Health Net Health Plan of Oregon, Inc.

Oregon Large Group CommunityCare 1T and HDHP Plan Coverage Document

2023

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.

We look forward to serving you. Contact us at www.healthnetoregon.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 8:00 a.m. to 5:00 p.m., Monday through Friday, except holidays. You'll find the number to call on the back of your 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 Health Plan of Oregon, Inc.

CommunityCare 1T Plan
Copayment and Coinsurance Schedule

CommunityCare: Convenient access to care.

When you receive Covered Services in our CommunityCare network, you are not responsible for any charges that exceed our contracted rates with our CommunityCare Providers.

The plan requires that you first select a Primary Care Provider (PCP) from our CommunityCare network. Your PCP coordinates all your health care. **Certain services including, but not limited to, Birthing Center services, Home Health Care, infusion services that can be safely administered in the home or in a home infusion suite, organ and tissue transplant services, Durable Medical Equipment, and Prosthetic Devices/Orthotic Devices 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 Plan Benefits.**

To confirm whether a Provider participates in our CommunityCare network, refer to our Provider directory, use the regularly updated Provider Search feature on our web site, or get in touch with a Customer Contact Center representative by using the contact information on the other side of this sheet.

Out-of-Network services are not covered except for urgent care and Emergency Medical Care. When urgent care or Emergency Medical Care services are performed by a Provider who is not participating in your CommunityCare network, you will pay the Participating Provider level of cost-sharing, regardless of whether the Provider is a Participating Provider or a Nonparticipating Provider, and without balance billing. Balance billing is the difference between a Nonparticipating Provider's billed charge and the Maximum Allowable Amount. Providers outside of your CommunityCare network may or may not be contracted with us.

We pay Nonparticipating Providers based on the MAA rates, not on billed amounts. The MAA may often be less than the amount a Provider bills for a service. Nonparticipating Providers may hold you responsible for amounts they charge that exceed the MAA we pay. Amounts that exceed our MAA 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**.

For more information about your rights regarding balance billing, see the "Your Rights and Protections Against Surprise Medical Bills" in the "Rights of Members" section of the Group Medical and Hospital Service Agreement.

Some benefits contain footnotes which provide additional coverage information. Please review the corresponding footnote reference in the Notes section of this Copayment and Coinsurance Schedule.

*Deductibles, plan limits, copayments and coinsurance amounts are dependent on the plan selected by the employer group.

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

For Covered Services, you pay:

Calendar Year Deductible	**For Covered Services, you pay:**
Annual Deductible per person	$[*] ■
Annual Deductible per family	$[*] ■

Benefit Maximums	**In-Network Providers**
Annual Out-of-Pocket Maximum ✚ (Combined Medical and Prescription Drugs)	$[*]
Annual Out-of-Pocket Maximum per family ✚ (Combined Medical and Prescription Drugs)	$[*]

Physician/Professional/Outpatient Care	**In-Network Providers**
Preventive care, women's and men's health care – Pap test, breast exam, pelvic exam, PSA test and digital rectal exam	No charge◆
Routine mammography	No charge◆
Physician services – office visits to Providers in family practice, pediatrics, internal medicine, general practice, obstetrics/gynecology, naturopath	$[*] per visit◆
Telemedical Services	$[*] per visit◆
Specialty Physician services – office visits to Providers in specialties other than above	$[*] per visit◆
Urgent Care center (for medical care other than mental health, behavioral health or substance abuse needs)	$[*] per visit◆
Urgent Care center (for mental health, behavioral health or substance abuse needs) ▲	$[*] per visit◆
Physician Hospital visits	[*]% contract rate
Diagnostic X-ray/EKG/Ultrasound	[*]% contract rate
Diagnostic laboratory tests	[*]% contract rate
Diagnostic Imaging, including CT/MRI/ PET/SPECT/EEG/Holter monitor/Stress test	[*]% contract rate
Allergy injections	[*]% contract rate
Therapeutic injections	[*]% contract rate
Maternity delivery care (professional services only) ⌘	[*]% contract rate
Outpatient rehabilitation therapy 30 days/year max⮙	$[*] per visit ◆
Outpatient Surgery Services in Office or Ambulatory Surgery Center	[*]% contract rate
Outpatient Surgery Services at Hospital based facility	[*]% contract rate

Hospital Care	**In-Network Providers**
Inpatient services ✪	[*]% contract rate
Inpatient rehabilitation therapy – 30 days/year max⮙	[*]% contract rate

*Deductibles, plan limits, copayments and coinsurance amounts are dependent on the plan selected by the employer group.

Emergency Services (for medical care other than mental health, behavioral health or substance abuse needs)	In-Network Providers
Outpatient emergency room services	$[*] per visit, then [*]% contract rate ◆*
Out-of-area inpatient admission from emergency room	[*]% contract rate
Emergency ground ambulance transport 3 trips/year max	[*]%
Emergency air ambulance transport 1 trip/year max	[*]%

Emergency Services (for mental health, behavioral health or substance abuse needs)	In-Network Providers
Outpatient emergency room services	$[*] per visit, then [*]% contract rate ◆*
Out-of-area inpatient admission from emergency room	[*]% contract rate
Emergency ground ambulance transport 3 trips/year max	[*]%
Emergency air ambulance transport 1 trip/year max	[*]%

Behavioral Health Services – Substance Use Disorder and Mental Health Conditions	In-Network Providers
Physician services, office visits ▲	$[*] per visit ◆
Outpatient services ▲	[*]% contract rate
Inpatient services ▲	[*]% contract rate

Other Services	In-Network Providers
Blood, blood plasma, blood derivatives	[*]% contract rate
Diabetes management – one initial program ⌀ ⌘	$[*] per program◆
Dialysis Services ♠	[*]% contract rate
Durable Medical Equipment and Prosthetic Devices/Orthotic Devices ⌀	[*]% contract rate (MAA applies to Nonparticipating Providers)
Health education – $150/year max for all qualifying classes	Any charges over maximum reimbursement of $50 per qualifying class. ⌘
Home health visits	[*]% contract rate
Home infusion therapy	[*]% contract rate
Hospice services	[*]% contract rate
Medical supplies (including allergy serums and injected substances) ⌘	[*]% contract rate (MAA applies to Nonparticipating Providers)
Outpatient chemotherapy (non-oral anticancer medications and administration)	[*]% contract rate
Skilled Nursing Facility care	

*Deductibles, plan limits, copayments and coinsurance amounts are dependent on the plan selected by the employer group.

[*]-days/year max .....[*]% contract rate
TMJ services – $[*]-lifetime max.....[*]% (MAA applies to Nonparticipating Providers)

Notes:

■ You must meet the specified Deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.

◆ Deductible is waived.

* Copayment is waived if you are admitted, and the inpatient admission Coinsurance will apply.

▲ For help with finding a Provider and information about mental health or Substance Use Disorder services, call 800-977-8216.

✚ After you reach the Out-of-Pocket Maximum in a Calendar Year, we will pay your covered CC1T services during the rest of that Calendar Year at 100% of our CC1T contract rates.

✪ The above Coinsurance for inpatient Hospital services is applicable for each admission for the hospitalization of an adult, pediatric or newborn patient. If a newborn patient requires admission to an intermediate or intensive care nursery, a separate Coinsurance for inpatient Hospital Services will apply.

Corrective shoes and arch supports including foot orthotics are excluded unless prescribed in the course of treatment for, or complications from, diabetes.

Members are eligible for no cost benefits for diabetes management from the beginning of a pregnancy for up to six weeks postpartum. For more information, please contact our Customer Contact Center.

⌘ Your payments do not apply to the annual Out-of-Pocket Maximum.

Visit/day limits do not apply to services to treat Mental Health Conditions.

♠ If you receive dialysis services due to a diagnosis of end-stage renal disease, you may be eligible to enroll in Medicare. For more information about Medicare enrollment, contact Medicare at 1-800-MEDICARE or log onto their web site at www.medicare.gov.

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

Health Net Health Plan of Oregon, Inc. • 888-802-7001 • www.healthnetoregon.com

*Deductibles, plan limits, copayments and coinsurance amounts are dependent on the plan selected by the employer group.

Health Net Health Plan of Oregon, Inc.

Large Group (51+) CommunityCare 1T Plan Contract

Group Plan Benefits and Group Medical and Hospital Service Agreement

2023

Welcome to Health Net Health Plan of Oregon, Inc. "Health Net"

This booklet explains how to get the care and services that are covered under this plan. This is an important legal document. Please keep it in a safe place. If you have any questions about this plan, please contact our Customer Contact Center at the phone number listed at the back of this Agreement.

Thank you for choosing Health Net.

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Health Net Health Plan of Oregon, Inc.
CommunityCare 1T 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.

Special terms used in this Group Plan Benefits section and Group Medical and Hospital Service Agreement to explain your plan have their first letter capitalized and appear in the "Definitions" section of the Group Medical and Hospital Service Agreement.

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" portion of this Group Plan Benefits section, including payment of any applicable Deductible, Coinsurance, and Copayments identified in the attached Copayment and Coinsurance Schedule.
- All services other than the limited preventive care services outlined in the Agreement are covered only if Medically Necessary as defined in the "Definitions" section of the Group Medical and Hospital Service Agreement.
- 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.
- To qualify as covered Medical Services and supplies, all services and supplies must be expressly set forth as benefits in this Group Plan Benefits section and must be performed by the Primary Care Provider or by another Participating Provider under a Referral, which requires the Prior Authorization of the Medical Director, except for: visits to a Participating Women's Health Care Provider for an annual gynecological examination and maternity care; visits to a Participating Provider covering in the absence of a Primary Care Provider; Emergency Medical Care; and routine laboratory or x-ray tests performed outside of a Hospital setting.

  When services are performed by or received from a Nonparticipating Provider, your expenses include a Calendar Year Deductible (if any), fixed dollar amounts for certain services and the amount by which billed charges exceed the Maximum Allowable Amount (MAA). 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.

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.

- **Covered Services From a Nonparticipating Provider at a Participating Facility**. Even though a Hospital or other Provider may be a Participating Provider, during your visit or stay you may receive Covered Services or Supplies, which are performed by or received from Nonparticipating Providers. If you receive Covered Services at an in-network facility (including, but not limited to, a licensed Hospital, an Ambulatory Surgical Center or other outpatient setting, a laboratory, or a radiology or imaging center) at which you receive Covered Services by an Out-of-Network Provider, the services provided by the Out-of-Network Provider will be payable at the in-network level of cost benefits and Deductible, if applicable, and without balance billing (balance billing is the difference between a Provider's billed charge and the Maximum Allowable Amount (MAA)). Such other types of Providers may include, but are not limited to, those who provide anesthesia services, emergency room Physician services, radiology (x-ray), pathology and laboratory services.
- **When Emergency Services are provided by a Nonparticipating Provider.** When Covered Services are received in connection with Emergency Care, you will pay the Participating Provider level of cost-sharing, regardless of whether the Provider is a Participating Provider or a Nonparticipating Provider, and without balance billing. Balance billing is the difference between a Nonparticipating Provider's billed charge and the Maximum Allowable Amount. When you receive Emergency Care from a Nonparticipating Provider, Your payment of the cost-sharing will accrue toward the Deductible (if applicable) and the Out-of-Pocket Maximum for Participating Providers.

  The Division of Financial Regulation (DFR) prohibits balance billing for emergency services received from a Nonparticipating Provider or facility.

  Oregon law protects consumers from surprise medical bills when they get emergency services or go to an in-network health facility and receive care from a Nonparticipating Provider without their consent. In this case, the law states that you only have to pay the Participating Provider level of cost sharing.

  For more information about your rights regarding balance billing, see the "Your Rights and Protections Against Surprise Medical Bills" in the "Rights of Members" section of the Group Medical and Hospital Service Agreement.

  If you believe you've been wrongly billed, you may contact the Division of Financial Regulation (DFR) at 1-888-887-4894 or CMS at 1-800-985-3059. Visit https://www.cms.gov/nosurprises for more information about your rights under federal law. Visit https://www.dfr.oregon.gov for more information about your rights under Oregon laws.
- A medical Service or Supply not expressly included in this Group Plan Benefits section is not a covered benefit, even if it is not specifically listed as an exclusion in the "Exclusions and Limitations" section of this Group Plan Benefits section.
- **Specialty Care Providers.** Medical Services for certain conditions or certain treatment procedures are covered only if such services are provided at Participating Providers that are designated as Specialty Care Providers. Services which require use of a Specialty Care Provider include but are not limited to:

  1. Birthing Center services

2. Home Health Care
3. Infusion services that can be safely administered in the home or in a home infusion suite
4. Organ and tissue transplant services
5. Durable Medical Equipment
6. Prosthetic Devices/Orthotic Devices

We have the right to require a Member to use a designated Specialty Care Provider as a condition to receive coverage under this Agreement. Specialty Care Providers may be located anywhere in the United States. Members may be required to travel out of the Service Area to receive care. If a Member is required by us 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 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 Nondiscrimination Notice section in the Group Medical and Hospital Service Agreement.
- The benefits, premiums and availability of insurance as described under this Agreement do not discriminate between individuals of the same class and equal expectation of life or between risks of essentially the same degree of hazard.

Physician and Professional Services

Benefits are subject to payment of any applicable Copayments or Coinsurance and will vary depending on whether the procedure is performed in a Physician's office or Hospital setting, outpatient, or Ambulatory Surgery Center setting. Applicable Copayments and Coinsurance can be found in your Copayment and Coinsurance Schedule.

Certain exclusions and limitations may apply. Be sure you read the "Exclusions and Limitations" and the "Prior Authorization" subsections of this Group Plan Benefits section and your Copayment and Coinsurance Schedule for additional benefit limitation information, before obtaining care.

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 tests, sleep studies, cardiac catheterization and other imaging and diagnostic services are covered. Imaging services including, but not limited to, MRA, MRI, 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 without a supporting diagnosis, except as recommended by the United States Preventive Services Task Force (USPSTF), are not covered.
- **Radiation Therapy.** Radiation therapy is covered.

- **Chemotherapy.** Chemotherapy and chemotherapy self-injectables are covered. Chemotherapy is the use of anticancer drugs to treat cancer. The chemotherapy benefit covers anticancer drugs and drugs used to treat the side effects of chemotherapy. It also includes administration of the drugs, and medical supplies related to the mixing and administration of the drugs. Orally administered anticancer medications are covered as a prescription benefit.
- **Office Visits with Primary Care Provider.** Your office visits to a Primary Care Provider, including Medical Services for illness or injury, are covered. Office procedures may 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.
- **Preventive Care.** Covered as provided in the "Preventive Care" subsection of this Group Plan Benefits section.
- **Home Visits.** Visits by a Primary Care Provider to your home are covered within the Service Area. Prior Authorization is required.
- **Specialty Physician Services.** Services of specialty Physicians and other specialty Providers are covered when they are Participating Providers. Referral is required.
- **Surgery.** Inpatient surgical procedures are covered only when Prior Authorized or as Emergency Medical Care. Certain outpatient surgical procedures may be covered only when Prior Authorized. Prior Authorization requirements can be verified by contacting us or as outlined in the "Prior Authorization" portion of this Group Plan Benefits section.
- **Family Planning.** Counseling and assessment for birth control are covered. Outpatient consultations, examinations, procedures, and Medical Services that are necessary to prescribe, dispense, deliver, distribute, monitor, and manage side effects, administer or remove a prescription contraceptive are covered. The Deductible, if any, is waived for these services.

  Contraception methods and counseling, as supported by the Health Resources and Services Administration (HRSA) guidelines, are covered as preventive care in the "Preventive Care" subsection of this Group Plan Benefits section.
- **Primary Care Provider Designation.** Health Net allows the designation of a Primary Care Provider. You have the right to designate any Primary Care Provider or any Women's Health Care Provider who participates in our network and who is available to accept you or your family members. Until you make this designation, we will designate one for you. 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 or any Women's Health Care Provider, you may contact us at:

  Health Net Health Plan of Oregon, Inc.
  13221 SW 68th Parkway, Suite 315
  Tigard, Oregon 97223

Customer Contact Center
Monday - Friday 8:00 a.m. to 5:00 p.m.
1-888-802-7001
www.healthnetoregon.com

Hearing and Speech Assistance
Monday - Friday 8:00 a.m. to 5:00 p.m.
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 network that 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, Suite 315
  Tigard, Oregon 97223

  Customer Contact Center
  Monday - Friday 8:00 a.m. to 5:00 p.m.
  1-888-802-7001
  www.healthnetoregon.com

  Hearing and Speech Assistance
  Monday - Friday 8:00 a.m. to 5:00 p.m.
  TTY: 711

  This Agreement will never provide less than the minimum benefits required by state and federal laws.

Hospital Inpatient Services

Certain exclusions and limitations may apply. Be sure you read the "Exclusions and Limitations" and the "Prior Authorization" subsections of this Group Plan Benefits section and your Copayment and Coinsurance Schedule for additional benefit limitation information, before obtaining care.

Medically Necessary Hospital inpatient services are covered as follows:

- **Hospital Inpatient.** Inpatient services are covered only when Prior Authorized or as Emergency Medical Care.

- **Hospital Room and Board and Inpatient Services.** While you are a patient in a Hospital, the following are covered: an average two-bed accommodation; general nursing care; meals; special diets; use of operating room and related facilities; intensive care unit and services; X-ray, laboratory, and other diagnostic tests; drugs; medications; biologicals; anesthesia and oxygen services; radiation therapy; chemotherapy; inhalation therapy; internal or implantable devices, such as pacemakers and hip joints, approved by the Food and Drug Administration and implanted during a surgery pursuant to a Prior Authorization.
- **Maternity Hospitalization.** Refer to the "Maternity Benefits" subsection of this Group Plan Benefits section.
- **Newborn Nursery Care.** Routine care in the Hospital nursery is covered for the Enrolled newborn Child.

Exclusions and Limitations:

A private room or services of private or special duty nurses other than as Medically Necessary when you are an inpatient in a Hospital. Personal comfort items, such as television, telephone, lotions, shampoos, meals in the home, guest meals in inpatient facilities, housekeeping services, etc. Outpatient prescription or other drugs and medications. 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.

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.

If you receive covered Medical Services and supplies from a Nonparticipating Provider, we use Medicare guidelines to determine coverage during a post-operative global period for surgical procedures.

- **State-Approved Programs.** Services performed by a state Hospital or state-approved program are not excluded if such services would otherwise be covered by this plan.

Outpatient Facility Services

Benefits are subject to payment of any applicable Copayments or Coinsurance and will vary depending on whether the procedure is performed in a Physician's office or Hospital setting, outpatient, or Ambulatory Surgery Center setting. Applicable Copayments and Coinsurance can be found in your Copayment and Coinsurance Schedule.

Certain exclusions and limitations may apply. Be sure you read the "Exclusions and Limitations" and the "Prior Authorization" subsections of this Group Plan Benefits section and your Copayment and Coinsurance Schedule for additional benefit limitation information, before obtaining care.

Medically Necessary outpatient services are covered as follows:

- **Diagnostic Services.** Diagnostic services, including radiology (X-ray), pathology, laboratory tests, sleep studies, cardiac catheterization, and other imaging and diagnostic services are covered. Imaging services including, but not limited to, MRA, MRI, 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.
- **Radiation Therapy.** Radiation therapy is covered.
- **Chemotherapy.** Chemotherapy and chemotherapy self-injectables are covered. Chemotherapy is the use of anticancer drugs to treat cancer. The chemotherapy benefit covers anticancer drugs and drugs used to treat the side effects of chemotherapy. It also includes administration of the drugs, and medical supplies related to the mixing and administration of the drugs. Orally administered anticancer medications are covered as a prescription benefit.
- **Outpatient Surgery.** Certain services may be covered only when Prior Authorized or as Emergency Medical Care. Prior Authorization requirements can be verified by contacting us or as outlined in the "Prior Authorization" portion of this Group Plan Benefits section.

  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.

Emergency Services

Certain exclusions and limitations may apply. Be sure you read the "Exclusions and Limitations" and the "Prior Authorization" subsections of this Group Plan Benefits section and your Copayment and Coinsurance Schedule for additional benefit limitation information, before obtaining care.

Emergency service(s) include "Emergency Medical Care" and "Emergency Medical Screening Exam" for evaluation, treatment and "Stabilization" of an "Emergency Medical Condition." See the "Definitions" section of the Group Medical and Hospital Service Agreement.

Emergency Medical Care is covered inside or outside the Service Area without Prior Authorization, including emergency eye care. See the "Definitions" section of the Group Medical and Hospital Service Agreement.

Emergency Inside the Service Area. If you have an Emergency Medical Condition inside the Service Area and you reasonably believe that the time required to contact your Primary Care Provider or to go to a Participating Provider Hospital or Urgent Care facility would seriously jeopardize your health (including an unborn child), 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 and reasonably believe that the time required to contact your Primary Care Provider would seriously jeopardize your health (including an unborn child), 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 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.

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 no later than 24 hours or by the next business day after admission or as soon as medically possible.

Follow-up and Continued Care. After Stabilization of an Emergency Medical Condition, all follow-up care must be provided by a Participating Provider in accordance with the terms and conditions of the Group Medical and Hospital Service Agreement and this Group Plan Benefits section. If you are hospitalized in a Nonparticipating Provider Hospital and require continuous care, you shall be transferred by us to a Participating Provider as soon as Stabilization has occurred. We must approve in advance any expenses incurred after Stabilization and transfer to a Participating Provider is medically feasible. All other services provided by a Nonparticipating Provider if you have refused a transfer after Stabilization are excluded.

Ambulance Transport. Licensed ground or air ambulance services are covered in the event of an Emergency Medical Condition. Air ambulance service is covered only when ground transportation is medically or physically inappropriate. Medically Necessary ambulance transport for facility-to-facility transfers is covered only when Prior Authorized. Prior Authorization requirements can be verified by contacting us or as outlined in the "Prior Authorization" section of this Group Plan Benefits. The maximum benefit is shown on the Copayment and Coinsurance Schedule.

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 standard, a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:

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

b. Result in serious impairment to bodily functions; or

c. Result in serious dysfunction of any bodily organ or part.

We also administer this Agreement in accordance with the definitions of "Emergency Medical Care," "Emergency Medical Screening Exam" and "Emergency Medical Services Transport" in the "Definitions" section of the Group Medical and Hospital Service Agreement.

Claims. All claims for Emergency Medical Care must contain sufficient information to establish the emergency nature of the care.

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 Pervasive Developmental Disorder or Autism, are as shown in the Copayment and Coinsurance Schedule under "Behavioral Health Services-Substance Use Disorders and Mental Health Conditions."

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 an Autism Service Provider providing treatment to the Member for whom the treatment plan was developed. The treatment must be administered by the Autism Service Provider.

- A licensed Physician or licensed psychologist must establish the diagnosis of Pervasive Developmental Disorder or Autism. In addition, the Autism Service Provider must submit the initial treatment plan to Health Net.
- The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Autism Service Provider for the specific patient being treated and must be reviewed by the Autism Service Provider no less than 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 Autism Service Provider must submit updated treatment plans to Health Net for continued behavioral health 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.
- Health Net may deny coverage for continued treatment if the requirements above are not met or if ongoing efficacy of the treatment is not demonstrated.

Autism Service Provider means one of the following:

- A Behavior Analysis Regulatory Board (BARB) registered health care professional; or
- A BARB licensed behavior analyst, certified by the Behavior Analyst Certification Board, Incorporated, as a Board-Certified Behavior Analyst and has successfully completed a criminal records check; or
- A BARB licensed assistant behavior analyst, certified by the Behavior Analyst Certification Board, Incorporated, as a Board-Certified Assistant Behavior Analyst, supervised by a behavior analyst who is licensed by the Behavior Analysis Regulatory Board and has successfully completed a criminal records check; or
- A BARB registered behavior analysis interventionist who has completed coursework and training prescribed by the BARB by rule, who receives ongoing oversight by a licensed behavior analyst or a licensed assistant behavior analyst, or by another licensed health care professional approved by the BARB and has successfully completed a criminal records check.

Exclusions and Limitations:

Applied behavioral analysis and other forms of behavioral health treatment for Autism and Pervasive Developmental Disorder requires Prior Authorization.

Blood

Blood transfusions, including blood processing, the cost of blood, unreplaced blood, and blood products, are covered.

Child Abuse Medical Assessments

Child abuse medical assessments are covered when provided under the direction of a licensed physician or other licensed health care professional trained in the evaluation, diagnosis, and treatment of child abuse in a community assessment center.

Child abuse medical assessment includes the taking of a thorough medical history, a complete physical examination and an interview for the purpose of making a medical diagnosis, determining whether or not the child has been abused and identifying the appropriate treatment or referral for follow-up for the child.

Community assessment center means a neutral, child-sensitive community-based facility or service provider to which a child from the community may be referred to receive a thorough child abuse medical assessment for the purpose of determining whether the child has been abused or neglected.

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, and either:
  a. The referring Provider has concluded that the Member's participation in such trial is appropriate; or
  b. 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. 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;

b. 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;

c. 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

d. 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; or

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

f. Exempt by federal law from the requirement to submit an INDA 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, if any, and Copayments or Coinsurance that apply to the drug, device or service being tested in the absence of an Approved Clinical Trial.

Colorectal Cancer Screenings

Colorectal cancer screening examinations and laboratory tests are covered as preventive care as listed under the "Preventive Care" subsection of this Group Plan Benefits section. Colorectal cancer screening

examinations and laboratory tests assigned either a grade of A or a grade of B by the United States Preventive Services Task Force (USPSTF) are covered.

For Members age 50 years and older, no cost sharing is applied for in-network services and coverage includes at a minimum:

- Fecal occult blood tests, fecal immunochemical tests;
- Sigmoidoscopies, colonoscopies, including the removal of polyps during a screening procedure if the insured has a positive result on any fecal test assigned either a grade of A or a grade of B by the United States Preventive Services Task Force; or
- Double contrast barium enemas.

If a Member is at high risk for colorectal cancer, the coverage shall include colorectal cancer screening examinations and laboratory tests as recommended by the treating Physician. For the purposes of this section an individual is at high risk for colorectal cancer if the individual has:

- A family medical history of colorectal cancer;
- A prior occurrence of cancer or precursor neoplastic polyps;
- A prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease or ulcerative colitis; or
- Other predisposing factors.

Craniofacial Anomalies

Dental and orthodontic services for the treatment of Craniofacial Anomalies are covered if the services are Medically Necessary to restore function. Craniofacial Anomalies are physical disorders identifiable at birth that affect the bony structures of the face or head, including, but not limited to, cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome.

Exclusions and Limitations:

Craniofacial Anomalies does not include developmental maxillofacial conditions that result in overbite, cross bite, malocclusion or similar developmental irregularities of the teeth or Temporomandibular Joint Disorder (TMJ).

Dental Anesthesia

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

- Is under the age of six 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 dental procedure must be approved by the Member's Physician.

The services must be performed in a Hospital or in an Ambulatory Surgery Center. Inpatient anesthesia services are covered only when Prior Authorized. 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 are covered up to the maximum of $1,000 provided that the services are furnished within 12 months after an injury or accident.

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 in accordance with accepted medical standards. If you are also covered under a dental plan provided through us, 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:

- Diabetes self-management programs are covered including: (a) one program of assessment and training, and (b) up to three hours annually, of assessment and training following a material change in the condition, medication, or treatment in an existing treatment of diabetes. Coverage is subject to the Copayment or Coinsurance amount shown on the "Copayment and Coinsurance Schedule" under "Other Services."
- Appropriate and Medically Necessary supplies and equipment related to Diabetes Management including blood glucose test strips, lancets, insulin syringes and needles as described in the "Medical Supplies" subsection of this Group Plan Benefits section.
- Routine foot care in connection with the treatment of diabetes.
- Medically necessary corrective shoes and arch supports, including foot orthotics.
- Screening for gestational diabetes, as supported by HRSA guidelines, is covered as preventive care in the "Preventive Care" subsection of this Group Plan Benefits section.
- You are eligible for no cost benefits for diabetes management from the beginning of your pregnancy for up to six weeks postpartum. For more information, please contact our Customer Contact Center at the phone number found at the back of this Agreement.

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.

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

Durable Medical Equipment, including your initial rental or purchase, is covered provided it 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. Medically Necessary lenses for the treatment of aphakia and keratoconus are covered as Durable Medical Equipment. Prior Authorization is required.

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 Durable Medical Equipment Medicare Administrative Contractor (DME MAC), Healthcare Common Procedure Coding System (HCPCS) Level II and Medicare National Coverage Determinations (NCD).

Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered as preventive care listed under "Preventive Care" subsection in the Group Plan Benefits section.

Exclusions and Limitations:

We may utilize a Specialty Care Provider of Durable Medical Equipment if you live in Oregon or Washington. 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.

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

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 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.

Gender Reassignment Services/Gender-affirming Treatment

Medically Necessary treatment for Gender Dysphoria, including, but not limited to, mental health treatment, pre-surgical and post-surgical hormone therapy (including puberty-delaying medications), and surgical services (such as genital, face, and chest reconstructive surgery) are covered. Services not Medically Necessary for the treatment of gender dysphoria or gender identity disorder are not covered. Surgical services must be performed by a qualified Provider in conjunction with gender reassignment surgery or a documented gender reassignment surgery treatment plan. Prior Authorization is required.

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, weight management, stress management, and smoking cessation. Qualifying classes must be taken at a Hospital or Clinic.

- We will cover up to the maximum reimbursement amount shown on the Copayment and Coinsurance Schedule for each health education class.
- The total benefit under this section is not to exceed the Calendar Year maximum shown on the Copayment and Coinsurance Schedule.

Hearing Aids and Hearing Assistive Technology

Hearing aid(s) and hearing assistance technology systems are covered as follows:

- **Hearing aid and accessories.** This plan covers one hearing aid per impaired ear. The hearing aid(s) must be prescribed, fitted, and dispensed by a licensed audiologist with the approval of a licensed Physician. The hearing aid(s) must be Medically Necessary for the treatment of hearing loss for a Member Enrolled under the plan. This plan also covers ear molds, replacement ear molds, and one box of replacement batteries per year for each hearing aid;
- **Cochlear implants.** Medically Necessary cochlear implants and bilateral cochlear implants including coverage for programming and reprogramming are covered. We will reimburse the cost of repair and replacement parts for cochlear implants if the repair or parts are not covered by warranty and are necessary for the device to be functional for the user;
- **Necessary diagnostic and treatment services (including hearing tests appropriate for age or developmental need, hearing aid checks, and aided testing);**
- **Bone conduction sound processors (if necessary for appropriate amplification of the hearing loss);**

- **Hearing assistive technology systems.** Hearing assistive technology systems means devices used with or without hearing aids or cochlear implants to improve the ability of a user with hearing loss to hear in various listening situations, such as being located a distance from a speaker, in an environment with competing background noise or in a room with poor acoustics or reverberation.

Exclusions and Limitations:

The maximum benefit for hearing aid(s), bone conduction sound processors and hearing assistive technology systems:

a. Every 36 months; or

b. For hearing aids, more frequently than every 36 months if modifications to an existing hearing aid will not meet the needs of a Member who is:

   1. Under 19 years of age; or

   2. 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution.

The maximum benefit for ear molds and replacement ear molds:

a. Up to four times per year for Enrollees who are younger than eight years of age;

b. At least once per year for Enrollees who are:

   1. Eight to 18 years of age; or

   2. 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution.

The maximum benefit for necessary diagnostic and treatment services:

a. At least twice per year for Enrollees younger than four years of age;

b. At least once per year for Enrollees who are four years of age or older.

This benefit is subject to the Deductibles, if any, Copayments or Coinsurance shown on the Copayment and Coinsurance Schedule that apply to Durable Medical Equipment. Prior Authorization is required.

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. Daily coverage is limited to what we would pay a participating Skilled Nursing Facility for 24-hour Skilled Nursing Services. Prior Authorization is required.

Exclusions and Limitations:

We may utilize a Specialty Care Provider of home health services if you live in Oregon or Washington. Prior Authorization is required for physical, occupational and speech therapy performed in the home. We do not cover Custodial Care.

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. Prior Authorization is required. Medically Necessary home injectables except insulin are covered when Prior Authorized.

Exclusions and Limitations:

We may utilize a Specialty Care Provider of home infusion services if you live in Oregon or Washington.

Hospice Care

Hospice Care is covered if you are terminally ill. Daily coverage is limited to what we would pay a participating Skilled Nursing Facility for 24-hour Skilled Nursing Services. Prior Authorization is required for inpatient Hospice and home Hospice 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. "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.

Maternity Benefits

Certain exclusions and limitations may apply. Be sure you read the "Exclusions and Limitations" and the "Prior Authorization" subsections of this Group Plan Benefits section and your Copayment and Coinsurance Schedule for additional benefit limitation information, before obtaining care.

Medically Necessary maternity care is covered as follows:

Availability. Maternity benefits are available for all Members (Subscriber, Subscriber's Enrolled spouse or Domestic Partner, and a Subscriber's Enrolled Dependent Child).

Prenatal and Postnatal Care. Prenatal and postnatal care is covered. This benefit is subject to the maternity delivery care (professional services only) Copayment or Coinsurance amount shown on the Copayment and Coinsurance Schedule.

Breastfeeding support, supplies and counseling, and screening for gestational diabetes as supported by HRSA guidelines, are covered as preventive care in the "Preventive Care" subsection of this Group Plan Benefits section.

You are eligible for no cost benefits for diabetes management from the beginning of your pregnancy for up to six weeks postpartum. For more information, please contact our Customer Contact Center at the phone number found at the back of this Agreement.

Universal Newborn Nurse Home Visits. This plan covers universal newborn nurse home visiting services in accordance with state law. These visits are covered for newborns up to age six (6) months, if the newborns are Enrolled in the health plan and reside in an area that is served by a universal newborn nurse home visiting program approved by the Oregon Health Authority. Unless you are on a Single or Family HDHP plan, coverage for universal newborn nurse home visits is provided at no cost share to you.

Hospital Room and Board. Hospital room and board for the mother are covered the same as for any other covered illness or injury. This benefit is subject to the inpatient services Copayment or Coinsurance amount shown on the Copayment and Coinsurance Schedule.

Delivery and Nursing Care. Delivery services and facilities and nursing care are covered. Birthing Center services will be directed 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.

Notification Required. Please notify us at the time of the first prenatal visit.

Abortion Services. Screening and counseling, interventions, and treatment. Services are covered at no cost when services are rendered by a Participating Provider.

Duty to Cooperate. Members who are a Surrogate at the time of Enrollment or Members who agree to a Surrogacy Arrangement during the Contract Year must, within 30 days of Enrollment or agreement to participate in a Surrogacy Arrangement, send us written notice of the Surrogacy Arrangement in accordance with the notice requirements as outlined in the Group Medical and Hospital Service Agreement. In the event that a Member fails to comply with this provision, we reserve the right to enforce this Plan Contract including recoupment of all benefits we paid on behalf of the Surrogate during the time that the Surrogate was insured under our contract.

Surrogacy Arrangement. Health care services for a Surrogate pregnancy are covered. If you enter into a Surrogacy Arrangement, Health Net reserves the right to recoup benefits for Covered Services we paid on behalf of the Surrogate during the time that the Surrogate was insured under our contract to the extent of amounts that are received by or paid on behalf of the Surrogate under a Surrogacy Arrangement. Health care services, including supplies and medication, to a Surrogate, including a Member acting as a Surrogate or utilizing the services of a Surrogate who may or may not be a Member, and any child born as a result of a Surrogacy Arrangement. This limitation applies to all health care services, supplies and medication provided to a Surrogate related to conception, pregnancy, or delivery in connection with the Surrogacy Arrangement including, but not limited to:

a. Prenatal care;

b. Intrapartum care (or care provided during delivery and childbirth);

c. Postpartum care (or care for the Surrogate following childbirth);

d. Mental Health Services related to the Surrogacy Arrangement;

e. Expenses relating to donor semen, including collection and preparation for implantation;

f. Donor gamete or embryos or storage of same relating to a Surrogacy Arrangement;

g. Use of frozen gamete or embryos to achieve future conception in a Surrogacy Arrangement;

h. Preimplantation genetic diagnosis relating to a Surrogacy Arrangement;

i. Any complications of the child or Surrogate resulting from the pregnancy; or

j. Any other health care services, supplies and medication relating to a Surrogacy Arrangement.

Exclusions and Limitations:

Services of a lay midwife are not covered.

Note: This provision does not amend the contract to restrict any terms, limits, or conditions that may otherwise apply to Surrogates and children born from Surrogates.

Any and all health care services, supplies or medication provided to any child birthed by a Surrogate as a result of a Surrogacy Arrangement are excluded, except where the child is the adoptive child of insureds possessing an active policy with us and/or the child possesses an active policy with us at the time of birth.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act:

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (e.g., your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Medical Supplies

Medical supplies are covered as follows:

- Diabetic supplies dispensed in accordance with any formulary adopted by us are covered, including syringes, blood glucose monitors and test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and pump accessories, insulin infusion devices, and foot care appliances for prevention of complications associated with diabetes. Insulin, glucagon emergency kits and prescriptive oral agents are excluded, unless covered under a Supplemental Prescription Benefit Schedule.
- 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.

- You are eligible for no cost benefits for diabetes management from the beginning of your pregnancy for up to six weeks postpartum. For more information, please contact our Customer Contact Center at the phone number found at the back of this Agreement.
- 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 are covered. Contact our Customer Contact Center at the phone number listed at the back of this Agreement 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 Participating Provider's office are covered.

Exclusions and Limitations:
Wound care products; incontinence products; generic multi-use products, reusables, and all other non-durable medical supplies are not covered.

Mental Health Conditions

Benefits are provided for Medically Necessary treatment of Mental Health Conditions.

Inpatient, residential, partial hospitalization and intensive outpatient services and some outpatient services require Prior Authorization. To obtain Prior Authorization please contact the Customer Contact Center at the phone number listed at the back of this Agreement.

Medically Necessary services provided for Mental Health Conditions are covered following the provisions of the "Office Visits," the "Specialty Physician Services," the "Hospital Inpatient Services," and the "Outpatient Services" subsections of this Group Plan Benefits section, and as shown in the Copayment and Coinsurance Schedule under "Behavioral Health Services-Substance Use Disorders and Mental Health Conditions."

We will not deny benefits for a Medically Necessary treatment or service for a Mental Health Condition based solely upon:

- An Enrollee's interruption of or failure to complete a prior course or treatment;
- Health Net's categorical exclusion of such treatment or service when applied to a class of Mental Health Conditions; or
- The fact that a court ordered the Enrollee to receive or obtain the treatment or service for a Mental Health Condition, unless otherwise allowed by law.

For purposes of this section:

"Facility" means a corporate or governmental entity or other Provider of services, licensed for the treatment of Mental Health Conditions.

"Program" means a particular type or level of service that is organizationally distinct within a Facility. A program that provides services for persons with both a Substance Use Disorder diagnosis and a Mental Health Condition shall be considered to be a distinct and specialized type of program for both Substance Use Disorder and Mental Health Conditions.

"Provider" means a person that has met our credentialing requirements, is otherwise licensed and eligible to receive reimbursement for coverage under the Agreement and is:

- A health care Facility;
- A residential Program or Facility;
- A day or partial hospitalization Program;
- An outpatient service; or
- An individual behavioral health or medical professional authorized for reimbursement under Oregon law.

Exclusions and Limitations:
No coverage is provided for the following services:

- The coverage of a treatment or service that is or may be excluded from coverage under state law;
- Educational or correctional services or sheltered living provided by a school or halfway house; however, a Member may receive covered outpatient services while in custody or living temporarily in a sheltered living situation or receive treatment or services related to a Member's education that are included in a Medically Necessary treatment plan provided by a Provider;
- Psychoanalysis or psychotherapy received as part of an educational or training program and not otherwise covered, regardless of diagnosis or symptoms that may be present;
- Expenses related to a stay at a sober living facility;
- A court-ordered sex offender treatment program; or
- Support groups.

In-home services are limited to persons who are homebound under the care of a Physician.

This Agreement will never provide less than the minimum benefits required by state and federal laws. This coverage complies with the requirements under the Mental Health Parity and Addiction Equity Act of 2008.

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, and a Participating Provider has issued a written order for the formula, and the formula comprises the sole source, or an essential source, of nutrition.

Oral and Maxillofacial Services

The following oral and maxillofacial services are covered when Prior Authorized:

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

- Maxillofacial prosthetic services for restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma, or birth and developmental deformities when the services are performed for the purpose of (1) controlling or eliminating infection or pain, or (2) restoring facial configuration or functions such as speech, swallowing, or chewing.

Organ and Tissue Transplants

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

- kidney transplants;
- pancreas after kidney transplants;
- cornea transplants;
- heart transplants;
- liver transplants;
- lung transplants;
- heart-lung transplants;
- concurrent kidney-pancreas transplants for patients with concomitant Type 1 diabetes and end-stage renal failure;
- adult autologous stem cell/bone marrow transplants;
- adult allogeneic stem cell/bone marrow transplants;
- pediatric autologous stem cell/bone marrow transplants;
- pediatric allogeneic stem cell/bone marrow transplants;
- pediatric bowel transplants;
- tissue typing and matching; and
- transplantation of cord blood stem cells

Transplantations of cord blood stem cells, tandem transplants (also known as sequential or double transplants), and mini transplants (non-myeloablative allogeneic stem cell transplants) are covered when Medically Necessary.

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.
- Non-human or artificial 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.
- High dose chemotherapy, which requires the support of a non-covered bone marrow transplant or autologous stem cell rescue.
- Bone marrow transplantation, stem cell rescue or hematopoietic support for human gene therapy (enzyme deficiencies), 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, freestanding infusion center, Ambulatory Surgery Center, outpatient dialysis center or outpatient Hospital, are covered under your medical plan with Prior Authorization. Refer to the Health Net website, www.healthnetoregon.com or call our Customer Contact Center at the phone number listed in the back of this Agreement for a list of drugs that require Prior Authorization. Prior Authorization is not required for prescription drugs and over-the-counter medications that are determined to be preventive as recommended by the United States Preventive Services Task Force (USPSTF) A and B recommendations.

Preventive Care

When preventive care services, as described in this section, 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 subject to your Nonparticipating cost share amount including Deductible (if any), as indicated on your Copayment and Coinsurance Schedule.

Covered recommended preventive care services can be found at https://uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations and can also be obtained by calling the Customer Contact Center at the phone number listed at the back of this Agreement.

Covered recommended preventive care services include the following:

- United States Preventive Services Task Force (USPSTF) recommended type “A” and “B” services;
- Immunizations and inoculations as recommended by the Advisory Committee on immunization
- Practices of the Center for Disease Control (CDC);

- Pediatric preventive care and screenings, as supported by the Health Resources and Services Administration (HRSA) guidelines;
- Women's health care services as supported by HRSA guidelines such as, screening for gestational diabetes; 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; breastfeeding support, supplies and counseling; and domestic violence screening and counseling;
- Other USPSTF recommendations for breast cancer screening, mammography, and prevention.

For a complete list of women's health care services supported by HRSA, visit https://www.hrsa.gov/womensguidelines2016/index.html or call the Customer Contact Center at the phone number listed at the back of this Agreement.

- Additionally, coverage is provided for the human papillomavirus (HPV) vaccine for Members between the ages of 11 and 26.
- Additional covered preventive services, not supported by HRSA, include:
  - Sexually transmitted infection screening and counseling;
  - Anemia screening;
  - Urinary tract infection screening;
  - Pregnancy screening;
  - Rh incompatibility screening;
  - BRCA1 or BRCA2 genetic mutation screening and counseling; and
  - Breast cancer chemoprevention counseling.

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

This Agreement will never provide less than the minimum benefits required by state and federal laws.

Prosthetic Devices and Orthotic Devices

Custom fitted Prosthetic Devices and Orthotic Devices that are Medically Necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience are covered, provided it is the least costly alternative that achieves a medically acceptable result. Coverage includes all services and supplies that are Medically Necessary for the effective use of a Prosthetic Device or Orthotic Device including, but not limited to, formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instruction to Members in the use of the device.

Exclusions and Limitations:
We may utilize a Specialty Care Provider for Prosthetic Devices and Orthotic Devices. Prior Authorization is required.

Repair or replacement is covered if determined to be Medically Necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience. Prosthetic Devices and Orthotic Devices are limited to those on the established list adopted by the Department of Consumer and Business Services. The list shall be no more restrictive than the list of prosthetic and Orthotic Devices and supplies in the Medicare fee schedule for Durable Medical Equipment, prosthetics, orthotics, and supplies.

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

This benefit is subject to the Deductibles, Copayments or Coinsurance shown on the Copayment and Coinsurance Schedule that apply to Prosthetic Devices and Orthotic Devices.

Reconstructive Breast Surgery

Reconstructive breast surgery is 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, or as part of approved gender affirming treatment, 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; treatment of physical complications from all stages of mastectomy, including lymphedemas; and inpatient care related to the mastectomy and post-mastectomy services. Prior Authorization is required.

Exclusions and Limitations:
Unless Medically Necessary, all other reconstructive breast surgery is excluded except as provided in this section.

Rehabilitation Therapy

For the purposes of this section:

Rehabilitation services are health care 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 therapy is covered as follows:

Medically Necessary therapy and services for the treatment of traumatic brain injury are covered.

Medically Necessary rehabilitation therapy for Pervasive Development Disorders or Autism is covered. This includes physical therapy, occupational therapy, or speech therapy services to restore or improve function.

The following services are covered in connection with other conditions when Medically Necessary: Hospital-based or outpatient physical, occupational and speech therapy, manipulations, cardiac rehabilitation, rehabilitation therapy following a covered mastectomy. The services must be based on a treatment plan authorized, as required by the plan or the Member's Physician. Such services are not covered when medical documentation does not support the Medical Necessity because of the Member's

inability to progress toward the treatment plan goals or when a Member has already met the treatment plan goals.

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, and cheerleaders.

Examples of health care services that are not rehabilitative services include, but are not limited to, Respite Care, day care, recreational care, residential treatment, social services, Custodial Care, or education services of any kind, including, but not limited to, vocational training.

The maximum benefits for inpatient and outpatient treatment are shown on the Copayment and Coinsurance Schedule. Prior Authorization is required.

Rehabilitative services to treat Mental Health Conditions are not subject to the day/visit limit maximums.

Skilled Nursing Care

Skilled Nursing Service in a participating Skilled Nursing Facility is covered. The maximum benefit is shown on the Copayment and Coinsurance Schedule. Prior Authorization is required.

Specialty Pharmacy

Certain drugs identified on the formulary are classified as Specialty Pharmacy Drugs under your plan. Specialty Pharmacy drugs are covered only under a Supplemental Prescription Benefit Schedule. 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.

Sterilization

Male and female sterilization services are covered.

Female sterilization, as supported by HRSA guidelines, is covered as preventive care as listed under the "Preventive Care" subsection of this Group Plan Benefits section.

Male sterilization services are covered at no cost when services are rendered by a Participating Provider.

Prior authorization requirements can be verified by contacting us as outlined in the "Prior Authorization" subsection in this Group Plan Benefits section.

Exclusions and Limitations:
Reversal of voluntary infertility (sterilization) is not covered.

Substance Use Disorder Benefits

Medically Necessary benefits for treatment of Substance Use Disorder are provided.

Inpatient, residential, partial hospitalization and intensive outpatient services and some outpatient services require Prior Authorization. To obtain Prior Authorization please contact the Customer Contact Center at the phone number listed at the back of this Agreement.

Medically Necessary services provided for Substance Use Disorder services are covered following the provisions of the "Office Visits," the "Specialty Physician Services," the "Hospital Inpatient Services," and the "Outpatient Services" subsections of this Group Plan Benefits section, and as shown in the Copayment and Coinsurance Schedule under "Behavioral Health Services-Substance Use Disorders and Mental Health Conditions."

We will not deny benefits for a Medically Necessary treatment or service for a substance use condition based solely upon:

- An Enrollee's interruption of or failure to complete a prior course or treatment;
- Health Net's categorical exclusion of such treatment or service when applied to a class of substance use conditions; or
- The fact that a court ordered the Enrollee to receive or obtain the treatment or service for a substance use condition, unless otherwise allowed by law.

For purposes of this section:

"Facility" means a corporate or governmental entity or other Provider of services licensed for the treatment of Substance Use Disorders.

"Program" means a particular type or level of service that is organizationally distinct within a Facility. A program that provides services for persons with both a Substance Use Disorder diagnosis and a Mental Health Condition shall be considered to be a distinct and specialized type of program for both Substance Use Disorder and Mental Health Conditions.

"Provider" means a person that has met our credentialing requirements, is otherwise licensed and eligible to receive reimbursement for coverage under the Agreement and is:

- A health care Facility;
- A residential Program or Facility;
- A day or partial hospitalization Program;
- An outpatient service; or
- An individual behavioral health or medical professional authorized for reimbursement under Oregon law.
- Preadmission authorization and continued stay authorization is required for both rehabilitation and non-emergent detoxification services. All admissions for rehabilitation are 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.

Exclusions and Limitations:
No coverage is provided for the following services:

- The coverage of a treatment or service that is or may be excluded from coverage under state law;
- Educational or correctional services or sheltered living provided by a school or halfway house; however, a Member may receive covered outpatient services while in custody or living temporarily in a sheltered living situation or receive treatment or services related to a Member's education that are included in a Medically Necessary treatment plan provided by a Provider;
- Expenses related to a stay at a sober living facility;
- A court ordered sex offender treatment program or;
- Support groups.

In-home services are limited to persons who are homebound under the care of a Physician.

This Agreement will never provide less than the minimum benefits required by state and federal laws. This coverage complies with the requirements under the Mental Health Parity and Addiction Equity Act of 2008.

Telemedicine

Telemedicine means the mode of delivering health services using information and telecommunication technologies to provide consultation and education or to facilitate diagnosis, treatment, care management or self-management of a patient's health care. Applicable Copayments, Coinsurance, and Deductible, if any, can be found in your Copayment and Coinsurance Schedule under "Telemedical Services."

We will provide coverage for services using telemedicine under the following conditions:

- We would otherwise provide coverage for the service when provided in person by the health professional;
- The service is Medically Necessary;
- The service is determined to be safely and effectively provided using telemedicine 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.

Unless otherwise permitted by a state of emergency as declared by the Oregon Governor, telemedicine applications and technologies shall include:

- Landlines, wireless communications, the internet, and telephone networks; and
- Synchronous or asynchronous transmissions using audio only, video only, audio and video and transmission of data from remote monitoring devices.

For the purpose of this provision, "audio only" means the use of audio telephone technology, permitting real-time communication between a health care Provider and a patient for the purpose of diagnosis, consultation or treatment. "Audio only" does not include:

- The use of facsimile, electronic mail, or text messages; or

- The delivery of health services that are customarily delivered by audio telephone technology and customarily not billed as separate services by a health care Provider, such as the sharing of laboratory results.

Exclusions and Limitations:
Services that are not otherwise covered are not covered when provided using telemedicine.

Unless all conditions listed in this section for such services are met, you may be responsible for billed charges from a Provider for services delivered using telemedicine. For more information, please contact our Customer Contact Center at the phone number listed at the back of this Agreement.

Temporomandibular Joint Syndrome (TMJ)

Services for the diagnosis and treatment of Temporomandibular Joint Syndrome are covered. The lifetime maximum benefit is shown on the Copayment and Coinsurance Schedule. Prior Authorization is required.

Tobacco Use Cessation Programs

Tobacco Use Cessation services and/or treatments that are assigned either a grade of A or a grade of B by the United States Preventive Services Task Force (USPSTF) are covered under the "Preventive Care" portion of this Plan Benefits section. These benefits apply to the annual Out-of-Pocket Maximum as shown on the Copayment and Coinsurance Schedule.

Tobacco cessation medications are covered as a pharmacy benefit under the Supplemental Prescription Benefit Schedule.

A Tobacco Use Cessation Program is defined as "A program recommended by a Physician that follows the United States Public Health Service guidelines for tobacco use cessation." Reimbursement includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products.

Tobacco use is defined as use of tobacco on average four or more times per week within no longer than the past six months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco.

Prior Authorization

The services requiring Prior Authorization as defined in the "Definitions" section of the Group Medical and Hospital Service Agreement are specified in this Group Plan Benefits section. You are responsible for obtaining Prior Authorization from us before obtaining such services. Prior Authorization may be obtained by you or your Provider by calling 888-802-7001 or by faxing a request to 800-495-1148. For Prior Authorization of mental health or Substance Use Disorder services, please call 800-977-8216. Coverage for those services will be provided only if Prior Authorization has been obtained from us.

A Provider request for Prior Authorization of non-emergency services must be answered within two business days, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning continued length of stay.

We will provide a single determination of Prior Authorization for all covered mastectomy-related services that are part of the Member's course or plan of treatment.

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. Health Net will confirm the recommended alternative has documented safety and efficacy to equal that of the requested service. Such alternative benefits shall be determined by us, in advance, in cooperation with you and your Primary Care Provider. The decision to accept Health Net's recommendation on the course of treatment shall remain up to you and your Participating 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.

Pharmacy Prior Authorization

To obtain Prior Authorization, please call our Customer Contact Center at 888-802-7001 or fax a request to 800-255-9198. Pharmacy requests may also be submitted electronically by your Provider through Cover-My-Meds.

Exclusions and Limitations (What's not covered)

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

- **Not Medically Necessary.** Any care not Medically Necessary as defined in the "Definitions" section of the Group Medical and Hospital Service Agreement and any Hospital or medical care services not specifically provided for in the Group 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 Group Plan Benefits section, the Copayment and Coinsurance Schedule, or any Supplemental Benefit Schedule.
- **Other Insurance.** All services or supplies rendered for any illness, injury, or condition to the extent that benefits are available to you as an insured under the terms of any other insurance (except group or individual health insurance) including without limitation automobile medical, personal injury protection, automobile no-fault, automobile uninsured or underinsured motorist, homeowners or renters, commercial premises or comprehensive general liability insurance coverage. If we pay benefits before any such insurance payments are made, reimbursement must be made out of any other subsequent insurance payments made to you and, when applicable, we may recover benefits already paid directly from the insurer, in accordance with the "Subrogation" section in the Group Medical and Hospital Service Agreement.
- **Experimental or Investigational Procedures.** Except as provided in the "Clinical Trials" subsection of this Group Plan Benefits section, 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. However, Emergency Medical Care for such complications is covered.

- **Services Without Referrals.** Non-emergency services by a Provider other than a Primary Care Provider without a Referral, if Referral is required pursuant to the "Participating Providers" section of the Group Medical and Hospital Service Agreement. Coverage for services of a Nonparticipating Provider is limited to a Maximum Allowable Amount fee.
- **Unauthorized Services.** Non-emergency services without Prior Authorization, if Prior Authorization is required pursuant to the "Prior Authorization" subsection of this Group Plan Benefits section.
- **Expenses Related to Non-Covered Services or Supplies.** Expenses, other than for Emergency Medical Care, for any condition or complication caused by any procedure, treatment, service, drug, device, product or supply excluded from coverage.
- **Hospital Room.** A private room or services of private or special duty nurses other than as Medically Necessary when you are an inpatient in a Hospital.
- **Alternative Care.** Chiropractic care, acupuncture, naturopathic medicine, massage therapy, therapeutic massage, and hypnotherapy. Medically Necessary services, other than the services listed in this exclusion, that are provided by a Naturopathic Physician (ND) and are within the scope of his or her licensure are not subject to this exclusion.
- **Dental Services.** Services performed in connection with treatment to teeth or gums, upper or lower jaw augmentation or reduction, including treatment or devices for disorders of the temporomandibular joint; all dental services and dentures except as specified under the "TMJ," "Oral and Maxillofacial Services," "Dental Anesthesia," and "Dental Injury" subsections of this Group Plan Benefits section or as otherwise covered under the "Preventive Care" section. Prior Authorization may be required.
- **Orthodontic Services and Dental Implants.** Except for treatment covered under the "Dental Injury" and "Oral and Maxillofacial Services" subsections of this Group Plan Benefits section.
- **Custodial Care; Respite Care.**
- **Optometrics, Eyewear, Vision and Hearing Examinations.** Eye refractions, regardless of diagnosis; routine eye examinations, 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 "Medical Supplies" subsection of this Group Plan Benefits section. Hearing screening and tests except as provided in the "Diagnostic Services" provision of the "Physician Services" subsection and the "Preventive Care" subsection of this Group Plan Benefits section. Hearing aids except as provided in the "Hearing Aids" subsection, masking devices, or other hearing devices or the fitting thereof.

- **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 "Oral and Maxillofacial Services," "Dental Injury," and "Gender Reassignment Services/Gender-affirming treatment" 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 not covered 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, hair transplantation, hair analysis, hairpieces and wigs, and cranial/hair prostheses are not covered.
- **Breast Reduction or Augmentation.** Reduction or augmentation mammoplasty, except if Medically Necessary or as provided in the "Reconstructive Breast Surgery" or "Gender Reassignment Services/Gender-affirming Treatment" subsections of this Group Plan Benefits section.
- **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, examinations or reports for school events, camp, employment, marriage, domestic partnership, trials or hearings, licensing, and insurance.
- **Immunizations and Inoculations.** Except as provided under the "Preventive Care" subsection of this Group Plan Benefits section. Immunizations for foreign travel/occupational purposes are not covered.
- **Diagnosis and 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 are not covered. 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 diagnosis and treatment includes but is not limited to:

  a. Evaluation and/or treatment of an inability to conceive.

  b. Evaluation and/or treatment of habitual abortion, including chromosomal analysis.

  c. Assisted reproductive technologies and artificial insemination.

  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.

- **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 provided in 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.
- **Diagnosis and treatment for learning disorders** in the absence of a DSM diagnosis.
- **Speech Generating Devices; Augmentative and Alternative Communication Devices or Communicators.** This exclusion does not include an artificial larynx for Members who have had a complete laryngectomy.
- **Speech Language Pathology Therapy.** Except for Covered Services provided in the "Rehabilitation Therapy" subsection of the Group Plan Benefits, speech language pathology therapy for emotional or behavioral disorders, which fall under special education and/or are provided by a school district, is not covered.
- **Chiropractic manipulations.** Except if Medically Necessary.
- **Treatment of Sexual Dysfunction.** In the absence of a DSM mental health disorder of sexual dysfunction being the primary diagnosis, medications, surgical treatment or hospitalization for treatment of impotency; penile implants; services, devices or aids related to treatment for any types of sexual dysfunction, congenital or acquired; sperm storage or banking are not covered.
- **Genetic Engineering.**
- **Recreational or Educational Therapy; Non-medical Self-help Training.** Except as specifically stated below, 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 Oregon.

  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. 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 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.

- 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 services related to behavioral health treatment for Pervasive Developmental Disorder or Autism as shown in the "Autism Spectrum and Pervasive Developmental Disorder" section.

- **Bone Bank and Eye Bank Charges.**
- **Counseling or training in connection with family, sexual, marital, or occupational issues** in the absence of a DSM diagnosis/mental health disorder are not covered.
- **Orthoptics, Pleoptics.**
- **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.
- **Services for any illness, condition or injury occurring in or arising out of the course of employment for which a claim has been approved under workers' compensation insurance coverage.** In an event you have not submitted a claim with the workers' compensation insurer or self-insured employer, and we deny payment for services on the basis of the claim being work-related, state law allows you to file a claim with your workers' compensation insurer or self-insured employer within 90 days from the date we reject the claim. If your workers' compensation claim is denied, the workers' compensation insurer or self-insured employer shall inform us of the denial, and we will process the claim for payment in accordance with the terms, conditions and benefits of this Agreement.
- **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 or probation unless by court order.
- **Education Related to Judicial or Administrative Proceedings.** No coverage shall be provided for educational programs to which drivers are referred by the judicial system or for volunteer mutual support groups.
- **Outpatient Prescription or Other Drugs and Medications.** 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.
- **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 unless the injuries were sustained before Enrollment in this plan.
- **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.
- **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 as outlined in the "Diabetes Management" and "Inborn Errors of Metabolism" subsections of this Group Plan Benefits section, or as listed in the "Preventive Care" subsection (as described in the USPSTF Guidelines).
- **Wilderness Residential Treatment Programs.** All services provided in wilderness residential treatment programs, except for Medically Necessary evidence-based interventions provided by appropriately licensed Providers.
- **Treatment by an Immediate Family Member or Self Treatment.** Services and supplies rendered by an immediate family member (spouse, Domestic Partner, parent, child, grandparent or sibling related by blood, domestic partnership, 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.
- **Conditions caused by your commission (or attempted commission) of a felony.** However, the following are not excluded:
  - Treatment for injuries as a result of an act of domestic violence or an injury resulting from a medical condition.
  - Treatment for injuries sustained solely as a consequence of the Enrolled Member being intoxicated or under the influence of a narcotic.
  - Court-ordered screening interviews or treatment programs when a person is convicted of Driving Under the Influence of Intoxicants (DUII).
- **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.
- **Services While in Custody.** A Member cannot be denied coverage of services or supplies while in custody of a local supervisory authority while disposition of charges are pending if the services or supplies would otherwise be covered by this plan. Coverage will be denied for the treatment of injuries resulting from a violation of law.
- **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.
CommunityCare 1T 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 Oregon.
- 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

This section defines words that will help you understand your plan. These words appear throughout this Agreement with the initial letter of the word in capital letters. Definitions do not imply coverage and are subject to eligibility rules, coverage limitations and exclusions specified elsewhere in this Agreement.

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

"Adverse Benefit Determination" means an insurer's denial, reduction, or termination of a health care item or service, or an insurer's failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on the insurer's:

- Denial of eligibility for or termination of Enrollment in a Health Benefit Plan; or
- Rescission or cancellation of a policy or certificate; or
- Source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services; or
- Determination that a health care item or service is Experimental, Investigational, or not Medically Necessary, effective, or appropriate; or

- Determination that a course or plan of treatment that an Enrollee is undergoing is an active course of treatment for purposes of continuity of care; or
- Denial, in whole or in part, of a request for Prior Authorization, a request for an exception to step therapy or a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to other Utilization Review requirements.

An Enrollee may receive, free of charge, reasonable access to documents used in the Adverse Benefit Determination.

"Agreement" means this Medical and Hospital Service Agreement, all attached Benefit Schedules and Copayment and Coinsurance Schedules, the Signature Sheet, any exhibits, supplements, addenda, attachments, amendments, endorsements, applications or riders, 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 Copayment and Coinsurance Schedule or other Benefit Schedule(s) which set forth the medical, Hospital, and other benefits provided under this Agreement.

"Birthing Center" means a homelike facility accredited by the Commission for Accreditation of Birth Centers that is equipped, staffed, and operated to provide maternity-related care, including: prenatal, labor, delivery and postpartum care.

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

"Clinic" means a facility that is devoted to the care of outpatients, in contrast to larger Hospitals, which also treat inpatients.

"Clinical Review Criteria" means screening procedures, decision rules, medical protocols and clinical guidance used by an insurer or other entity in conducting Utilization Review and evaluating:

- Medical Necessity;
- Appropriateness of an item or health service for which Prior Authorization is requested or for which an exception to step therapy has been requested; or
- Any other coverage that is subject to Utilization Review.

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

"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.

"Craniofacial Anomalies" means a physical disorder identifiable at birth that affects the bony structures of the face or head including, but not limited to, cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome. Craniofacial Anomalies does not include developmental maxillofacial conditions that result in overbite, cross bite, malocclusion or similar developmental irregularities of the teeth or Temporomandibular Joint Disorder (TMJ).

"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 or Domestic Partner, 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" Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). 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.

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

- The spouse or Domestic Partner of the Subscriber.

- A Child of the Subscriber, from birth and extending 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 requiring the Subscriber to provide health coverage for the Child. Proof of compliance with this requirement must be furnished annually.

  "Child" means a natural child of the Subscriber, an adopted child of the Subscriber, or a stepchild of the Subscriber during the marriage or Domestic Partnership of the Subscriber and the natural parent, or a child of the Subscriber's Domestic Partner during the Domestic Partnership, but does not include foster children, wards, or children who are the subject of an Assignment of Parental Rights, even if decreed by a court. "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 Oregon. As defined in ORS 743A.090(5), child means an individual who has not reached 26 years of age at the time of the adoption or placement for adoption. Placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligations. Coverage for any Dependent child of a Subscriber shall not be terminated by the child's attaining the limiting age if the child is and continues to be Disabled and is not eligible to be covered under any government program except Medicaid. Proof of disability must be furnished annually. 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.

"Domestic Partner" means a person who is in a "domestic partnership" with the Subscriber. In accordance with Oregon State law a domestic partner is defined as described below:

- A domestic partnership is defined as "a civil contract entered into in person between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon."
- Any time that coverage is extended to a spouse it must also extend to a domestic partner.

The Subscriber is required to provide notice of termination of the relationship to the Subscriber Group.

"Drug Discount" or "Coupon" or "Copay Card" means cards or Coupons typically provided by a drug manufacturer to discount the Copayment and/or Coinsurance or your other out-of-pocket costs (e.g., Deductible or Out-of-Pocket Maximum).

"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 employee who is eligible for coverage under a group Health Benefit Plan.

"Emergency Medical Care" means the services and supplies to diagnose and treat an Emergency Medical Condition, including a behavioral health assessment, to the extent they are required for the Stabilization of the condition including;

- An Emergency Medical Services Transport;
- An Emergency Medical Screening Exam or behavioral health assessment that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition;
- Such further medical examination and treatment to the extent they are required for the Stabilization of the Member;
- Behavioral health assessment means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a patient's need for immediate crisis Stabilization.

"Emergency Medical Condition" means a medical condition:

- That manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:
  a. Place the health of a Member, or an unborn child in the case of a pregnant Member, in serious jeopardy;
  b. Result in serious impairment to bodily functions; or
  c. Result in serious dysfunction of any bodily organ or part;
- With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another Hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child; or
- That is a behavioral health crisis.

"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.

"Emergency Medical Services Transport" means an emergency medical services Provider's evaluation and Stabilization of a Member experiencing a medical emergency and the transportation of the Member to the nearest medical facility capable of meeting the needs of the Member. Emergency medical services Provider means a person who has received formal training in prehospital and emergency care and is licensed to attend any person who is ill or injured or who has a disability.

"Enrollment" or "Enroll" or "Enrolled" means the completion and signing of the necessary Enrollment forms, including the Enrollment application, by or on behalf of an eligible person and acceptance by us. Enrolled Members include Subscriber, spouse, or Domestic Partner, and/or Dependents.

"Expedited Review" means any request for benefits under the Agreement where applying normal review 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 request, in the opinion of a Physician with knowledge of the Member's medical condition.

"Experimental" or "Investigational" means services which a reasonably substantial, qualified, responsible, relevant segment of the medical community does not accept as proven to be safe and effective in treating a particular illness or condition and in improving the length and quality of life. In determining whether health care services are Experimental or Investigational, we will evaluate the services with regard to the particular illness or disease involved and will consider factors such as: the demonstrated effectiveness of the services in improving the length and quality of life; the incidence of death and complications associated with the services; alternative methods of treatment; whether the services are provided under an experimental or investigational protocol or study; whether the services are under continued scientific testing and research and reports in current medical and scientific literature concerning such testing and research; the positions of governmental agencies and other institutions (including without limitation Medicare, the Agency for Health Care Policy and Research and the American Medical Association) regarding the experimental or investigational nature of the services; whether the FDA has approved drugs for the use proposed; and the patient's physical, mental and psychological condition.

"Grievance" means:

- A communication from an Enrollee, or an authorized representative (defined as an individual who by law or by the consent of a person may act on behalf of the person) of an Enrollee, expressing dissatisfaction with an Adverse Benefit Determination, without specifically declining any right to appeal or review that is:
  a. in writing, for an Internal Appeal or an external review; or
  b. in writing or orally, for an expedited response or an expedited external review; or
- A written complaint submitted by an Enrollee or an authorized representative of an Enrollee regarding the following:
  a. availability, delivery or quality of a health care service;
  b. claims payment, handling or reimbursement for health care services, in which the Enrollee has not submitted a request for an Internal Appeal, and the complaint is not disputing an Adverse Benefit Determination; or
  c. matters pertaining to the contractual relationship between an Enrollee and an insurer.

"Health Benefit Plan" means any Hospital expense, medical expense or Hospital or medical expense policy or certificate, Subscriber contract of a health care service contractor, any plan provided by a multiple employer welfare arrangement or by another benefit arrangement 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 Oregon and of the locality in which it is located or provides services; and (c) 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. In the event of Emergency Medical Care, Hospital Services must be obtained from a Participating Provider if one is reasonably available.

"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.

"Internal Appeal" means a review by us of an Adverse Benefit Determination made by us.

"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, Domestic Partner, or minor child under a covered Participant'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 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 that we use to calculate what we pay for covered Medical Services and supplies provided by a Nonparticipating Provider or Out-of-Network Provider. MAA may be less than the amount billed for those Medical Services and supplies. MAA is calculated as the lesser of the amount billed by the Nonparticipating Provider or the amount determined in the order 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 Copayment and Coinsurance Schedule.

- The MAA for Out-of-Network Emergency Care will be the greatest of: (1) the amount negotiated with Participating Providers for the emergency service provided, excluding any in-network Copayment or Coinsurance; (2) the amount calculated using the same method we generally use to determine payments for Nonparticipating Providers, excluding any in-network Copayment or Coinsurance; or (3) the amount paid under Medicare Part A or B, excluding any in-network Copayment or Coinsurance.
- The MAA for covered outpatient pharmaceuticals (including but not limited to injectable medications) dispensed and administered to the patient by a Nonparticipating Provider, 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.
- The MAA for Covered Services and Supplies, excluding Emergency Medical Care and outpatient pharmaceuticals, received from a Nonparticipating Provider is a percentage of what Medicare would pay (known as the Medicare allowable amount). Medicare pays 100% of the Medicare allowable amount.
- The MAA for facility services, including but not limited to Hospital, Skilled Nursing Facility, and Outpatient Surgery, is determined by applying 160% of the Medicare allowable amount.
- The MAA for Physician and all other types of services and supplies is the lesser of the billed charge or 160% of the Medicare allowable amount.
- 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.

- MAA is subject to other limitations on covered Medical Services. See your Copayment and Coinsurance Schedule, Group Plan Benefits section, and any Supplemental Benefit Schedules and Amending Attachments for specific Deductibles, (if any), benefit limitations, maximums, requirements, and multiple surgery payment policies that limit the amount that we pay for covered Medical Services and supplies. 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 or diagnosis codes used were inconsistent with Medicare procedure coding rules or reimbursement policies.

The Medicare allowable amount is subject to automatic adjustment by the Centers for Medicare and Medicaid Services (CMS), an agency of the federal government which regulates Medicare.

The following example shows how MAA applies to claims payment:

For illustration purposes only, Nonparticipating 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

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 also contract with networks 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 Nonparticipating Provider services to a fee negotiation service to negotiate the MAA for the service or supply provided directly with the Nonparticipating Provider. In either of these two situations, 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, and Copayments or Coinsurance.

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.healthnetoregon.com or contact our 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 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 health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are:

- 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.
- An Oregon-licensed 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.

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 provisions in the "Rights of Members" section of this Group Medical and Hospital Service Agreement.

"Medicare" means The Health Insurance for the Aged and Disabled 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 Condition" means any mental disorder covered by diagnostic categories listed in the "Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition" (DSM-5). The exception of a disorder does not include or extend to a co-morbidity disorder accompanying the excepted disorder.

"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.

"Orthotic Device" means a rigid or semi rigid device supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck.

"Out-of-Pocket Maximum" 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.

"Participant" means an individual who is an employee or member of a Subscriber Group and is entitled, in accordance with the Group's established eligibility rules, to participate in the health and welfare plan sponsored by Subscriber Group. Participant also includes employees of entities that are eligible, in accordance with the Group's eligibility rules, to participate in the health and welfare plan sponsored by Subscriber Group.

"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 provide health care services to Members of this CommunityCare 1T Plan with an expectation of receiving payment, other than Copayments or Coinsurance, directly or indirectly from us and such contract or other arrangement is in effect at the time such services are rendered.

"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 Oregon or in the state in which medical care is rendered.

"Post-Service Claim" means any claim for benefits under the Agreement, which does not otherwise qualify as a "Pre-Service Claim" as, defined herein.

"Pre-Service Claim" means any claim for benefits under the Agreement where such benefits require separate approval or authorization before they can be considered covered under the Agreement.

"Primary Care Provider" means the Participating Provider who is authorized by us to act as a Primary Care Provider and who is designated by the Member as the Provider through whom the Member must obtain all of the health care benefits provided by this Agreement except annual gynecological examinations, maternity care, and Emergency Medical Care. Primary Care Providers are listed in our Provider Directory.

"Prior Authorization" means a form of Utilization Review that requires a Provider or a Member to request written or oral approval 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 services authorized by the Prior Authorization are performed on a date more than five days after the Prior Authorization is issued and the Member is ineligible on that date;
    b. The Prior Authorization specifies a date on which coverage terminates and services were obtained after that date; or
    c. The Prior Authorization was obtained through misrepresentation.
- We will answer a request for Prior Authorization of non-emergency services within two working 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 Device" means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg.

"Provider" means any Physician, health professional, Hospital, home health agency, pharmacy, laboratory, or other entity or person who is professionally licensed or certified by the appropriate state agency to diagnose or treat a bodily injury or illness and who is acting within the scope of his or her license to furnish Covered Services and Supplies.

"Referral" means authorization obtained from us in advance of receiving Medical Services from a Participating Provider other than a Member's Primary Care Provider.

"Respite Care" Respite care is furnished to a person in an inpatient setting in order to provide short-term relief for family members or others caring for that person.

"Service Area" means the counties in northwest Oregon including, Washington, Multnomah, Clackamas, Tillamook, Clatsop, Columbia, and Clark county in southwest 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.

"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 woman who is in active labor, to perform the delivery, including the delivery of the placenta.

"Subscriber" means a Participant 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. One person from each family unit Enrolled as a Member hereunder, who signs and executes the necessary Enrollment application form shall be considered the Subscriber under this Agreement and shall exercise all rights, privileges, and responsibilities of a Subscriber with respect to us.

"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 Participants. A Subscriber Group is limited to an entity that would, under Oregon law, be eligible for a group medical policy or contract. In order to qualify as a Subscriber Group, an entity must meet our current underwriting standards for the product sought.

"Substance Use Disorder" means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes on a recurring basis with the individual's social, psychological, or physical adjustment to common problems. For purposes of this Agreement, Substance Use Disorder includes addiction to or dependency on tobacco and tobacco products but does not include addiction to or dependence on foods.

"Surrogacy Arrangement" means an understanding in which a woman (the Surrogate) agrees to become pregnant and carry a child (or children) for another person (or persons) who intend to raise the child (or children), whether or not the Surrogate receives payment for acting as a Surrogate.

"Surrogate" means a gestational carrier who, as part of a Surrogacy Arrangement, (a) uses her own egg that is fertilized by a donor or (b) has a fertilized egg placed in her body but the egg is not her own.

"Urgent Care" means those 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.

"Utilization Review" means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings. Health Net uses Clinical Review Criteria (that are evidence-based and continuously updated based on new evidence and research and take into account new developments in treatment) when conducting Utilization Review.

"Women's Health Care Provider" means a Participating Provider who is an obstetrician or gynecologist, Physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health or a licensed nurse midwife, practicing within the applicable lawful scope of practice.

Monthly Payments (Premiums)

- The monthly premium rate is set forth on the Signature Sheet. If the state of Oregon 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, effective as of the date stated in a notice sent to 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 coverage 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. We may charge a fee for any payment that is returned as unfunded. 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.
- 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.
- We reserve the right to change the premium rates under this Agreement at any time. Written notice of premium rate change will be given to Subscriber Group at least 60 days prior to the effective date of the change.

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 a Participant of the Subscriber Group and live or work in the Service Area and must meet the Subscriber Group's eligibility criteria. Eligibility is not based on any health status related factors.
- **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. Dependent coverage will terminate when a Member ceases to be an eligible Dependent. Eligibility is not based on any health status related factors.

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 on the application 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.** Participants and/or their Dependents may Enroll within 31 days of becoming eligible for coverage, subject to any waiting period as required by the group. Waiting periods for Enrollment are defined as beginning on the date the employee becomes a qualifying employee and must not exceed 90 days. 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.** Participants and/or Dependents who do not Enroll when initially eligible may Enroll by submitting a completed application form during the open Enrollment period specified on the Signature Sheet.
- **Newborn or Newly Adopted Child.** A newborn child or a child placed with a Member for the purpose of adoption will be covered from the moment of birth or the date of adoption, placement for adoption if the Child is Enrolled as a Member within the first 30 days. If additional premium is required, coverage shall not take effect unless application and premium required are received within 31 days after birth or placement. Additional premium is required if Enrollment of the additional Dependent places the family in a higher premium bracket.

  After the first 31 days, a newborn child must meet the definition of Dependent in the "Definitions" section of this Group Medical and Hospital Service Agreement in order to continue coverage under the plan.
- **Other Newly Eligible Dependents.** A Subscriber may Enroll a newly eligible Dependent by submitting a completed application form within 31 days of attaining eligibility. Enrollment is effective the first day of the following month or as specified on the group application.

Special Enrollment.

a. Loss of Other Coverage. A Participant 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, dissolution of a domestic partnership, death, termination of employment, reduction in hours of employment, a Dependent Child ceasing to be a Dependent Child, Medicaid plan or Children's Health Insurance Plan (CHIP). If loss of coverage is due to discontinuation of employer contributions or exhaustion of COBRA continuation under such other group coverage, a completed application form must be submitted within 30 days of loss. Enrollment is effective the first day of the following month.

b. Newly Acquired Dependents. A Participant and/or newly acquired Dependents can Enroll in this Agreement by submitting a completed application form within 30 days of marriage, domestic partnership, birth, or placement for adoption. Enrollment is effective the first day of the following month.

c. Premium Assistance under a Medicaid plan or SCHIP. A Participant and/or Dependents can Enroll in this Agreement by submitting a completed application form at any time, once becoming eligible for premium assistance under a Medicaid plan or SCHIP.

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 but must not exceed 90 days.

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 furnishes benefits for the hospitalization after the termination of prior coverage, then services and benefits will not be covered under this Agreement for that Member until the Member is discharged from the Hospital or benefits under the prior coverage are exhausted, whichever is earlier.

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 insurance 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 the 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, it may be discontinued or non-renewed based on the following circumstances:
  a. For nonpayment of the required premiums by the Subscriber Group.
  b. For fraud or intentional misrepresentation of material fact by the Subscriber Group, or with respect to the coverage of a Member by the Member or the Member's representative.
  c. Failure of the Subscriber Group to maintain minimum participation requirements as follows: Where coverage is offered on a contributory basis, health plan Enrollment represents the greater of 75% of the eligible active employee population or 38 Enrolled active employees; if more than one health plan is offered, Health Net's Enrollment represents the greater of 38% of the eligible active employee population or 19 Enrolled active employees; if coverage is offered on a non-contributory basis, health plan Enrollment will be 100% of the Eligible Employee population.
  d. Failure of the Subscriber Group to meet the participation requirement(s) as set forth in the group proposal offer.
  e. For noncompliance with the contribution requirements as outlined in this Agreement.
  f. When we discontinue offering or renewing, or offering and renewing, all of our group Health Benefit Plans in this state or in a specified Service Area within this state. In order to discontinue plans under this Agreement, we:
     1. Must give notice of the decision to the Director of the Department of Consumer and Business Services and to all Subscriber Groups covered by the plans;
     2. May not cancel coverage under the plans for 180 days after the date of the notice required under section f.1 above if coverage is discontinued in the entire state or, except as provided in section f.3 below, in a specified Service Area;
     3. May not cancel coverage under the plans for 90 days after the date of the notice required under section f.1 above if coverage is discontinued in a specified Service Area because of an inability to reach an agreement with Providers to provide services under the plans within the Service Area; and
     4. Must discontinue offering or renewing, or offering and renewing, all Health Benefit Plans issued by us in this state or in the specified Service Area.
  g. When we discontinue offering and renewing a group Health Benefit Plan in a specified Service Area within this state because of an inability to reach an agreement with Providers to provide services under the plan within the Service Area. In order to discontinue a plan under this paragraph, we:
     1. Must give notice of the decision to the director and to all Subscriber Groups covered by the plan;
     2. May not cancel coverage under the plan for 90 days after the date of the notice required under section f.1 above; and
     3. Must offer in writing to each Subscriber Group covered by the plan, all other group Health Benefit Plans that we offer in the specified Service Area. We shall offer the plans at least 90 days prior to discontinuation.

h. When we discontinue offering or renewing, or offering and renewing, a Health Benefit Plan for all groups in this state or in a specified Service Area within this state, other than a plan discontinued under section f. of this Group Medical and Hospital Service Agreement, with respect to plans that are being discontinued, we must:

1. Offer in writing to each Subscriber Group covered by the plan, all Health Benefit Plans that we offer in the specified Service Area.
2. Offer the plans at least 90 days prior to discontinuation.
3. Act uniformly without regard to the claims experience of the affected Subscriber Groups or the health status of any current or prospective Member.

i. When the director orders us to discontinue coverage in accordance with procedures specified or approved by the director 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 Member.

- We may modify this Agreement at the time of renewal. The modification is not a discontinuation of this Agreement under section e. or g. above, of this Group Medical and Hospital Service Agreement. Written notice of modifications, including modifications to preventive benefits, will be given to Subscriber Group at least 60 days prior to the Effective Date of the renewal. The 60-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 the "Termination" section of this Group Medical and Hospital Service Agreement, 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. We may charge a fee to reinstate the Agreement after termination.

- **Continued payment of monthly premiums.** Subject to continued payment of monthly premiums, if a Subscriber or a covered Dependent is in the Hospital on the day this Agreement is terminated and immediately replaced by a group contract with another company, we will continue to accept and pay toward covered expenses incurred during the balance of that hospitalization. The covered expenses must be incurred for the same sickness, injury or pregnancy that was under treatment before this Agreement terminated. Eligibility for benefits will end upon discharge from the Hospital or when benefits of this Agreement are exhausted, whichever happens first. In no other situation will we pay for the benefits of this Agreement toward expenses incurred by a person who is not then covered.
- Coverage under this Agreement for a Member also will terminate on 30 days' written notice if the Member knowingly permits another to use his or her plan identification card or has otherwise misused our plan.

Coverage under this Agreement for a Member will also terminate on 30 days' written notice: (a) if a Member intentionally presents a claim for a payment that falsely represents that the services or supplies were Medically Necessary in accordance with professionally accepted standards; (b) if a Member intentionally makes a false statement or false representation of a material fact to us for our use in determining rights to a health care payment; and (c) if the Member intentionally conceals the occurrence of any event affecting his or her initial or continued right under this Agreement or conceals or fails to disclose any information with intent to obtain services, supplies, or payment to which the Member or any other person is not entitled. We shall have the right to obtain a refund from the Member for all Medical Services paid for by us which were not legitimately eligible for coverage under this Agreement.

After the effective date of a termination, pursuant to this section, 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.

If a Member, other than a Dependent Child entitled to continued coverage, ceases to meet the requirement to live or work in the Service Area, we in our discretion may terminate the Member effective at midnight on the last day of the month in which the Member last resided or worked in the Service Area.

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 or converts his or her membership in accordance with the "Federal Continuation of Coverage," and "Oregon State Continuation of Coverage" sections of this Group Medical and Hospital Service Agreement. If a Subscriber does not work for 120 consecutive working days, the Subscriber will be deemed to have left employment with the Subscriber Group.

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 under 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) ensuring compliance with COBRA; (b) giving Members timely notice, in accordance with COBRA, of their continuation coverage option; (c) notifying us within 15 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 the 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 its 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.

Oregon State Continuation of Coverage

- Continuation of our group coverage under this section is available to Subscribers and Enrolled Dependents when the Subscriber Group is not required to offer continuation of coverage under COBRA.
- A Member who would otherwise lose coverage under this Agreement may continue uninterrupted coverage hereunder upon payment of applicable monthly premiums if:

a. The Member was covered under this Agreement, or similar predecessor Agreement, for at least three consecutive months immediately before coverage under this Agreement would otherwise terminate; and

b. The Member's coverage under this Agreement would otherwise terminate due to termination of the Subscriber's employment or the Subscriber's death, dissolution of a domestic partnership, or divorce.

- Continuation of coverage is not available if a Subscriber is eligible for: (a) Federal Medicare coverage; or (b) a medical-hospital benefit plan that did not cover him or her when his or her eligibility under this Agreement ended.
- Continuation coverage is available for all Dependents who were Enrolled at the time coverage terminated. All Dependents who were Enrolled under this Agreement must continue to be covered with the Subscriber or with the surviving or divorced spouse or Domestic Partner who is continuing coverage.
- Members who wish to have continued coverage under this Agreement must sign a special application form for themselves and their Enrolled Dependents within 31 days after the Subscriber's termination of employment, dissolution of a domestic partnership, divorce, or death. The Subscriber Group must send the application to us along with its next regular monthly billing. The billing should note the individuals who are continuing group coverage.
- If a Member wishes to continue group coverage, the correct premium must be paid to the Subscriber Group each month in advance. The Subscriber Group must then send the premium payments to us along with its regular monthly premium. We will accept continuation of premiums only if they are included in the Subscriber Group's regular monthly premium payments. Please Note: The first premium must be sent to the Subscriber Group with the signed application within 31 days of the date the Member's group coverage was terminated.
- A Member's continuation of coverage will end on the last day of the month during which any one of the following occurs:
  a. Nine months expire from the time eligibility for group coverage normally would have ended;
  b. We fail to receive full premiums for the Member with the Subscriber Group's regular monthly payment;
  c. The Member becomes insured under any other group health plan or becomes eligible for Medicare;
  d. We received 30-day written notice through the Subscriber Group that the Member wishes to terminate group coverage; or
  e. This Agreement is terminated by either the Subscriber Group or us.
- A Subscriber who has terminated employment by reason of layoff shall not be subject upon any rehire that occurs within nine months of the time of the layoff to any waiting period prerequisite to coverage under this Agreement if the Subscriber was eligible for coverage at the time of the termination and regardless of whether the Subscriber continues coverage during the layoff.

- A Member age 55 or older who would otherwise lose coverage due to the death of a Subscriber, divorce, dissolution of a domestic partnership, or legal separation from a Subscriber may continue coverage for himself or herself and his or her Dependent children who would otherwise lose coverage due to the death, divorce, dissolution of a domestic partnership, or legal separation. This section applies only if the Subscriber Group has 20 or more Subscribers. Termination of coverage under this section shall be on the earlier of:
  a. The failure to pay premiums when due;
  b. The termination of this Agreement;
  c. The date on which the Member becomes covered under another group health plan;
  d. The date on which the Member becomes eligible for Medicare coverage; or
  e. For Dependent children only, the date on which a Dependent ceases to meet the requirements according to the definition of Dependents in the "Definitions" section of this Group Medical and Hospital Service Agreement.

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 with:
  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. If you had completed all or part of an exclusionary or waiting period under this Agreement before your entry into active military service, you will not be required to complete that period a second time.

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.

Participating Providers

- Each Member must select a Primary Care Provider through which all care must be delivered or coordinated. Members should consult our Participating Provider Directory for this CommunityCare 1T Plan for a list of Participating Providers, including Women's Health Care Providers, authorized to act as Primary Care Providers. This selection must be identified on the Enrollment application at the time of Enrollment. In making such a selection, if that Primary Care Provider is a member of a contracting medical group, the Member may also be choosing the medical group from which all covered specialist Physician and associated Hospital services are received, except when a Referral is made for services outside the medical group or for Emergency Medical Care. No benefits are provided to a Member prior to his or her selection of a Primary Care Provider, except for Emergency Medical Care.
- A Member may change his or her Primary Care Provider by calling our Member Service Department. A Member's Primary Care Provider may be changed at the Member's request no more than four times in any Calendar Year.
- A Referral is required for services rendered by any Provider other than a Member's Primary Care Provider except the following: visits to a Women's Health Care Provider for an annual gynecological examination and maternity care; mammography screening; visits to a Provider covering in the absence of the Member's Primary Care Provider; Emergency Medical Care; and routine laboratory or x-ray tests performed outside of a Hospital setting. When services with a specific Provider are expected to occur repeatedly over a short period of time, the Member may request a "standing" Referral (meaning that a separate Referral is not needed for each service with that Provider during that period). In unusual cases where specialty treatment is urgently needed but which does not qualify as Emergency Medical Care, Prior Authorization by the Medical Director shall be obtained by telephone, with subsequent confirmation through a Referral. Prior Authorization by telephone shall not be required if treatment is urgently needed after normal business hours and telephone Prior Authorization cannot be obtained within a reasonable time, but subsequent confirmation through a Referral shall be obtained.
- If a Member receives care from a nonparticipating Physician or other nonparticipating health care Provider except as stated under "General Terms Under Which Benefits Are Provided" section, without a required Prior Authorization, the Member shall be responsible for the cost of those services. Failure of the Nonparticipating Provider to obtain the Prior Authorization shall in no way relieve the Member of the financial responsibility for services received from that Provider. If you receive care for covered Medical Services and supplies from a Participating Physician or other participating health care Provider without a required Prior Authorization, that Provider is not permitted to bill you for those services.
- Upon Enrollment, each Member will be issued a plan identification card. It is the Member's responsibility to notify us if the card is not received within a reasonable time after the Member's Effective Date of coverage. In addition, 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 must obtain all Medical Services from Participating Providers and in accordance with any Prior Authorization and Referral requirements, even when a Member expects payment to be made by another plan or a third party. Members should consult our Participating Provider Directory for a list of Participating Providers, including Women's Health Care Providers, authorized to act as primary care Providers.

- For personal reasons, a Member may refuse to accept a procedure or treatment recommended by the treating Physician.
- 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. To be covered by us, non-emergency Medical Services provided to Members must be obtained from Participating Providers.
- The fact that Members and Participating Providers each have contractual relationships with us does not prevent a Member from obtaining nor a Participating Provider from providing services 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 Referrals, 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 Medical Director's sole judgment of 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.
- We shall use ordinary care in the exercise of our power and in the performance of our obligations under this Agreement.
- A Nonparticipating Provider must cooperate with our requirements for review of treatment and to the same extent as a Participating Provider in order to be eligible for reimbursement.

General Limitations

- **Discontinued or Modified Benefits.** Benefits provided by this Agreement may be discontinued or modified on at least 60 days prior written notice to the Subscriber, subject to prior approval by the Department of Consumer and Business Services. You do not acquire 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. Your right is to receive only such benefits as are expressly provided for and in effect on the date of each treatment. The 60-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. Upon termination of this Agreement or 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," "Oregon State Continuation of Coverage" 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 for services that are Medically Necessary.** Benefits and services are available only as Medically Necessary. Benefits and services are available only through Primary Care Providers except for annual gynecological examinations, maternity care, mammography screening, Emergency Medical Care or services provided by Referral to Providers. A Member shall contact his or her Primary Care Provider directly.
- **Members temporarily residing outside the Service Area,** such as those on temporary (not more than three months) work assignments and a covered Dependent Child residing permanently outside the Service Area, are covered outside the Service Area for Emergency Medical Care only; all other covered Medical Services must be received in the Service Area through the Primary Care Provider, including follow-up care related to an Emergency Medical Condition.
- **Benefits are available only in the Service Area, except for Emergency Medical Care.**
- **Unauthorized Benefits.** Members who are treated by a Provider other than a Primary Care Provider without a Referral, if required pursuant to the "Participating Providers" subsection, or without a Prior Authorization, if required pursuant to the "Prior Authorization" portion 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 Copayment and Coinsurance Schedule or any Supplemental 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.
- **Nonparticipating Provider Claims.** Written notice of claim for treatment of accident or sickness outside the Service Area must be given to us within 90 days after the date of treatment or as soon as reasonably 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 as soon as reasonably 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. We will not reimburse the cost of treatment received at a Hospital that is a Nonparticipating Provider if the required notice is not provided. The claim will be paid or denied within 30 days following receipt of the claim, or if additional information is needed to make the determination, we will notify the Member and the Provider in writing within 30 days following receipt of the claim and provide an explanation of the additional information needed to process the claim. Claims must include a statement describing the services rendered, date of services and charges therefore. 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

Written notice of claims for Mental Health Conditions and Substance Use Disorder should be addressed to:

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

- **Filing a Grievance or Appeal.** Any Grievance or Appeal brought to recover on this Agreement shall be limited to the Grievance and Appeal procedure under the "Grievances and Appeals" section of this Group Medical and Hospital Service Agreement. No Grievance or Appeal including, but not limited to, inquiries regarding denial of claims for payments or for services, may be brought more than 180 days from the date of the Adverse Benefit Determination to file a Grievance requesting reconsideration of the decision, unless the complainant is legally incapacitated throughout that year in which case the Grievance or Appeal must be brought as soon as reasonably possible.
- **Calendar Year.** 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. All provisions of law or professional ethics forbidding, restricting or treating as privileged or confidential such information are waived by or on behalf of each Member hereunder by acceptance of the benefits of this Agreement, and Members shall sign any specific releases necessary to effect this provision. Except as provided above, all such information shall be confidential and shall not be disclosed except as allowed by federal and state law.
- **Your right to information about Health Net.** The following information about Health Net is available upon request: An annual summary of Grievances and Appeals, an annual summary of utilization review policies, an annual summary of quality assessment activities, the results of all publicly available accreditation surveys, an annual summary of health promotion and disease prevention activities, an annual summary of scope of network and accessibility of services.

  This information is available from the Department of Consumer and Business Services by calling (503) 947-7984 or the toll free message line at (888) 877-4894, or by writing to the Oregon Division of Financial Regulation (DFR), Consumer Advocacy Unit, PO Box 14480; Salem, OR 97309-0405 or through the Internet at http://dfr.oregon.gov/gethelp/Pages/file-a-complaint.aspx, or by e-mail at DFR.InsuranceHelp@oregon.gov . You may also call the Customer Contact Center at the phone number listed at the back of this Agreement.
- **Nondiscrimination.** A 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. Subscriber Group must conform to underwriting requirements on the Group Effective Date hereof and throughout the term of this Agreement and all succeeding terms.

- **Filing an Appeal.** A Member has the right to file an Appeal under the "Grievances and Appeals" section of this Group Medical and Hospital Service Agreement if dissatisfied with an Adverse Benefit Determination and may then submit an unresolved claim to arbitration under the "Grievances and Appeals" section of this Group Medical and Hospital Service Agreement. An Enrollee may receive, free of charge, reasonable access to documents used in the Adverse Benefit Determination.
- Upon the request, we will provide the following:
  - Reasonable access to and copies of all documents, records, and other information relevant to a claim or request for coverage to a Member or the Member's authorized representative.
  - Information, free of charge, on the processes, strategies, evidentiary standards, and other factors used to make Medical Necessity determinations of mental health or Substance Use Disorder benefits.
  - Compliance with these disclosure requirements is not determinative of compliance with any other provisions of applicable federal or state law.

Your Rights and Protections Against Surprise Medical Bills. When you get Emergency Care or are treated by an Out-of-Network Provider at an in-network Hospital or Ambulatory Surgical Center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's Copayments, Coinsurance and/or Deductible.

- **What is "balance billing" (sometimes called "surprise billing")?** When you see a doctor or other health care Provider, you may owe certain out-of-pocket costs, like a Copayment, Coinsurance, or Deductible. You may have additional costs or have to pay the entire bill if you see a Provider or visit a health care facility that isn't in your health plan's network.

  "Out-of-Network" means Providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-Network Providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's Deductible or annual out-of-pocket limit.

  "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an Out-of-Network Provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

  You're protected from balance billing for:

  - Emergency services. If you have an Emergency Medical Condition and get emergency services from an Out-of-Network Provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as Copayments, Coinsurance, and Deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
  - Services provided by an Out-of-Network Provider will be payable at the in-network level of cost benefits and Deductible, if applicable, and without balance billing (balance billing is the difference between a Provider's billed charge and the Maximum Allowable Amount (MAA)).

- **Certain services at an in-network Hospital or Ambulatory Surgical Center.** When you get services from an in-network Hospital or Ambulatory Surgical Center, certain Providers there may be Out-of-Network. In these cases, the most those Providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

  If you get other types of services at these in-network facilities, Out-of-Network Providers can't balance bill you, unless you give written consent and give up your protections.

  You're *never* required to give up your protections from balance billing. You also aren't required to get Out-of-Network care. You can choose a Provider or facility in your plan's network.

- **When balance billing isn't allowed, you also have these protections:**
  - You're only responsible for paying your share of the cost (like the Copayments, Coinsurance, and Deductible that you would pay if the Provider or facility was in-network). Your health plan will pay any additional costs to Out-of-Network Providers and facilities directly.
  - Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "Prior Authorization").
    - Cover emergency services by Out-of-Network Providers.
    - Base what you owe the Provider or facility (cost-sharing) on what it would pay an in-network Provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or Out-of-Network services toward your in-network Deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Division of Financial Regulation (DFR) at 1-888-887-4894 or CMS at 1-800-985-3059. The federal phone number for information and complaints is: 1-800-985-3059. Visit https://www.cms.gov/nosurprises for more information about your rights under federal law. Visit https://www.dfr.oregon.gov for more information about your rights under Oregon laws.

Grievances and Appeals

A Member is always encouraged to promptly contact our Customer Contact Center at the phone number listed at the back of this Agreement whenever there is a question, inquiry or a complaint about availability, or delivery, or quality of health care services under this Agreement or any other act by us. Our Customer Contact Center can also offer assistance in filing a Grievance when you have a complaint and ask for help to put it in writing. If the problem relates to an Adverse Benefit Determination, please consider the Internal Appeal process outlined below.

- **Internal Appeal and External Review.**
  a. **Internal Appeal.** A Member aggrieved by denial of a claim, or an Adverse Benefit Determination has 180 days from the date of receipt of our denial letter to request an Appeal and submit to our Grievances and Appeals department all information in support of the claim, including additional supporting information, if any. An Appeal must be submitted in writing. A written request can be made by sending it to us at: Health Net Health Plan of Oregon, Inc. Grievances and Appeals Department, 13221 SW 68th Parkway, Suite 315, Tigard, OR 97223. When the Appeal requires an expedited response, it is not required to be submitted in writing but can be submitted orally by contacting our Customer Contact Center. We will acknowledge the Appeal within 7 days and report our decision and rationale within 30 days (72 hours for Expedited Reviews). A person who was involved in the consideration of the initial denial will not be involved in determining our decision during this Internal Appeal process. The Member will be informed of the determination in writing and notified of further Appeal rights as well as the possible right of Members participating in ERISA-qualified plans to seek legal redress under Section 502(a) of ERISA, Civil Enforcement. You will have the opportunity to receive continued coverage of an ongoing course of treatment previously approved by the insurer, pending the conclusion of the Internal Appeal process. If the insurer's denial is not reversed, you will be responsible to pay for the disputed item or service.

  b. **External Review. You have the right to request that your claim be submitted for external review by an Independent Review Organization (IRO).** This right applies to an Adverse Benefit Determination that is based on whether a course or plan of treatment is: (i) Medically Necessary; (ii) Experimental or Investigational; (iii) subject to the provisions described in the "Continuity of Care" section of this Group Medical and Hospital Service Agreement; or (iv) delivered in an appropriate health care setting and with the appropriate level of care; (v) whether an exception to the health benefit plan's prescription drug formulary should be granted.

  To be eligible for external review, the Member must (i) have exhausted the Internal Appeals process shown above; and (ii) provide us a signed Authorization to Use and Disclose Health Information (waiver) to release medical records to the IRO. The waiver with instructions and a return address and fax number is provided directly to the Member with an adverse appeal determination. Members can also obtain a copy of the waiver on the Health Net website at www.healthnetoregon.com or call our Customer Contact Center at the phone number listed on the back of the membership card to request a copy of the waiver.

  We may waive the requirement of compliance with the Internal Appeals process and have a dispute referred directly to external review upon the Member's consent, including when a Member simultaneously requests expedited internal and expedited external reviews.

  The following describes the external review process:

  1. The Member, or an authorized representative, applies in writing for external review of an Adverse Benefit Determination by us within the external review eligibility period. The external review eligibility period is the period within 180 calendar days following the Member's receipt of our final written decision of an Adverse Benefit Determination from our Internal Appeal process.
  2. We will notify the Oregon Division of Financial Regulation (DFR) of your request for an external review no later than the second business day (immediately for Expedited Reviews) after receipt of the request.

3. The DFR will notify us of the assigned IRO no later than 1 business day after receipt of the notice from us; and will notify the Member of the assigned IRO no later than 2 business days after receipt of the notice from us.
4. We will provide the IRO information regarding the Adverse Benefit Determination, as well as a signed waiver from the Member granting the IRO access to medical records, no later than 5 business days (24 hours for Expedited Reviews) after receipt of the notice from the DFR.
5. A Member may submit additional information to the IRO no later than 5 business days after receipt of notice of the appointment of the IRO or 24 hours in the case of an Expedited Review.
6. The IRO will make the decision no later than 30 calendar days (72 hours for Expedited Reviews) after our receipt of the Member's external review request. The IRO will notify the Member and us of the decision no later than 5 calendar days after the decision is made.

Health Net Health Plan of Oregon will pay the cost for external review. The Member who applies for external review of an Adverse Benefit Determination must provide complete and accurate information to the IRO in a timely manner. **We hereby state that we will abide by the decisions rendered by the IRO, including decisions, which may conflict with our definition of Medically Necessary. If we fail to comply with the decision of the IRO, the Member has a right to bring a lawsuit against us.** If the Member is a participant in an ERISA-qualified plan, the Member also has the alternate right to seek legal redress under Section 502(a) of ERISA, Civil Enforcement.

c. **Expedited External Review.** We will expedite the external review if the Adverse Benefit Determination, that qualifies for Expedited Review, concerns an admission, the availability of care, a continued stay or a health care service for a medical condition for which the Enrollee received Emergency Medical Care and has not been discharged from a health care facility, or if a Provider with an established clinical relationship to the Enrollee certifies in writing and provides supporting documentation that the ordinary time period for external review would seriously jeopardize the life or health of the Enrollee or the Enrollee's ability to regain maximum function.

- Appeal of Utilization Review Determination.
  a. When you or a Provider first appeal a decision to deny Prior Authorization or benefits for services as not Medically Necessary or Experimental:
     1. We shall acknowledge receipt of the notice of Appeal within 7 calendar days of receiving the notice; and
     2. A medical consultant shall review the Appeal and decide the issue within 30 days of receipt of the notice.
  b. We shall treat an Appeal from a decision by a medical consultant under this section as an Appeal under section b. above of this Group Medical and Hospital Service Agreement.
  c. Nothing in this section shall prevent a Member from filing a Grievance under this section of this Group Medical and Hospital Service Agreement.
- An otherwise applicable standard for timeliness outlined in this section of the Group Medical and Hospital Service Agreement does not apply when:
  a. The period of time is too long to accommodate the clinical urgency of the situation;

b. The Member (or the Provider in the case of an Appeal) does not reasonably cooperate;

c. Circumstances beyond the control of a party prevent complying with the standard, but only if notice of inability to comply is given promptly; or

d. The request qualifies as an Expedited Review as defined, in which case we will review and report our decision and rationale within 72 hours for Expedited Reviews unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or health insurance policy.

- In addition, a Member has the right to file a complaint with or seek other assistance from the Oregon DFR. If a Member chooses to do so, assistance is available. Contact the Oregon Division of Financial Regulation, Consumer Advocacy Unit at PO Box 14480, Salem, OR 97309-0405, Contact them by phone at 503-947-7984 or toll free at 888-877-4894, by email at DFR.InsuranceHelp@oregon.gov or online at http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx.
- A Subscriber Group or Member aggrieved by any action by us, including an Adverse Benefit Determination, must first exhaust the Grievance procedure as set forth in the "Grievances and Appeals" section of this Group Medical and Hospital Service Agreement. Arbitration is not required in Oregon, but when the Grievance procedure is exhausted, an aggrieved Subscriber Group or Member may submit his or her claim to binding arbitration. The arbitration shall be conducted in accordance with the Commercial Rules of the American Arbitration Association in effect at the time the arbitration is commenced, before an arbitrator(s) selected by mutual agreement of the Subscriber Group or Member and us or, failing agreement, the American Arbitration Association. Information regarding the arbitration rules is available from our Customer Contact Center. Arbitration proceedings shall be governed by Oregon law unless Oregon law conflicts with Federal Code and shall be held in the Member's county of residence in Oregon or another county in Oregon if agreed upon between the Member and us. Unless there is a mutual agreement between the Subscriber or Member and us to use the arbitration process, the decision resulting from the arbitration will only be binding on the party that demanded arbitration.
- Any legal action arising out of this Agreement must be filed in the state of Oregon.
- We will furnish to the Subscriber Group for delivery to each Eligible Employee or Member of the Subscriber Group a copy of this Agreement outlining the essential features of the coverage of the Eligible Employee or Member, to whom the benefits are payable, and the rights and conditions applicable in obtaining such benefits. If Dependents are included in the coverage, only one statement will be issued for each family unit.
- Upon the request of a Member, applicant, or prospective applicant, we will provide our annual report on Grievances and Internal Appeals and requests for external review, which is submitted to the Oregon DFR annually.

Coordination of Benefits

- This Coordination of Benefits provision applies when a covered Participant or a covered Dependent has health care coverage under more than one plan.

- 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, hospital-medical-surgical-dental care or treatment or other care described in separate policy endorsements to this benefit policy. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered part of the same plan and there is no coordination among those separate contracts.
    a. Plan includes: group and individual insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as Skilled Nursing care; and Medicare or any other federal governmental plan, as permitted by law and group and individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.
    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 care coverage under more than one plan.
- When this plan is primary, it determines payment for its benefit 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 may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total allowable expense.

- **"Allowable expense"** is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a covered 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 methodology or other similar reimbursement methodology, 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.

  d. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the Provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

  e. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include but are not limited to second surgical options, Prior Authorization of admissions, and preferred Provider arrangements.

- **"Closed panel plan"** is a plan that provides health care benefits to covered person primarily in the form of services through a panel of providers that have contracted with or are 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 a 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 coverage that are superimposed over base plan hospital and surgical benefits, and insurance type coverage that are written in connection with a closed panel plan to provide Out-of-Network benefits.

a. In general, when there is a basis for a claim under this plan and another plan, this plan is a 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 section 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, which covers the person as other than 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 in a domestic partnership, married or are living together, whether or not they have ever been in a domestic partnership or 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 in a domestic partnership or 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 both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of section b.2.A. above of this section shall determine the order of benefits;

iii. 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 section b.2.A. of this Section shall determine the order of benefits; or

iv. 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. the plan of the parent with custody of the child;
2. the plan of the Domestic Partner or spouse of the parent with the custody of the child;
3. the plan of the parent not having custody of the child;
4. the plan of the Domestic Partner or 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 section b.2.A. or section b.2.B. above shall determine the order of benefits as if those individuals were the parents of the child.

D. For a Dependent child who has coverage under either or both parents' plans and also has coverage as a Dependent under a Domestic Partner or spouse's plan, the rule in "Longer/Shorter Length of Coverage" section below applies.

E. In the event the Dependent child's coverage under the Domestic Partner or spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in section b.2.A. above, to the Dependent child's parent and the Dependent's spouse or Domestic Partner.

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 above 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 other 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 or 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 section b.1 above can determine the 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, or Subscriber 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, the allowable expenses shall be shared equally between the plans meeting the definition of "Plan" above 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.** This section applies when in accordance with the order of benefit determination rules stated in the "Order of Benefit Determination Rules" section above, this plan is a secondary plan to one or more other plans. In that event, the benefits of this plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in section a. below.

  a. The benefits of this plan will be reduced so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to an allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the 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 do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

  b. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one closed panel plan, coordination of benefits shall not apply between that plan and the other closed panel plans.

- **Right to Receive and Release Necessary Information.** Certain facts about health care coverage are needed to apply these Coordination of Benefits provisions and to determine benefit payable under this plan and other plans. 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 apply these provisions and to pay the claim.

- **Facility of Payment.** Any payment made under another plan may include an amount, which should have been paid under this plan. If so, we may pay that amount to the organization, which made the payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

- **Right of Recovery.** If the amount of the payments made by us is more than it should have paid under this Coordination of Benefits provision, we may recover the excess from one or more of: (a) the persons it has paid or for whom it has paid; (b) insurance companies; or (c) other organizations. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

  a. A secondary plan which provides benefits in the form of services may recover the reasonable cash value of providing the services from the primary plan to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan.

  b. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by the plan, which provides benefits in the form of services.

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.
- All benefits provided under this Agreement shall be reduced by any amounts to which a Member is entitled based on his or her enrollment under the program commonly referred to as Medicare when federal law permits Medicare to pay before a group health plan.

Subrogation

In the event any Medical or Hospital Service or benefit is provided for, or any payment is made, or credit extended to a Member under this Agreement, we shall be subrogated and shall succeed to the Member's rights of recovery against any person or any organization including the right at our discretion to bring suit against any and all liable third parties. A Member shall pay over to us all sums recovered by suit, settlement or otherwise in an amount equal to such Medical or Hospital Service or benefit provided to the extent that: (1) The Member or covered Dependent(s) first receives full compensation for Member's or covered Dependent's injuries; and (2) The reimbursement or subrogation is paid only from the total amount of the recovery in excess of the amount that fully compensates for the Member's/covered Dependent's injuries.

- The Member shall take such action, furnish such information and assistance and execute such assignments or other instruments as we may require to facilitate enforcement of its subrogation rights and shall take no action prejudicing our rights and interests under this Agreement.
- In some cases, the Member or covered Dependent(s) may have a legal right to recover costs for health care from a third party that may be responsible for the illness or injury. The following rules apply:
    a. If we have provided any benefits, we shall be entitled to recover the amount paid from the proceeds of any settlement or recovery the Member or a covered Dependent(s) receives from the third party to the extent that:
        1. The Member or covered Dependent(s) first receives full compensation for the Member's or covered Dependent's injuries; and
        2. The reimbursement or subrogation is paid only from the total amount of the recovery in excess of the amount that fully compensates for the Member's or covered Dependent's injuries.
    b. The Member or covered Dependent(s) must hold the rights of recovery in trust for us, up to the amount of benefits already provided.
    c. We may require Member or covered Dependent(s) to sign and deliver all legal papers necessary to secure our rights and the rights of the Member or covered Dependent(s). If requested, the Member or covered Dependent(s) must sign an agreement to hold the proceeds of any recovery in trust for us.
    d. We will pay our share of the expenses of obtaining a recovery, such as attorney fees and court costs, out of any part of that recovery which is reimbursed to us.

- Most motor vehicle liability policies are required by law to provide liability insurance, primary medical payments insurance, and uninsured motorist insurance, and many motor vehicle policies also provide underinsurance coverage.
    a. If we pay benefits before motor vehicle insurance payments are made, reimbursement must be made out of any subsequent motor vehicle insurance payments made to the Member and, when applicable, we may recover benefits already paid directly from the motor vehicle insurer or out of any settlement or judgment which the Member obtains by exercising his/her rights against a third party to the extent that:
        1. The Member or covered Dependent(s) first received full compensation for the Member's or covered Dependent's injuries; and
        2. The reimbursement or subrogation is paid only from the total amount of the recovery in excess of the amount that fully compensates for the Member's or covered Dependent's injuries.
    b. The Member must give us information about any motor vehicle insurance payments which may be available to the Member; and (2) if we ask, the Member must sign an agreement to hold the proceeds of any recovery in trust for us.
- 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 or covered Dependent(s) is not entitled under this Agreement; or
    b. We pay a person who is not eligible for benefits at all.

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 Participants 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 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.

Continuity of Care

- If the Member is undergoing treatment with a Participating Provider on the date our contract with that Participating Provider will terminate, the Member may be able to continue to receive care from that Provider, subject to the following conditions:
  a. The Member must be undergoing an active course of treatment that is Medically Necessary on the date the contract would otherwise terminate; and
  b. The benefits available to the Member under this Agreement, in relation to that course of treatment, would otherwise be eliminated or reduced to a benefit level below the benefit level specified in the plan for Nonparticipating Providers if the Member continued to receive care from that Provider; and
  c. Our contract with the Participating Provider terminates for reasons allowed under Oregon statute; and
  d. Both the Member and the Provider agree that it is desirable to continue the course of treatment with that Provider; and
  e. If the course of treatment is related to the Member's pregnancy, the Member has already entered the second trimester of that pregnancy; and
  f. The Provider agrees to continue the relationship with us as a Participating Provider, in relation to the course of treatment for that Member, as if the contract between that Provider and us had not terminated. This relationship shall continue for the duration of the course of treatment, as specified in the "Continued Course of Treatment" section below of this Group Medical and Hospital Service Agreement.
- When a contract with a Participating Provider will terminate, we will notify all Members who we know, or reasonably should know, are under the care of that Participating Provider. If we first learn that a Member is affected at a later date, we will notify that Member within 10 days of identifying that Member. The notice will be in writing and notify affected Members of the termination and the right to Continuity of Care as provided under the "Continuity of Care" section of this Group Medical and Hospital Service Agreement. The notice will be provided as soon as we are aware of the termination, but in no event later than 10 days following the effective date of the termination. For the purpose of the "Continued Course of Treatment" section below of this Group Medical and Hospital Service Agreement, the date of the notice will be the earlier of the date the notice was received by the Member, and the date we receive or approve the request for Continuity of Care. If the Participating Provider is part of an Independent Practice Association (IPA), we may allow the IPA to deliver the notice to the Member for us, if the notice otherwise meets all other requirements of this section of this Group Medical and Hospital Service Agreement.

- **Continued Course of Treatment.** A course of treatment continued under this provision will be treated as if the Provider was still a Participating Provider, until the following dates:
  a. For pregnancy; the later of (i) 45 days following the birth of the child; and (ii) when the care for that pregnancy ends.
  b. For all other conditions; when the care for that condition ends.
  c. However, in no instance shall the provisions of this section extend beyond the 120th day following the date the Member was notified of the termination of the contract with the Participating Provider and the Member's right to Continuity of Care.

Miscellaneous

- By this Agreement, 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 amended, modified, or terminated by mutual agreement between us and Subscriber Group without the consent or concurrence of any Member. Any modification or amendment must be in writing and signed by us. We may submit any proposed amendment or modification in writing to Subscriber Group. If Subscriber Group does not reject the proposed amendment or modification in writing within 30 days, it shall be deemed to be agreed to by the Subscriber Group and shall be effective as an amendment or modification, as the case may be, on the 31st day following such submission.
- Members or applicants for membership shall complete and submit to us such applications and other forms or statements 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, Suite 315 Tigard, Oregon 97223;
  b. To Member at the address of record;
  c. To Subscriber Group at the address indicated on the Signature Sheet.
- ENTIRE CONTRACT; CHANGES: This Agreement, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Agreement shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No insurance producer has authority to change this Agreement or to waive any of its provisions.

- A Member's Copayments and Coinsurance are limited as stated on the Copayment and Coinsurance Schedule attached hereto. It is the Member's responsibility to maintain accurate records of the Coinsurance and Copayments made during the Calendar Year for application of the maximum. Any claims for personal reimbursement for exceeding the maximum must be submitted and accompanied by the required documentation 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 the services were rendered unless you were legally incapacitated, or the claims will be ineligible for reimbursement. No documentation need be submitted until the maximum has been met.
- 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.
- When the premium for this Agreement or any part thereof is paid by an employer under the terms of a collective bargaining agreement, if there is a cessation of work by employees covered under this Agreement due to a strike or lockout, this Agreement, upon timely payment of the premium to us, will continue in effect with respect to employees covered under this Agreement on the date of the cessation of work who continue to pay their individual contribution and who assume and pay the contribution due from the employer.
    a. When a covered employee pays the monthly premium pursuant to this section, if the Subscriber Group is not a trustee of a fund established or maintained in whole or in part by an employer, the employee's individual contribution shall be: (1) the rate in this Agreement on the date the cessation of work occurs, applicable to an individual in the class to which the employee belongs as set forth in this Agreement; or (2) if this Agreement does not provide for a rate applicable to individuals, an amount equal to the amount determined by dividing the total monthly premium in effect under this Agreement at the date of cessation of work by the total number of persons insured under the policy on such date.
    b. When an employee covered under this Agreement pays a premium pursuant to this section, if the Subscriber Group is a trustee of a fund established or maintained in whole or in part by an employer, the employee's individual contribution shall be the amount which the employee and employer would have been required to contribute if the cessation of work had not occurred.
    c. When an employee elects to continue coverage under this section, each individual premium rate under this Agreement may be increased by 20% during the period of cessation of work in order to provide sufficient compensation to us for increased administrative costs and increased mortality and morbidity.
    d. Coverage under this section shall not continue beyond the earlier of: (1) the time that 75% of covered employees continue coverage; (2) the time at which an employee takes full-time employment with another employer; or (3) six months after cessation of work by the covered employees.

- Subscriber Group and each Subscriber acknowledge that we, as most managed 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 Oregon, 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.
- **Notice of Initial Benefit Determination.** We will notify the Member of the initial benefit determination within the timeframes described below:
    a. Expedited Reviews will be decided upon no later than 72 hours following receipt of the request. If additional information is needed to make a determination, we will notify the Member within 24 hours following receipt of the request.
    b. Pre-Service Claims will be decided upon no later than 15 days following receipt of the claim. If additional information is needed to make a determination, we will notify the Member within 15 days following receipt of the claim. The Member will have up to 45 days to provide the additional information. We will make a final determination within 15 days following receipt of the additional information, or within 15 days of the end of the 45-day period if the Member has not responded.
    c. Post-Service Claims will be decided upon no later than 30 days following receipt of the claim. If additional information is needed to make a determination, we will notify the Member and Provider within 30 days following receipt of the claim. We will make a final determination within 30 days following receipt of the additional information.
- 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 Oregon and is governed by the laws of the state of Oregon.
- 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 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.
- 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.
- Continuation of benefits after injury or illness covered by workers' compensation claim. Health insurance will continue to be in effect if an employee incurs an injury or illness for which a workers' compensation claim is filed as long as timely payment by the employee of the premiums which includes the individual contribution and contributions due from the employer under the applicable benefit plan continue. The employee may continue such coverage until whichever of the following occurs first:
  a. The employee takes full-time employment with another employer; or
  b. Six months from the date that the employee first makes the premium payment under this continuation of benefits provision following their workers' compensation claim.
- 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 insurance shall avoid the insurance 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.
- 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.
- When this Agreement immediately replaces a Subscriber Group's previous Health Net CommunityCare 1T Plan Agreement in the middle of a Calendar Year, we will credit amounts accumulated toward annual Deductibles, if any, and Out-of-Pocket Maximums.

- This Agreement will not be denied or canceled solely because the mother of the Member used drugs containing diethylstilbestrol prior to the Member's birth.
- TRANSFER OF MEDICAL RECORDS: A health care Provider may charge a reasonable fee for the preparation, copying, postage or delivery costs for the transfer of your medical records. Any fees associated with the transfer of medical records are the Member's responsibility.

  However, if you have been Enrolled in another Health Net EPO plan included with a larger network than this plan, you are eligible for a one-time reimbursement for the cost of transferring your medical records during your first 3 months of Enrollment in this plan. Health Net will reimburse up to $50 when you transfer your medical records from a Provider who participates in the larger Health Net EPO network but not in this plan's network. You will be required to file a claim with Health Net to get the reimbursement. Please contact our Customer Contact Center at the phone number listed at the back of this Agreement for information on how to submit a claim.

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.

Nondiscrimination Notice

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

HEALTH NET:

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

If you need these services, contact Health Net's Customer Contact Center at 1-888-802-7001 (TTY: 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/smartscreen/main, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

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, LLC. 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 change this Notice. We reserve 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.

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

Internal Protections of Oral, Written and Electronic PHI:

Health Net protects your PHI. We have privacy and security processes to help. These are some of the ways we protect your PHI:

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

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.
- ***Health Care 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 health care 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 PHI 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*** - We may use or disclose 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 disclose 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 previously 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 PHI, 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 purposes 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 your 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 health care 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 Receive a 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 https://www.hhs.gov/hipaa/filing-a-complaint/what-to-expect/index.html.

  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 Health Plan of Oregon, Inc.
Attn: Compliance Department
P.O. Box 11740
Eugene, OR 97440-1740
Telephone: 1-888-802-7001
Fax: 1-844-426-5370
Email: PrivacyOregon@centene.com

For Oregon Members only, if you believe that we have not protected your privacy and wish to complain, you may file a complaint by calling or writing:

Oregon Department of Health and Human Services
Attn: Privacy Officer
500 Summer St. NE, E24
Salem, OR 97301
Phone: 1-503-945-5780 or Fax: 1-503-947-5396
E-mail: dhs.privacyhelp@state.or.us

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, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- 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 Health Net at 1-800-522-0088.

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 the Customer Contact Center at the number on your ID card or call 1-888-802-7001 (TTY: 711).

Amharic

ለቋንቋ አገልግሎት ምንም ክፍያ የለውም። አስተርጓሚ ማግኘት ይችላሉ። የተነበበልዎትን እና የተወሰኑ በቋንቋዎ የተላኩልዎትን ሰነዶች መግኘት ይችላሉ። ለእርዳታ፣ ለደንበኞች ግንኙነት ማዕከል በመታወቂያ ካርድዎ ላይ ያለውን ቁጥር ይደውሉ ወይም በ 1-888-802-7001 (TTY: 711) ይደዉሉ።

Arabic

الخدمات اللغوية المجانية. يمكنك الاستعانة بمترجم فوري، كما يمكنك طلب قراءة المستندات عليك وإرسال بعض منها إليك بلغتك. للحصول على المساعدة، يمكنك الاتصال بمركز اتصالات العملاء على الرقم الموجود على بطاقة 1-888-802-7001. (TTY: 711) معرف العضوية الخاصة بك أو الاتصال على

Chinese

免費語言服務。您可以取得口譯服務。我們可以把文件朗讀給您聽，也可以把部分翻譯成您語言的文件寄送給您。如需協助，請撥打會員卡上的電話號碼聯絡客戶 聯絡中心，或撥打電話1-888-802-7001 (聽障專線(TTY)：711)。

Cushite (Oromo)

Tajaajila afaaniif kaffaltii hin qabu. Turjubaana argachuu ni dandeessu. Sanadii isiniif dubbifamee fi afaan keessaniin muraasaan isniif ergame argachuu ni dandeessu. Gargaarsaaf, Wiirtuu Qunnamtii Maamilaa tiif lakkoofsicha kaardii enyummaa keessan irra jirutti bilbilaa ykn 1-888-802-7001 (TTY: 711) itti bilbilaa.

German

Es stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Sie können einen Dolmetscher hinzuziehen. Die Dokumente können Ihnen vorgelesen werden und einige sind in Ihrer Muttersprache erhältlich. Für Unterstützung rufen Sie bitte unser Kundendienstzentrum unter der auf Ihrer Versicherungskarte angegebenen Nummer oder unter der Rufnummer 1-888-802-7001 (TTY: 711) an.

Japanese

無料の言語支援サービス。通訳をご利用いただけます。日本語で文書を読み上げたり、文書によっては日本語版をお届けすることも可能です。支援をご希望の 方は、IDカードに記載の番号にてカスタマーコンタクトセンターまでお電話いただくか、1-888-802-7001 (TTY: 711)までお電話ください。

Korean

무료 언어 서비스. 귀하는 통역사를 이용하실 수 있습니다. 귀하에게 편한 언어로 서류 낭독 서비스 및 번역 서비스를 받으실 수 있습니다. 도움이 받으시려면 본인의 ID 카드에 기재된 고객 서비스 센터 안내번호 또는 1-888-802-7001 (TTY: 711)번으로 전화해주십시오.

Cambodian (Khmer)

សេវាភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្របបាន។ អ្នកអាចឲ្យសគអានឯកសារជូនអ្នក និងសុំើឯញ កសារខ្ៃះជូនអ្នក ជាភាសារបេអ្ំ នក។ េំរាប់ជំនួយ ទូរ័ព្ទសៅមជឈមណ្ឌលទំនាក់ទំនងអ្តិលិជនតាមសលខ្សៀសលបើណ្័ ណ ID របេអ្ំ នក ឬសៅសលខ្ 1-888-802-7001 (TTY: 711)។

Laotian

ການບໍລິການ ້ດານພາສາ ີ່ທີ່ ບເສຍ ີ່ຄາ. ີ່ທານສາມາດໍຂບາຍແປພາສາ. ີ່ທານສາມາດ ີ່ອານເອກະສານ ແລະ ໍຈານວນ ີ່ໜ ງໄ້ດ ີ່ສ ງໃ້ຫ ີ່ທ ານເັປນພາສາຂອງ ີ່ທານແ ້ລວ. ເ ີ່ພອໍຂຄວາມ ີ່ຊວຍເ ຫອ, ໂທຫາູສນິຕດີ່ ຕລູ ກ ້ຄາໄ້ດ ີ່ທເລກໝາຍີ່ຢູ ເທິ ງ ັບດ ID ຂອງ ີ່ທານ ຫ ໂທ 1-888-802-7001 (TTY: 711).

Punjabi

ਭਾਸਾ ਸੇਵਾਵਾਂ ਲਈ ਕੋਈ ਲਾਗਤ ਨਹੀਂ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਤੁਹਾਨ ੂੰ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਦਸਤਾਵੇਜ਼ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦ ੇ ਹੋ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸਾ ਵਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਗਏ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ID ਕਾਰਡ 'ਤੇ ਗਾਹਕ ਸੁੰਪ੍ਰਕ ਕਦੇਂ ਰ ਨੂੰ ਕਾਲ ਕਰ ੋ ਜਾਂ 1-888-802-7001 (TTY: 711)।

Russian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика.

Вам могут прочесть документы на русском языке и выслать переводы некоторых из них. Если вам требуется помощь, звоните в Центр обслуживания клиентов по номеру, указанному на вашей идентификационной карте, или по номеру 1-888-802-7001 (линия TTY: 711).

Spanish

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llame al Centro de Comunicación con el Cliente al número que se encuentra en su tarjeta de identificación o llame al 1-888-802-7001 (TTY: 711).

Tagalog

Mga Walang Bayad na Serbisyo sa Wika. Maaari kayong kumuha ng tagasaling-wika (interpreter). Maaaring basahin sa inyo ang mga dokumento at ipadala sa inyo ang ilan nang nakasalin sa inyong wika. Para sa tulong, tumawag sa Customer Contact Center sa numero sa inyong ID card o tumawag sa 1-888-802-7001 (TTY: 711).

Health Net Health Plan of Oregon, Inc.
13221 SW 68th Parkway, Ste. 315
Tigard, Oregon 97223
1-888-802-7001

Customer Contact Center
Monday - Friday 8:00 a.m. to 5:00 p.m.
1-888-802-7001
www.healthnetoregon.com

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

Effective 1/2023