 20 years of age and younger only.
    - Surgical access of an unerupted tooth. Clients 20 years of age and younger only.
    - Placement of device to facilitate eruption of impacted tooth. Covered in conjunction with D7280 and when Medically Necessary.
    - Biopsy of oral tissue - hard (bone, tooth). Clients 20 years of age and younger only.
    - Biopsy of oral tissue - soft (all others). Covers tooth reimplantation/Stabilization of accidentally evulsed or displaced teeth for clients 20 years of age and younger.
    - Brush biopsy - transepithelial sample collection. Covers tooth reimplantation/Stabilization of accidentally evulsed or displaced teeth for clients 20 years of age and younger.
    - Complex periodontal procedures (osseous surgery including flap entry and closure and mucogingivolplastic surgery) once per Member per quadrant in a five-year period
  - Nonsurgical periodontal services
    - Periodontal scaling and root planing once per quadrant in a two-year period for ages thirteen and older, with Prior Authorization;
    - Full mouth debridement to enable comprehensive evaluation and diagnosis

- Periodontal maintenance
  - Periodontal maintenance once per quadrant in a twelve-month period for ages thirteen and older, with Prior Authorization;

- Removable Prosthodontic Services
  - Complete dentures
    - One complete denture upper and lower, and one replacement denture per lifetime after at least five years from the seat date;
  - Resin partial dentures. One resin based partial denture, replaced once within a three-year period;
  - Adjustments to dentures;
  - Repairs to complete and partial dentures;
  - Denture rebase procedures. Rebasing and relining of complete or partial dentures once in a three-year period, if performed at least six months from the seating date;
  - Denture reline procedures;
  - Other removable prosthetic services;
- Oral Surgery and Reconstruction Section
  - Extractions and surgical extractions, routine and surgical extractions (includes local anesthesia, suturing, if needed, and routine postoperative care);
  - Alveoloplasty – surgical preparation of ridge for dentures;
  - Uncomplicated oral surgery procedures including removal of teeth, incision and drainage;
  - Complex oral surgery procedures including surgical extractions of teeth, impactions, and residual root removal;
  - General dental anesthesia or intravenous sedation administered;
    - In connection with extractions of partially or completely bony impacted teeth;
    - To safeguard the Member's health;
    - For covered procedure performed in a dental office if Medically Necessary because a child is under eight years of age or physically or developmentally Disabled.
  - Drugs and/or medications when used with parenteral conscious sedation, deep sedation, or general anesthesia;
  - Inhalation of nitrous oxide, one per day
  - Local anesthesia and regional blocks, including office-based oral and parenteral conscious sedation, deep sedation or general anesthesia; and
  - Post-surgical complications;
- Adjunctive services including anesthesia, professional visits and consults, behavior management, post-surgical complications, and occlusal guards;
  - Palliative treatment (relief of pain)
    - Palliative (emergency) treatment, not to include pulpal debridement, for treatment of dental pain, limited to once per day, per client;
    - Two house/extended care facility calls per facility, per Provider, per Member
    - One Hospital or Ambulatory Surgical Center call per day per Provider per Member

- Anesthesia for Members 8 years of age and younger, from 9 to 19 years of age, or physically or developmentally Disabled, deep sedation or general anesthesia services are covered on a case-by-case basis and when prior authorized, except for oral surgery services. For oral surgery services, deep sedation or general anesthesia services do not require Prior Authorization;

- Occlusal Orthotic Devices
  - Occlusal guards when Medically Necessary and prior authorized, for members from 12 to 19 years of age when member has permanent dentition;

- Medically Necessary orthodontia.
  - Benefits for Medically Necessary comprehensive orthodontic treatment must be approved by Health Net dental consultants for a member who has one of the medical conditions such as, cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement and the following craniofacial anomalies: hemifacial microsomia; craniosynostosis syndromes; cleidocranial dental dysplasia; arthrogryposis; Marfan syndrome; or other severe craniofacial deformities, which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits do not cover the following orthodontic treatment or orthodontic related services: replacement of lost or repair of broken orthodontic appliances; orthodontic treatment for cosmetic purposes; orthodontic treatment that is not Medically Necessary. All orthodontic treatment must be Prior Authorized.
  - Coverage for Medically Necessary orthodontia is also provided for medical conditions as indicated on the WA Modified Handicapping Labiolingual Deviation (HLD) Index Score that result in a score of 25 or higher.

Pediatric Vision Services

This plan covers routine vision services and supplies for Enrolled children through the last day of the month in which the Child turns 19 years of age as described in the Basic Benefit Copayment and Coinsurance Schedule. You must utilize Participating Providers. The vision services benefits are provided by Health Net. Health Net contracts with Envolve Vision, Inc., a vision services provider panel, to administer the vision services benefits. A list of Participating Providers is available at www.healthnet.com or by calling our Customer Contact Center at the phone number listed at the back of this Agreement.

Covered Services include:

- Routine vision screening;
- A comprehensive eye exam for children, including dilation if professionally indicated, and with refraction every Calendar Year;

- One pair of prescription lenses every Calendar Year. Optional lenses and treatments include:
  - UV Treatment
  - Tint (Fashion & Gradient & Glass-Grey)
  - Standard Plastic Scratch Coating
  - Standard Polycarbonate
  - Photocromatic / Transitions Plastic
  - Standard Anti-Reflective Coating
  - Polarized
  - Standard Progressive Lens
  - Hi-Index Lenses
  - Blended segment Lenses
  - Intermediate vision Lenses
  - Select or ultra-progressive lenses
- One pair of Provider selected frames every Calendar Year;
- A one-year supply of Medically Necessary contact lenses are covered, once every Calendar Year in lieu of the lenses and frame benefits. The benefit includes the evaluation, fitting and follow-up care relating to contact lenses. If determined to be Medically Necessary, contact lenses will be covered in lieu of eyeglasses at a minimum for the treatment of: Keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism;
- Subnormal or Low Vision Aids. One comprehensive low vision evaluation is covered every 5 years; follow up care of four visits every 5 years, low vision aids, including high-power spectacles, magnifiers or telescopes (limited to one aid per year).

Coverage for pediatric vision benefits is not subject to your plan's medical Deductibles.

Exclusions and Limitations:

- Visual therapy;
- Two pairs of glasses may not be ordered in lieu of bifocals;
- Medical treatment of eye disease or injury, which is otherwise covered under the medical/surgical benefits of the plan;
- Nonprescription (plano) lenses;
- Prosthetic devices and services, which are otherwise covered under the rehabilitative and habilitative benefit category.

Prescription Drug Benefits

This plan covers pharmacy services as described below. Coverage is subject to any Deductible, Copayments, Coinsurance and benefit maximum shown on the Basic Benefit and Coinsurance Schedule for pharmacy service benefits, except as stated below.

For purposes of this section:

- "Formulary" or "Essential Rx Drug List" means the list of prescription drugs that we cover.
- "Brand name" means a drug that has a trade name and is protected by a patent.
- "Generic drug" means drugs that are equivalent to the brand name drug, but are available only after the brand name drug patent has expired.
- "Non-preferred brand name drugs" mean drugs that are brand name with a generic equivalent.
- "Compounded medications" means drug orders that have at least one ingredient that is Federal Legend or state restricted in a therapeutic amount, is Medically Necessary, and are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form and require a prescription order for dispensing.
- For definitions of Tier 1, Tier 2 and Tier 3, see "**How much do I have to pay to get a prescription filled**?" in the Pharmacy Disclosure Notice in the Group Medical and Hospital Service Agreement.
- To find out which tier a specific drug falls under, see the Essential Rx Drug List, which is available on www.healthnet.com or by calling the Customer Contact Center at the phone number listed at the back of this Agreement.

Coverage includes:

- All Medically Necessary prescription drugs, compounded medications of which at least one ingredient is a prescription drug, self-administered anticancer medications, preventive pharmacy medications, women's contraception methods and any other drug which under law may only be dispensed by written prescription of a duly licensed health care Provider, diabetic supplies, and insulin.
- Prescription medications associated with an Emergency Medical Condition, including those purchased in a foreign country.
- All FDA-approved prescribed drugs, medications or drug therapies that are the sole prescription drug available for a covered medical condition.

Coverage is subject to the qualifications, limitations and exclusions below:

- The amount of drug to be dispensed per filled prescription shall be for such quantities as directed by the Physician, but in no event shall the quantity exceed a 30-day supply when filled in a pharmacy or a 90-day supply when filled through mail order. Benefits are based on FDA approved dosing guidelines. Coverage includes "off-label" (the prescribed use of a drug which is other than that stated in its FDA approved labeling) indications when use is supported by standard reference compendia, the majority of relevant peer-reviewed medical literature, or by the Federal Secretary of Health and Human Services.
- **Some drugs, including but not limited to compounded medications, require Prior Authorization and/or may have a dosage or quantity restriction set by the Plan.**
- All drugs, including insulin and diabetic supplies, must be dispensed by a Participating Provider pharmacy, except for Emergency Medical Care.
- Coinsurance and other amounts you pay for prescription drugs apply toward your plan's medical Out-of-Pocket Maximum.

- The level of benefit you receive is based on the Essential Rx Drug List (EDL) status of the drug at the time your prescription is filled. Only drugs listed on the EDL are covered. The Essential Rx Drug List may be revised up to four times per Calendar Year based on the recommendations of the Pharmacy and Therapeutics Committee. Any such changes including additions and deletions from the Essential Rx Drug List will be communicated to Participating Providers and posted on the www.healthnet.com website.
- If a drug is not on the EDL, your doctor can ask for an exception. To request an exception, your doctor can submit a Prior Authorization request along with a statement supporting the request. Requests for Prior Authorization may be submitted by telephone, mail, or facsimile (fax). If we approve an exception for a drug that is not on the EDL, the non-preferred brand tier (Tier 3) Copayment applies, and we will provide coverage for the approved drug for the duration of the prescription, including refills. If you are suffering from a condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug that is not on the EDL, then you, your designee or your doctor can request an expedited review. Expedited requests for Prior Authorization will be processed within 24 hours after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make a determination. If your prescribed medication is not on the EDL, and the Prior Authorization request has been denied, you have the right to file an Appeal with us regarding your medication coverage. For more information about the Appeals process, see the "Grievance and Appeals" section of the Group Medical and Hospital Service Agreement.
- Compounded medications are subject to the Tier 3 Copayment. Brand name drugs with generic equivalents are subject to the Tier 3 Copayment and/or Coinsurance as soon as a generic becomes available.
- Certain insulin products are provided at the Tier 1 generic Copayment or Coinsurance level. Refer to the Essential Rx Drug List for a list of the specific insulin products and their benefit level.
- For more information on your right to safe and effective pharmacy services, see the "Pharmacy Disclosure Notice" in the Group Medical and Hospital Service Agreement section.
- **Specialty Pharmacy.** Certain drugs identified on the Essential Rx Drug List are classified as Specialty Pharmacy drugs under your plan. Specialty Pharmacy drugs are high cost biologic, injectable and oral drugs typically dispensed through a limited network of pharmacies and having significantly higher cost than traditional pharmacy benefit drugs.
- **Self-administered Injectable Medications.** Self-administered injectable medications are covered. Quantities are limited to a 30 day supply, except for insulin, which may be offered for more than a 30 day supply. Also covered is a teaching dose of self-administered injectable medications, which is limited to three doses per medication per lifetime.
- **Self-administered Anticancer Drugs.** Medically Necessary self-administered anticancer drugs used to kill or slow the growth of cancerous cells which under law may only be dispensed by written prescription of a duly licensed health care Provider are covered. Copayments or Coinsurance are required, as shown on the Copayment and Coinsurance Schedule.

- **Preventive Pharmacy.** Preventive Pharmacy medications require a prescription and are limited to prescription drugs and over-the-counter medications that are determined to be preventive per the United States Preventive Services Task Force (USPSTF) A and B recommendations and guidelines. Such preventive medications include aspirin, fluoride, folic acid, vitamin D, iron and medication for tobacco use cessation. No Deductible, Copayment and/or Coinsurance shall apply for each prescription or refill of a generic class drug when dispensed by a Participating Provider pharmacy. If a generic class drug is not available, no Deductible, Copayment and/or Coinsurance shall apply for each prescription or refill of a brand name drug. Deductible, Copayment and/or Coinsurance will apply to brand name drugs that have generic equivalents.

  Compounded medications and prescriptions or refills dispensed by a Nonparticipating Provider pharmacy are not covered.

- **Contraception Methods**. All Food and Drug Administration (FDA) approved male and female contraceptive methods, patient education, counseling, and prescription-based sterilization procedures are covered when dispensed by a Participating Provider pharmacy. FDA approved, over-the-counter contraceptive methods do not require a prescription from your Provider. Contraceptives available through the retail pharmacy include vaginal, oral, transdermal and emergency contraceptives, and condoms. For the purpose of coverage provided under this provision, "emergency contraceptives" means FDA-approved drugs taken after intercourse to prevent pregnancy. No Deductible, Copayment and/or Coinsurance shall apply for each prescription or refill of a brand name or generic class drug when dispensed by a Participating Provider pharmacy. This plan will cover a twelve-month refill of contraceptive drugs obtained at one time by the Member, unless the Member requests a smaller supply or the prescribing Provider instructs that the Member must receive a smaller supply. This plan allows Members to receive the contraceptive drugs on site at the Provider's office. Refills that are obtained in the last quarter of the Contract Year will not be covered if a twelve-month supply of the contraceptive drug has already been dispensed during the Contract Year. However, coverage may not be denied if the Member changes their contraceptive method within the 12-month period.

  Abortifacient drugs, compounded medications, and prescriptions or refills dispensed by a Nonparticipating Provider pharmacy are not covered.

- **Tobacco Cessation Medications.** Food and Drug Administration (FDA) approved prescription drugs classified as smoking cessation medications are covered when dispensed by a Participating Provider pharmacy. FDA approved, over-the-counter tobacco cessation medications require a prescription from your Participating Provider. No Deductible, Copayment and/or Coinsurance shall apply for each prescription or refill of a generic class drug when dispensed by a Participating Provider pharmacy. If a generic class drug is not available, no Deductible, Copayment and/or Coinsurance shall apply for each prescription or refill of a brand name drug. Deductible, Copayment and/or Coinsurance will apply to brand name drugs that have generic equivalents.

- **Diabetic Drugs and Supplies.** Prescription Drugs for the treatment of diabetes (including insulin) are covered. Diabetic supplies are also covered, including pen delivery systems, disposable insulin needles and syringes, disposable insulin pen needles, blood glucose monitors and test strips; lancet puncture devices and lancets when used in monitoring blood glucose levels. Additional supplies are covered under your medical benefits. Please refer to the "Medical Supplies" subsection of this Group Plan Benefits section.

- **Growth Hormone Drugs.** Growth hormone drugs are covered if determined to be Medically Necessary and if our medical/pharmacy policy criteria are met for certain medical conditions. Prior Authorization is required.
- **Reimbursement** (minus the Deductible, Copayment and/or Coinsurance) will be made for prescriptions filled by a Nonparticipating Provider pharmacy for Emergency Medical Care , upon presentation of receipts to Health Net and sufficient documentation to establish the need for Emergency Medical Care. We use a prudent layperson standard to determine whether the criteria for Emergency Care have been met. The prudent layperson standard is outlined in the definition of "Emergency Medical Condition" in the "Definitions" section of the Group Medical and Hospital Service Agreement.
- Upon request, for a Member taking two or more prescription drugs, your Participating Provider pharmacy will synchronize refill dates so that drugs refilled at the same frequency may be refilled concurrently. If your request is for a new prescription drug, we will permit filling the prescription drug:
  - for less than a one-month supply if synchronization will require more than a 15 day supply or;
  - for more than a one-month supply of the prescription drug if synchronization will require a 15 day supply or less.

  We will adjust your Copayment and/or Coinsurance to reflect shorter or longer coverage.

Exclusions and Limitations:

The following items are excluded from the prescription drug coverage:

- Drugs and medicines prescribed or dispensed other than as described in the "Prescription Drug" benefits section.
- Early refills other than for changes in directions, (all medications), or for prescription topical ophthalmic products (eye drops). Please refer to the "Pharmacy Disclosure Notice" for information regarding specific criteria for early refills for prescription topical ophthalmic products.
- Over-the-counter drugs other than insulin and preventive pharmacy medications, tobacco cessation medications as noted above in this section.
- Any prescription drug for which an over-the-counter therapeutic equivalent is available, except for preventive pharmacy medications, tobacco cessation medications prescribed by a Provider.
- Diabetic supplies (other than blood glucose test strips, lancets, insulin syringes and needles) except as covered under the "Medical Supplies" subsection of this Group Plan Benefits section.
- Hypodermic Syringes and Needles (other than insulin syringes and needles).
- Injectable medications other than those listed as injections on the Essential Rx Drug List.
- Dietary supplements, food, health and beauty aids, herbal remedies, and vitamin preparations other than prescription prenatal vitamins and prescription vitamins with fluoride, and supplements or vitamins which are prescribed for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations as described in the "Preventive Pharmacy" section above.

- Medical foods except as covered under the "Inborn Errors of Metabolism" subsection in the Group Plan Benefits section.
- Drugs for the treatment of onychomycosis (nail fungus);
- Drugs used for infertility;
- Drugs used for appetite suppression or drugs for body weight reduction.
- In the absence of a DSM mental health disorder of sexual dysfunction being the primary diagnosis, drugs used for sexual enhancement to improve sexual performance to treat erectile dysfunction or to increase libido are not covered.
- Growth hormone injections or treatments, except to treat documented growth hormone deficiencies as described in the "Growth Hormone Drugs" section above.
- Prescription refills due to loss, theft, or damage.
- Drugs and medicines used for diagnostic purposes.
- Supply amounts for prescriptions that exceed the FDA's or Health Net's indicated usage recommendation unless Medically Necessary and Prior Authorization is obtained from Health Net.
- Prescriptions relating to an inpatient/outpatient confinement filled at a Hospital pharmacy prior to discharge for use at home (take-home medications) except for prescriptions for a 24-hour supply or less, following an emergency room visit.
- Except as covered for the treatment of gender affirming conditions, drugs that are prescribed for cosmetic or appearance enhancement purposes, including but not limited to hair loss and anti-aging cosmetic purposes.

Preventive Care

When preventive care services are received from a Participating Provider, they are covered at no cost share to you. If the primary purpose of the office visit is unrelated to a preventive care service, or if other non-preventive care services are received during the same office visit, the non-preventive care, services are payable at benefit levels indicated on your Copayment and Coinsurance Schedule. If you receive services from a Nonparticipating Provider, benefits are payable at the Out-of-Network level of benefits.

Preventive care services are based on guidelines established by government agencies and professional medical communities. Your Physician will evaluate your health status (including, but not limited to, your risk factors, family history, gender and/or age) to determine the appropriate preventive care services and frequency as per the preventive care guidelines. Preventive care services include:

- Services with an "A" or "B" rating by the United States Preventive Services Task Force (USPSTF), immunizations as recommended by the Advisory Committee on immunization Practices of the Center for Disease Control (CDC), and services or screening recommended by the Health Resources and Services Administration (HRSA);
- Periodic health evaluations;
- Regular well-baby and well-child visits;

- Preventive vision and hearing screening;
- Blood pressure, diabetes, and cholesterol tests;
- Immunizations against diseases such as measles, polio, or meningitis, flu or pneumonia;
- Screening for depression including screening for maternal depression;
- Outpatient lab and radiology for preventive screening and tests;
- Women's Health Care Services such as, screening for Osteoporosis; gestational diabetes; Hepatitis B for pregnant women; pelvic exams, pap spear and clinical breast exams; human papillomavirus (HPV) DNA testing for women 30 years and older; sexually-transmitted infection counseling; human immunodeficiency virus (HIV) screening and counseling; FDA-approved contraception methods and contraceptive counseling; sterilization; breastfeeding support, supplies and counseling; and domestic violence screening and counseling;
- Screening mammograms (2-D and 3-D). See "Outpatient Services, Diagnostic Services" for mammograms needed because of a medical condition;
- Breast cancer screening, mammography (2-D and 3-D) and prevention;
- Prostate cancer screening, when recommended by the Provider, advanced registered nurse practitioner or physician assistant. Includes digital rectal exams and prostate-specific antigen (PSA) tests;
- Colon cancer screening. Includes exams, colonoscopy, sigmoidoscopy and fecal occult blood test. Covered colonoscopy/sigmoidoscopy services include Medically Necessary sedation. (Note, colon cancer screening is covered for Members who are at least 50 years old, or less than 50 years old and at a high risk or very high risk for colorectal cancer);
- Nutritional therapy as outlined in the "Nutritional Counseling Services" subsection of this Group Plan Benefits section.
- Phenylketonuria (PKU) screenings
- Health Education as outlined in the "Health Education Services" subsection of this Group Plan Benefits section;
- Obesity screening, counseling and behavioral interventions for adults who have a body mass index of 30 kg/m2 or higher and children and adolescents six years and older who qualify as obese, as recommended by the United States Preventive Services Task Force (USPSTF) A and B recommendations;
- Tobacco use counseling and intervention;
- Preventive drugs. (See "Prescription Drugs Benefits" subsection of this Group Plan Benefits section for more information.);

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

You can get a complete list of the preventive care services on our website at www.healthnet.com. This list may be changed as required by state and federal changes to preventive guidelines. The list will include website addresses where you can see current federal preventive guidelines.

Reconstructive Surgery

Reconstructive Breast Surgery as required by the Women's Health and Cancer Rights Act of 1998, reconstructive breast surgery following a covered mastectomy which resulted from disease, illness or injury is covered. If you receive benefits for a mastectomy and elect breast reconstruction with the mastectomy, benefits include coverage for: reconstruction of the breast on which the mastectomy has been performed, including but not limited to nipple reconstruction, skin grafts and stippling of the nipple and areola; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; mastectomy bras; treatment of physical complications from all stages of mastectomy, including lymphedemas; and inpatient care related to the mastectomy and post-mastectomy services.

We will cover other Reconstructive Surgery that: (1) we determine to be Medically Necessary to repair a significant functional disorder as a result of illness or injury; or (2) is performed to repair congenital defects of a child.

Exclusions and Limitations:

All other reconstructive breast surgery; reduction or augmentation mammoplasty except as provided in this section.

Rehabilitation and Habilitation Therapy

For the purposes of this section:

Rehabilitation Services are Medically Necessary services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or Disabled. These services may include physical and occupational therapy, speech language pathology and psychiatric rehabilitation services in a variety of inpatient and or outpatient settings.

Rehabilitation and habilitation therapy is covered as follows:

Rehabilitation therapy for physical impairments in Members with severe mental illness, including Pervasive Developmental Disorder and Autism that develops or restores, to the maximum extent practicable, the functioning of an individual, is considered Medically Necessary when criteria for rehabilitation therapy are met.

The following are covered when expected to significantly improve an acute condition or acute exacerbation of a chronic condition: short-term Hospital-based or outpatient physical, occupational and speech therapy, cardiac rehabilitation, pulmonary rehabilitation, and rehabilitation therapy following a covered mastectomy. Prior Authorization is required. The Calendar Year maximum for outpatient rehabilitation therapy does not apply to services which are billed as Home Health visits, rehabilitation therapy for cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions.

Coverage for habilitative services and/or therapy is limited to Medically Necessary services that assist an individual in partially or fully acquiring or improving age appropriate skills and functioning and that are necessary to address a health condition, to the maximum extent practical, when provided by a

Participating Provider, licensed physical, speech or occupational therapist, aural therapist, or other contracted Provider, acting within the scope of his or her license, to treat physical and mental health conditions, subject to any required Prior Authorization from us. The services must be based on a treatment plan authorized, as required by us or the Member's Physician.

The maximum benefits for inpatient and outpatient treatment are shown on the Copayment and Coinsurance Schedule. The rehabilitation therapy maximum, however, does not apply to services which are billed as Home Health visits, rehabilitation therapy for cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions.

Exclusions and Limitations:

Speech therapy is not covered for occupational or recreational voice strain that could be needed by professional or amateur voice users, including but not limited to public speakers, singers, cheerleaders. Speech therapy for developmental delay, except in the case of swallowing deficit or as provided in the "Neurodevelopmental Therapy" provision of this section. Speech therapy for emotional problems and/or disorders. Hearing therapy.

Examples of health care services that are not rehabilitative or habilitative include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, vocational services or Custodial Care, chore services to assist with basic needs, or education services of any kind, including, but not limited to, vocational training.

Habilitative services received at a school-based health care center are covered unless the habilitative services and devices are delivered through the federally-established program, such as the individualized education program (IEP).

Sexual Reassignment Services

Medically Necessary sexual reassignment services including, but not limited to, surgical services, for the treatment of gender dysphoria and/ or gender identity disorder are covered. Services deemed not Medically Necessary for the treatment of gender dysphoria and/ or gender identity disorders are not covered. Prior Authorization is required.

Please refer to the "Prior Authorization" section for more information regarding Prior Authorization requirements.

Skilled Nursing Care

Skilled Nursing care in a participating Skilled Nursing Facility is covered. Covered Services include room and board for a semi-private room, respite care, plus services and supplies, including pharmacy services and prescriptions filled at the Skilled Nursing Facility pharmacy while confined in the facility, and services provided by a licensed behavioral health provider for a covered diagnosis.

A patient may go from acute nursing care to Skilled Nursing care without leaving the Hospital. When that happens, this benefit starts on the day that the care becomes primarily Skilled Nursing Care. The Skilled Nursing Facility may be a separate institution or section of the Hospital licensed as a Skilled Nursing Facility. All services in the Skilled Nursing Facility, even if in the same facility, are paid as a separate admission from the Hospital admission.

Skilled Nursing care is covered only during certain stages of recovery. It must be a time when inpatient Hospital care is no longer Medically Necessary, but care in a Skilled Nursing care facility is Medically Necessary. Coverage includes, upon request of the Enrollee, provision of care at the Skilled Nursing Facility in which the Enrollee resided immediately prior to the Hospitalization, when Medically Necessary, and if the requested Skilled Nursing Facility is appropriately licensed and accepts our terms and conditions, when applicable. Your doctor must actively supervise your care while you are in the Skilled Nursing Facility.

Exclusions and Limitations:

Long-term nursing and custodial home care is not covered. The facility must satisfy our standards, terms and conditions for long-term care facilities, accept our rates, and have all applicable licenses and certifications. Prior Authorization is required from us before you get treatment.

The maximum benefit is 60 days per year as shown on the Copayment and Coinsurance Schedule. Prior Authorization is required.

Sterilization

Male and female sterilization procedures, including tubal ligation and vasectomies, are covered at no cost when services are rendered by a Participating Provider. Refer to the applicable out-of-network Deductible and Coinsurance for preventive care and preventive screenings in the Basic Benefit Copayment and Coinsurance Schedule for services received from a Nonparticipating Provider.

Prior Authorization may be required depending on the location where the services are performed. Prior Authorization requirements can be verified by contacting us or as outlined in the "Prior Authorization" portion of this Group Plan Benefits section.

Exclusions and Limitations:

Reversal of voluntary infertility (sterilization) is not covered.

Telemedical Services

Coverage for Telemedical services is subject to the Deductible, Copayment or Coinsurance indicated on your Basic Benefit Copayment and Coinsurance Schedule. Services that are not otherwise covered are not covered when provided in the Telemedical format.

- We will provide coverage for Telemedical services under the following conditions:
- We would otherwise provide coverage of the health care service when provided in person by the Provider;
- The health care service is Medically Necessary;
- The health care service is a service recognized as an Essential Health Benefit;
- The service is determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards; and
- The application and technology used to provide the health service is attested to meet all standards required by state and federal laws governing the privacy and security of protected health information.

For the purposes of this section:

"Distant site" means the site at which a Physician or other licensed Provider, delivering a professional service, is physically located at the time the service is provided through Telemedicine;

"Originating site" means the physical location of the patient receiving health care services through Telemedicine and may include:

- Hospital;
- Rural health clinic;
- Federally qualified health center;
- Physician's or other health care provider's office;
- Community mental health center;
- Skilled Nursing Facility;
- Home or any location determined by the individual receiving the service; or
- Renal dialysis center, except an independent renal dialysis center.

"Store and forward technology" means the transmission of a Member's medical information from an Originating Site to the health care Provider at a Distant Site which results in medical diagnosis and management of the Member, is not a real-time communication and does not include the use of audio-only telephone, facsimile, or email; and

"Telemedicine" or "Telemedical" means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the Originating Site and the Provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, "telemedicine" does not include the use of audio-only telephone, facsimile, or email.

Exclusions and Limitations:

Services that are not otherwise covered are not covered when provided in the Telemedical format.

Temporomandibular Joint Syndrome (TMJ)

Inpatient and outpatient temporomandibular joint (TMJ) disorders are covered, which have one or more of the following characteristics:

- An abnormal range of motion or limitation of motion of the TMJ;
- arthritic problems with the TMJ;
- internal derangement of the TMJ; and/or
- pain in the musculature associated with the TMJ.
- Covered Services for the purposes of this TMJ benefit, mean those services that are:
- Reasonable and appropriate for the treatment of a disorder of the TMJ, under all the factual circumstances of the case;

- effective for the control or elimination of one or more of the following, caused by a disorder of the TMJ: pain, infection, disease, difficulty in speaking or difficulty in chewing or swallowing food;
- recognized as effective, according to the professional standards of good medical practice; and
- not Investigational or primarily for cosmetic purposes.

Exclusions and Limitations:

Prior Authorization is required.

Alternative Care Benefit: Chiropractic/Acupuncture/Naturopathic Services, Massage Therapy

Services and supplies are covered only when obtained from licensed Providers. Licensed Providers for these benefits include chiropractors, acupuncturists, naturopathic Providers, and massage therapists. Members have the ability to select a licensed naturopathic physician (ND) as their primary care provider and receive primary care services within the scope of the ND's license.

Copayments or Coinsurance are required for each covered visit as shown on the Copayment and Coinsurance Schedule.

Covered Services include:

- Procedures performed within the scope of the Provider’s license, registration and/or certification.
- New patient consultations/examinations to determine the nature of the problem.
- Subsequent visits for further evaluation and Medically Necessary treatment.
- Diagnostic X-rays ordered or performed within a chiropractic scope of license.
- Diagnostic X-rays, Magnetic resonance imaging (MRI), CAT scans, bone scans, and nuclear radiology ordered or performed within a naturopathic scope of license.
- Unlimited acupuncture visits for Chemical Dependency.

Exclusions and Limitations for all Provider types:

- Benefits for manipulations, acupuncture and massage therapy are limited to the visit maximums shown on the Copayment and Coinsurance Schedule;
- Over-the-counter drugs and remedies;
- X-ray and clinical laboratory tests except for Chiropractic and Naturopathic services;
- Hypnotherapy, behavior training, sleep therapy and weight programs;
- Transportation costs including local ambulance charges;
- Special nutritional formulas, food supplements such as vitamins and minerals, or special diets;
- Education programs, non-medical self-care, self-help training or any related diagnostic testing
- Treatment for asthma or addiction (including, but not limited to, smoking cessation);

- Durable Medical Equipment.

Exclusions and Limitations:

Unless ordered or performed within a naturopathic scope of license:

- Magnetic resonance imaging (MRI), CAT scans, bone scans, nuclear radiology, and diagnostic radiology;
- Prescription medications;
- Surgical services;
- Thermography.

Other exclusions and limitations may apply. Be sure to read the "Exclusions and Limitations" portion of this Group Plan Benefits section and your Copayment and Coinsurance schedule for additional benefit limitation information, before obtaining care.

Case Management

We will have the right to authorize benefits for services and supplies excluded or not specifically covered under this Agreement as a substitute for other, possibly more costly, Covered Services or Supplies. Such alternative benefits shall be determined by us, in advance, in cooperation with you and your Provider and will only be covered upon Prior Authorization. The decision on the course of treatment shall remain up to you and your Provider. Our decision in any specific instance to authorize benefits that would not otherwise be covered under this Agreement shall not commit us to cover the same or similar benefits for the same or any other Member in other instances. By authorizing alternative benefits, we shall not waive our right to enforce all terms, limitations and exclusions of this Agreement.

Included under this case management provision is the substitution of Home Health Care, provided in lieu of hospitalization or other institutional care, furnished by licensed home health, Hospice and home care agencies licensed in accordance with state law, and provide services within the scope of such license, at equal or lesser cost.

Such expenses may include coverage for Durable Medical Equipment which permits the insured to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day health care, home health, Hospice and home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments.

Substitution of less expensive or less intensive services shall be made only with the consent of the Member and upon the recommendation of the Member's attending Physician or Provider that such services will adequately meet the Member's needs. The decision to substitute less expensive or less intensive services shall be determined based on the medical needs of the individual Member.

Prior Authorization and Notification

Prior Authorization for Medical Services, including services for mental health and Chemical Dependencies: The services requiring Prior Authorization are specified on the www.healthnet.com website and in this Group Plan Benefits section (below). Except in the case of Emergency Medical Care, these services are only covered if Prior Authorization has been obtained from us. You or your Provider

may call us to request the Prior Authorization. When you receive care from a Participating Provider, the Participating Provider is responsible for obtaining Prior Authorization on your behalf.

For Urgent Care review requests:

If the information provided is sufficient to review the request for Medical Necessity, Prior Authorization requests will be approved or denied within 48 hours. If the information provided is not sufficient to approve or deny the request, within 24 hours we will contact the requesting provider to submit additional information to make the Prior Authorization determination. We will allow 48 hours for the provider to submit the requested information. We will approve or deny the Prior Authorization request within 48 hours of receipt of the requested additional information.

For concurrent review requests that are also Urgent Care review:

Prior Authorization requests will be approved or denied as soon as possible, no later than 24 hours, provided the request is made at least 24 hours prior to the expiration of previously approved period of time or number of treatments.

For non-urgent pre-service review requests:

If the information provided is sufficient to review the request for Medical Necessity, non-urgent or routine requests will be completed within five calendar days. If the information provided is not sufficient to approve or deny the request, within 5 calendar days we will contact the requesting provider to submit the additional information to make the Prior Authorization determination. We will allow five calendar days for the provider to submit the requested information. We will approve or deny the Prior Authorization request within four calendar days of receipt of the requested additional information.

For post-service review requests, a determination will be made no later than 30 days following the receipt of the request. If additional information is needed to make a determination, we will notify the Member and Provider within 30 days following the receipt of the request. We will make a final determination within 30 days following the receipt of the additional information.

You may request a referral for specialist services for an extended period of time if you have a complex or chronic medical condition.

We will not retrospectively deny claims for services which were Prior Authorized at the time the care was rendered.

To obtain Prior Authorization, please call our Customer Contact Center, 1-888-802-7001. For Prior Authorization of mental health or Chemical Dependency services, please call (800) 977-8216. For Prior Authorization for Pediatric Dental Services please call 877-410-0176.

Inpatient Services:

- Acute rehabilitation facility
- Behavioral health or substance abuse facility
- Hospice
- Hospital
- Skilled nursing facility

Note: Prior Authorization is not needed for the first 48 hours of inpatient Hospital Services following a vaginal delivery, or the first 96 hours following a cesarean section. However, please notify us within 24

hours following birth. Prior Authorization must be obtained for a scheduled cesarean section or if the Physician determines that a longer Hospital stay is Medically Necessary either prior to or following the birth.

Outpatient Procedures/Services/Equipment:

- Balloon sinuplasty
- Bariatric procedures
- Behavioral health and substance abuse services
  - Prior Authorization is not required for office visits
  - Psychological Testing
  - Neuropsychological Testing
  - Outpatient Detox
  - Outpatient ECT
  - Outpatient ECT (outpatient facility authorization)
  - Transcranial Magnetic Stimulation (TMS)
  - Applied Behavioral Analysis (ABA)
  - Treatment Plan/Reports (for continued ABA behavioral health treatment)
  - Partial Hospital Program or Day Hospital (PHP)
  - Half-Day Partial
  - Intensive Outpatient Program (IOP)
- Blepharoplasty (includes brow ptosis)
- Breast reduction and augmentation
- Capsule endoscopy
- Chondrocyte implants
- Clinical trials
- Cochlear implants
- Custom orthotics
- Dermatology (in-office procedures)
  - Chemical exfoliation and electrolysis
  - Dermabrasion/chemical peel
  - Laser treatment
  - Skin injections and implants
- Durable medical equipment (DME)

- Enhanced external counterpulsation (EECP)
- Excision, excessive skin and subcutaneous tissue (including lipectomy and panniculectomy) of the abdomen, thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad and other areas
- Experimental/Investigational services and new technologies
- Genetic testing
- Liposuction
- Mastectomy for gynecomastia
- Neuro or spinal cord stimulator
- Occupational and speech therapy (except for initial evaluation and management visit and up to six consecutive treatment visits with a contracting provider if it is for a treatment of a new or recurrent condition for which the Member has not been treated by the Provider within the previous 90 days and is not currently undergoing any active treatment)
  - Includes home setting
- Orthognathic procedures (includes TMJ treatment)
- Otoplasty
- Outpatient diagnostic procedures
  - Computed tomography (CT)
  - Magnetic resonance angiography (MRA)
  - Magnetic resonance imaging (MRI)
  - Nuclear cardiac imaging procedures
  - Positron emission tomography (PET)
  - Echocardiography
- Outpatient Pharmaceuticals (submitted under medical benefit claims)
- Outpatient physical therapy (except for initial evaluation and management visit and up to six consecutive treatment visits with a contracting provider if it is for treatment of a new or recurrent condition for which the Member has not been treated by the Provider within the previous 90 days and is not currently undergoing any active treatment)
  - Includes home setting
- Penile implant
- Prosthetics
- Rhinoplasty
- Septoplasty
- Sexual reassignment surgery
- Spinal surgery (includes laminotomy, discectomy, vertebroplasty and nucleoplasty)

- Total joint replacements
  - Includes ankle, hip, knee and shoulder
- Transplant related services including evaluation
- Treatment of varicose veins
- Uvulopalatopharyngoplasty (UPPP) and laser-assisted UPPP
- Vermilionectomy (lip shave), with mucosal advancement
- Vestibuloplasty
- X-Stop

Prior Authorization for outpatient prescription drugs: The Essential Rx Drug List identifies the drugs that require Prior Authorization and drugs that have dosage or quantity restriction. You may call the Customer Contact Center to find out if a particular drug on the Essential Rx Drug List requires Prior Authorization. The current Essential Rx Drug List is available on our website at www.healthnet.com under the pharmacy information. You may also request a copy of the current Essential Rx Drug List, and it will be mailed to you.

If your prescription drug requires Prior Authorization and you do not get Prior Authorization, when you go to the pharmacy to fill your prescription, your pharmacy will tell you that it needs to be Prior Authorized. You or your pharmacy should call your Provider to let him or her know to request the Prior Authorization from us. Your Provider can fax us a Prior Authorization form for review. You can buy the prescription drug before it is prior authorized, but you must pay the full cost. If the drug is authorized after you bought it, you can send us a claim for reimbursement.

Prior Authorization for Pediatric Dental Services:

- X-rays (Radiographs). Cephalometric films once in a two-year period, only on a case-by-case basis. X-rays not listed as covered require Prior Authorization;
- Stainless steel crowns for primary anterior teeth once every three years; if age thirteen and older;
- Metal/porcelain crowns and porcelain crowns on anterior teeth only;
- Apexification for apical closures for anterior permanent teeth only on a case-by-case basis;
- Gingivectomy/gingivoplasty, only on a case-by-case basis;
- Periodontal scaling and root planing once per quadrant in a two-year period for ages thirteen and older;
- Periodontal maintenance once per quadrant in a twelve-month period for ages thirteen and older;
- Anesthesia for members from 9 to 19 years of age, or physically or developmentally Disabled, deep sedation or general anesthesia services are covered on a case-by-case basis, except for oral surgery services. For oral surgery services, deep sedation or general anesthesia services do not require Prior Authorization;
- Occlusal guards when Medically Necessary, for members from 12 to 19 years of age when member has permanent dentition.

Notification: You do not need Prior Authorization for Emergency Medical Care. If you are admitted to a Hospital as part of Emergency Medical Care, please notify Health Net as soon as possible, but no later than 24 hours or by the next business day after admission. If you are admitted to an Out-of-Network Provider Hospital, you may be given the option to transfer to a Participating Provider Hospital as soon as it is safe to do so.

Additionally, Health Net does not require Prior Authorization for dialysis services or maternity care. However, please notify Health Net upon initiation of dialysis services or at the time of the first prenatal visit.

We may revise the Prior Authorization list from time to time. Any such changes including additions and deletions from the Prior Authorization list will be communicated to Participating Providers and posted on the www.healthnet.com website.

Exclusions and Limitations (What's not covered)

All of the following benefits, accommodations, care, services, equipment, medications or supplies are expressly excluded from coverage:

- **Not Medically Necessary.** Any care deemed not Medically Necessary or not in accordance with accepted medical standards by the Medical Director, and any Hospital or medical care services not specifically provided for in the Medical and Hospital Service Agreement or this Group Plan Benefits section.
- **In Excess of Benefit Maximums or Limitations.** All services or supplies that exceed any maximum cost or time (days or visits) limitation imposed in this Schedule or your Basic Benefit Copayment and Coinsurance Schedule.
- **Third-Party Liability.** Covered Services and Supplies for injuries or illnesses for which another person or entity is legally responsible or agrees to a settlement for the injury or illness. If we pay benefits before any such payments are made, reimbursement must be made in accordance with the "Right of Recovery" section in the Group Medical and Hospital Service Agreement.
- **Experimental or Investigational Procedures.** Medical, surgical or other health care procedures, treatments, devices, products or services (collectively, "health care services") which are determined by us to be Experimental or Investigational, and complications directly caused thereby, except as outlined in the "Clinical Trials" subsection of the Group Plan Benefits section.
- **Unauthorized Services**. Non-emergency services without a Prior Authorization, if Prior Authorization is required pursuant to the "Prior Authorization" subsection of this Group Plan Benefits section, and the "Participating Providers" section of the Group Medical and Hospital Service Agreement.
- **Expenses Related to Non-covered Services or Supplies.** Expenses for any condition or complication caused by any procedure, treatment, service, drug, device, product or supply excluded from coverage.

- **Dental Services.** Services performed in connection with treatment to teeth or gums, upper or lower jaw augmentation or reduction, or orthognathic surgery, including treatment or internal or external Prosthetic Devices for disorders of the temporomandibular joint; all Dental Services and dentures except as specified under the "Dental Hospitalization," "Dental Anesthesia," "Dental Injury," "TMJ," "Oral and Maxillofacial Services," and "Pediatric Dental Services" subsections of this Group Plan Benefits section or as otherwise covered under the "Preventive Care" section or for a child with a congenital anomaly.
- **Orthodontic Services and Dental Implants**. Except for treatment covered under the "Dental Injury" and "Pediatric Dental" subsections of this Group Plan Benefits section.
- **Custodial Care; Respite Care, except as provided in the "Hospice Care" and "Hospital Inpatient Services" section of this Group Plan Benefits section.**
- **Optometrics, Eyewear, Vision and Hearing Examinations**. Eye refractions, regardless of diagnosis; eye exercises; visual analysis; therapy or training; radial keratoplasty; photo refractive keratotomy and clear lensectomy. Also excluded are eyeglasses and all other types of vision hardware or vision corrective appliances and contact lenses except as provided in the "Durable Medical Equipment and External Prosthetic Devices," "Medical Supplies" and "Pediatric Vision" subsections of this Group Plan Benefits section. Hearing screening exams and tests except as provided in the "Diagnostic Services" provision of the "Physician Services" section and the "Preventive Care" subsections of this Group Plan Benefits section.
- **Non-covered Equipment and Supplies.** Corrective appliances and artificial aids; braces; disposable or non-prescription or over-the-counter supplies, such as ace bandages, splints, and syringes unless dispensed by a Participating Provider and except as specifically provided elsewhere in this Group Plan Benefits section; exercise and hygiene equipment; support garments; electronic monitors; devices other than blood glucose monitors to perform medical tests on blood or other body substances or excretions; devices or equipment not exclusively medical in nature including but not limited to sauna baths, spas, elevators, light boxes, air conditioners or filters, humidifiers or dehumidifiers; orthopedic chairs and motorized scooters; devices or equipment which can be used in the absence of a medical need; or modifications to the home or motorized vehicles. Corrective shoes and arch supports including foot orthotics are excluded unless prescribed in the course of treatment for, or complications from, diabetes.
- **Cosmetic Services**. Except for treatment covered under the "Sexual Reassignment Services," "Oral and Maxillofacial Services" and "Dental Injury" subsections of this Group Plan Benefits section. All cosmetic or other services rendered to improve a condition which falls within the normal range of function are excluded unless they are Medically Necessary. Services performed to reshape normal structures of the body in order to improve or alter your appearance and/or self-esteem and are not primarily to restore an impaired function of the body are not covered. In addition, genital surgery for the purpose of changing genital appearance, except as covered under "Sexual Reassignment Services", hair transplantation, hair analysis, hairpieces and wigs, and cranial/hair prostheses are not covered.

  This exclusion does not apply to Reconstructive Surgery that: (1) we determine to be Medically Necessary to repair a significant functional disorder as a result of illness or injury; or (2) is incident to a Medically Necessary mastectomy; or (3) is performed to repair congenital defects of a child.

- **Preparation and Presentation of Medical or Psychological Reports or Physical Examinations Required Primarily for Your Protection and Convenience or for Third Parties.** Including but not limited to expenses related to examinations, preparation or presentation of reports for school events, camp, employment, marriage, trials or hearings, licensing and insurance.
- **Immunizations and Inoculations**. Except as provided under the "Preventive Care" subsection of this Group Plan Benefits section.
- **Payment for Care for Conditions That State or Local Law Requires Be Treated in a Public Facility.** No payment will be made for any care or treatment given for an injury, illness, or physical or mental or nervous condition arising during and occurring as a direct result of your active service in the United States Armed Forces, as determined by the Secretary of Veteran's Affairs.
- **Treatment of Infertility,** except as covered as outlined in the "Fertility Preservation" subsection of this Group Plan Benefits section. Except for Emergency Medical Care, complications caused by treatment for infertility. Infertility is the failure of a couple during normal childbearing years to achieve conception after one or more years of regular sexual intercourse without practicing contraceptive measures. Sexual dysfunction that prevents successful intercourse may also be considered infertility. Infertility-related treatment includes but is not limited to:
  a. Treatment of an inability to conceive.
  b. Treatment of habitual abortion, including chromosomal analysis.
  c. Assisted reproductive technologies and artificial insemination.
- **Reversal of Voluntary Infertility (Sterilization).**
- **Weight Loss Surgery or Complications Caused by Weight Loss Surgery.** Except for Emergency Medical Care, diagnosis, treatment, rehabilitation services and diet supplements for any classification of obesity, including but not limited to morbid obesity, (regardless of co-morbidities), except as covered under the "Preventive Care" subsection of this Group Plan Benefits section.
- **Personal Comfort Items.** Such as television, telephone, lotions, shampoos, meals in the home, guest meals in inpatient facilities, housekeeping services, etc.
- **Speech Generating Devices; Augmentive and Alternative Communication Devices or Communicators**. This exclusion does not include an artificial larynx for Members who have had a complete laryngectomy.
- **Rehabilitation Therapy.** Except as provided in the "Rehabilitation and Habilitative Therapy" and "Neurodevelopmental Therapy" subsections of this Group Plan Benefits section.
- **Treatment of Sexual Dysfunction**. Medications, surgical treatment or hospitalization for treatment of impotency; penile implants; services, devices, Prosthetic Devices, or aids related to treatment for any types of sexual dysfunction, congenital or acquired; sperm storage or banking, except as covered as outlined in the "Fertility Preservation" subsection of this Group Plan Benefits section.
- **Genetic Engineering.**
- **Recreational or Educational Therapy; Non-medical Self-help Training except as outlined in the "Services for Education or Training Purposes" section below.**
- **Bone Bank and Eye Bank Charges.**

- **Counseling or training in connection with life transition problems (including occupational, family and marital problems), paraphilias, and sexual disorders.**
- **Orthoptics, pleoptics (visual therapy and/or training), visual analysis.**
- **No-charge Items.** Services and supplies for which the Member is not required to pay or that the Member would receive at no cost in the absence of health coverage; services and supplies for which the Member is not billed by a Provider or for which we are billed a zero dollar charge.
- **Any illness, condition or injury occurring in or arising out of the course of employment.** Any illness, condition or injury occurring in or arising out of the course of employment suffered by a Member who is a sole proprietor, partner or corporate officer of the Subscriber Group who is not a worker subject to mandatory workers' compensation coverage and who in fact does not have workers' compensation coverage, shall be covered to the same extent as if it had not occurred in or arisen out of the course of employment.
- **Treatment Related to Judicial or Administrative Proceedings**. Court-ordered care, unless determined to be Medically Necessary and Prior Authorized by us. Psychiatric therapy as a condition of parole, probation or court order.
- **Professional Athletic Training and Competition.** Diagnosis, treatment and rehabilitation services for injuries sustained while practicing for or competing in a professional or semi-professional athletic contest.
- **Programs for the Specific Intent of Pain Management.**
- **Biofeedback.** Biofeedback for the treatment of vulvodynia, ordinary muscle tension, or for the management of chronic pain in pain rehabilitation programs.
- **Routine Foot Care.** Including treatment for corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes, as shown in the "Diabetes Management" subsection of this Group Plan Benefits section.
- **Preventive and Routine Examinations, Services, Testing, and Supplies.** Except as outlined in the "Preventive Care" subsection of this Group Plan Benefits section.
- **Nutritionist.** Services of a nutritionist, except for specific conditions such as diabetes, high blood pressure, and anemia, or as outlined in the "Inborn Errors of Metabolism," "Nutrition Counseling Services" or "Preventive Care" subsections of this Group Plan Benefits section.
- **Wilderness Residential Treatment Programs.** All services provided in wilderness residential treatment programs.
- **Treatment by an Immediate Family Member or Self Treatment.** Services and supplies rendered by an immediate family member (spouse, State Registered Domestic Partner and/or Non-Registered Domestic Partner, parent, child, grandparent or sibling related by blood, marriage or adoption) or services and supplies, or medications prescribed or ordered by an immediate family member of the Member; Member self-treatment, including but not limited to self-prescribed medications and medical self-ordered services and laboratory tests.
- **Outside the United States.** Services provided outside the United States which are not Emergency Medical Care.

- **Hearing Care**. Except as outlined in the "Preventive Care" subsection of this Group Plan Benefits section, we do not cover hearing care, routine hearing examinations, programs or treatment for hearing loss, including, but not limited to, hearing aids (externally worn or surgically implanted) and the surgery and services necessary to implant them, This exclusion does not apply to cochlear implants.
- **Services for Educational or Training Purposes.** Except for services related to behavioral health treatment for Pervasive Developmental Disorder or Autism as shown in the "Autism Spectrum and Pervasive Developmental Disorder" section, all other services related to or consisting of education or training, including for employment or professional purposes, are not covered, even if provided by an individual licensed as a health care provider by the state of Washington. Examples of excluded services include education and training for non-medical purposes such as:
  - Gaining academic knowledge for educational advancement to help students achieve passing marks and advance from grade to grade. For example: This Agreement does not cover tutoring, special education/instruction required to assist a child to make academic progress; academic coaching; teaching members how to read; educational testing or academic education during residential treatment.
  - Developing employment skills for employment counseling or training, investigations required for employment, education for obtaining or maintaining employment or for professional certification or vocational rehabilitation, or education for personal or professional growth.
  - Teaching manners or etiquette appropriate to social activities.
  - Behavioral skills for individuals on how to interact appropriately when engaged in the usual activities of daily living, such as eating or working, except for behavioral health treatment as indicated above in conjunction with the diagnosis of Pervasive Developmental Disorder or Autism.
- **Conditions caused by your commission (or attempted commission) of a felony.** However, this plan provides coverage for the treatment of an injury resulting from an act of domestic violence, or if the injury was sustained solely as a consequence of the Enrolled Member being intoxicated or under the influence of a narcotic.
- **Missed Appointments**. Charges to a Member for failure to keep a scheduled appointment are not covered.
- **Hair Analysis and Replacement**. Hair transplantation, hair analysis, hairpieces and wigs, and cranial/hair prostheses are not covered.
- **Non-Licensed Providers**. Treatment or services rendered by non-licensed health care Providers, treatment or services outside the scope of a license of a licensed health care provider and treatment or services for which the Provider of services is not required to be licensed. This includes treatment or services from a non-licensed Provider under the supervision of a licensed Physician, except for services related to behavioral health treatment for Pervasive Developmental Disorder or Autism as shown in the "Autism Spectrum and Pervasive Developmental Disorder" subsection of this Group Plan Benefits section.
- **Non-Standard Therapy**. Yoga, hiking, rock climbing and any other type of sports activity are not covered.

Health Net

Health Net Health Plan of Oregon, Inc.
Washington PPO Plan
Group Medical and Hospital Service Agreement

Introduction

- This Agreement is entered into between us and the Subscriber Group named on the attached Signature Sheet.
- We are an authorized health care service contractor in the State of Washington.
- Subscriber Group desires to make available prepaid comprehensive health care services to eligible persons who participate in its Health Benefit Plan.
- In consideration of the mutual promises of the parties and the periodic payment to us of the required premiums and subject to the terms and conditions contained in this Agreement, we agree to provide Subscribers and their Enrolled Dependents with Medical and Hospital Services and other benefits specified in this Agreement.
- It is agreed by the parties that this is not an indemnity health insurance contract but is an agreement to provide Subscribers and their Enrolled Dependents with health care benefits as specified by this Agreement. All interpretations of this Agreement shall be guided by such nature of this Agreement.

Definitions

The following terms, when used in this Agreement, are defined as follows:

"Adverse Benefit Determination" means:

- A denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of an enrollee's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review (i.e. Prior Authorization), as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.
- Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit;
- A rescission of coverage determination; or
- A carrier's denial of an application for coverage.

"Agreement" means this Plan Contract, which includes the Medical and Hospital Service Agreement and Group Plan Benefits section, all attached Copayment and Coinsurance Schedules, any exhibits,

supplements, addenda, attachments, amendments, endorsements, conditions of enrollment, and underwriting assumptions. Additionally, employers will receive a Signature Sheet, a copy of their group application, and any information submitted as part of an application for this Agreement or for membership under this Agreement. A copy of the Agreement serves as both the description of coverage portion of the contract between us and the Subscriber Group, and when distributed to a Member, as the Member's Evidence of Coverage (EOC) document.

"Ambulatory Surgery Center" means a facility that performs outpatient surgery not routinely or customarily performed in a Physician's or dentist's office, and is able to meet health facility licensure requirements.

"Anniversary Date" means an anniversary of the Effective Date as identified on the Signature Sheet of this Agreement.

"Appeal" means a written or oral request submitted by or on behalf of a Member to review and reconsider an Adverse Benefit Determination.

"Applied Behavior Analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human social behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior and that is provided by:

- A licensed health care professional;
- A behavior analyst or an assistant behavior analyst; or
- A behavior analysis interventionist.

"Autism" means a developmental disability significantly affecting verbal and nonverbal communication and social interaction. Other characteristics that may be associated with Autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences. Essential features are typically but not necessarily manifested before age three. Autism may include Autism spectrum disorders such as but not limited to autistic disorder, Pervasive Developmental Disorder - not otherwise specified and, Asperger's syndrome.

"Benefit Schedule" means the attached exhibits identified as the Coinsurance Schedule or other Benefit Schedule(s) which set forth the medical, Hospital and other benefits provided under this Agreement.

"Calendar Year" means the period of time beginning January 1 and ending December 31. Each succeeding January 1 will start a new Calendar Year.

"Chemical Dependency" means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated by state or federal law and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

"Coinsurance" means the percentage of a Provider's covered charge stated in your Basic Benefit Copayment and Coinsurance Schedule to be paid by Members directly to Providers for Covered Services.

"Contract Year" means the period of time beginning on the Effective Date of the Agreement and continuing for one year or until the Anniversary Date of the Agreement, whichever occurs earlier. Each Anniversary Date begins a new Contract Year.

"Copayment" means the fixed dollar amount stated in your Basic Benefit Copayment and Coinsurance Schedule to be paid by Members directly to Providers for Covered Services. The Deductible is waived for services where the Member's responsibility is a Copayment rather than Coinsurance. The office visit Copayment includes Physician services only.

"Covered Services" or "Covered Services and Supplies" means Medically Necessary services and/or supplies that are payable or eligible for reimbursement, subject to any Deductibles, Copayments, Coinsurance, benefit limitations or maximums, under the Agreement.

"Custodial Care" means care that does not require the continuing services of skilled medical or allied health professionals or that is designed primarily to assist a Member in activities of daily living, whether provided in an institution or in the home. Custodial Care includes but is not limited to medical care and services which can reasonably be provided to a Member by a medically non-licensed individual such as a parent, spouse, child or other resident of the home, help in walking, getting in and out of bed, bathing, dressing, use of the toilet or commode, feeding, preparation of special diets, and supervision of medications that are ordinarily self-administered.

"DSM" The Diagnostic and Statistical Manual of Mental Disorders. The reference book, published by the American Psychiatric Association, is the diagnostic standard for most mental health professionals in the United States.

"Deductible" The amount that the covered Member must pay toward the cost of Covered Services before the plan pays benefits.

"Dental Services" Fees are based on whether or not you seek services from a Participating Provider or a Nonparticipating Provider.

If you see a Participating Provider, your Group Plan Benefits are based on MAC. MAC stands for Maximum Allowable Charge, which is a discounted fee negotiated between us and a Participating Provider. There is usually a difference between the amount your Provider actually charges for a service, and how much of that billed charge the Provider has agreed to accept as payment in full for services under a Participating Provider contract. If you see a Participating Provider, your plan pays a percentage of MAC, and you are not responsible for any billed amounts above the MAC allowance.

If you see a Nonparticipating Provider, your Group Plan Benefits are based on MAA: MAA stands for Maximum Allowable Amount. The MAA is determined by us, based on data obtained regarding fees usually charged by Providers for the same service within the same geographic area. There is usually a difference between the amount your Provider actually charges for a service, and how much of that billed charge we allow as the Maximum Allowable Amount. Your plan pays a percentage of the MAA amount rather than a percentage of the billed charge. If your Provider charges more than the MAA, you are responsible for the difference between the billed charge and the MAA.

"Dependent" means any Member of a Subscriber's immediate family who is one of the following:

- The spouse or State Registered Domestic Partner of the Subscriber.
- A Non-Registered Domestic Partner of the Subscriber.

- A Child, as described below, who is covered up to the last day of the month in which that child becomes age 26, including a child who is the subject of a Qualified Medical Child Support Order (QMCSO) requiring the Subscriber to provide health coverage for the child. The QMCSO must be furnished to us to initiate Enrollment.

"Child" means a natural child of the Subscriber, an adopted child of the Subscriber, or a stepchild of the Subscriber during the marriage of the Subscriber and the natural parent, or a child of the Subscriber's State Registered Domestic Partner or Non-Registered Domestic Partner during the State Registered Domestic Partnership, or the Non-Registered Domestic Partnership, but does not include foster children, wards, or children who are under temporary custody of the Subscriber or spouse. "Child" also does not include children of Dependents unless the Subscriber is a court-appointed guardian. Provided, however, that a child who is placed with a Subscriber for the purposes of adoption shall be considered a Dependent of the Subscriber as required by the laws of the State of Washington. Placement for adoption means the assumption and retention by a Subscriber or spouse of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. Coverage of any Dependent child of a Subscriber shall not be terminated by the child's attaining the relevant limiting age if the child is and continues to be Disabled. Proof of disability must be furnished within 31 days of reaching a limiting age and not more frequently than annually after the first two years of continued coverage. We will not deny Enrollment of a Child because the Child was: (a) born out of wedlock; (b) is not claimed on the parent's federal tax return; or (c) does not reside with the parent or within our Service Area.

"Disabled" means when the Dependent is both (1) incapable of self-sustaining employment by reason of developmental disability or physical handicap and (2) chiefly dependent upon the Subscriber for support and maintenance. Coverage for any Dependent child of a Subscriber shall not be terminated by the child's attaining the relevant limiting age if the child is and continues to be Disabled. Proof of disability must be furnished within 31 days of reaching a limiting age and not more frequently than annually after the first two years of continued coverage.

"Durable Medical Equipment" means equipment (a) which can withstand repeated use; (b) the only function of which is for treatment of a medical condition or for improvement of function related to the medical condition; (c) which is of no use in the absence of the medical condition; and (d) which is appropriate for home use.

"Effective Date" means the date of this Agreement as stated on the Signature Sheet. The date coverage is effective for individual Subscribers and Dependents is described herein.

"Eligible Employee" means an individual who works a minimum number of hours per week, as specified on the Group Application, at the business of the Employer and otherwise has a bona fide employee/employer relationship with the Subscriber Group. The term excludes individuals who work on a temporary or substitute basis or as an independent contractor.

"Emergency Medical Care" means otherwise covered health care services Medically Necessary to evaluate and treat an Emergency Medical Condition, provided in a Hospital emergency department.

"Emergency Medical Condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would:

- Place the health of a Member, or an unborn child, in the case of a pregnant Member, in serious jeopardy;

- Result in serious impairment to bodily functions; or
- Result in serious dysfunction of any bodily organ or part.

"Emergency Medical Screening Exam" means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

"Enrollment" or "Enroll" or "Enrolled" means the completion and signing of the necessary enrollment forms by or on behalf of an eligible person and acceptance by us.

"Essential Health Benefits" are a set of health care service categories (as defined by the Affordable Care Act) that must be covered by qualified health plans starting in 2014. Categories include: Ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including dental and vision care.

"Expedited Appeal" means any Appeal for benefits under the Agreement where applying normal Appeal consideration time periods could: (a) seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or (b) subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the basis for the Appeal, in the opinion of a Physician with knowledge of the Member's medical condition.

"Experimental" or "Investigational" means any procedure, treatment, therapy, drug, biological product, facility, equipment, device or supply which we have determined, not to have been demonstrated as safe, effective, and medically appropriate for use in the treatment of an illness, injury, or condition at issue ("Illness") as compared with the conventional means of treatment or diagnosis. "Experimental or Investigational" also includes services, supplies, drugs, and procedures that we determine to be educational or the subject of a clinical trial.

In making this determination, we shall refer to evidence from the Washington medical community, which may include one or more of the following sources:

- Evidence from national medical organizations, such as the National Centers for Health Services Research;
- peer-reviewed medical and scientific literature;
- publications from organizations such as the American Medical Association;
- professionals, specialists, and experts; and
- written protocols and consent forms used by the proposed treating facility or other facility administering substantially the same drug, device or medical treatment.

For us to determine that the drug, device, service or supply is not Experimental or Investigational, it must meet all of the following criteria:

- If it is a drug or device which cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA), final FDA approval must have been obtained at the time the drug or device was furnished. Interim FDA approvals for a Phase I, II, or III trial, pre-market approval applications and Investigational exemptions are not sufficient. Our approval for drugs and devices which have been given final approval by the FDA will be limited to: (a) the uses and indications for which the drug or device was licensed or (b) uses and indications which We determine are recognized or approved in accordance with generally accepted professional medical standards in the Washington medical community as being safe, effective and medically appropriate for use in the treatment of the "Illness."
- If it is a service or supply, it must be recognized or approved in accordance with generally accepted professional medical standards in the Washington medical community as being safe, effective and medically appropriate for use in the treatment of the "Illness" as compared to the conventional means of treatment or diagnosis. Any required approval of any federal government or agency, or any state government or agency, must have been obtained prior to the time of use.

Evidence will not be considered conclusive if the service or supply is: (a) the subject of ongoing Phase I, II, or III clinical trials; or (b) it is under study to determine maximum tolerated dose, toxicity, safety or medical appropriateness as compared with the conventional treatment or diagnosis; or (c) if its safety, effectiveness or medical appropriateness is the subject of substantial debate within the Washington medical community.

The fact that a Physician or other medical professional or expert prescribes, orders, recommends, recognizes, or approves any procedure, treatment, therapy, drug, biological product, facility, equipment, device, or supply does not in itself make the procedure, treatment, therapy, drug, biological product, facility, equipment, device, or supply non-Experimental or non-Investigational within this definition.

The fact that the service or supply is authorized by law or otherwise for use in testing, trials, or other studies on human patients shall not in itself make the service or supply non-Experimental or non-Investigational.

"Grievance" means a written complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for Medical Services or for not providing Medical Services, including dissatisfaction with medical care, waiting time for Medical Services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

"Habilitative Services" Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Examples of health care services that are not habilitative include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, vocational services or Custodial Care, chore services to assist with basic needs, or education services of any kind, including, but not limited to, vocational training.

"Health Benefit Plan" means any Hospital expense, medical expense or Hospital or medical expense policy or certificate, health care service contractor or health maintenance organization Subscriber contract, any plan provided by a multiple employer welfare arrangement or by another benefit arrangement as recognized by federal law and defined in the federal Employee Retirement Income Security Act of 1974, as amended to the extent that the plan is subject to state regulation.

"Home Health Care" means a program of care provided by a public agency or private organization or a subdivision of such an agency or organization which (a) is primarily engaged in providing Skilled Nursing Services in homes or places of residence of its patients; (b) is licensed according to applicable laws of the State of Washington and of the locality in which it is located or provides services; and (c) if the Member resides within the Service Area, has a written agreement with us as an agency or organization to provide Home Health Care to Members under this Agreement.

"Hospice" means a program provided by a public agency or private organization that is primarily engaged in providing services to terminally ill persons. The Hospice and its employees must be licensed in accordance with applicable state and local laws and certified by Medicare.

"Hospice Care" is care provided by a Hospice and designed to provide medical and supporting care to the terminally ill and their families. Hospice Care is designed to be provided primarily in the patient's home.

"Hospital" means an institution which is either:

- An institution which is primarily engaged in providing, on an inpatient basis, medical care and treatment for sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be located on its premises, under the supervision of a staff of Physicians and with 24 hour-a-day nursing services; or
- An institution not meeting all the requirements of (a) above, but which is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations or pursuant to Title XVIII of the Social Security Act as amended.

In no event shall the term "Hospital" include a convalescent nursing home or any institution or part thereof which is used principally as a convalescent facility, rest facility, or nursing facility.

"Hospital Services" means those Medically Necessary services for inpatients and outpatients which are generally and customarily provided by acute care general Hospitals, and which are prescribed, directed, or authorized by a Physician in accordance with this Agreement. "Hospital Services" shall also include Medically Necessary services rendered in the emergency room and/or the outpatient department of any Hospital. Except for Emergency Medical Care, Prior Authorization is required for Hospital Services.

"Individual Practice Association" or "IPA" means a Physicians' group which has contracted with us as a Participating Provider.

"Initial Enrollment Period" means the 31 days following the date an individual first becomes eligible for coverage under this Agreement.

"Late Enrollee" means an individual who enrolls in a group Health Benefit Plan subsequent to the Initial Enrollment Period during which the individual was eligible for coverage but declined to Enroll. However, an eligible individual shall not be considered a Late Enrollee if:

- The individual applies for coverage during an Open Enrollment Period;
- A court has ordered that coverage be provided for a spouse or minor child under a covered Subscriber's Health Benefit Plan and request for Enrollment is made within 31 days after issuance of the court order;
- The individual is employed by a Group Subscriber who offers multiple Health Benefit Plans and the individual elects a different Health Benefit Plan during an Open Enrollment Period agreed upon by Group Subscriber and us;

- The Department of Social and Health Services determines that it is cost-effective to Enroll a person eligible for medical assistance under chapter 74.09 in an employer-sponsored health plan for which he or she is otherwise eligible;
- The individual qualifies for Special Enrollment under the "Enrollment and Effective Date" section of this Group Medical and Hospital Service Agreement.

"Maximum Allowable Amount (MAA)" is the amount on which we base our reimbursement for Covered Services and Supplies received by a Nonparticipating Provider, which may be less than the amount billed for those services and supplies. We calculate MAA as the lesser of the amount billed by the Nonparticipating Provider or the amount determined as set forth below. MAA is not the amount that we pay for a Covered Service or Supply; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles and other applicable amounts set forth in your Basic Benefit Copayment and Coinsurance Schedule.

- The Maximum Allowable Amount for covered outpatient pharmaceuticals (including but not limited to injectable medications) dispensed and administered to the patient in an outpatient setting, including, but not limited to, Physician office, outpatient Hospital facilities, and services in the patient's home will be the lesser of billed charges or the "Average Wholesale Price" for the drug or medication. "Average Wholesale Price" is the amount listed in a national pharmaceutical pricing publication, and accepted as the standard price for that drug by Health Net.
- MAA for Medical Services is a percentage of what Medicare would pay (known as the Medicare allowable amount). Medicare pays 100% of the Medicare allowable amount. The percentage of Medicare at which we pay out-of-network claims is 160%.
- In the event there is no Medicare allowable amount for a billed service or supply code, MAA shall be determined by us, based on the Medicare allowable amount for equivalent services or supplies.
- In the event there is no Medicare allowable amount for a billed service or supply code:
    a. Maximum Allowable Amount for professional and ancillary services shall be 100% of FAIR Health's Medicare gapfilling methodology. Services or supplies not priced by gapfilling methodology shall be the lesser of: (1) the average amount negotiated with Preferred Providers within the geographic region for the same Covered Services or Supplies provided; (2) 50th percentile of FAIR Health database of professional and ancillary services not included in FAIR Health Medicare gapfilling methodology; (3) 160% of Medicare allowable Amount for the same Covered Services or Supplies under alternative billing codes published by Medicare; or (4) 50% of the Out-of-Network Provider's billed charges for Covered Services. A similar type of database or valuation service will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination.
    b. Maximum Allowable Amount for facility services shall be the lesser of: (1) the average amount negotiated with Preferred Providers within the geographic region for the same Covered Services or Supplies provided; (2) 100% of the derived amount using a method developed by Data iSight for facility services (a data service that applies a profit margin factor to the estimated costs of the services rendered), or a similar type of database or valuation service, which will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination; (3) 160% of the Medicare allowable amount for the same Covered Services or Supplies under alternative billing codes published by Medicare; or (4) 50% of the Out-of-Network Provider's billed charges for Covered Services.

The following example shows how MAA applies to claims payment:

For illustration purposes only, Out-of-Network Provider: 70% Plan Payment / 30% Member Coinsurance:

Nonparticipating Provider's billed charge for extended office visit.....$128.00
MAA allowable for extended office visit (example only; does not mean that MAA always equals this amount).....$102.40
Your Coinsurance is 30% of MAA: 30% x $102.40 (assumes Deductible has already been satisfied).....$30.72
You also are responsible for the difference between the billed charge ($128.00) and the MAA amount ($102.40).....$25.60
Total amount of $128.00 charge that is your responsibility.....**$56.32**

- The MAA may also be subject to other limitations on covered expenses. See the "Plan Benefits," "Exclusions and Limitations," "Group Medical and Hospital Service Agreement" and "General Limitations" sections for specific benefit limitations, maximums, Prior Authorization requirements and payment policies that limit the amount we pay for certain Medical Services. We use available guidelines of Medicare and/or Medicaid to assist in our determination as to which services and procedures are eligible for reimbursement. We will, to the extent applicable, apply Medicare claim processing rules to claims submitted. We will use these rules to evaluate the claim information and determine accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying Medicare rules may affect the MAA if it is determined the procedure and/or diagnosis codes used were inconsistent with Medicare procedure coding rules and/or reimbursement policies.
- The Medicare allowable amount is subject to automatic adjustment by the Center for Medicare and Medicaid Services (CMS), an agency of the federal government which regulates Medicare.

NOTE: We have the right to adjust, without notice, the MAA. Claims payment will be determined according to the schedule in effect at the time the charges are incurred. Claims payment will also never exceed the amount the Out-of-Network Provider charges for the service or supply. You should contact the Customer Contact Center if you wish to confirm the Covered Expenses for any treatment or procedure you are considering.

In addition to the above, from time to time, we may contract with vendors that have contracted fee arrangements with Providers ("third-party networks"). In the event we contract with a third-party network that has a contract with the Nonparticipating Provider, we may, at our option, use the rate agreed to by the third-party network as the MAA. Alternatively, we may, at our option, refer a claim for Out-of-Network services to a fee negotiation service to negotiate the MAA for the Service or Supply provided directly with the Out-of-Network Provider. In either of these two circumstances, you will not be responsible for the difference between the MAA and the billed charges. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance at the Out-of-Network level.

In addition, we may, at our option, refer a claim for Nonparticipating Provider services to a fee negotiation service to negotiate the MAA for the service or supply provided directly with the Nonparticipating Provider. In that situation, if the Nonparticipating Provider agrees to a negotiated MAA, You will not be responsible for the difference between the MAA and the billed charges. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance at the Out-of-Network level.

In the event that the billed charges for covered Medical Services and supplies received from a Nonparticipating Provider are more than the MAA, You are responsible for any amounts charged in excess of the MAA, in addition to applicable Deductibles, Copayments or Coinsurance, except where the Nonparticipating Provider's fee is determined by reference to a third-party network agreement or the Nonparticipating Provider agrees to a negotiated MAA.

The MAA for covered Medical Services and supplies may be revised periodically by us.

For more information on the determination of MAA or for information, services and tools to help you further understand your potential financial responsibilities for out-of-network Services and Supplies please log on to www.healthnet.com or call the Customer Contact Center at the number on your Member identification card.

"Medicaid" means the program of medical coverage provided by the states under Title XIX of the Social Security Act, as amended by Public Law 89-97, including any amendments which may be enacted in the future.

"Medical Director" means a Medical Director of our plan or his or her designee. A decision of the Medical Director which substantially affects a Member is subject to the "Rights of Members" section of this Group Medical and Hospital Service Agreement, and will be made in the exercise of the Medical Director's reasonable judgment, subject to all of the terms and conditions of this Agreement.

"Medical Services" means those Medically Necessary health care services which are performed, prescribed or directed by a Physician, except as expressly limited or excluded by this Agreement.

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

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

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

Determination of Medical Necessity is done on a case by case basis. The fact that a Provider of services has performed or prescribed a procedure or treatment or the fact that it may be the only available treatment for a particular illness, injury, or sickness does not make the procedure or treatment Medically Necessary. The determination of the Medical Director regarding what is Medically Necessary will control, subject only to the "Rights of Members" section of this Group Medical and Hospital Service Agreement.

"Medicare" means The Health Insurance for the Aged Act, Title XVIII of the Social Security Act and all amendments.

"Member" or "Enrollee" means any Subscriber or Dependent who satisfies all of the requirements of this Agreement, who has been Enrolled by us and for whom the current monthly premium has been received by us.

"Mental Health Services" means Medically Necessary outpatient and inpatient services provided to treat mental disorders covered by the most current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association with the exception of the following services: life transition problems, specified codes related to encounters for circumstances other than a disease or injury, and sexual disorders as found in the DSM, 4th edition, published by the American Psychiatric Association; Skilled Nursing Facility Services, home health care, residential treatment, and Custodial Care; and court ordered treatment unless Medically Necessary.

"Nonparticipating Provider or Out-of-Network Provider" means any Provider who is not a Participating Provider at the time services are rendered to a Member.

"Non-Registered Domestic Partner" means a person who is in a "Domestic Partnership" with the Subscriber. A Non-Registered Domestic Partnership is defined as a relationship of two people 18 years of age or older who are not related by blood closer than first cousins.

The partnership must meet the eligibility requirements established by the Subscriber Group and agreed to by us and the relationship must meet the definition of Domestic Partnership. The Subscriber is required to provide notice of termination of the relationship.

"Open Enrollment Period" is a period of time each Calendar Year, during which eligible individuals and their Dependents, may Enroll, or change their current coverage, outside of a special enrollment period. The Group decides the exact dates for the Open Enrollment Period. Changes requested during the Open Enrollment Period become effective on the first day of the calendar month following the date the request is submitted, or on any date approved by us.

"Out-of-Pocket Maximum" The annual Out-of-Pocket Maximum includes the annual Deductible. After you reach the Out-of-Pocket Maximum in a Calendar Year, we will pay your Covered Services during the rest of that Calendar Year at 100% of our contract rates for PPO services and at 100% of MAA for Out-of-Network (OON) services. You are still responsible for OON billed charges that exceed MAA.

"Participating Provider" means a licensed or certified Physician, health professional, Hospital, home health agency, pharmacy, laboratory, or other licensed or certified entity or person who has entered into a contract or other arrangement to participate in the Health Net PPO DV Network and provide health care services to Members of this PPO Plan with an expectation of receiving payment, other than Deductibles, Coinsurance, and Copayments, directly or indirectly from us, and such contract or other arrangement is in effect at the time such services are rendered. For more information, see the "Participating Providers" section in the Group Medical and Hospital Service Agreement.

"Peer Review Committee" means the panel of Participating Physicians designated and appointed by an IPA and/or our Board of Directors.

"Pervasive Developmental Disorder" means a neurological condition that includes Asperger's syndrome, Autism, developmental delay, developmental disability or intellectual disability.

"Physician" means any doctor licensed to practice medicine or osteopathy in Washington or in the state in which medical care is rendered.

"Prior Authorization" means written or oral approval obtained from us in advance of receiving specified medical treatment or supplies covered under this Agreement. Prior Authorization is not required for Emergency Medical Care.

- A Prior Authorization issued by us shall be binding in accordance with its terms for 30 days, except that a Prior Authorization shall not be binding if:
  a. The Prior Authorization specifies a date on which coverage terminates and services were obtained after that date; or
  b. The Prior Authorization was obtained through misrepresentation.
- We will not retrospectively deny claims for services which were Prior Authorized at the time the care was rendered.
- We will answer a request for Prior Authorization of non-emergency services within five (5) calendar days.
- A Physician will retain responsibility for recommendations related to whether a service or procedure, and where it is to be performed, is appropriate for treating a specific medical condition.

"Prosthetic Devices" means artificial substitutes that are required to replace all or any part of a body organ or extremity.

"Provider" means any licensed or certified Physician, health professional, registered nurse, advanced registered nurse practitioner, podiatrist, mental health care professional, Hospital, home health agency, pharmacy, laboratory, or other entity or person who is licensed or certified and is acting within the scope of his or her license to furnish Covered Services and Supplies.

"Residential Treatment Center" is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. Health Net requires that all Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

"Service Area" means all the counties in the state of Washington.

"Signature Sheet" means the sheet attached to this Agreement and identified as such.

"Skilled Nursing Facility" has the same meaning as Extended Care Facility in Title XVIII of the Social Security Act and regulations but is limited to those facilities with a contract or other arrangement with us.

"Skilled Nursing Service" has the same meaning as Extended Care Service in Title XVIII of the Social Security Act and regulations except that it does not include a requirement of prior hospitalization; is interpreted as if all Members were covered under both parts of Title XVIII; and applies only to services performed, prescribed, or directed by a Participating Physician. "Post-Hospital Extended Care Service" has the same meaning as Title XVIII of the Social Security Act and regulations but applies only to services performed, prescribed, or directed by a Participating Physician.

"Small Employer" or "Small Group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that employed an average of at least one but no more than fifty employees, during the previous Calendar Year and employed at least one employee on the first day of the plan year, is not formed primarily for

purposes of buying health insurance, and in which a bona fide employer-employee relationship exists. In determining the number of employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a Small Employer and for the purpose of determining eligibility, the size of a Small Employer shall be determined annually. Except as otherwise specifically provided, a Small Employer shall continue to be considered a Small Employer until the plan anniversary following the date the Small Employer no longer meets the requirements of this definition.

"Stabilization" means to provide medical treatment as necessary to:

- Ensure that, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur during or to result from the transfer of the patient from a facility; and
- With respect to a pregnant women who is in active labor, to perform the delivery, including the delivery of the placenta.

"State Registered Domestic Partner" means a person who has entered into a civil contract with the Subscriber, both of whom meet the requirements for a valid state registered domestic partnership as established by state law and who have been issued a certificate of state registered domestic partnership by the secretary of state's office.

"Subscriber" means an Eligible Employee who meets all applicable requirements of this Agreement, who has Enrolled hereunder by submitting an Enrollment application which has been approved by us, and for whom the monthly premium has been received by us in accordance with the terms hereof.

"Subscriber Group" means the entity, such as an employer, trust or association, sponsoring the health and welfare plan pursuant to which the benefits of this Agreement are made available to Eligible Employees. A Subscriber Group is limited to an entity that would, under Washington law, be eligible for a group medical policy or contract.

"Urgent Care" means services which are provided for the relief of acute pain or initial treatment of an acute infection or a medical condition that requires medical attention, but for which a brief time lapse before care is obtained does not endanger life or permanent health. Urgent Care services include, but are not limited to, treatment for minor sprains, fractures, pain, and heat exhaustion. An individual patient's urgent condition may be determined to be an emergency upon evaluation by an urgent care health care Provider.

"Women's Health Care Provider" means any generally recognized medical specialty of licensed practitioners who provides Women's Health Care Services; licensed practitioners when providing Women's Health Care Services; licensed midwives; and advanced registered nurse practitioner specialists in women's health and midwifery, practicing within the applicable lawful scope of practice.

"Women's Health Care Services" means organized services to provide health care to women, inclusive of the women's preventive services required by the U.S. Department of Health and Humans Services. These services include, but are not limited to, maternity care, reproductive health services, gynecological care, general examination, preventive care as Medically Necessary, and medically appropriate follow-up visits for these services. These services also include any appropriate health care service for other health problems, discovered and treating during the course of a visit to a Women's Health Care Provider for a Women's Health Care Service, within the scope of the Provider's practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and preventive services include: contraceptive services, testing and

treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and complications of pregnancy.

Monthly Payments (Premiums)

- The monthly premium rate is set forth on the Signature Sheet. If the State of Washington or any other taxing authority imposes upon us any new or additional tax or license fee which is levied upon or measured by premium, by our gross receipts, or by any portion of either, then we may amend this Agreement to increase the premium by an amount sufficient to cover all such taxes or license fees rounded to the nearest cent. Such premium increases are subject to review and approval by the Washington State Office of the Insurance Commissioner (OIC) and would take effect as of the date stated in a notice sent to the Subscriber Group. The Effective Date of such a premium increase shall not be earlier than the date of the imposition of such tax or license fee increase. We shall also have the right to change the premium as of any date as permitted or mandated by law or regulation.
- Premiums are due on the first day of each month. Each monthly premium shall be calculated on the basis of our records reflecting the number of Subscribers and Dependents in each premium classification, as set forth on the Signature Sheet, at the time of calculation and at the premium rate then in effect. Subscriber Group shall submit to us, on behalf of each Subscriber and Enrolled Dependents, the entire amount due, on or before the first day of the month for which coverage is provided. If a payment is rejected by the financial institution on which it is drawn, premium is not considered paid until the payment, or an alternate payment, is honored by the issuing financial institution. Subscriber Group assumes responsibility for collection of the contributory portion of the premium, if any, from each Subscriber.
- Only Members for whom the premium is actually received shall be entitled to benefits, and then only for the period to which such premium is applicable. If the required premium for the Agreement is not received within 25 days of the due date, the Agreement shall terminate automatically. Thereafter, the Agreement will be reinstated only by renewed application and re-Enrollment in accordance with all requirements of this Agreement.
- The total amount paid monthly under this Agreement may change from time to time to reflect any change in the status of a Member or any change in the type of membership applicable to the Member (single, two party or family) or any change in state or federal benefit mandates.
- Subscriber Group shall provide us with notice of changes in eligibility and Enrollment within 30 days of the Effective Date of such changes. At our option, retroactive adjustments for premium may be made for any additions or terminations of Members and changes in coverage classification not reflected in our records at the time the monthly premium is calculated by us. However, in no event shall we refund to a Subscriber Group any premiums paid for a Member by Subscriber Group if the request for such refund is made later than 60 days after our receipt of payment for said retroactively terminated Member.

- We reserve the right to change the premium rates of this Agreement effective at renewal, or when specific factors of the current coverage of the Subscriber Group have changed, on at least 60 days written notice before the effective date of the premium rate adjustment. Such premium changes are subject to review and approval by the Washington State Office of the Insurance Commissioner (OIC). For the purpose of this section, specific factors include, but are not limited to: company relocation, legislative changes, and increase or decrease in enrollment. For information regarding changes to current coverage, please contact your Subscriber Group.
- We reserve the right to change any provisions of this Agreement effective at renewal on at least 30 days written notice before the renewal to the Subscriber Group. Such changes are subject to review and approval by the Washington State Office of the Insurance Commissioner (OIC).

Eligibility

- **Subscriber:** To be eligible to Enroll as a Subscriber, a person must, at the time of Enrollment and throughout the term of this Agreement, be an Eligible Employee of the Subscriber Group and must meet the Subscriber Group's eligibility criteria.
- **Dependent:** To be eligible to Enroll as a Dependent, a person must be a Dependent of a Subscriber and must meet the Subscriber Group's eligibility criteria. A Dependent who is Enrolled as a Member will continue as an eligible Dependent through the last day of the month in which such Dependent ceases to meet the requirements of a Dependent.

  Subscriber Group's eligibility criteria must be provided on the Group Application which is a part of this Agreement. If the criteria on an approved Group Application conflict with any eligibility criteria elsewhere in this Agreement, then the criteria in this Group Medical and Hospital Service Agreement shall prevail.

  During the term of this Agreement, Subscriber Group shall make no change in its eligibility standards for purposes of this Agreement unless such change is agreed to by us.

  Any ineligible person Enrolled under this Agreement will not be entitled to benefits hereunder. We will refund to the Subscriber Group any premium paid for the ineligible person in excess of any benefits paid for the time the person was ineligible or for the last six months prior to discovery of the ineligibility, whichever is shorter (the "refund period"). We shall also be entitled to repayment from the ineligible person for the cost of benefits provided during the refund period in excess of the premium received by us for the ineligible person for that period. If the ineligible person was carried by Subscriber Group as a Subscriber, we shall also be entitled to repayment from the Subscriber Group for the cost of benefits provided during the refund period in excess of the premium received by us for the ineligible person during that period.

Enrollment and Effective Date

- **Initial Eligibility.** Eligible Employees and/or their Dependents may Enroll by submitting a completed application form within 31 days of the first day of employment, transfer or the first day of eligibility for health benefits. Coverage shall become effective as specified on the Signature Sheet, provided that a completed application form and the required premium payment are received within 31 days of the person's first day of eligibility.

- **Open Enrollment.** Eligible Employees and/or Dependents who do not Enroll when initially eligible may Enroll by submitting a completed application form during the Open Enrollment Period.
- **Newborn Child.** A newborn child of the Subscriber, the Subscriber's Enrolled spouse or domestic partner, will be covered as a Dependent for 21 days from the moment of birth. To continue coverage after 21 days, a newborn child must meet the definition of "Dependent" in the "Definitions" section of this Group Medical and Hospital Service Agreement, and if an additional premium is required, you must submit a written request to us to add the Dependent within 60 days of the birth, and pay any required premiums. If you do not notify us within 60 days when an additional premium is required, the Child will be considered a Late Enrollee.
- **Newly Adopted Child.** Coverage for a newly-adopted Child, or a Child who has been placed for adoption with you and for whom the application procedures for adoption have been completed while your coverage is in effect, will be provided on the same basis as any other newly eligible Dependent. Placement for adoption means the assumption and retention by a Subscriber or Enrolled spouse or domestic partner of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. An adopted child shall not be considered a Dependent child for coverage purposes upon termination of such legal obligations. This coverage applies to children under the age of 18 years at the time of adoption.

  You must submit a written request to us to add the Dependent within 60 days following the date of adoption or placement for adoption if an additional premium is required, and pay any required premium. If you do not notify us within 60 days when an additional premium is required, the Child will be considered a Late Enrollee.
- **Other Newly Eligible Dependents**. A Subscriber may Enroll a newly eligible Dependent by submitting a completed application form within 60 days of attaining eligibility. Enrollment is effective on the day the Dependent becomes eligible.
- **Special Enrollment.**
  a. Loss of Other Coverage. An Eligible Employee and/or Dependents who previously declined coverage under this Agreement because of coverage under another Health Benefit Plan can Enroll in this Agreement by submitting a completed application form within 60 days of loss of such other coverage because of legal separation; divorce; termination of domestic partnership; death; termination of employment; reduction in hours of employment; permanent change in residence, work or living situation where the health plan under which the Employee and/or Dependents were covered does not provide service in that new person's service area; discontinuation of employer contributions; discontinuation of benefits to the class of similarly situated individuals as the Employee and/or Dependents; attainment of a policy lifetime maximum; loss of individual or group coverage purchased on the health benefit exchange due to an error on the part of the exchange, the issuer or the U.S. Department of Health and Human Services; or exhaustion of COBRA continuation under such other group coverage.

     An Eligible Employee and/or Dependents who previously declined coverage under this Agreement because of coverage under another employer plan can Enroll under this Agreement if the other employer's coverage is lost, unless the loss is based on the Employee and/or Dependents voluntarily terminating the coverage or if the coverage ended due to misrepresentation of a material fact affecting coverage or fraud related to the terminated coverage. A Participant and/or Dependents who previously declined coverage under this Agreement because of coverage under a Medicaid plan, under the Children's Health Insurance

Plan (CHIP) or under a public program providing health benefits, and has lost eligibility for that program can Enroll in this Agreement by submitting a completed application form within 60 days of loss of such coverage. Enrollment is effective the first day of the following month after the application for coverage is received.

b. Marriage or commencement of domestic partnership. An Eligible Employee and/or Dependent can Enroll in this Agreement by submitting a completed application form within 60 days of marriage or commencement of domestic partnership. Enrollment is effective the first day of the following month after marriage or commencement of domestic partnership.

c. Birth, placement of adoption or adoption. An Eligible Employee and/or new Dependent can Enroll in this Agreement by submitting a completed application form within 60 days of birth, placement of adoption or adoption. Enrollment is effective the date of the birth, placement of adoption or adoption.

The special enrollee will be offered the same benefit package offered to members of the group who enrolled when first eligible. The special enrollee will not be required to pay more for coverage than other members of the group who enrolled in the same coverage when first eligible.

A child who experiences one of the qualifying events mentioned above, if the selected plan is not the plan in which the parent is enrolled, or if the parent does not have coverage, will have access to any benefit package offered to employees, even if that requires the issuer to permit the parent to switch benefit packages.

- **Late Enrollee.**

a. Late enrollees are not guaranteed coverage upon their late enrollment. Any person who is denied coverage as a late enrollee may enroll for coverage during the Subscriber Group's next Open Enrollment Period for coverage to begin at the following Anniversary Date, or during a Special Enrollment Period.

b. Late enrollees do not include those who experience a qualifying event, and are eligible for enrollment during a Special Enrollment period.

c. Employee eligibility wait periods established by the Subscriber Group may apply.

If a Member is confined as an inpatient in a Hospital on the Effective Date of this Agreement, and prior coverage terminating immediately before the Effective Date of this Agreement does not furnish benefits for the hospitalization after the termination of prior coverage, then services and benefits will be covered under this Agreement for that Member on the coverage Effective Date of this Agreement. Such coverage is subject to all terms, conditions, exclusions and definitions in the Group Plan Benefits section and this Group Medical and Hospital Service Agreement.

Subscriber Group shall notify us no later than the next billing cycle of any changes which may affect Member eligibility.

Subscriber Group shall require each Member to disclose to us at the time of Enrollment, at the time of receipt of Covered Services and Supplies, and from time to time as requested by us, the existence of any other group coverage the Member may have, the identity of the carrier, and the group through whom the coverage is provided.

We shall have the right, at reasonable times, to examine the records of Subscriber Group and Subscriber Group's subcontractors, including payroll records, with respect to eligibility and monthly premiums under this Agreement. Subscriber Group shall have the right, at reasonable times, to examine our records

pertaining to Subscriber Group with respect only to Enrollment, eligibility and receipt of monthly premiums under this Agreement.

Termination

- This Agreement is renewable with respect to all Members at the option of the Subscriber Group except the group can be non-renewed or discontinued based on the following:
  a. For nonpayment of the required premiums by the Subscriber Group;
  b. If the Subscriber Group is convicted of insurance fraud under state or local laws;
  c. For noncompliance with the minimum participation or contribution requirements shown on the Signature Sheet or otherwise identified in this Agreement;
  d. For violation of our published policies that have been approved by the Insurance Commissioner;
  e. When the Agreement is materially breached;
  f. If upon written approval from the Insurance Commissioner, we cease to offer this particular Agreement form;
  g. If we cease to offer coverage in the group market under which the Agreement is issued;
  h. If we are withdrawing from a Service Area or from a segment of a Service Area because we have demonstrated to the Insurance Commissioner that our clinical, financial or administration capacity to serve existing Members would be exceeded;
  i. When the Insurance Commissioner orders us to discontinue coverage in accordance with procedures specified or approved by the Insurance Commissioner upon finding that the continuation of the coverage would not be in the best interest of the Members or would impair our ability to meet contractual obligations;
  j. When, in the case of a group Health Benefit Plan that delivers Covered Services through a specified network of health care Providers, there is no longer any Member who lives or works in the Service Area of the Provider network;
  k. When, in the case of a Health Benefit Plan that is offered only through one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any enrollee.

  If we discontinue this particular Agreement form or cease to offer coverage in the group market, we will provide advance notice no less than 60 days as required to the Insurance Commissioner. In the event of a cancellation, the coverage shall continue with respect to services provided prior to the Effective Date of cancellation. We will provide written notification 90 days in advance to the Subscriber Group.

- We may modify this Agreement at the time of renewal on at least 30 days written notice before the renewal to the Subscriber Group. Modifications that pertain to product or benefits are subject to review and approval by the Washington State Office of the Insurance Commissioner (OIC). The modification is not a discontinuation of this Agreement under this section above. Written notice of modifications will be given to Subscriber Group at least 30 days prior to the Effective Date of the renewal. The 30-day notice requirement does not apply to normal and customary administrative changes that do not have an actuarial impact, such as formulary changes, or to a decrease or increase required by state or federal law.
- Notwithstanding any provision of this section to the contrary, we may rescind an Agreement for fraud, or intentional misrepresentation of material fact by a Subscriber Group and the coverage of a Member may be rescinded for fraud, or intentional misrepresentation of material fact by the Member.
- In the event of termination of this Agreement on one of the grounds specified in this Agreement, termination will be effective as to the Subscriber Group and all Subscribers and Enrolled Dependents irrespective of whether monthly premiums have been received for periods beyond the termination date. However, in no event will this Agreement continue beyond the last day of the month for which monthly premiums have been received. Premium will be charged and collected for any period between the date through which premiums are paid and the termination date. If the Agreement is to terminate due to the required premium not paid when due, we will provide a written notice to the Policyholder, specifying the last date the premiums may be paid (no less than 10 days from the date of the notice) in order to reinstate the Agreement.
- Coverage under this Agreement for a Member will also terminate on 30 days' written notice if the Member commits insurance fraud or fraudulent acts against us, as defined by the state of Washington.
- After the Effective Date of a termination pursuant to this Agreement, neither we nor the Participating Providers shall have any further obligation to provide care for the condition under treatment and no claim shall be paid by us for treatment arising after such termination date.
- The membership of a Subscriber and all Dependents shall terminate in the event that the Subscriber leaves employment with the Subscriber Group or otherwise becomes ineligible, unless the Subscriber or any Dependent continues his or her membership in accordance with the "Federal Continuation of Coverage" and "Continuation of Coverage Under State Law" sections of this Group Medical and Hospital Service Agreement.
- A Non-Registered Domestic Partner losing group coverage under this Agreement because of termination of the Non-Registered Domestic Partnership is not entitled to Federal Continuation of Coverage under the "Federal Continuation of Coverage" section of the Group Medical and Hospital Service Agreement.
- Except as expressly provided in this section, all rights to benefits hereunder shall cease as of the Effective Date of termination.

- We shall notify Subscriber Group by mail on a form that complies with applicable law within 10 days after this Agreement is terminated and not replaced by the Subscriber Group. This provision shall apply when an employer terminates participation in a multiple employer trust as well as in the event of termination of this Agreement when held by a multiple employer trust. If notice is not given as required by this section, coverage shall continue from the date notice should have been provided until the date notice is received and premiums for that period shall be waived.
- The Subscriber Group may voluntarily terminate this Agreement for any reason upon 30 days written notice to us. When the group coverage is terminated by the Subscriber Group and replaced by other group coverage, no notice of termination will be given to the Member by us.

Federal Continuation of Coverage

- **Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")**
  a. If Subscriber Group is required to offer continuation coverage under the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and any regulations thereunder, as now in effect or as amended from time to time, then we shall provide such coverage to Members, but only to the extent Subscriber Group is required by federal law to offer such coverage. All provisions of this Agreement not expressly superseded by COBRA shall apply to such COBRA continuation coverage.

  b. Subscriber Group is solely responsible for (a) assuring compliance with COBRA; (b) giving Members timely notice, in accordance with COBRA, of their continuation coverage option; (c) notifying us within 14 days of a Member's election to continue coverage and the applicable maximum coverage period; and (d) notifying us of any event which terminates Subscriber Group's obligation to provide the Member with COBRA continuation coverage before the end of the maximum coverage period.

  c. A Member must apply for COBRA continuation coverage within 60 days of the termination date of coverage, or the date the Member receives specific notice of his or her COBRA continuation coverage rights, whichever is later.

  d. If Subscriber Group fails to give the Member notice of any COBRA continuation rights or to give us notice of any COBRA election, each within the time stated in this section above, we shall be entitled to charge Subscriber Group, and Subscriber Group shall pay the greater of (a) charges for Medical Services incurred by the Member prior to notice to us of the Member's exercise of COBRA rights or (b) the applicable premium amount for coverage retroactive to the date of the Member's qualifying event under COBRA. In any event, we will provide COBRA continuation coverage only for the minimum period required to enable Subscriber Group to meet our obligations under COBRA and, for purposes of this section, such period will always begin on the date of the Member's qualifying event. If we, in the exercise of reasonable judgment, determine that Subscriber Group willfully failed to give timely notice to a Member of any required COBRA continuation rights, we may refuse to provide COBRA continuation coverage to the Member.

  e. The cost of COBRA continuation coverage will be 102 percent of the applicable group rate (including any portion previously paid by Subscriber Group), except where COBRA continuation coverage has been extended due to disability in which case the cost will be 150 percent of the applicable group rate for the period of extension.

f. The provisions of this section will terminate if this Agreement terminates. Subscriber Group's violation of its obligations under this section shall constitute grounds for termination of this Agreement.

- **The Family and Medical Leave Act of 1993 (FMLA)**

If your Employer is subject to the requirements of The Family and Medical Leave Act of 1993 (FMLA), you may be eligible to continue coverage during a family leave. Consult your Employer for details.

Per federal regulations, a State Registered Domestic Partner and the State Registered Domestic Partner's covered children losing group coverage under this Agreement are not eligible for Federal Continuation of Coverage.

Continuation Coverage Under State Law

Members may have the right to continuation of coverage after group coverage is lost. This provision applies when the group is not required by federal law to offer COBRA or when Members are not eligible for COBRA. Check with your employer to find out if a continuation plan is being offered.

After coverage under this provision ends, the Member may be eligible to enroll in an individual plan with another insurance carrier, or through the Washington Health Benefit Exchange.

Continuation of Coverage During a Labor Dispute

- If your compensation is suspended or terminated directly or indirectly due to strike, lockout, or other labor dispute, you may continue your coverage by paying premiums directly to the Employer, for a period not exceeding six months. During that period of time, the Agreement may not be altered or changed. Thereafter, you will have the opportunity to purchase an individual policy.

  The amount of your monthly payment for continued coverage will be equal to the full group monthly cost for the coverage, including any portion usually paid by the Employer. Such premium rate will be the applicable rate then in effect for coverage under the group plan on the date work ceases.

  If you have Dependents covered on the date you cease to work, in order to continue your coverage you must also continue coverage for your Dependents by including the monthly cost for Dependents coverage with your monthly payment for continued coverage.

  Your continued coverage under the special provision will cease on the earliest of:

  a. the premium due date on or next after the end of the 6-month period from the date you ceased to work because of the strike, lockout, or labor dispute; or

  b. the premium due date on or next after the date the strike, lockout, or other labor dispute ends.

Reinstatement Of Medical Coverage After Military Leave

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), when your coverage under this Agreement ends because you enter into active service in the United States Armed Forces, you may again be covered if:

- You return to active full-time employment with your Subscriber Group; and

- You make a written request for reinstatement to us within:
  a. 90 days of your discharge from active services; or
  b. one year following hospitalization which continues after your discharge from active service.

The coverage provided will be the same coverage provided by your Subscriber Group to other Employees and Dependents at the time of application. Your coverage will start on the date we receive your request for reinstatement.

Each of your Dependents who were covered under this Agreement immediately prior to your entry into active military service will also be reinstated for coverage on the date your coverage begins again, if otherwise eligible. Eligible Dependents born during the period of active military duty will have the same rights as other Dependents under this Agreement.

No payment will be made for any care or treatment given for an injury, illness, or physical or mental or nervous condition arising during and occurring as a direct result of your active service in the United States Armed Forces, as determined by the Secretary of Veterans' Affairs.

Participating Providers

If a Member receives care from a Participating Provider, the Participating Provider is responsible for obtaining Prior Authorization on the Member's behalf, and the Member will not be responsible for the cost of the services if Prior Authorization is not obtained. However, if a Member receives care from a Nonparticipating Physician or other Nonparticipating health care Provider without a required Prior Authorization, the Member is responsible for obtaining Prior Authorization and shall be responsible for the cost of those services. Failure of a Nonparticipating Provider to obtain the Prior Authorization shall in no way relieve the Member of the financial responsibility for services received from that Nonparticipating Provider.

Participating Providers are a part of the Health Net PPO DV Network, which consist of the following sub-networks:

- The medical benefits are provided by Health Net using the Health Net PPO Network and contracted providers in the First Choice Networks.
- Chiropractic, Acupuncture, Naturopathic and Massage Therapy benefits are provided by Health Net using contracted Providers in the First Choice Networks.
- Mental Health and Chemical Dependency benefits are provided by Health Net. Health Net contracts with MHN and First Choice Networks to administer the mental health and chemical dependency benefits.
- Vision service benefits are provided by Health Net. Health Net contracts with Envolve Vision, Inc., a vision services provider panel, to administer the vision services benefits.
- Pediatric dental benefits are provided by Health Net. Health Net contracts with DBP Networks to administer the pediatric dental benefits. Refer to Dental Plan Contract for details about your dental coverage.

A list of Participating Providers is available at www.healthnet.com or by calling our Customer Contact Center at the phone number listed at the back of this Agreement.

Members who believe they do not have sufficient access to Participating Providers for Covered Services within the Service Area may contact the Customer Contact Center at the phone number listed at the back of the Agreement, prior to receiving care, to request a benefit exception. The Member's request will be evaluated by the Customer Contact Center representative to determine if the existing Participating Providers meets the access standards, as they apply to the Member's specific circumstance. If the requested Covered Service is determined to be available in-network, as per the applicable access standard, the Member will be informed accordingly and the relevant Participating Providers will be communicated to the Member at that time. If it is determined that the Member does not have sufficient access to Participating Providers within the Service Area, as determined by the access standard, a benefit exception will be processed internally such that the Member's cost will not exceed what the Member's cost would have been if the service were provided by a Participating Provider. Under such exceptions, applicable requirements for Medical Necessity, Prior Authorization and all other plan provisions remain in force.

Upon Enrollment, each Member will be issued a plan identification card. It is the Member's responsibility to present the card to each health care Provider at the time of service.

To ensure the maximum available benefits under this Agreement, Members should obtain all Medical Services from Participating Providers and in accordance with any Prior Authorization requirements, even when a Member expects payment to be made by another plan or a third party. Care furnished by a Nonparticipating Provider is generally reimbursed at a lower level.

In the event a Participating Provider terminates their contract without cause, if the Participating Provider is a primary care provider for Subscribers and/or Enrolled Dependent(s) covered under this Plan Agreement, the Participating Provider shall continue to render Covered Services to primary care Subscriber's and/or Enrolled Dependent(s) until the earliest of the following:

- the date services being rendered to Subscribers and/or Enrolled Dependent(s) by Provider are completed or medically appropriate provisions have been made for another Provider to assume responsibility for providing such Covered Services.
- 60 days following notice to affected Subscribers and/or Enrolled Dependent(s) of termination of the contract; or
- the end of the Subscribers and/or Enrolled Dependent(s) Group Health Plan Open Enrollment Period.

If a Member resides outside the Service Area and is unable to receive services from Participating Providers, the Member's Coinsurance for Covered Services will be at the Nonparticipating Provider Level specified in the Coinsurance Schedule.

Delegation of Authority

- Subscriber Group hereby delegates and vests with us the authority to determine whether a treatment, procedure, or other type of health care is Medically Necessary or otherwise covered under the terms of this Agreement.

  A Member has the right to file an Appeal under the "Grievance and Appeals" and "Independent Review Process" sections of this Group Medical and Hospital Service Agreement if dissatisfied with a determination. For these purposes, our final decision shall be the decision reached after our internal Appeals procedure has been exhausted.

- A Washington doctor of medicine or osteopathy shall be responsible for all final recommendations regarding the necessity or appropriateness of services or the facility where they will be provided and shall consult as appropriate with medical and mental health specialists in making such recommendations.

General Limitations

- Benefits provided by this Agreement may be revoked or modified. No Member acquires a vested right to continue to receive a benefit as set forth in this Agreement on or after the Effective Date of any revocation or change to such benefit. A Member's right is to receive only such benefits as are expressly provided for and in effect on the date of each treatment. Upon termination of a Member's coverage under this Agreement, a Member's right to continued benefits consists solely of those benefits expressly set forth in the "Federal Continuation of Coverage" and "Continuation of Coverage Under State Law" sections of this Group Medical and Hospital Service Agreement.
- Members are entitled to receive benefits subject to the exclusions and limitations as stated in any provision of this Agreement.
- Benefits are available only as Medically Necessary.
- Coverage for the services of a Nonparticipating Provider is limited to and based on a Maximum Allowable Amount fee.
- Members who are treated by a Provider without a Prior Authorization, if required pursuant to the "Prior Authorization" subsection of the Group Plan Benefits section, will have any and all such claims denied by us.
- All benefits, exclusions and limitations set forth in the attached Benefit Schedules are incorporated herein by this reference.
- To the extent that a natural disaster, war, riot, civil insurrection, epidemic, or any other emergency or similar event not within our control results in our facilities, personnel, or financial resources being unavailable to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of this Agreement, we are required only to make a good faith effort to provide or arrange for the provision of the service, taking into account the impact of the event. For purposes of this section, an event is not within our control if we cannot exercise influence or dominion over its occurrence.
- Written notice of claim for Nonparticipating Provider benefits must be given to us within 90 days after the date of treatment or as soon as medically possible, but in no event later than one year from the date of treatment unless the Member is legally incapacitated throughout that year. If a Member is hospitalized at a Hospital that is a Nonparticipating Provider, the Member shall or shall cause the Hospital or the Subscriber to notify us by telephone of the hospitalization on the first business day after the admission or in the case of Emergency, as soon as medically possible. In the event that a Member is unable to personally contact us or is unable to instruct some other person to do so, the notification period will not begin until such time as the Member is again able to notify us. If a Member is conscious and able to communicate with others, he or she shall be deemed capable of notifying us. Written notice of claims should be addressed to:

Health Net Health Plan of Oregon, Inc.
Attn: Commercial Claims
P.O. Box 9040
Farmington, MO 63640-9040

- Any Appeal or Grievance brought to recover on this Agreement shall be limited to the Grievances and Appeals under the "Grievances and Appeals," "Independent Review Process" and "Review of Investigational or Experimental Therapies" sections of this Group Medical and Hospital Service Agreement. No Appeal or Grievance, including but not limited to inquiries regarding denial of claims for payments or for services, may be submitted more than 180 days following the receipt of the denial notification.
- Any benefit limitation or other dollar amount that is calculated on an annual basis hereunder shall be calculated on the basis of a Calendar Year.

Rights of Members

- **Confidentiality of Medical Records:** We shall have access to information from medical records of Members and information received by Physicians in the course of the Physician/patient relationship and the right to use such information as is reasonably necessary in connection with our administration of this Agreement, for records review incident to any peer review, quality assurance program or utilization review program.
- **Right to Limit Disclosure of Health Information**
  a. We will limit disclosure of any information, including health information, about an individual who is the subject of the information if the individual clearly states in writing that disclosure to specified individuals of all or part of that information could jeopardize the safety of the individual. Disclosure of information under this provision will be limited consistent with the individual's request, such as a request for us to not release any information to an Enrolled spouse or domestic partner to prevent domestic violence.
  b. We will not disclose nonpublic personal health information concerning health services related to reproductive health, sexually transmitted diseases, Chemical Dependency and mental health, including mailing appointment notices, calling the home to confirm appointments, or mailing a bill or explanation of benefits to a Subscriber or certificate holder, if the individual who is the subject of the information makes a written request. In addition, we will not require an adult individual to obtain the Subscriber's or other covered person's authorization to receive health care services or to submit a claim.
  c. We will recognize the right of any minor who may obtain health care without the consent of a parent or legal guardian pursuant to state or federal law, to exclusively exercise rights granted under this section regarding health information; and

d. We will not disclose any nonpublic personal health information related to any health care service to which the minor has lawfully consented, including mailing appointment notices, calling the home to confirm appointments, or mailing a bill or explanation of benefits to a policyholder or other covered person, without the express authorization of the minor. In addition, we will not require the minor to obtain the Subscriber's or other covered person's authorization to receive health care services or to submit a claim as to health care which the minor may obtain without parental consent under state or federal law.

e. When requesting nondisclosure, the individual shall include in the request:

1. His or her name and address;
2. Description of the type of information that should not be disclosed;
3. In the case of reproductive health information, the type of services subject to nondisclosure;
4. The identity or description of the types of persons from whom information should be withheld;
5. Information as to how payment will be made for any benefit cost sharing;
6. A phone number or e-mail address where the individual may be reached if additional information or clarification is necessary to satisfy the request.

- **Non-Discrimination**: Member may not be canceled or non-renewed on the basis of the status of his or her health or health care needs, provided however, that this paragraph shall not negate, waive, alter or otherwise change any other provisions of this Agreement.

- **Disclosure of Written Information:**

  Upon the request, we will provide any of the following information in written form:

  - Any documents, instruments, or other information referred to in the medical coverage Agreement;
  - Procedures for obtaining Prior Authorization for health care services;
  - A description of any reimbursement or payment arrangements, including, but not limited to, capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions, between us and a Provider or network;
  - Descriptions and justifications for Provider compensation programs, including any incentives or penalties that are intended to encourage Providers to withhold services or minimize or avoid referrals to specialists;
  - An annual accounting of all payments made by the carrier which have been counted against any payment limitations, visit limitations, or other overall limitations on a person's coverage under a plan;
  - A copy of our Grievance process for claim or service denial and for dissatisfaction with care; and
  - Accreditation status with one or more national accreditation organizations, whether we track health care effectiveness performance using the health employer data information set (HEDIS), whether it publicly reports its HEDIS data, and how interested persons can access its HEDIS data.

- Access to and copies of all documents, records and other information relevant to a claim.
- Any Medical Necessity criteria for any or all Essential Health Benefits categories, no later than 30 days following the receipt of the request.

Information on the processes, strategies, evidentiary standards and other factors used to make Medical Necessity determinations of mental health or substance use disorder benefits.

- **Benefits and Prescription Drugs.** You have the right to request a copy of your covered benefits, including the current formulary drug list (EDL), inclusive of the definitions of terms, as well as the policies regarding prescription drug benefits and how they become approved for or taken off the EDL If your prescribed medication is not on the EDL, and a Prior Authorization request has been denied, you have the right to file an Appeal with us regarding your medication coverage. For more information about the Appeals process, see the "Grievance and Appeals" section below.

Grievances and Appeals

A Member is always encouraged to promptly contact the Customer Contact Center whenever there is a question, inquiry or a complaint about the availability, delivery, quality of health care services, a claim or Adverse Benefit Determination, or any other specific problem arising under this Agreement. If the problem is not resolved at that level, a Member has the Grievance and Appeals rights described below. We will assist a Member in filing a Grievance or an Appeal when he or she has a complaint and asks for help to put it in writing.

Grievances. To process a Grievance, we will review the Grievance and make our determination, and then mail notification of our decision to the Member. Grievance determinations are not Adverse Benefit Determinations and are not subject to the Appeals rights described below or the rights to the independent review process as described under the "Independent Review Process" section.

A Member, his/her Physician or his/her authorized representative may file a Grievance regarding expressed dissatisfaction with the quality of service performed by a Provider, vendor, or Health Net staff. Additionally, a Member, his/her Physician or his/her authorized representative may file a Grievance regarding their dissatisfaction with the quality of care provided by a Provider, Provider's staff or vendor. Health Net will gather the necessary information, which may include medical records, claims, etc., in order to conduct a thorough review of the Member's concerns. Health Net will provide a written response to the Grievance within 45 days from the date of receipt of the Grievance.

To submit a Grievance:

Grievances can be initiated through either written or verbal request. A Member, his/her Physician or authorized representative may submit a written request by sending it to us at: Health Net Health Plan of Oregon, Inc. Grievances and Appeals Department, P.O. Box 10342, Van Nuys, CA 91410-0342. Verbal requests can be made by a Member, his/her Physician or his/her authorized representative by calling us at 1 (888)-802-7001.

Appeals. We will provide written notice to a Member, or his or her designated representative of an Adverse Benefit Determination. The written notice will explain our decision and the supporting coverage or clinical reasons; and our Appeal process, including information, as appropriate, about how to exercise the Member's rights to obtain a second opinion, and how to continue receiving services. We do not require that a Member file a complaint prior to seeking Appeal of an Adverse Benefit Determination.

To submit an Appeal:

Appeals can be initiated through either written or verbal request. You, your physician, or your authorized representative may submit a written request by sending it to us at: Health Net Health Plan of Oregon, Inc. Grievances and Appeals Department, P.O. Box 10342, Van Nuys, CA 91410-0342. You, your physician, or your authorized representative may submit a verbal request by calling us at 1-888-802-7001.

Appeals, including Expedited Appeals, must be pursued within 180 days of your receipt of our original Adverse Benefit Determination decision that you are appealing. If you don't Appeal within this time period, you will not be able to continue to pursue the Appeal process and may jeopardize your ability to pursue the matter in any forum. When we receive a request for Appeal, we will send a written acknowledgement within 72 hours of receiving the request.

Upon request and free of charge, you, or your representative, have the right to review copies of all documents, records, and information relevant to any claim that is the subject of the determination being appealed.

If you or your treating Provider determines that your health could be jeopardized by waiting for a decision under the regular Appeal process, you or your Provider may specifically request an Expedited Appeal. Please see Expedited Appeals later in this section for more information.

If we reverse our initial Adverse Benefit Determination, which we may do at any time during the review process, we will provide you with written or electronic notification of the decision immediately, but in no event more than two business days of making the decision.

If you request a review of an Adverse Benefit Determination, we will continue to provide coverage for disputed inpatient care benefits or any benefit for which a continuous course of treatment is Medically Necessary, pending outcome of the review. If we prevail in the Appeal, you may be responsible for the cost of coverage received during the review period. The decision at the external review level is binding unless other remedies are available under state or federal law.

Internal Appeals are reviewed by an employee or employees who were not involved in the initial decision that you are appealing. You or your representative, on your behalf, will be given a reasonable opportunity to provide written materials, including written testimony. In Appeals that involve issues requiring medical judgment, the decision is made by our staff of health care professionals. If the Appeal involves an experimental or investigational treatment, a written notice of the decision will be sent within 20 working days after receiving the Appeal. We may extend the review period beyond 20 days only with your written consent. For all other Appeals, the written notice will be sent within 14 days of receipt. You will be notified if we require additional time. For good cause, we may extend the time it takes to make a review determination by up to 16 additional days without your written consent, but we will notify you of the extension and the reason for the extension.

To process an Appeal, we will:

- Provide written notice to the Member when the Appeal is received;
- Assist the Member with the Appeal process;

- Make our decision regarding the Appeal within 14 days of the date the Appeal is received, unless we notify the Member that an extension is necessary to complete the Appeal. The extension will not go beyond 30 days of the date the Appeal is received without the informed written consent of the Member. The decision regarding an Expedited Appeal will be made within seventy-two hours of the date the Appeal is received;
- Cooperate with a representative authorized in writing by the Member;
- Consider information submitted by the Member;
- Investigate and resolve the Appeal; and
- Provide written notice of our resolution of the Appeal to the Member and, with the permission of the Member, to the Member's Provider. The written notice will explain our decision and the supporting coverage or clinical reasons and the Member's right to request Independent Review of our decision.

Expedited Appeals:

An Expedited Appeal is available if one of the following applies:

- You are currently receiving or are prescribed treatment for a medical condition; or
- Your treating Provider believes the application of regular Appeal timeframes on a concurrent care claim could seriously jeopardize your life, overall health or ability to regain maximum function, or would subject you to severe and intolerable pain; or
- the Appeal is regarding an issue related to admission, availability of care, continued stay or health care services received on an emergency basis where you have not been discharged.

You may request concurrent expedited internal and external review of Adverse Benefit Determinations. When a concurrent expedited review is requested, we will not extend the timelines by making the determinations consecutively. The requisite timelines will be applied concurrently.

Internal Expedited Appeal:

The internal Expedited Appeal request should state the need for a decision on an expedited basis and must include documentation necessary for the Appeal decision. Verbal notice of the decision will be provided to you and your representative as soon as possible after the decision, but no later than 72 hours of receipt of the Appeal. This will be followed by written notification within 72 hours of the date of decision.

In addition, a Member has the right to file a complaint with or seek other assistance from the Office of the Washington State Insurance Commissioner. If a Member chooses to do so, assistance is available. Contact the Office of the Washington State Insurance Commissioner, Consumer Protection Division, at PO Box 40255, Olympia, WA 98504-0255. Contact them by phone at 1-800-562-6900, or online at http://www.insurance.wa.gov/your-insurance/health-insurance/appeal/.

Independent Review Process

A Member may seek review by a certified Independent Review Organization (IRO) of our Adverse Benefit Determination, after exhausting our Appeals process and receiving a decision that is unfavorable to the Member, or after we have exceeded the timelines for Appeals provided above, without good cause and without reaching a decision. Members have up to 180 days to submit a request for external review.

This right also applies to an Adverse Benefit Determination that is based on our requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

We will forward your request to a State Assigned Independent Reviewer who will communicate to you the outcome of your review. You will be notified of the name of the assigned IRO and contact information. The IRO will accept additional information in writing from you for up to five business days after it receives the assignment.

We will provide to the appropriate certified independent review organization, not later than the third business day after the date we receive a request for review, a copy of:

- Any medical records of the Member that are relevant to the review;
- Any documents used by us in making the determination to be reviewed by the certified independent review organization;
- Any documentation and written information submitted to us in support of the Appeal; and
- A list of each Physician or health care Provider who has provided care to the Member and who may have medical records relevant to the Appeal. Health information or other confidential or proprietary information in our custody may be provided to an independent review organization, subject to rules adopted by the Insurance Commissioner of the state of Washington.

The medical reviewers from a certified independent review organization will make determinations regarding the Medical Necessity or appropriateness of, and the application of health plan coverage provisions to, health care services for a Member. The medical reviewers' determinations must be based upon their expert medical judgment, after consideration of relevant medical, scientific, and cost-effectiveness evidence, and medical standards of practice in the state of Washington. The certified independent review organization must ensure that determinations are consistent with the scope of covered benefits as outlined in the Agreement. Medical reviewers may override our Medical Necessity or appropriateness standards if the standards are determined upon review to be unreasonable or inconsistent with sound, evidence-based medical practice.

Once a request for an independent review determination has been made, the independent review organization must proceed to a final determination, unless requested otherwise by both us and the Member, or his or her representative.

Either we or the Member may request an expedited external review if the Adverse Benefit Determination or internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service for which:

- The Member received emergency services but has not been discharged from a facility; or
- involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the enrollee or jeopardize the enrollee's ability to regain maximum function.

The independent review organization must make its decision to uphold or reverse the Adverse Benefit Determination or final internal Adverse Benefit Determination and notify the enrollee and the carrier or health plan of the determination as expeditiously as possible but within not more than seventy-two hours after the receipt of the request for expedited external review. If the notice is not in writing, the

independent review organization must provide written confirmation of the decision within forty-eight hours after the date of the notice of the decision.

We will timely implement the certified independent review organization's determination, and will pay the certified independent review organization's charges.

When a Member requests independent review of a dispute, and the dispute involves our decision to modify, reduce, or terminate an otherwise covered health service that a Member is receiving at the time the request for review is submitted and our decision is based upon a finding that the health service, or level of health service, is no longer Medically Necessary or appropriate, we will continue to provide the health service if requested by the Member until a determination is made. If the determination affirms our decision, the Member will be responsible for the cost of continued health service.

Review of Investigational or Experimental Therapies

We do not cover Experimental or Investigational drugs, devices, procedures or therapies, except as outlined in the "Clinical Trials" subsection of the Group Plan Benefits section.

In determining whether services are Experimental or Investigational, We will consider whether the services are in general use in the medical community of the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular Illness or disease, and whether they are proven to be safe and efficacious.

When we deny a request for benefits or do not allow Prior Authorization of a service, whether made in writing or through other claim presentation or set out in the Agreement, because of an Experimental or Investigational exclusion or limitation, we will do so in writing within twenty working days of receipt of a fully documented request. We may extend the review period beyond twenty days only with the informed written consent of the Member. The denial letter will identify by name and job title the individual making the decision and fully disclose:

- The basis for the denial of benefits or refusal of Prior Authorization of services;
- The procedure through which the decision to deny benefits or to refuse the Prior Authorization services may be appealed;
- What information the Member is required to submit with the Appeal; and
- The specific time period within which we will reconsider its decision.

A final determination will be made and provided to the Member in writing within 20 working days of receipt of the fully documented Appeal, unless we notify the applicant that an extension is necessary. We may extend the review period beyond 20 days only with the informed written consent of the Member. An Appeal will be expedited if the Member's Provider or our Medical Director determines that following the Appeal response, timelines could seriously jeopardize the applicant's life, health, or ability to regain maximum function. The decision regarding an Expedited Appeal will be made within 72 hours.

The Appeal will be reviewed by a person or persons qualified by reasons of training, experience and medical expertise to evaluate it; and

The Appeal will be reviewed by a person or persons other than the person or persons making the initial decision to deny benefits or to refuse Prior Authorization of services.

When the initial decision to deny benefits or to refuse Prior Authorization of services is upheld upon Appeal, the written notice will set forth;

- The basis for the denial of benefits or refusal to Prior Authorization of services; and
- The name and professional qualifications of the person or persons reviewing the Appeal.

Health Net does not require that an Enrollee file a complaint or Grievance prior to seeking Appeal of a decision or review of an Adverse Benefit Determination.

Any legal action arising out of this Agreement must be filed in the state of Washington.

Coordination of Benefits

- This Coordination of Benefits provision applies when a covered Subscriber or a covered Dependent has health care coverage under more than one plan. If you are covered by more than one Health Benefit Plan, and you do not know which is your primary plan, you or your Provider should contact any of the heath plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within 30 calendar days.

  Caution: All health plans have timely claim filing requirements. If you or your Provider fail to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your Provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

  To avoid delays in claim processing, if you are covered by more than one plan you should promptly report to your Providers and plans any changes in your coverage.

- The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

- **"Plan"** means any of the following which provide benefits or services for, or because of, medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no coordination of benefits among those separate contracts. However, if coordination of benefits rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which coordination of benefits does not apply is treated as a separate plan.

  a. Plan includes: group, individual or blanket disability insurance contracts and group or individual contract issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plans, as permitted by law.

b. Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare Supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

- Each contract or other arrangement for coverage described above is a separate plan. Also, if an arrangement has two or more parts and the Coordination of Benefits provision applies to only one of the two, each of the parts is a separate plan.
- **"This plan"** means, in a Coordination of Benefits provision, the part of this Agreement that provides benefits for health care expenses to which the Coordination of Benefits provision applies and which may be reduced because of the benefits of other plans. Any other part of this Agreement providing health care benefits is separate from this plan. This Agreement may apply one Coordination of Benefits provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another Coordination of Benefits provision to coordinate other benefits.
- The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health coverage under more than one plan.

  When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim. This means that when this plan is secondary, it must pay the amount which, when combined with what the primary plan paid, totals 100% of the highest allowable expense. In addition, if this plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the primary plan) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that Calendar Year, whether or not they are an allowable expense under this plan. If this plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.
- **"Allowable expense"** means a health care expense, including Coinsurance or Copayments and without reduction for Deductibles, but excluding pharmacy or vision care expenses, that is covered at least in part by one or more plans covering the person for whom the claim is made. When coordinating benefits, any secondary plans must pay an amount which, together with the payment made by the primary plan, cannot be less than the same allowable expense as the secondary plan would have paid if it was the primary plan. In no event will a secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings.

  When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense and a benefit paid. An expense that is not covered by any of the plans covering the person is not an allowable expense.

  The following are examples of expenses that are not allowable expenses:

  a. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an allowable expense, unless one of the plans provides coverage for private Hospital room expenses.

b. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

c. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

- **"Closed panel plan"** is a plan that provides health care benefits to covered persons in the form of services through a panel of Providers who are primarily employed by the plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.
- **"Custodial parent"** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.
- **Order of Benefit Determination Rules.** If this Coordination of Benefits provision applies, the order of benefit determination rules should be looked at first. These rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan. The benefits of this plan may be reduced when under the order of benefit determination rules; another plan determines its benefits first.

  Except as provided in the paragraph below, a plan that does not contain a coordination of benefits provision that is consistent with this section is always primary unless the provision of both plans state that the complying plan is primary.

  Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of the basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel to provide out-of-network benefits.

  a. When there is a basis for a claim under this plan and another plan, this plan is generally considered the secondary plan which has its benefits determined after those of the other plan unless: (1) the other plan has rules coordinating its benefits with those of this plan; and (2) both those rules and this plan's rules as set forth in item b below require that this plan's benefits be determined before those of the other plan.

  b. This plan determines its order of benefits using the first of the following rules which applies:

     1. **Non-Dependent/Dependent**. The benefits of the plan that covers the person other than as a Dependent, for example as an employee, Member, Subscriber or retiree. The benefits of the plan which covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent, and primary to the plan covering the person as other than a Dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, Member, Subscriber or retiree is the secondary plan and the other plan is the primary plan.

2. **Dependent Child covered under more than one plan**. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one plan the order of benefits is determined as follows:

   A. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

      i. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in that year; but

      ii. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period.

   B. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

      i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

      ii. If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for the health care expenses, the plan of the parent assuming financial responsibility is primary;

      iii. If a court decree states both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of item b.2.a above of this section shall determine the order of benefits;

      iv. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of item b.2.a above of this section shall determine the order of benefits; or

      v. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

         1. first the plan of the parent with custody of the child;

         2. then, the plan of the spouse of the parent with the custody of the child;

         3. then, the plan of the parent not having custody of the child;

         4. finally, the plan of the spouse of the parent not having custody of the child.

   C. For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of items b.2.A and b.2.B above of this section shall determine the order of benefits as if those individuals were the parents of the child.

3. **Active/Inactive Employee.** The benefits of a plan which covers a person as an active employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a plan which covers that person as an inactive employee who is laid off or retired (or as that employee's Dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Non-Dependent/Dependent" section of this section can determine the order of benefits.
4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or federal law is covered under another plan, the plan covering the person as an employee, Member, Subscriber, or retiree or covering the person as a Dependent of an employee, Member, Subscriber, or retiree is the primary plan and the COBRA or state of other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Non-Dependent/Dependent" section of this section can determine order of benefits.
5. **Longer/Shorter Length of Coverage.** If none of the previous rules determines the order of benefits, the benefits of the plan which covered the employee, Member, Subscriber or retiree longer are determined before those of the plan which covered that person for the shorter time.
6. If the preceding rules do not determine the order of benefits within thirty calendar days after receipt of the information to pay the claim, the allowable expenses shall be shared equally between the plans meeting the definition of plan in this section. In addition, this plan will not pay more than it would have paid had it been the primary plan.

- **Effect on the Benefits of This Plan.** When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan must make the payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total allowable expense for that claim. Total allowable expense is the highest allowable expense of the primary plan or the secondary plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.
- **Right to Receive and Release Necessary Information.** Certain facts are needed to apply these coordination of benefits provisions. We have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell or get the consent of any person to do this. Each person claiming benefits under this plan must give us any facts we need to pay the claim.
- **Facility of Payment.** If payments that should have been made under this plan are made by another plan, we have the right, at our discretion, to remit to the other plan the amount we determine appropriate to satisfy the intent of this provision. The amounts paid to the other plan are considered benefits paid under this plan. To the extent of such payments, we are fully discharged from liability under this plan.
- **Right of Recovery.** We have the right to recover excess payment whenever we have paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Coordination of Benefits provision. We may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

Contact your State Insurance Department for questions about Coordination of Benefits.

Medicare

In certain situations, this Agreement is secondary to Medicare. This means that when a Member is enrolled in Medicare and this Agreement at the same time, Medicare pays benefits for Covered Services first and we pay second, in accordance with federal law.

Right of Recovery

If we pay or arrange for a Member to receive Covered Services and Supplies for injuries or illnesses for which another person or entity is legally responsible or agrees to a settlement for the injury or illness (the "Responsible Party"), then we or our agent is entitled to recover in full from the Responsible Party for the amount paid by us. The Member agrees:

- To cooperate with us or our agent and do whatever is reasonably necessary to assist to secure its rights;
- That we or our agent has a lien on any recovery, settlement or judgment which may be had from or against a Responsible Party to the extent that it has made payment for Covered Services and Supplies but only after the Member has been fully compensated;
- To pay from any recovery, settlement or judgment (and the Member hereby authorizes his or her attorney to pay from any recovery, settlement or judgment), any and all amounts to which we or our agent is entitled under this section, unless otherwise agreed to by us or our agent in writing;
- To promptly give any and all written directions, authorizations and assignments as are requested by us or our agent to assist in accomplishing or confirming the above;
- That the benefits under this Agreement will be reduced if a Responsible Party has reimbursed a Member or paid for services which we would have covered as part of that benefit; and
- To do nothing to prejudice our rights.
- We have the right to recover a mistaken payment from the person paid or anyone else who benefited from it, including a Provider of services, if:
    a. We make a payment to which a Member is not entitled under this Agreement; or
    b. We pay a person who is not eligible for benefits at all.

In exercising our Right of Recovery, we will not attempt to recover from the Member unless the Member has been made whole by the responsible party.

Independent Agents

- The relationship between Subscriber Group and a Subscriber is that of plan sponsor and participant and is defined by the Group's health and welfare plan. We have no involvement in that relationship. The relationship between Subscriber Group and us is that of purchaser and seller and is entirely governed by the provisions of this Agreement. In addition, Subscriber Group acts as the agent of those Eligible Employees who are Subscribers with respect to all terms and provisions of this Agreement. Because the Subscriber pays the premium to us indirectly through his or her agent, the Subscriber Group, the relationship between a Subscriber and us is also that of purchaser and seller and is entirely governed by the provisions of this Agreement.
- The relationship between us and Participating Providers is that of independent contractors. Participating Providers are independent professionals who operate their own offices and business, make their own medical decisions, and provide services to entities and patients other than us and our Members. Participating Providers agree to methods and rates of payment from us, concurrent and retrospective review by us of Medical Services provided to Members, and our medical management procedures.
- The fact that Members and Participating Providers each have contractual relationships with us does not prevent a Member from obtaining services, from a Participating Provider, that are not covered by us. We have no direct control over the examination, diagnosis or treatment of a Member. We do perform medical management, including but not limited to case review for purposes of determining coverage, consultation with Providers regarding Prior Authorization, and concurrent and retrospective review of Medical Services provided to Members. The purpose of our medical management procedures is to encourage the lowest cost method of treating a Member which, based upon the prevailing standards of medical treatment, meets the needs of the Member. These procedures are not intended to ration care or limit care to methods not appropriate to treat a Member's condition. These procedures are not intended to create a Physician/patient relationship or to replace the relationship between a Member and his or her Physician. A Member is always entitled to obtain, at his or her own expense, services not covered under the terms of this Agreement.
- The Subscriber Group agrees to indemnify and hold us and our directors, officers and employees harmless against any loss and all claims, lawsuits, settlements, judgments, costs, penalties, and expenses including attorneys' fees resulting from or arising out of the willful misconduct or dishonest, fraudulent, reckless, unlawful, or negligent acts or omissions of the Subscriber Group, any of its directors, officers, or employees or any Members Enrolled under this Agreement, except to the extent that such losses, claims, lawsuits, settlements, judgments, costs, penalties, or expenses result from the misconduct or dishonest, negligent, unlawful, reckless, or fraudulent act on the part of us or any of our directors, officers, employees, or parent, subsidiary, or otherwise affiliated entities.
- We shall use ordinary care in the exercise of our power and in the performance of our obligations under this Agreement.

- We agree to indemnify and hold harmless the Subscriber Group, its officers, and employees against any loss and all claims, lawsuits, settlements, judgments, costs, penalties, and expenses including attorneys' fees resulting from or arising out of the willful misconduct or dishonest, fraudulent, reckless, unlawful, or negligent acts or omissions of us or any of our directors, officers, or employees, or parent, subsidiary, or other affiliated entities except to the extent that such losses, claims, lawsuits, settlements, judgments, costs, penalties and expenses result from the misconduct or dishonest, fraudulent, reckless, negligent or unlawful acts or omissions of the Subscriber Group, its directors, officers or employees or any Members Enrolled under this Agreement.

Miscellaneous

- By this Agreement, the Subscriber Group makes our coverage available to all eligible persons. By electing medical and Hospital coverage pursuant to this Agreement, or accepting benefits hereunder, all Members legally capable of contracting agree to all terms, conditions, and provisions hereof. This Agreement may be terminated by mutual agreement between us and Subscriber Group without the consent or concurrence of any Member.
- In the event of Health Net's insolvency, you may continue to receive Covered Services from Health Net Participating Providers for the duration of the period for which premiums were paid on your behalf to Health Net or until you are discharged from a Participating Provider inpatient facility, whichever time is greater. In the event of cessation of operations, enrollees will be notified in writing in a timely manner with a description and instructions specific to the cessation or operations event.
- Members shall complete and submit to us forms as we may reasonably request.
- Cards issued by us to Members are for identification only. Possession of our identification card confers no right to service or other benefits. The holder of our identification card must be a Member on whose behalf all amounts under this Agreement have actually been paid. Any person receiving services or other benefits to which he or she is not entitled shall be charged at the usual rates of the Provider. If any Member permits the use of his or her plan identification card by any other person, such card may be reclaimed by us, and all rights of such Member and his or her Dependents may be terminated without notice at our election. Such Member shall be liable to us for all associated costs.
- We may adopt reasonable policies, procedures, rules and interpretations not inconsistent with this Agreement to promote orderly and efficient administration of this Agreement.
- Any notice under this Agreement shall be given by the U.S. mail, postage paid, addressed as follows:
  a. To us at 13221 SW 68th Parkway, Tigard, Oregon 97223;
  b. To Member at the address of record;
  c. To Subscriber Group at the address indicated on the Signature Sheet.
- This Agreement, as defined in the "Definitions" section of this Medical and Hospital Service Agreement, constitutes the entire contract between the Subscriber Group, Subscriber and us.
- A Member's Copayments and Coinsurance are limited as stated on the Copayment and Coinsurance Schedule attached hereto.

- The benefits of this Agreement are personal to the Member. The Member may not assign such benefits nor may the Member assign or otherwise transfer any claim, right of recovery or right to payment arising under this Agreement.
- The rights of Members and our obligations shall be determined solely by this Agreement without regard to any other agreement or relationship between us and any Provider, Physician, Group Subscriber or other person. No Provider (except for services actually rendered by such Provider) or any director, officer, employee, agent or representative of ours is liable for the conduct of any Provider in furnishing health care services.
- Subscriber Group and each Subscriber acknowledge that we, as most health care organizations, operate on a system which may involve one, more or all of the following: financial incentives, medical management and utilization review. Subscriber Group and all Subscribers acknowledge that, absent a declaration that any of the foregoing is contrary to public policy in the State of Washington, such system does not violate medical ethics nor constitute negligence, fraud, breach of trust or a tortious breach of the Physician/patient relationship.
- We rely substantially upon licensing and regulatory authorities, continuing education requirements, Peer Review Committees, medical and Hospital staff decisions, Provider representations and insurability in the selection of Participating Providers. We are not responsible for the decisions of Providers.
- It is understood that nothing in this Agreement shall entitle either party to this Agreement to recover attorneys' fees from the other party in the event of litigation between the parties, except as provided for by statute.
- Each party shall advise the other as to matters that come to their attention with respect to potential substantial legal actions involving matters related to this Agreement, and shall promptly advise each other of legal actions commenced against each party that come to their attention. Each party shall fully cooperate with the other in the defense of any action arising out of matters related to this Agreement by providing without additional fee all information relating to disputed claims and providing necessary testimony.
- Waiver of any default shall not be deemed to be a waiver of any subsequent default. Waiver or breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach and shall not be construed to be a modification of the terms of this Agreement unless stated to be such in writing, signed by the parties and attached to this Agreement.
- Members must submit claims to us for all services provided by Nonparticipating Providers within 90 days from the date the services were rendered or as soon as medically possible, but in no event later than one year from the date services were rendered unless the Member is legally incapacitated throughout that year. Claims filed by Medicaid must be received no later than three years from the date the services were rendered. Claims must include a statement describing the services rendered, date of services and charges therefore.
- Notwithstanding any other provision of this Agreement, the provisions of this Agreement which, on or after the Group Effective Date, are in conflict with applicable state or federal laws or state or federal regulations, are hereby amended to conform to the minimum requirements of such laws or regulations.

- This Agreement is issued and delivered in the State of Washington and is governed by the laws of the State of Washington.
- When services are provided to a Member by a Participating Provider in accordance with the terms of this Agreement, the Member is responsible only for payment of the contractually stated Copayments, Deductibles, and Coinsurance and for non-Covered Services. A Member shall not be responsible for amounts owed by us to a Participating Provider even if we are unable to pay.
- Benefits under this contract will not be denied for any Covered Services performed by a registered nurse licensed to practice in the state of Washington or in the state in which medical care is rendered if:
  a. The service performed was within the lawful scope of such nurse's license and;
  b. This contract would have been provided benefits if such service had been performed by a Physician licensed to practice in the state of Washington or in the state in which medical care is rendered.
- No benefit, right or any interest of any beneficiary under this Agreement can be assigned or transferred and any such assignment or transfer shall be held invalid and void. Payment of any benefits hereunder shall, at our exclusive option, be made directly to the Physician, Hospital or institution providing their services, or to his or her representative, or directly to the beneficiary. Exception: We will make benefit payments for ambulance services directly to the ambulance company.
- We may assign this Agreement to its successor in interest or an affiliate. We reserve the right to contract with other corporations, associations, partnerships, or individuals to provide services and supplies described in this Agreement.
- Subscriber Group warrants that it presently has and will maintain throughout the term of this Agreement all coverage required of it by applicable workers' compensation or employer's liability laws or other laws of similar purpose.
- If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions and the Agreement shall remain in force and effect, and in no way shall be affected, impaired, or invalidated.
- The headings in this Agreement are provided solely for convenience of reference and are not a part of this Agreement or guides to interpretation hereof.
- In the absence of fraud, all statements made by applicants, Subscriber Group or a Member shall be deemed representations and not warranties, and no statement made for the purpose of effecting coverage shall void the coverage or reduce benefits unless contained in a written instrument signed by Subscriber Group or a Member, a copy of which has been furnished to Subscriber Group or to the Member or the Member's beneficiary.
- We do not consider the availability or eligibility for medical assistance under Medicaid in any state when considering eligibility for coverage or paying benefits for eligible Members under this plan.
- Benefits payable under this Agreement are subject to the Deductible shown in the Copayment and Coinsurance Schedule which must be satisfied each Calendar Year before benefits will be paid.

The annual Out-of-Pocket Maximum includes the annual Deductible. After you reach the Out-of-Pocket Maximum in a Calendar Year, we will pay your Covered Services during the rest of the Calendar Year at 100% of our contracted rates for PPO services and at 100% of MAA for Out-of-Network (OON) services. You are still responsible for OON billed charges that exceed MAA.

When this Agreement immediately replaces a Subscriber Group's previous Health Net PPO Plan Agreement in the middle of a Calendar Year, we will credit amounts accumulated toward annual Deductibles and Out-of-Pocket Maximums.

Medical Loss Ratio (MLR) Rebates

- In conjunction with the requirements of the federal Affordable Care Act, upon Health Net's request, the Subscriber Group shall provide the Subscriber Group's average number of employees employed on business days during the previous Calendar Year, in order for Health Net to accurately categorize the Subscriber Group, for purposes of determining the appropriate MLR value that is applicable to the Subscriber Group.

Pharmacy Disclosure Notice

YOUR RIGHT TO SAFE AND EFFECTIVE PHARMACY SERVICES

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you would like more information about the Pharmacy drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please contact Health Net at 1-888-802-7001 or visit www.healthnet.com.

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900 or www.insurance.wa.gov. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health Washington State Board of Pharmacy at 360-236-4700, www.doh.wa.gov, or HSQACSC@doh.wa.gov.

“Does this plan limit or exclude certain drugs my health care Provider may prescribe, or encourage substitutions for some drugs?”

The Plan formulary is maintained by the Health Net Pharmacy and Therapeutics Committee. The Pharmacy and Therapeutics Committee includes local and national practicing physicians and pharmacists who review FDA approval information and clinical research studies to make formulary recommendations and decisions. A copy of the current formulary is available through the Customer Contact Center at 1-888-802-7001 or visit our website at: www.healthnet.com.

Formulary and drug product decisions are based on the following:

- Proven safety and effectiveness
- Accepted for use by the medical community
- Economical efficiency

An approved generic equivalent shall mean a generic drug has been given an “A” therapeutic equivalent code by the Department of Health and Human Services.

Please refer to the “Prescription Drug Benefits” subsection of the Group Plan Benefits section for specific information regarding limitations, exclusions, and substitutions for drugs.

"When can my plan change the approved drug list (formulary)? If a change occurs, will I have to pay more to use a drug I had been using?”

The formulary is reviewed and updated on an ongoing basis, and it may be revised up to four times per year based on the recommendations of the Pharmacy and Therapeutics Committee. Most changes involve the addition of new drugs to the formulary. Changes to existing formulary drugs may impact a drug you are using and may require a higher Copayment. We will provide a written notice to members currently affected by a change in the existing formulary as soon as reasonably possible.

“What should I do if I want a change from limitations, exclusions, substitutions or cost increases for drugs specified in this plan?”

If you receive a denial or partial denial of an authorization request you may contact a Pharmacy Services representative to discuss the determination. If additional information is presented or may be obtained from your Physician for consideration against the Prior Authorization criteria, a second review may be

requested. You may contact a Pharmacy Services representative at 1-888-802-7001 between the hours of 8:00 am-6:00 pm PST Monday through Friday, excluding holidays. You have the right to appeal the denial or partial denial of an authorization request. The Appeal must be submitted either orally or in writing within 180 days of the date of the denial notice. We will resolve and respond in writing to Appeals within 14 days. If a delay could seriously jeopardize your life or health you may request an expedited review in writing or over the phone by contacting a Customer Contact Center representative. Expedited reviews are completed no later than 72 hours following receipt.

Send written Appeals to:
Health Net Health Plan of Oregon, Inc.
Grievances and Appeals Department
P.O. Box 10342
Van Nuys, CA 91410-0342

"How much do I have to pay to get a prescription filled?"

- Tier 1 is the lowest Copayment/Coinsurance level. This level includes but is not limited to most generic drugs.
- Tier 2 is the intermediate Copayment/Coinsurance level. This level includes but is not limited to preferred brand name drugs that have no generic equivalent.
- Tier 3 is a higher Copayment/Coinsurance level. This level includes non-preferred brand name drugs (and brand name drugs with a generic equivalent). These are drugs that are not listed in Tier 1 or Tier 2. In most cases there are alternatives in Tier 1 or Tier 2 for drugs found in this highest tier.
- Compounded medications are prescription orders that have at least one ingredient that is Federal Legend or state restricted in a therapeutic amount, is Medically Necessary, and are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form and require a prescription order for dispensing. Coverage for compounded medication requires the Tier 3 Drug Copayment/Coinsurance and subject to the Deductible, if any. These drugs require Prior Authorization and will be subject to review for Medical Necessity.
- Prescribed, Self-Administered anticancer medications are covered at the same level as injectable anticancer medications. Refer to your Basic Benefit Copayment and Coinsurance Schedule for specific benefit levels.
- Specialty Pharmacy medications. Certain drugs identified on the formulary are classified as Specialty Pharmacy drugs under your plan. Specialty Pharmacy drugs are high cost biologic, injectable and oral drugs typically dispensed through a limited network of pharmacies and having significantly higher cost than traditional pharmacy benefit drugs.

Please refer to your Basic Benefit Copayment and Coinsurance Schedule for specific information on your prescription drug costs.

"What if my prescription requires Prior Authorization?"

Your doctor can submit a Prior Authorization request via telephone, mail, or facsimile (fax) for review. A Pharmacy Services representative is available at 1-888-802-7001 between the hours of 8:00-6:00 Monday through Friday, excluding holidays.

For Urgent Care review requests:

If the information provided is sufficient to review the request for Medical Necessity, Prior Authorization requests will be approved or denied within 48 hours. If the information provided is not sufficient to approve or deny the request, within 24 hours we will contact the requesting provider to submit additional information to make the Prior Authorization determination. We will allow 48 hours for the provider to submit the requested information. We will approve or deny the Prior Authorization request within 48 hours of receipt of the requested additional information.

For non-Urgent Care review requests:

If the information provided is sufficient to review the request for Medical Necessity, non-urgent or routine requests will be completed within five calendar days. If the information provided is not sufficient to approve or deny the request, within 5 calendar days we will contact the requesting provider to submit the additional information to make the Prior Authorization determination. We will allow five calendar days for the provider to submit the requested information. We will approve or deny the Prior Authorization request within four calendar days of receipt of the requested additional information.

"What if I am in immediate need of my prescription but it requires Prior Authorization?"

Your doctor can submit a Prior Authorization request via telephone, mail, or facsimile (fax) for review. A Pharmacy Services representative is available at 1-888-802-7001 between the hours of 8:00-6:00 Monday through Friday, excluding holidays. However, under certain conditions, coverage for emergency prescription fills of a limited amount will be provided for a prescribed medication that requires a Prior Authorization if the delay in the approval will place the person's health in serious jeopardy.

The emergency fill is applicable when:

- The pharmacy is unable to obtain Prior Authorization, in a timely manner, from the health plan outside of business hours; or
- The health plan is unable to reach the prescribing physician for full consultation.

The dosage of the emergency fill must either be the minimum packaging size available at the time dispensed, or up to a 7-day supply. The applicable copayment and/or coinsurance as shown in the Outpatient Prescription Drug benefits section of the Schedule of Benefits will apply. This copayment and/or coinsurance will depend on the drug tier as shown on the Essential Rx Drug List or formulary.

In the event the medication is to be continued for treatment beyond the emergency fill authorization, Health Net may apply formulary or utilization restrictions that will be reviewed following Health Net's Prior Authorization guidelines.

"Do I have to use certain pharmacies to pay the least out of my own pocket under this health plan?"

Prescriptions must be purchased at a Participating Pharmacy in order to be covered under the prescription benefit. There are approximately 1,200 independent and chain pharmacies in the state of Washington that are participating with Health Net. If you need to verify that a specific pharmacy is

participating with Health Net, please call the Customer Contact Center at 1-888-802-7001 or visit our website at www.healthnet.com.

"How many days' supply of most medications can I get without paying another copay or other repeating charge?"

You may receive up to a 30-day supply when ordered in a participating retail pharmacy.

You may receive up to a 90-day supply when ordered through our contracted mail order pharmacy.

Some drugs, including but not limited to compounded medications, require Prior Authorization and/or may have a dosage or quantity restriction set by the Plan.

If your Physician has increased your dose, he or she needs to notify your pharmacy of the change in directions. Your pharmacy may contact us for an override if this change will result in an early refill request.

Please refer to your Basic Benefit Copayment and Coinsurance Schedule for information on the days' supply available under your benefit.

A pharmacist is authorized to provide one early refill of a prescription for Topical Ophthalmic products if the following criteria are met:

- The refill is requested at or after 70% of the predicted days of use of:
  - The date the original prescription was dispensed; or
  - The date that the last refill of the prescription was dispensed.
- The prescriber indicates on the original prescription that a specific number of refills will be needed; and
- The refill does not exceed the number of refills that the prescriber indicated on the original prescription.

"What other pharmacy services does my health plan cover?"

There are no additional pharmacy services covered under the Policy.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL 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** (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.

Covered Entities Duties:

Health Net is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Health Net is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of your unsecured PHI.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

Health Net reserves the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. Health Net will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your rights, our legal duties, or other privacy practices stated in the Notice. We will make any revised Notices available on the Health Net website, located below.

www.healthnet.com/portal/common/content/iwc/corp_info/book/legal_info.action#noticeprivacyPracticesContent

Permissible Uses and Disclosures of Your PHI:

The following is a list of how we may use or disclose your PHI without your permission or authorization:

- ***Treatment*** - We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making Prior Authorization decisions related to your benefits.

- ***Payment*** - We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, issuing premium billings, reviewing services for medical necessity, and performing utilization review of claims.
- ***HealthCare Operations*** - We may use and disclose your PHI in the performance of our health care operations. These activities may include providing customer services, responding to complaints and appeals, providing case management and care coordination, conducting medical review of claims and other quality assessment and improvement activities. We may also in our health care operations disclose PHI to business associates with whom we have written agreements containing terms to protect the privacy of your PHI. We may disclose your PHI to another entity that is subject to the federal Privacy Rules and that has a relationship with you for its health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, case management and care coordination, or detecting or preventing healthcare fraud and abuse.
- ***Group Health Plan/Plan Sponsor Disclosures*** - We may disclose your PHI to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the PHI (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of your PHI:

- ***Fundraising Activities*** - We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.
- ***Underwriting Purposes*** - If applicable, We may use or disclosure your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.
- ***Appointment Reminders/Treatment Alternatives*** - We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.
- ***As Required by Law*** - If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.
- ***Public Health Activities*** - We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclosure your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness products or services under the jurisdiction of the FDA.

- ***Victims of Abuse and Neglect*** - We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.
- ***Judicial and Administrative Proceedings*** - We may disclose your PHI in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request, or similar legal request.
- ***Law Enforcement*** - We may disclose your relevant PHI to law enforcement when required to do so, such as in response to a court order, court-ordered warrant, subpoena or summons issued by a judicial officer, or a grand jury subpoena. We may also disclose your relevant PHI for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person.
- ***Coroners, Medical Examiners and Funeral Directors*** - We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.
- ***Organ, Eye and Tissue Donation*** - We may disclose your PHI to organ procurement organizations or entities engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissues.
- ***Threats to Health and Safety*** - We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
- ***Specialized Government Functions*** - If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI to authorized federal officials for national security and intelligence activities, the Department of State for medical suitability determinations and for protective services of the President or other authorized persons.
- ***Workers' Compensation*** - We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- ***Emergency Situations*** – We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- ***Inmates*** - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.
- ***Research*** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of your PHI that Require Your Written Authorization

We are required to obtain your written authorization to use or disclose your protected health information, with limited exceptions, for the following reasons:

Sale of PHI – We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing – We will request your written authorization to use or disclose your PHI for marketing purposed with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes – We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Individuals Rights

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

- ***Right to Revoke an Authorization*** - You may revoke an authorization at any time, the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.
- ***Right to Request Restrictions*** - You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment or healthcare operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.
- ***Right to Request Confidential Communications*** - You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason is for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where you PHI should be delivered.
- ***Right to Access and Received Copy of your PHI*** - You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

- ***Right to Amend your PHI*** - You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- ***Right to Receive an Accounting of Disclosures*** - You have the right to receive a list of instances within the last 6 years period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.
- ***Right to Receive a Copy of this Notice*** - You may request a copy of our Notice at any time by using the contact information list at the end of the Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.
- ***Right to File a Complaint*** - If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-800-368-1019, (TTY: 1-866-788-4989) or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

Contact Information

If you have any questions about this Notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone using the contact information listed below.

Health Net Privacy Office
Attn: Privacy Official
P.O. Box 11740
Eugene, OR 97440-1740

Telephone: 1-844-426-5340
Fax: 1-844-426-5340
Email: ComplianceOregon@centene.com

Submit your complaint online at: https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf or by writing to: Office for Civil Rights, US Department of Health and Human Services, 2201 Sixth Avenue – M/S: RX-11, Seattle WA 98121-1831, phone (800) 368-1019.

FINANCIAL INFORMATION PRIVACY NOTICE

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

We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect:

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information:

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, such as other insurers;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security:

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About this Notice:

If you have any questions about this notice:

Please call the toll-free phone number on the back of your ID card or contact the Health Net at 1-800-522-0088.

****This Notice of Privacy Practices also applies to enrollees in any of the following Health Net entities:** Health Net of California, Health Net Life Insurance Company, Health Net Health Plan of Oregon, Inc., Managed Health Network, Health Net Community Solutions, Inc. Rev. 3/26/2018.

NOTICE OF NONDISCRIMINATION

Health Net complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:

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

If you need these services, contact Health Net's Customer Contact Center at 1-888-802-7001, TTY number: 711.

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a Grievance by calling the number above and telling them you need help filing a Grievance; Health Net's Customer Contact Center is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

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

NOTICE OF LANGUAGE ASSISTANCE

English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card. Employer group members please call 1-888-802-7001 (TTY: 711).

Amharic
ከፍያ የሌለው የቋንቋ አገልግሎት፡፡ አስተርጓሚ ማግኘት ይችላሉ፡፡ ሰነዶች እንዲዘጋጅልዎ ማድረግ ይችላሉ፡፡ እርዳታ ለማግኘት በመታወቂያ ላይ ያለውን ቁጥር ይደውሉ፡፡ አመልካቾች 1-888-802-7001 (TTY: 711) ይደውሉ፡፡

Arabic
خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية. يرجى من أعضاء مجموعة أصحاب العمل الاتصال على الرقم 1-888-802-7001 (TTY: 711).

Chinese
免費語言服務。您可使用口譯員。您可請人將文件內容唸給您聽。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡。雇主團體的會員請致電 1-888-802-7001（TTY：711）。

Cushite (Oromo)
Waa Lacag la'aan Adeegyada Luuqada. Waxaad heli kartaa turjubaan. Waxaad heli kartaa in waraaqaha laguu aqriyo. Wixii caawin ah, naga soo wac lambarka ku qoran kaarka Aqoonsigaaga. Xubnaha kooxda badrooniga fadlan soo wac 1-888-802-7001 (TTY: 711).

German
Kostenloser Sprachendienst. Dolmetscher sind verfügbar. Dokumente können Ihnen vorgelesen werden. Wenn Sie Hilfe benötigen, rufen Sie uns unter der Nummer auf Ihrer ID-Karte an. Arbeitgeber-Gruppenmitglieder rufen bitte unter 1-888-802-7001 (TTY: 711) an.

Japanese
無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、ID カードに記載されている番号までお電話ください。雇用主を通じた団体保険のメンバーの方は、1-888-802-7001（TTY：711）までお電話ください。

Korean
무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 문서 낭독 서비스도 받으실 수 있습니다. 도움을 원하시면, 보험 ID에 수록된 번호로 전화해 주십시오. 고용주 그룹 가입자분은 1-888-802-7001 (TTY: 711) 번으로 전화해 주십시오.

Cambodian (Khmer)
សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរស័ព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក។ សមាជិកក្រុមនិយោជក សូមទាក់ទងទៅលេខ 1-888-802-7001 (TTY: 711)។

Laotian
ລິການພາສາບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍຜູ້ແປພາສາໄດ້. ທ່ານສາມາດຂໍໃຫ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງໄດ້. ເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ, ກະລຸນາໂທຫາພວກເຮົາໄດ້ຕາມເບີທີ່ມີຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ. ສະມາຊິກກຸ່ມນາຍຈ້າງ ກະລຸນາໂທຫາເບີ 1-888-802-7001 (TTY: 711).

Punjabi
ਬਿਨਾਂ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਆਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਡੇ ਲਈ ਦਸਤਾਵੇਜ਼ਾਂ ਪੜ੍ਹੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਰੋਜ਼ਗਾਰਦਾਤਾ ਗਰੁੱਪ ਦੇ ਸਦੱਸ, ਕਿਰਪਾ ਕਰਕੇ 1-888-802-7001 (TTY: 711) 'ਤੇ ਫ਼ੋਨ ਕਰੋ।

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Если вы участник коллективного плана, предоставляемого работодателем, звоните по телефону 1-888-802-7001 (TTY: 711).

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación. Los afiliados del grupo del empleador deben llamar al 1-888-802-7001 (TTY: 711).

Tagalog
Walang Gastos na Mga Serbisyo sa Wika. Maaari kayong kumuha ng isang interpreter. Maaari ninyong ipabasa ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card. Para sa mga miyembro ng grupo ng employer, mangyaring tumawag sa 1-888-802-7001 (TTY: 711).

Ukrainian
Безплатні послуги перекладу. Ви можете скористуватися послугами перекладача. Вам можуть прочитати ваші документи. Щоб отримати допомогу, телефонуйте нам за номером, який вказаний на вашій ідентифікаційній картці (ID). Учасників групового страхового плану від працедавця просимо телефонувати за номером 1-888-802-7001 (TTY: 711).

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu c`âu được đọc cho nghe tài liệu. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị. Các thành viên thuộc chương trình theo nhóm của chủ sử dụng lao động vui lòng gọi số 1-888-802-7001 (TTY: 711).

OR WA Commercial Off-Exchange Member Notice of Language Assistance

Contact us

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Suite 200
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1-888-802-7001
www.healthnet.com

Hearing and Speech Assistance
Monday - Friday 8:00 a.m. to 5:00 p.m.
TTY 1-888-802-7122

Customer Contact Center
Monday - Friday 7:30 a.m. to 5:00 p.m.
1-888-802-7001
www.healthnet.com

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