Health Net Health Plan of Oregon, Inc.

PPO Plan Coverage Document

Plan [XXX-XXXXXX]

2025

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.
Copayment and Coinsurance Schedule

PPO Plan

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

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

When you receive Covered Services from a Provider in our PPO network, you are not responsible for charges that are above our contracted rates. We recommend that you contact your treating Provider to discuss the other types of Providers that may be used for your services, as Out-of-Network Provider charges will be reimbursed at the out-of-network level. **Certain services including but not limited to 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 Group Plan Benefits.**

Out-of-Network Benefits: Except for Emergency Medical Care, when services are performed by a Provider who is not in our PPO network, your expenses include a Calendar Year Deductible, fixed dollar amounts for certain services and the amount by which billed charges exceed the Maximum Allowable Amount (MAA) for other services. There are some additional exceptions for when you receive services from a Nonparticipating Provider in a participating facility.

We pay Out-of-Network 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. Out-of-Network Providers may therefore 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**.

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

Emergency Medical Care 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)).

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.

Professional Medical Services and Supplies

All benefits are subject to Copayments and Coinsurance amounts listed in this Schedule unless otherwise noted.

	For Covered Services, you pay:	
Calendar Year Deductible	**PPO Network you pay**	**Out-of-Network you pay**
All benefits are subject to the Deductible unless otherwise noted.		
Annual Deductible per person	**$[*]** ■	**$[*]** ■
Annual Deductible per family	**$[*]** ■	**$[*]** ■
Benefit Maximums	**PPO Network you pay**	**Out-of-Network you pay**
Annual Out-of-Pocket Maximum per person (combined medical and prescription drug) ✚	**$[*]**	**$[*]**
Annual Out-of-Pocket Maximum per family (combined medical and prescription drug) ✚	**$[*]**	**$[*]**
Physician/Professional/Outpatient Care	**PPO Network you pay**	**Out-of-Network you pay**
Preventive care, women's and men's health care - Pap test, breast exam, pelvic exam, PSA test and digital rectal exam	No charge ◆	**[*]%** MAA ◆
Routine mammography	No charge ◆	**[*]%** MAA ◆
Diagnostic and supplemental breast imaging*	No charge ◆	**[*]%** MAA
Physician services - office visits to Providers in family practice, pediatrics, internal medicine, general practice,		

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

obstetrics/gynecology, naturopath	First 3 visits **$[*]**◆, then **$[*]** per visit▼◆	**[*]%** MAA
Specialty Physician services - office visits to Providers in specialties other than above	**$[*]** per visit ◆	**[*]%** MAA
Urgent Care center (for Medical Services other than Behavioral Health Conditions or Substance Use Disorders)	**$[*]** per visit ◆	**$[*]** MAA ◆
Urgent Care center (for Behavioral Health Conditions or Substance Use Disorders) ▲	First 3 visits **$[*]**◆, then **$[*]** per visit ▼◆	**[*]%** MAA
Physician Hospital visits	**[*]%** contract rate	**[*]%** MAA
Diagnostic x-ray/ EKG/Ultrasound	**$[*]** per visit ◆	**[*]%** MAA
Diagnostic laboratory tests	**$[*]** per visit ◆	**[*]%** MAA
Diagnostic imaging, including CT/MRI/PET/SPECT/EEG/ Holter monitor/stress test	**[*]%** contract rate	**[*]%** MAA
Allergy and therapeutic injections	**[*]%** contract rate	**[*]%** MAA
Maternity delivery care (professional services only)	**[*]%** contract rate	**[*]%** MAA
Outpatient rehabilitation therapy - 30 visits/year max ♣♥	**$[*]** per visit◆	**[*]%** MAA
Outpatient habilitation therapy - 30 visits/year max ♣♥	**$[*]** per visit◆	**[*]%** MAA
Outpatient surgery in office or Ambulatory Surgery Center	**[*]%** contract rate	**[*]%** MAA
Outpatient at Hospital based facility	**[*]%** contract rate	**[*]%** MAA

Hospital Care	**PPO Network you pay**	**Out-of-Network you pay**
Inpatient services ✪	**[*]%** contract rate	**[*]%** MAA
Inpatient rehabilitation therapy - 30 days/year max ♣♥	**[*]%** contract rate	**[*]%** MAA
Inpatient habilitation therapy - 30 days/year max ♣♥	**[*]%** contract rate	**[*]%** MAA
Emergency Care (for medical care other than Behavioral Health Conditions or Substance Use Disorders)	**PPO Network you pay**	**Out-of-Network you pay**
Outpatient emergency room services	**[*]%** contract rate ◘	**[*]%** ◘

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

Inpatient admission from emergency room	**[*]%** contract rate	**[*]%**
Emergency ground ambulance transport	**[*]%**	**[*]%**
Emergency air ambulance transport	**[*]%**	**[*]%**

Emergency Care (for Behavioral Health Conditions or Substance Use Disorders)	**PPO Network you pay**	**Out-of-Network you pay**
Outpatient emergency room services	**[*]%** contract rate ◘	**[*]%** ◘
Inpatient admission from emergency room	**[*]%** contract rate	**[*]%**
Emergency ground ambulance transport	**[*]%**	**[*]%**
Emergency air ambulance transport	**[*]%**	**[*]%**

Behavioral Health Services– Substance Use Disorder and Behavioral Health Conditions	**PPO Network you pay**	**Out-of-Network you pay**
Physician services, office visits ▲	First 3 visits **$[*]**◆, then **$[*]** per visit▼◆	**[*]%** MAA
Outpatient services ▲	**[*]%** contract rate	**[*]%** MAA
Inpatient services ▲	**[*]%** contract rate	**[*]%** MAA

Other Services	**PPO Network you pay**	**Out-of-Network you pay**
Acupuncture care - maximum of 36 visits/Calendar Year in and out-of-network combined ⦿	**$[*]** per visit ◆	**[*]%** MAA
Blood, blood plasma, blood derivatives	**[*]%** contract rate	**[*]%** MAA
Chiropractic care ⦿	**$[*]** per visit◆	**[*]%** MAA
Diabetes management - one initial program ⌘	**$[*]** per program ◆	**[*]%** MAA
Dialysis services ♠	**[*]%** contract rate	**[*]%** MAA
Durable Medical Equipment ⌘	**[*]%** contract rate	**[*]%** MAA
Hearing aids ╬	**[*]%** contract rate ◆	**[*]%** MAA
Home health visits	**[*]%** contract rate	**[*]%** MAA
Home infusion services	**[*]%** contract rate	**[*]%** MAA
Hospice services	**[*]%** contract rate	**[*]%** MAA

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

Medical supplies (including allergy serum and injected substances)	**[*]%** contract rate	**[*]%** MAA
Naturopathic care (alternative care) ⦿	First 3 visits **$[*]** ◆, then **$[*]** per visit ◆ ▼	**[*]%** MAA
Newborn nurse home visits (covered for newborns up to age six (6) months)	No charge ◆	**[*]%** MAA
Outpatient chemotherapy (non-oral anticancer medications and administration)	**[*]%** contract rate	**[*]%** MAA
Outpatient pharmaceutical/ infusion services	**[*]%** contract rate	**[*]%** MAA
Prosthetic Devices/Orthotic Devices	**[*]%** contract rate	**[*]%** MAA
Skilled Nursing Facility care - 60 days/year max	**[*]%** contract rate	**[*]%** MAA
TMJ services - $500/lifetime max	**[*]%** contract rate	**[*]%** MAA
Telemedical services	**$[*]** per visit ◆	**[*]%** MAA
Therapeutic massage - maximum of 27 visits/Calendar Year in and out-of-network combined ⦿	**$[*]** per visit ◆	**[*]%** MAA
Tobacco use counseling	No charge ◆	**[*]%** MAA

Notes

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

◆ Deductible is waived.

✪ 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.

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

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

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

♣ We may approve an additional benefit of up to 30 visits/days per condition when Medical Necessity criteria are met, not to exceed 60 visits/days total.

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

⚹ 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.

♥ **Visit/day limits do not apply to services to treat Behavioral 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.

╬ The maximum benefit for hearing aid(s) is one per ear per year. The maximum benefit for bone conduction sound processors and hearing assistive technology systems is every 36 months, or more frequently if modifications to an existing hearing aid will not meet the needs of an enrollee who is under 19 years of age; or 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution.

⦿ This plan covers alternative care services as described above. Health Net contracts with American Specialty Health Group, Inc. (ASH Group) to administer the alternative care service benefits. A list of Participating Providers is available at www.healthnetoregon.com or by calling our Customer Contact Center at the phone number listed at the back of this Agreement.

▼ A **$[*]** Copayment will apply to first three office visits listed under Physician services, Behavioral Health Services and Naturopathic care combined.

* Includes diagnostic mammography, breast magnetic resonance imaging (MRI), and breast ultrasound.

Outpatient Prescription Drug Benefits

Copayments and/or Coinsurance amounts you pay for prescription drugs apply toward your plan's Out-of-Pocket Maximum as shown in the "Benefit Maximums" section above. Deductible is waived for prescription drug benefits.

	In Pharmacy (Per Fill Up to a 30 day[1] Supply), you pay:	Mail Oder (Per Fill Up to a 90 day[1] Supply), you pay:
Tier 1 [3, 4]	**$[*]**	**$[*]**
Tier 2 [2, 3]	**$[*]**	**$[*]**
Tier 3 [2, 3]	**[*]%**	**[*]%**
Specialty Pharmacy [3]	**[*]%**	Mail order not available
Orally administered anticancer medications	**[*]%**	Mail order not available
Preventive Pharmacy including Tobacco Cessation Medications and contraception methods	No Copayment and/or Coinsurance. Deductible waived	No Copayment or Coinsurance. Deductible waived

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

[1] If certain requirements are met, you may be eligible for a 90-day supply when filled in a pharmacy (with three times the retail copay).

[2] If a generic equivalent exists but a brand name drug is requested and approved, you may be required to pay an ancillary charge equal to the difference between the cost of the generic drug and the brand name drug in addition to the applicable Copayment and/or Coinsurance.

[3] For the treatment of diabetes, the amount you pay for prescription insulin shall not exceed $35 for a 30-day supply or $105 for a 90-day supply. Deductible is waived.

[4] See the "Prescription Drug Benefits" section under "Group Plan Benefits" for information regarding opioid use disorder medications.

Pediatric Vision Benefits

This plan covers routine vision Services and Supplies for children under age 19 as described below. You must utilize Participating Providers. A list of Participating Providers is available at www.healthnetoregon.com or by calling our Customer Contact Center at the phone number on the bottom of this Schedule.

Copayments and/or Coinsurance and other amounts you pay for pediatric vision benefits do not apply toward your plan's medical Deductibles.

	You pay:
Routine eye exam (limit: 1 per Calendar Year)	$0 Copayment
Provider selected frames (limit: 1 per Calendar Year)	$0 Copayment
Lenses (limit: 1 pair per Calendar Year) including:	$0 Copayment
• Single vision, bifocal, trifocal, lenticular	
• Glass or Plastic	
Optional lenses and treatment include:	$0 Copayment
• UV Treatment	
• Tint (Fashion & Gradient & Glass-Grey)	
• Standard Plastic Scratch Coating	
• Standard Polycarbonate	
• Photochromic/Transitions Plastic	
• Standard Anti-Reflective Coating	
• Polarized	
• Standard Progressive Lens	
• Hi-Index Lenses	
• Blended segment lenses	
• Intermediate vision lenses	

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

- Select or ultra-progressive lenses

Provider selected contact lenses (in lieu of eyeglass lenses): ..... $0 Copayment

- Daily wear: Up to 3 month supply of daily disposable, single vision.
- Extended wear: Up to 6 month supply of monthly or 2 week disposable, single vision.
- Conventional: 1 pair from a selection of provider designated contact lenses.
- Medically Necessary

Pediatric Dental Benefits

Necessary Dental Care for children under age 19 is covered. This plan covers limited pediatric dental services that are provided in Diagnostic and Preventive, Basic, and Major Services (including orthodontics) as outlined in the plan summary.

You can see any licensed dentist and receive benefits for Covered Services and Supplies. However, if you do see a Participating Provider, charges for Covered Services will be limited to Health Net's contracted amount with the Provider. You can obtain a list of Participating Providers by calling our Customer Contact Center at the phone number listed at the bottom of this Schedule.

Pediatric Dental Deductibles (if any), Copayments and/or Coinsurance and other amounts you pay for pediatric dental benefits apply toward your plan's medical Out-of-Pocket Maximum.

Coverage is as follows:

Deductible per Member	**$100 per Calendar Year**

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

Covered Services	**For Covered Services, you pay:**

Diagnostic and Preventive Services ..... No charge (MAA applies to Nonparticipating Providers)
Including:

- Initial and periodic oral examinations
- Oral Evaluations, include specialist evaluations
- Topical fluoride treatment, fluoride varnish
- Preventive dental education
- Roentgenology (x-rays)
- Prophylaxis services (cleanings)

Basic Services: ..... 50% (MAA applies to Nonparticipating Providers)
Including:

- Sealants, Space Maintainers, including removable acrylic, fixed band type, and recementation.
- Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries.
- Endodontics

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

- Periodontics
- Oral surgery

Major Services: ..... 50% (MAA applies to Nonparticipating Providers)
Including:

- Crowns
- Denture and bridge work

Medically Necessary Orthodontia..... 50% (MAA applies to Nonparticipating Providers)

- Benefits for comprehensive orthodontic treatment are approved by Health Net Dental, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities, which result in physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be Prior Authorized.

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.

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Health Net Health Plan of Oregon, Inc.

Vision Benefits

Supplemental Benefit Schedule Elite E1010-1

Purpose and Function of this Schedule
The purpose of this schedule is to provide vision Benefits to Subscriber Groups selecting this supplemental benefit in addition to the Basic Benefits. This schedule is an amending attachment to the Basic Benefit Schedule.

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

The benefits for eye examination and eyewear are covered as shown below and are subject to the limitations, options, and exclusions as described herein. To receive maximum benefits, you must utilize Participating Providers. **For insureds under age 19, please refer to your medical Schedule of Benefits for pediatric Vision Services provided at no cost to the insureds through participating Vision Providers.** A list of Participating Providers is available at www.healthnetoregon.com or by calling our Customer Contact Center at the number at the bottom of this Schedule. When services are received from a Participating Provider, we make payment directly to the Provider. You are responsible for paying the Copayment to the Provider.

Benefits

Benefits are based on the following Schedule:

Eye Exam	Participating Provider	Any Other Provider
Exam	After you pay a **$[*]** Copayment, Covered Services are paid in full by the plan.	You are reimbursed up to **$[*]** of the cost for Covered Services.
Exam Options (fit and follow-up)		

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

Eye Exam	Participating Provider	Any Other Provider
Standard contact lenses	After you pay up to **$[*]**, Covered Services are paid in full by the plan.	You receive no discount.
Premium contact lenses	You receive **[*]%** off retail cost.	You receive no discount.
Eyewear (lenses and frame)		
Single vision lenses	Covered in full after a **$[*]** Copayment.	You are reimbursed up to **$[*]**.
Lined bifocal lenses	Covered in full after a **$[*]** Copayment.	You are reimbursed up to **$[*]**.
Lined trifocal lenses	Covered in full after a **$[*]** Copayment.	You are reimbursed up to **$[*]**.
Lenticular lenses	Covered in full after a **$[*]** Copayment.	You are reimbursed up to **$[*]**.
Standard progressive lenses	Covered in full after a **$[*]** Copayment.	You are reimbursed up to **$[*]**.
Premium progressive lenses	**$[*]** Copayment, then **[*]%** of total charge less **$[*]** allowance.	You are reimbursed up to **$[*]**.
Frame	Covered up to **$[*]** allowance. You will receive a **[*]%** discount on the balance over your allowance.	You are reimbursed up to **$[*]**.
Lens Options		
UV Coating	Covered in full after a **$[*]** Copayment.**	You receive no discount.
Tint, solid and gradient	Covered in full after a **$[*]** Copayment.**	You receive no discount.
Standard scratch-resistance	Covered in full after a **$[*]** Copayment.**	You receive no discount.
Standard polycarbonate	Covered in full after a **$[*]** Copayment.**	You receive no discount.
Standard anti-reflective	Covered in full after a **$[*]** Copayment.**	You receive no discount.
Other add-ons and services	You receive **[*]%** off retail	You receive no discount.

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

Eye Exam	Participating Provider	Any Other Provider
	cost.**	
Contact lenses (instead of spectacle lenses and frame) – Materials		
Conventional	You receive a maximum allowance of **$[*]**, plus a discount of **[*]%** over your allowance.	You are reimbursed up to **$[*]** of the cost for Covered Services.
Disposables	You receive a maximum allowance of **$[*]**, you are responsible for any remaining balance over your allowance.	You are reimbursed up to **$[*]** of the cost for Covered Services.
Medically Necessary	Paid in full.	You are reimbursed up to **$[*]** of the cost for Covered Services.
Frequency of Service		
Examination	Once every 12 months from the last date of service.	Once every 12 months from the last date of service.
Lenses	Once every 12 months from the last date of service.	Once every 12 months from the last date of service.
Frame	Once every 12 months from the last date of service.	Once every 12 months from the last date of service.
Contact lenses in lieu of lenses	Once every 12 months from the last date of service.	Once every 12 months from the last date of service.

** Your Copayment or eyewear discount applies to any optional items purchased with your lenses and/or frames from a Participating Provider. Listed items are examples of optional items.

Limitations, Options and Exclusions

- To receive maximum Benefits, you must utilize Participating Providers. A list of Participating Providers is available at www.healthnetoregon.com or by calling our Customer Contact Center.
- When services are received from a Participating Provider, we make payment directly to the Provider. You are responsible for paying the Copayment to the Provider.
- There is no Benefit for professional services or materials connected with:
  a. Orthoptics or vision training, subnormal vision aids and any associated supplemental testing.
  b. Aniseikonic lenses.

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

c. Medical or surgical treatment of the eyes or supporting structures.

d. Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under this plan.

e. Services for any illness, condition or injury occurring in or arising out of the course of employment for which there is an approved workers' compensation claim.

f. Plano nonprescription lenses and nonprescription sunglasses.

g. Lost or broken materials except at normal intervals when services are otherwise available.

- Benefits may not be combined with any discount, promotional offering, or other group Benefits plans. Allowances are one-time use Benefits; no remaining balance.
- Value Added Discounts

  Contact Lenses – Participating Providers offer preferred pricing and direct delivery on annual supplies of select brands of disposable contact lenses.

  Lasik or PRK – You may have a discount available for these services. Please contact our Customer Contact Center for more information.

  Continued Eyewear Savings – After your initial Benefits have been utilized, you may be able to receive ongoing discounts on additional eyewear purchases at Participating Provider locations. Please contact our Customer Contact Center for more information.

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This summary presents general information only and does not include all Benefits, details and exclusions.

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Health Net Health Plan of Oregon, Inc.

PPO Plan Contract

Group Plan Benefits and Group Medical and Hospital Service Agreement

2025

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

This booklet explains how to get the care and prescription drugs 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.

PPO Plan

GROUP PLAN BENEFITS

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

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, Copayments and/or Coinsurance identified in the attached Copayment and Coinsurance Schedule.
- All services other than the 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, guarantee the service or supply will be a covered benefit. Covered Medical Services and Supplies are set forth as benefits in this Group Plan Benefits section.

- A Medical Service or Supply not expressly included in this Group Plan Benefits section is not considered a covered benefit. A Medical Service or Supply not specifically listed as an exclusion in the "Exclusions and Limitations" portion of this Group Plan Benefits section is not guaranteed as a covered benefit.
- We reserve the right to modify benefits under this Agreement at any time. Written notice of benefit changes, including modifications to preventive benefits, will be provided to Enrollees at least 60 days prior to the effective date of the change.
- The coverage described in this Group Plan Benefits section shall be consistent with the Essential Health Benefits coverage requirements in accordance with the Affordable Care Act (ACA). The Essential Health Benefits are not subject to any annual or lifetime dollar limits.
- The benefits described under this Agreement do not discriminate on the basis of race, ethnicity, nationality, gender, gender identity, gender expression, age, disability, sexual orientation, genetic information, or religion, and are not subject to any pre-existing condition exclusion period. Please refer to the Nondiscrimination Notice section in the Group Medical and Hospital Service Agreement.

Participating Providers

Under the PPO network benefit level, you receive medical care from a Participating Provider listed in our Participating Provider directory available at www.healthnetoregon.com. Simply call the Participating Provider to schedule an appointment.

When you receive Covered Services from Providers in our PPO network, your expenses include a Calendar Year Deductible (if any), fixed dollar amounts for certain services or a fixed percentage that is applied to our contracted rates with PPO Providers. The percentage of our contracted rate that is your responsibility is shown in the attached "Copayment and Coinsurance Schedule."

When you receive Covered Services from a Provider in our PPO network, you are not responsible for charges that are above our contracted rates. We recommend that you contact your treating Provider to discuss the other types of Providers that may be used for your services, as Out-of-Network Provider charges will be reimbursed at the out-of-network level.

Certain services are only covered if provided by Participating Providers that are designated as a Specialty Care Provider. See "Specialty Care Providers" section below for details.

Specialty Care Providers

We may utilize Participating Providers that are designated as Specialty Care Providers for Medical Services related to certain conditions or certain treatment procedures. Services which may 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 infusion suite (an alternative care site to a home, Physician office or Hospital setting, where patients can receive infusion therapy of specialty drugs in a safe, monitored environment)
4. Organ and tissue transplant services
5. Durable Medical Equipment

6. Prosthetic Devices/Orthotic Devices
7. Wigs

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.

Nonparticipating Providers

- **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 Medical 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 Medical 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.cms.gov/nosurprises for more information about your rights under Oregon laws.

- **Covered Services from a Nonparticipating Provider** (other than for emergency or Urgent Care or from a Nonparticipating Provider at a participating facility).

  Subject to the Specialty Care Provider requirements, you may choose to obtain covered Medical Services and Supplies from a Nonparticipating Provider. Please see "Specialty Care Providers" above for services that are only covered by Participating Providers. You may incur higher out-of-pocket expenses if you receive Services or Supplies from a Nonparticipating Provider.

  When services are performed by or received from a Nonparticipating Provider, your expenses 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.

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. For children, you may designate a pediatrician as the primary care Provider. You may select a naturopathic provider as your primary care Provider if the Provider is credentialed by Health Net as a primary care Provider.

Upon enrollment, you will be assigned to a primary care Provider within the county where you reside. For information on how to select or change your primary care Provider, and for a list of the participating primary care Providers or any Women's Health Care Provider, you may contact our Customer Contact Center at the phone number listed at the back of this Agreement, or visit us at www.healthnetoregon.com.

Physician and Professional Services

Benefits are subject to payment of any applicable Copayments, Coinsurance, and/or Deductible, 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, Coinsurance, and/or Deductible can be found in your Copayment and Coinsurance Schedule.

Certain exclusions and limitations may apply. Be sure you read the "Exclusions and Limitations" and "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.

- **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.
- **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.
- **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" portion of the Group Plan Benefits section.
- **Home Visits.** Visits to your home are covered. Prior Authorization is required.
- **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 our Customer Contact Center at the phone number listed at the back of this Agreement, or visit us at www.healthnetoregon.com.
- **Office Visits.** Your office visits, 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 for 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.
- **Radiation Therapy.** Radiation therapy is covered.
- **Specialty Physician Services.** Services of specialty Physicians and other specialty Providers are covered with or without a referral from the primary care Physician.

- **Surgery.** Inpatient or outpatient surgical procedures are covered only when Prior Authorized or as Emergency Medical Care.

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 "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.** While you are a patient in a Hospital, an average two-bed accommodation; general nursing care; meals; special diets; use of operating room and related facilities; intensive care unit and services; 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.
- **Hospitalization for dental procedures** is covered when the patient has another serious medical condition that may complicate the dental procedure, such as serious blood disease, unstable diabetes, or severe cardiovascular disease, or the patient is physically or developmentally Disabled with a dental condition that cannot be safely and effectively treated in a dental office.

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. 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.

- **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 "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 Medical Care

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. Benefits payable to Nonparticipating Providers are paid at the Participating Provider level specified in the Copayment and Coinsurance Schedule.

See your Copayment and Coinsurance Schedule for additional benefit information.

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

Emergency Room. Services of a Hospital emergency room are limited to treatment of an Emergency Medical Condition and are not covered if merely for your convenience.

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. To ensure the maximum available benefits under this Agreement, you should obtain your follow-up care after Stabilization of an Emergency Medical Condition from Participating Providers and in accordance with any Prior Authorization requirements. If you are hospitalized in a Nonparticipating Provider Hospital, you will be financially responsible for any care that we determine is not Medically Necessary. Care and treatment provided after Stabilization is no longer considered Emergency Medical Care. If you have been admitted to a Nonparticipating Provider Hospital and require continuous care, we can help transfer you to a Participating Provider as soon as Stabilization has occurred. Continuation of care from a Nonparticipating Provider Hospital beyond what is required to evaluate or stabilize your condition in an emergency will be reimbursed at the out-of-network level for Covered Services unless we authorize Medically Necessary continuous care.

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. Applicable Copayments and Coinsurance can be found 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 Medical 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.

Additional exclusions and limitations may apply. Be sure you read the "Exclusions and Limitations" portion of this Group Plan Benefits section.

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.

Urgent Care

Medically Necessary Urgent Care services are covered under this Group Plan Benefits. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance identified in the attached Copayment and Coinsurance Schedule.

Alternative Care

This plan covers alternative care services as described below. Health Net contracts with American Specialty Health Group, Inc. (ASH Group) to administer the alternative care service benefits. A list of Participating Providers is available at www.healthnetoregon.com or by calling our Customer Contact Center at the phone number listed at the back of this Agreement.

Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance identified in the attached Copayment and Coinsurance Schedule.

Chiropractic Services are covered as follows:

- Patients have direct access to participating chiropractors. A new or established patient examination is performed by the participating chiropractor to determine the nature of the Member's problem and, if Covered Services appear warranted, a proposed treatment plan of services to be furnished is prepared. A Copayment is required.
- A re-examination may be performed by the participating chiropractor to assess the need to continue, extend or change an approved treatment plan. A re-evaluation may be performed as a single service or in conjunction with additional services. Whether performed as a single service or in conjunction with other services, the service(s) are considered a visit for any visit maximums. Whether performed as a single service or in conjunction with other services, a Copayment is required.

- Subsequent office visits, as set forth in an approved treatment plan, may involve an adjustment, a brief reexamination and other services, in various combinations. A Copayment is required for each visit to the office.
- Adjunctive therapy, as set forth in an approved treatment plan, may involve modalities such as ultrasound, hot packs, cold packs, electrical muscle stimulation and other therapies.
- X-rays and clinical laboratory tests not performed within the chiropractor's office are payable in full when referred by a participating chiropractor and approved as Medically Necessary. Radiological consultations are a covered benefit when approved as Medically Necessary services and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or Hospital.
- Chiropractic appliances are covered when prescribed by a participating chiropractor and approved as Medically Necessary.
- Chiropractic Services, except for the initial visit, may be subject to verification of Medical Necessity for treatment of Musculoskeletal and Related Disorders.

Chiropractic Exclusions and Limitations:

a. Services or treatments not approved as Medically Necessary, except for a new patient examination and urgent services.

b. Services for examinations and/or treatments from participating chiropractors for conditions other than those related to Musculoskeletal and Related Disorders.

c. Hypnotherapy, behavior training, sleep therapy and weight programs.

d. Thermography.

e. Services, lab tests, x-rays and other treatments not documented as Medically Necessary and appropriate or classified as Experimental or Investigational and/or as being in the research stage.

f. Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology and any diagnostic radiology other than covered plain film studies.

g. Transportation costs including local ambulance charges.

h. Education programs, nonmedical lifestyle or self-help or any self-help physical exercise training or related diagnostic testing.

i. Services or treatments for pre-employment physicals or vocational rehabilitation.

j. Services covered under public liability insurance and services for any illness, condition or injury occurring in or arising out of the course of employment for which there is an approved workers' compensation claim.

k. Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all chiropractic appliances or Durable Medical Equipment, except as specifically outlined.

l. Prescription drugs or medicines including proprietary medicines or medications not requiring a prescription order.

m. Services provided by a chiropractor practicing outside the states of Oregon and Washington (state of residency), except for urgent services.

n. Hospitalization, anesthesia, manipulation under anesthesia and other related services.

o. Auxiliary aids and services, including, but not limited to, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

p. Adjunctive therapy not associated with spinal, muscle or joint manipulation.

q. Vitamins, minerals or other similar products.

Acupuncture Services are covered as follows:

- Patients have direct access to contracted acupuncturists for their initial visit. A new or established patient examination is performed by the participating acupuncturist to determine the nature of the Member's problem and, if Covered Services appear warranted, a treatment plan of services to be furnished is prepared. A Copayment is required.
- A re-examination may be performed by the participating acupuncturist to assess the need to continue, extend or change an approved treatment plan. A reevaluation may be performed as a single service or in conjunction with additional services. Whether performed as a single service or in conjunction with other services, the service(s) are considered a visit for any visit maximums. Whether performed as a single service or in conjunction with other services, a Copayment is required.
- Subsequent office visits, as set forth in an approved treatment plan, may involve acupuncture treatment, a brief reexamination and other services in various combinations. A Copayment is required for each visit to the office.
- Adjunctive therapy, as set forth in an approved treatment plan, may involve modalities such as acupressure, moxibustion and other therapies.
- All Acupuncture Services, except for the initial visit, may be subject to verification of Medical Necessity for treatment of Musculoskeletal and Related Disorders, nausea and/or pain.

Acupuncture Exclusions and Limitations:

a. Services or treatments not approved as Medically Necessary, except for a new patient examination and urgent services.

b. Services for examinations and/or treatments from participating acupuncturists for conditions other than those related to Musculoskeletal and Related Disorders, nausea and/or pain.

c. Hypnotherapy, behavior training, sleep therapy and weight programs.

d. Thermography.

e. Services, lab tests, x-rays and other treatments not documented as Medically Necessary and appropriate or classified as Experimental or Investigational and/or as being in the research stage.

a. Radiological x-rays, magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, diagnostic radiology, and laboratory services.

f. Transportation costs including local ambulance charges.

g. Education programs, nonmedical lifestyle or self-help or self-help physical exercise training or any related diagnostic testing.

h. Services or treatments for pre-employment physicals or vocational rehabilitation.

i. Services covered under public liability insurance and services for any illness, condition or injury occurring in or arising out of the course of employment for which there is an approved workers' compensation claim.

j. Air conditioners/purifiers, therapeutic mattresses, supplies, Durable Medical Equipment or appliances, or any other similar device.

k. Prescription drugs or medicines including proprietary medicines or medications not requiring a prescription order.

l. Services provided by an acupuncturist practicing outside the states of Oregon and Washington (state of residency), except for urgent services.

m. Hospitalization, anesthesia, manipulation under anesthesia and other related services.

n. Auxiliary aids and services, including, but not limited to, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

o. Adjunctive therapy not associated with acupuncture.

p. Vitamins, minerals or other similar products.

q. Nutrition supplements which are Native American, South American, European or of any other origin.

r. Nutrition supplements obtained by Member through an acupuncturist, health food store, grocery store or by any other means.

s. Clinical laboratory services or any other type of diagnostic test or service.

Therapeutic Massage Services are covered as follows:

- Patients have direct access to a Participating Provider of Therapeutic Massage Services for up to four visits. All visits beyond the first four visits annually must be verified as Medically Necessary to be eligible for coverage for myofascial, Musculoskeletal and Related Disorders or pain syndromes. A Copayment is required for each therapeutic massage session/office visit.
- After the first four visits, the Participating Provider of Therapeutic Massage Services will provide therapeutic massage in support of a covered medical condition. The Participating Provider of therapeutic massage service develops an applicable treatment plan and submits it for approval. A Copayment is required for each therapeutic massage session/office visit.
- Subsequent sessions include therapeutic massage and possibly a brief reassessment of patient status and progress toward therapy goals. A Copayment is required for each therapeutic massage session/office visit with the Participating Provider of therapeutic massage service. The subsequent session includes all services related to the therapeutic massage, a brief reassessment if necessary and any consultative support services.
- Any treatment for a minor under the age of 18 requires parental consent and participation.

Therapeutic Massage Exclusions and Limitations:

1. Services beyond the fourth annual visit for treatments of conditions other than those related to myofascial, Musculoskeletal and Related Disorders or pain syndromes.

2. Therapeutic Massage Services beyond the fourth annual visit that are not verified as Medically Necessary.
3. Therapeutic Massage Services rendered by a Participating Provider of Therapeutic Massage Services that are not delivered in accordance with the therapeutic massage benefit plan, including, but not limited to, limited Therapeutic Massage Services rendered directly in conjunction with chiropractic, acupuncture or naturopathic services.
4. Hypnotherapy, behavior training, sleep therapy and weight programs.
5. Services and/or treatments not documented as Medically Necessary and appropriate or classified as Experimental or Investigational and/or as being in the research stage.
6. Transportation costs including local ambulance charges.
7. Education programs, nonmedical lifestyle or self-help or any self-help physical exercise training or any related diagnostic testing.
8. Services or treatments for pre-employment physicals or vocational rehabilitation.
9. Services covered under public liability insurance and services for any illness, condition or injury occurring in or arising out of the course of employment for which there is an approved workers' compensation claim.
10. Air conditioners/purifiers, therapeutic mattresses, supplies, Durable Medical Equipment or appliances.
11. Prescription drugs or medicines including proprietary medicines or medications not requiring a prescription order.
12. Services provided outside the scope of a massage therapist's license.
13. Hospitalization.
14. Auxiliary aids and services, including, but not limited to, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.
15. Adjunctive therapy whether or not associated with therapeutic massage.
16. Vitamins, minerals, nutrition supplements or other similar products.

Naturopathic Services are covered as follows:

- Patients have direct access to Participating Provider of naturopathic services for their initial visit. A new or established patient examination or consultation, including the history and physical examination, is performed by the Participating Provider of naturopathic services to determine the nature of the Member's problem. Applicable Copayments and Coinsurance can be found in your Copayment and Coinsurance Schedule.
- An office visit represents an all-inclusive per diem rate for all services associated with the office visit, including evaluation or reevaluation, any consultative services and any adjunctive services.

- Adjunctive therapy is limited to that which is allowed by the Provider's state scope of practice and, is also limited to noninvasive modalities such as diathermy, electrical stimulation, hot and cold packs, hydrotherapy, manipulation, massage, range of motion exercises and therapeutic ultrasound. Acupuncture is also covered as allowed by the Provider's state scope of practice. Whether this is provided independent of an examination, or in conjunction with an examination on the same date of service, a Copayment is required.
- Diagnostic tests are limited to those allowed by the Provider's state scope of practice and required for further evaluation of the Member's condition.
- Covered conditions and services are limited to those the Provider is qualified to treat or perform pursuant to state licensure and scope of practice, excluding obstetrics, surgery, invasive procedures, psychological services and services listed as Limitations and Exclusions.

Naturopathic Exclusions and Limitations:

a. Services or treatments not approved as Medically Necessary, except for a new patient examination and urgent services.

b. Services for examinations and/or treatments for conditions that are not listed as a covered condition or listed as an exclusion.

c. Immunizations, vaccinations, injectables and intravenous infusions (does not include venipuncture for the purpose of obtaining blood samples for laboratory studies).

d. Preventive health services, such as those defined by the following: (a) United States Preventive Services Task Force (USPSTF) recommended type "A" and "B" services; (b) Immunizations and inoculations as recommended by the Advisory Committee on immunization Practices of the Center for Disease Control (CDC); (c) Pediatric preventive care and screenings, as supported by the Health Resources and Services Administration (HRSA) guidelines; (d) Women’s health care services not included in the "Preventive Care" portion of the Group Plan Benefits section, as supported by HRSA guidelines; (e) Other USPSTF recommendations for breast cancer screening, mammography and prevention, are not available under the alternative care benefit. Members seeking such services should consult their primary Physician. See the "Primary Care Provider Designation" provision under the "General Terms Under Which Benefits Are Provided" section for more information.

e. Hypnotherapy, behavior training, sleep therapy and weight programs.

f. Thermography

g. Services, lab tests, x-rays and other treatments not documented as Medically Necessary and appropriate; those classified as Experimental or Investigational; those that are in the research stage; and/or those not specifically referenced as covered diagnostic tests in the naturopathy Covered Services section above.

h. Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology and diagnostic radiology other than covered plain film studies.

i. Transportation costs including local ambulance charges.

j. Education programs, lifestyle or self-help programs or any self-help physical exercise training or related diagnostic testing.

k. Services or treatments for pre-employment physicals or vocational rehabilitation.

l. Services covered under public liability insurance and services for any illness, condition or injury occurring in or arising out of the course of employment for which there is an approved workers' compensation claim.

m. Air conditioners/purifiers, therapeutic mattresses, supplies, Durable Medical Equipment or appliances.

n. Prescription drugs or medicines.

o. Hospitalization, anesthesia, manipulation under anesthesia and other related services.

p. Auxiliary aids and services, including, but not limited to, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

q. Adjunctive therapy that is considered to be invasive or not listed on the payor summaries.

General Alternative Care Exclusions and Limitations:

a. Any procedure not performed in a Provider setting.

b. Expenses for a Procedure in Progress begun prior to the Member's eligibility. Services rendered after the date a Member's coverage terminates.

c. Hospitalization or other facility charges.

d. Reconstructive surgery, regardless of whether or not the surgery is incidental to a disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.

e. Procedures that are considered to be Experimental or Investigational. The fact that an Experimental or Investigational service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental or Investigational for that particular condition.

f. Drugs and medications obtainable with or without a prescription, unless dispensed and utilized in the Provider's office during the patient visit.

g. Educational programs, Services and Supplies to teach nutritional and oral hygiene techniques.

h. 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.

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 Behavioral 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.

Behavioral Health Conditions

Benefits for Medically Necessary treatment of Behavioral Health Conditions 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 Behavioral Health Conditions are covered following the provisions of the "Office Visits," the "Specialty Physician Services," the "Hospital Inpatient Services," and the "Outpatient Facility 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 Behavioral Health Conditions."

Health Net will not deny benefits for a Medically Necessary treatment or service for a Behavioral 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 Behavioral Health Conditions; or
- The fact that a court ordered the Enrollee to receive or obtain the treatment or service for a Behavioral 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 Behavioral 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 Behavioral Health Condition shall be considered to be a distinct and specialized type of program for both Substance Use Disorder and Behavioral 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;
- Support groups; or
- 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.

Biofeedback

Medically Necessary benefits for biofeedback therapy treatment are provided when included as part of a treatment plan. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance.

Exclusions and Limitations:

Coverage is limited to ten (10) treatments per lifetime.

Blood

Blood transfusions, including blood processing, the cost of blood, unreplaced blood, and blood products, are covered. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance identified in the Copayment and Coinsurance Schedule.

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. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance.

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. The Member provides medical and scientific information establishing that their 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; or
  e. Items or services that are not covered by the Health Benefit Plan if provided outside of the clinical trial.
- An 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. 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, 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" portion 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 45 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, preventive 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 (USPSTF); 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, which 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. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance.

Exclusions and Limitations:

Craniofacial Anomalies does not include developmental maxillofacial conditions that result in overbite, crossbite, 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:

- 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. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance.

Dental Injury

Accidental injury by external force or trauma is covered.

For purposes of this section:

"Accidental Injury" is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental Injury does not include illness, infection (except infection of a cut or nonsurgical wound) or damage to the teeth or dental prosthesis caused by chewing.

Services are limited to Emergency Medical Care and Medically Necessary follow up care to sound natural teeth as a result of an accidental injury. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance.

Exclusions and Limitations:

Except for the initial examination, services for the treatment of injury to the jaw or natural teeth require Prior Authorization to qualify for benefits.

Damage to teeth caused by chewing or biting is not considered a dental injury.

Covered services do not include cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance or dental Services or Supplies or treatment for disorders of the jaw except as set out under the "Dental Services" subsection of this Group Plan Benefits section.

Dental implants are excluded. Spot grinding, restorative, or mechanical devices; orthodontics, inlays or onlays, crowns, bridgework, dental splints (whether custom fit or not), dental implants or other dental appliances and related surgeries to treat dental conditions related to the dental trauma are not covered under any circumstances.

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 "Prescription Drug Benefits" and "Medical Supplies" subsections 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" portion 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. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance identified in the Copayment and Coinsurance Schedule.

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 web site at www.medicare.gov/.

Durable Medical Equipment

Durable Medical Equipment, including your initial rental or purchase, is covered provided it is prescribed by your Physician, and is the least costly alternative that achieves a medically acceptable result. Coverage includes, but is not limited to, braces, splints, prostheses, orthopedic appliances and Orthotic Devices, supplies or apparatus used to support, align, or correct deformities or to improve the function of moving parts. Medically Necessary lenses for the treatment of aphakia and keratoconus are covered as Durable Medical Equipment. Prior Authorization is required. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance identified in the Copayment and Coinsurance Schedule.

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).

As supported by HRSA guidelines, breastfeeding devices and supplies (including one breast pump per pregnancy) are covered as preventive care listed under the "Preventive Care" portion of this Group Plan Benefits section.

Exclusions and Limitations:

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

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. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance identified in the Copayment and Coinsurance Schedule.

Habilitative Services

Coverage is provided for habilitative services and/or therapy that assist an individual in partially or fully acquiring, maintaining, or improving age appropriate skills and functioning and that are necessary to address a health condition, to the maximum extent practical, when provided by a Participating Provider, licensed physical, speech or occupational therapist or other contracted Provider, acting within the scope of their license, to treat physical and Behavioral Health Conditions, subject to any required Prior Authorization from us. The services must be based on a treatment plan authorized, as required by us or

the Member's Physician. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance identified in the Copayment and Coinsurance Schedule.

Exclusions and Limitations:

Habilitative 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.

Speech therapy is not covered for occupational or recreational voice strain that could be needed by professional or amateur voice users, including, but not limited to, public speakers, singers, cheerleaders.

Health care services that are not habilitative include, but are not limited to, Respite Care, day care, recreational care, residential treatment, social services, and Custodial Care.

Inpatient habilitative services are limited to:

- A maximum of 30 days per Calendar Year.
- We may also approve an additional 30 days per condition when Medical Necessity criteria are met, not to exceed 60 days total.

Outpatient habilitative services are limited to:

- A maximum of 30 visits per Calendar Year. We may approve an additional benefit of up to 30 visits per condition when Medical Necessity criteria are met, not to exceed 60 visits total.
- The maximum benefits for inpatient and outpatient treatment are shown on the Copayment and Coinsurance Schedule. Prior Authorization is required.

Habilitative services to treat Behavioral Health Conditions are not subject to day limits/maximums.

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. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance.

Hearing Aids and Hearing Assistive Technology

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

- **Hearing aid and accessories**. Hearing aid means any nondisposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords. 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 one box of replacement batteries per year for each hearing aid;

- **Ear molds and replacement ear molds.** This plan covers ear molds and replacement ear molds (as Medically Necessary) at least four times per plan year for enrollees who are younger than eight years of age, and at least once per year for enrollees who are eight to 18 years of age, or 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution;
- **Cochlear implants**. Medically Necessary cochlear implants, bilateral cochlear implants and other assistive listening devices, including fitting, programming and reprogramming performed by a licensed audiologist, 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** Covered at least twice per year for enrollees who are younger than four years of age and at least once per year for enrollees who are four years of age or older. Coverage includes hearing tests appropriate for age or developmental need, hearing aid checks, conformity evaluations, and aided testing;
- **Bone conduction sound processors, headbands, and Prosthetic Device parts (if necessary for appropriate amplification of the hearing loss)**; and
- **Assistive listening devices.** Assistive listening devices means devices used with or without hearing aids or cochlear implants to provide access to sound or 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) is limited to one per ear per year. The maximum benefit for bone conduction sound processors and hearing assistive technology systems is every 36 months, or more frequently if modifications to an existing hearing aid will not meet the needs of an Enrollee who is under 19 years of age; or 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution.

This benefit is subject to Deductibles, if any, Copayments or Coinsurance shown on the Copayment and Coinsurance Schedule. 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. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance identified in the Copayment and Coinsurance Schedule.

Exclusions and Limitations:

We may utilize a Specialty Care Provider of home health services if you live in the Service Area. 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 an infusion suite (an alternative care site to a home, Physician office or Hospital setting, where patients can receive infusion therapy of specialty drugs in a safe, monitored environment) 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. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance identified in the Copayment and Coinsurance Schedule.

Exclusions and Limitations:

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

Hospice Care

Hospice Care is covered if you are terminally ill. 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. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance identified in the Copayment and Coinsurance Schedule.

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. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance.

Maternity Benefits

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

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 are 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" portion 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. Refer to the applicable out-of-network Deductible and Coinsurance for preventive care in the Copayment and Coinsurance Schedule for services received from a Nonparticipating 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 PPO Plan Contract on the basis of fraud or misrepresentation of material fact, up to and including recoupment of all benefits we paid on behalf of the Surrogate during the time that the Surrogate was insured under our contract, plus interest, attorneys' fees, costs and all other remedies available to us.

  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. Please see the "Exclusions and Limitations" section.

Exclusions and Limitations:

Services of a lay midwife are not covered.

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, and are subject to any applicable Deductible, Copayments and/or Coinsurance identified in the Copayment and Coinsurance Schedule:

- 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 covered under the "Prescription Drug Benefits" subsection of this Group Plan Benefits section.
- 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.
- Nondurable 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.
- Nondurable medical supplies provided in the Provider’s office are covered.

Exclusions and Limitations:

Wound care products; incontinence products; generic multi-use products, reusables, and all other nondurable medical supplies are not covered.

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. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance.

Oral and Maxillofacial Services

The following oral and maxillofacial services are covered when Prior Authorized, and are subject to any applicable Deductible, Copayments and/or Coinsurance:

- 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 (nonmyeloablative allogeneic stem cell transplants) are covered when Medically Necessary.

Companion and recipient travel expenses including transportation, board and lodging authorized by us in connection with approved transplant procedures are limited to a maximum of $5,000 per transplant. Housing and travel expenses for transplant services are not considered Essential Health Benefits.

Prior Authorization is required for transplant evaluation, services, and procedures related to a transplant. You will be directed by us 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. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance

Exclusions and Limitations:

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

Certain outpatient pharmaceuticals, whether administered in a Physician's office, infusion suite, 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.

Outpatient pharmaceuticals administered by a health care professional for the treatment of cancer, or a covered drug administered by an enrollee’s oncology clinic to treat a symptom, complication or consequence of cancer, is not required to be dispensed from a participating pharmacy.

Pediatric Dental Services

Routine dental care for Enrolled children is covered through the last day of the month in which the child turns 19 years of age. This plan covers limited pediatric dental services that are provided in Diagnostic and Preventive, Basic, and Major Services (including orthodontics) as outlined on your Copayment and Coinsurance Schedule.

You can see any licensed dentist and receive benefits for Covered Services and Supplies. If you see a Participating Provider, charges for Covered Services will be limited to Health Net’s contracted amount with the Provider. However, if you see a Nonparticipating Provider, MAA charges will apply. Please see the "Maximum Allowable Amount (MAA)" portion of this Group Plan Benefits section for more

information. You can obtain a list of Participating Providers by calling our Customer Contact Center at the phone number listed at the back of this Agreement.

Pediatric Dental Deductibles (if any), Copayments and/or Coinsurance and other amounts you pay for pediatric dental benefits apply toward your plan's medical Out-of-Pocket Maximum.

Diagnostic and Preventive Services including:

- Initial and periodic oral examinations
- Oral Evaluations, include specialist evaluations
- Topical fluoride treatment, fluoride varnish
- Preventive dental education
- Roentgenology (x-rays)
- Prophylaxis services (cleanings)

Basic Services including:

- Sealants, Space Maintainers, including removable acrylic, fixed band type, and recementation.
- Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries.
- Endodontics
- Periodontics
- Oral surgery

Major Services including:

- Crowns
- Denture and bridge work

Medically Necessary Orthodontia:

- Benefits for comprehensive orthodontic treatment are approved by Health Net Dental, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher Collins syndrome, Pierre Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities, which result in physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions
  and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be Prior Authorized.

Benefit Description:

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic & Preventive	**Dental Deductible applies**	**Dental Deductible applies**

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Services		
Exam		
D0120 Periodic oral evaluation	No Charge	No Charge (MAA applies)
D0140 Limited oral evaluation - problem focused	No Charge	No Charge (MAA applies)
D0145 Oral evaluation for a patient under 3 years of age and counseling with a primary caregiver	No Charge	No Charge (MAA applies)
D0150 Comprehensive oral evaluation - new or established patient	No Charge	No Charge (MAA applies)
D0160 Detailed and extensive oral evaluation - problem focused, by report	No Charge	No Charge (MAA applies)
D0170 Re-evaluation - limited, problem focused	No Charge	No Charge (MAA applies)
D0171 Re-evaluation - post-operative office visit	No Charge	No Charge (MAA applies)
D0180 Comprehensive periodontal evaluation - new or established patient	No Charge	No Charge (MAA applies)
Exams (D0120, D0145, D0150, or D0180) a maximum of twice every 12 months with the following limitations: 1. *D0150: once every 12 months when performed by the same practitioner;* 2. *D0150: twice every 12 months when performed by different practitioners;* 3. *D0180: once every 12 months.*		
Diagnostic Imaging		
D0210 Intraoral - complete series (including bitewings)	No Charge	No Charge (MAA applies)
D0220 Intraoral - periapical - first film	No Charge	No Charge (MAA applies)
D0230 Intraoral - periapical each additional film	No Charge	No Charge (MAA applies)
D0240 Intraoral - occlusal film		
D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	No Charge	No Charge (MAA applies)

D0251 Extra-oral posterior dental radiographic image	No Charge	No Charge (MAA applies)
D0270 Bitewing - single film	No Charge	No Charge (MAA applies)
D0272 Bitewings - two films	No Charge	No Charge (MAA applies)
D0273 Bitewings - three films	No Charge	No Charge (MAA applies)
D0274 Bitewings - four films	No Charge	No Charge (MAA applies)
D0277 Vertical bitewings - 7 to 8 films	No Charge	No Charge (MAA applies)
D0310 Sialography	No Charge	No Charge (MAA applies)
D0320 Temporomandibular joint arthrogram, including injection	No Charge	No Charge (MAA applies)
D0321 Other temporomandibular joint radiographic images, by report	No Charge	No Charge (MAA applies)
D0322 Tomographic survey	No Charge	No Charge (MAA applies)
D0330 Panoramic film	No Charge	No Charge (MAA applies)
D0340 Cephalometric film	No Charge	No Charge (MAA applies)
D0350 Oral/facial photographic images	No Charge	No Charge (MAA applies)
D0372 Intraoral tomosynthesis - comprehensive series of radiographic images	No Charge	No Charge (MAA applies)
D0373 Intraoral tomosynthesis - bitewing radiographic image	No Charge	No Charge (MAA applies)
D0374 Intraoral tomosynthesis - periapical radiographic image	No Charge	No Charge (MAA applies)
D0387 Intraoral tomosynthesis - comprehensive series of radiographic images - image capture only	No Charge	No Charge (MAA applies)
D0388 Intraoral tomosynthesis - bitewing radiographic image - image capture only	No Charge	No Charge (MAA applies)
D0389 Intraoral tomosynthesis - periapical radiographic image - image capture only	No Charge	No Charge (MAA applies)
D0393 Treatment simulation using 3D image volume	No Charge	No Charge (MAA applies)
D0394 Digital subtraction of 2 or more images or image volumes of the same modality	No Charge	No Charge (MAA applies)
D0395 Fusion of 2 or more 3D image volumes of 1 or more modalities	No Charge	No Charge (MAA applies)

D0701 Panoramic radiographic image - image capture only	No Charge	No Charge (MAA applies)
D0702 2-D cephalometric radiographic image - image capture only	No Charge	No Charge (MAA applies)
D0703 2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Charge	No Charge (MAA applies)
D0705 Extra-oral posterior dental radiographic image - image capture only	No Charge	No Charge (MAA applies)
D0706 Intraoral - occlusal radiographic image - image capture only	No Charge	No Charge (MAA applies)
D0707 Intraoral - periapical radiographic image - image capture only	No Charge	No Charge (MAA applies)
D0708 Intraoral - bitewing radiographic image - image capture only	No Charge	No Charge (MAA applies)
D0709 Intraoral - comprehensive series of radiographic images - image capture only	No Charge	No Charge (MAA applies)
D0801 3D dental surface scan - direct	No Charge	No Charge (MAA applies)
D0802 3D dental surface scan - indirect	No Charge	No Charge (MAA applies)
D0803 3D facial surface scan - direct	No Charge	No Charge (MAA applies)
D0804 3D facial surface scan - indirect	No Charge	No Charge (MAA applies)

Radiographs:

1. *Routine radiographs once every 12 months.*
2. *Bitewing radiographs for routine screening once every 12 months.*
3. *Maximum of six radiographs for any one emergency. More can be added if dentally necessary.*
4. *For insureds under age six, radiographs may be billed separately every 12 months as follows:*
    a. *D0220 - once.*
    b. *D0230 - a maximum of five times.*
5. *D0270 - a maximum of twice, or D0272 once; for panoramic (D0330) or intra-oral complete series (D0210) once every five years, but both cannot be done within the five-year period.*
6. *Insureds must be a minimum of six years old for filling intra-oral complete series (D0210). The minimum standards for reimbursement of intra-oral complete series are:*

a. *For insureds age six through 11 - a minimum of 10 periapical and two bitewings for a total of 12 films.*

b. *For insureds ages 12 and older - a minimum of 10 periapical and four bitewings for a total of 14 films.*

7. *If fees for multiple single radiographs exceed the allowable reimbursement for a full mouth complete series (D0210), reimburse for the complete series. Additional films may be covered if dentally or medically appropriate, e.g., fractures.*

Test and Examinations

D0414 Lab processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	No Charge	No Charge (MAA applies)
D0415 Collection of microorganisms for culture and sensitivity	No Charge	No Charge (MAA applies)
D0422 Collection and preparation of genetic sample material for laboratory analysis and report	No Charge	No Charge (MAA applies)
D0423 Genetic test for susceptibility to disease-specimen analysis	No Charge	No Charge (MAA applies)
D0460 Pulp vitality tests	No Charge	No Charge (MAA applies)
D0470 Diagnostic casts	No Charge	No Charge (MAA applies)
D0600 Nonionizing diagnostic procedure	No Charge	No Charge (MAA applies)
D0601 Caries risk assessment and documentation, with a finding of low risk	No Charge	No Charge (MAA applies)
D0602 Caries risk assessment and documentation, with a finding of moderate risk	No Charge	No Charge (MAA applies)
D0603 Caries risk assessment and documentation, with a finding of high risk	No Charge	No Charge (MAA applies)
D0606 Molecular testing for public health related pathogen, including coronavirus	No Charge	No Charge (MAA applies)
D0999 Unspecified diagnostic procedure, by report	No Charge	No Charge (MAA applies)

Oral Pathology Laboratory

D0472 Accession of tissue, gross examination, prep, and transmission of written report	No Charge	No Charge (MAA applies)
D0473 Accession of tissue, gross and microscopic examination, prep, and transmission of written report	No Charge	No Charge (MAA applies)
D0474 Accession of tissue, gross and microscopic exam, includes assessment of margins, prep, and transmission of report	No Charge	No Charge (MAA applies)
D0475 Decalcification procedure	No Charge	No Charge (MAA applies)
D0476 Special stains for microorganisms	No Charge	No Charge (MAA applies)
D0477 Special stains, not for microorganisms	No Charge	No Charge (MAA applies)
D0478 Immunohistochemical stains	No Charge	No Charge (MAA applies)
D0479 Tissue in-situ hybridization, including interpretation	No Charge	No Charge (MAA applies)
D0480 Processing and interpretation of exfoliative cytological smears, including preparation and transmission of written report	No Charge	No Charge (MAA applies)
D0481 Electron microscopy	No Charge	No Charge (MAA applies)
D0482 Direct immunofluorescence	No Charge	No Charge (MAA applies)
D0483 Indirect immunofluorescence	No Charge	No Charge (MAA applies)
D0484 Consultation on slides prepared elsewhere	No Charge	No Charge (MAA applies)
D0485 Consultation, including preparation of slides from biopsy materials supplied by referring source	No Charge	No Charge (MAA applies)
D0486 Laboratory accession of trans epithelial cytologic sample, micro exam, preparation, and transmission of written report	No Charge	No Charge (MAA applies)
D0502 Other oral pathology procedures, by report	No Charge	No Charge (MAA applies)

Preventive Services

Prophylaxis Cleaning

D1110 Prophylaxis - adult (age 14 and older)	No Charge	No Charge (MAA applies)
D1120 Prophylaxis - child (age 14 and under)	No Charge	No Charge (MAA applies)

Fluoride

D1206 Topical application of fluoride varnish	No Charge	No Charge (MAA applies)
D1208 Topical application of fluoride - excluding varnish	No Charge	No Charge (MAA applies)

Other Preventive Services

D1310 Nutritional counseling for control of dental disease	No Charge	No Charge (MAA applies)
D1320 Tobacco counseling for the control and prevention of oral disease	No Charge	No Charge (MAA applies)
D1321 Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance abuse	No Charge	No Charge (MAA applies)
D1330 Oral hygiene instructions	No Charge	No Charge (MAA applies)
D1355 Caries preventive medicament application - per tooth	No Charge	No Charge (MAA applies)

Prophylaxis

1. *Limited to twice per 12 months.*
2. *Additional prophylaxis benefit provisions may be available for persons with high-risk oral conditions due to disease process, pregnancy, medications or other medical treatments or conditions, severe periodontal disease, rampant caries and/or for persons with disabilities who cannot perform adequate daily oral health care.*

Fluoride

1. *Limited to twice every 12 months for children under age 19.*
2. *Additional topical fluoride treatments may be available, up to a total of 4 treatments per insured within a 12-month period, when high-risk conditions or oral health factors are clearly documented for the following insureds who:*
   - *Have high-risk oral conditions due to disease process, medications, other medical treatments or conditions, or rampant caries;*
   - *Are pregnant;*

- *Have physical disabilities and cannot perform adequate, daily oral health care;*
- *Have a developmental disability or other severe cognitive impairment that cannot perform adequate, daily oral health care; or*
- *Are under age 7 with high-risk oral health factors, such as poor oral hygiene, deep pits and fissures (grooves) in teeth, severely crowded teeth, poor diet, etc.*

Basic Services	Dental Deductible applies	Dental Deductible applies
D1351 Sealant - per tooth	50%	50% (MAA applies)
D1352 Preventive resin restoration in a high caries risk patient - permanent tooth	50%	50% (MAA applies)
D1353 Sealant repair - per tooth	50%	50% (MAA applies)
D1354 Interim caries arresting medicament application	50%	50% (MAA applies)
Space Maintainers		
D1510 Space maintainer - fixed - unilateral	50%	50% (MAA applies)
D1516 Space maintainer - fixed bilateral, maxillary	50%	50% (MAA applies)
D1517 Space maintainer - fixed – bilateral, mandibular	50%	50% (MAA applies)
D1520 Space maintainer - removable - unilateral	50%	50% (MAA applies)
D1526 Space maintainer - removable - bilateral, maxillary	50%	50% (MAA applies)
D1527 Space maintainer - removable - bilateral, mandibular	50%	50% (MAA applies)
D1551 Re-cement or re-bond bilateral space maintainer - maxillary	50%	50% (MAA applies)
D1552 Re-cement or re-bond bilateral space maintainer - mandibular	50%	50% (MAA applies)
D1553 Re-cement or re-bond unilateral space maintainer - per quadrant	50%	50% (MAA applies)
D1556 Removal of fixed unilateral space maintainer - per quadrant	50%	50% (MAA applies)
D1557 Removal of fixed bilateral space maintainer - maxillary	50%	50% (MAA applies)

D1558 Removal of fixed bilateral space maintainer - mandibular	50%	50% (MAA applies
D1575 Distal shoe space maintainer - fixed unilateral	50%	50% (MAA applies)
D1999 Unspecified preventive procedure, by report	50%	50% (MAA applies)
Amalgam Restorations		
D2140 Amalgam - one surface, primary or permanent	50%	50% (MAA applies)
D2150 Amalgam - two surfaces, primary or permanent	50%	50% (MAA applies)
D2160 Amalgam - three surfaces, primary or permanent	50%	50% (MAA applies)
D2161 Amalgam - four or more surfaces, primary or permanent	50%	50% (MAA applies)
Resin-Based Composite Restorations		
D2330 Resin-based composite - one surface, anterior	50%	50% (MAA applies)
D2331 Resin-based composite - two surfaces, anterior	50%	50% (MAA applies)
D2332 Resin-based composite - three surfaces, anterior	50%	50% (MAA applies)
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior)	50%	50% (MAA applies)
D2390 Resin-based composite crown, anterior	50%	50% (MAA applies)
D2391 Resin-based composite - one surface, posterior	50%	50% (MAA applies)
D2392 Resin-based composite - two surfaces, posterior	50%	50% (MAA applies)
D2393 Resin-based composite - three surfaces, posterior	50%	50% (MAA applies)
D2394 Resin-based composite - four or more surfaces, posterior	50%	50% (MAA applies)

Sealants (D1351)

1. *Covered only for children under 16 years of age.*
2. *Limits coverage to:*

a. *Permanent molars; and*

b. *Only one sealant treatment per molar every five years, except for visible evidence of clinical failure.*

Space Maintenance

1. *Covers fixed and removable (but not lost or damaged) space maintainers (D1510, D1515, D1520 and D1525)*

Restorative

D2410 Gold foil - one surface	50%	50% (MAA applies)
D2420 Gold foil - two surfaces	50%	50% (MAA applies)
D2430 Gold foil - three surfaces	50%	50% (MAA applies)
D2510 Inlay - metallic - one surface	50%	50% (MAA applies)
D2520 Inlay - metallic - two surfaces	50%	50% (MAA applies)
D2530 Inlay - metallic - three or more surfaces	50%	50% (MAA applies)
D2542 Onlay - metallic - two surfaces	50%	50% (MAA applies)
D2543 Onlay - metallic - three surfaces	50%	50% (MAA applies)
D2544 Onlay - metallic - four or more surfaces	50%	50% (MAA applies)
D2610 Inlay - porcelain/ceramic - one surface	50%	50% (MAA applies)
D2620 Inlay - porcelain/ceramic - two surfaces	50%	50% (MAA applies)
D2630 Inlay - porcelain/ceramic - three or more surfaces	50%	50% (MAA applies)
D2642 Onlay - porcelain/ceramic - two surfaces	50%	50% (MAA applies)
D2643 Onlay - porcelain/ceramic - three surfaces	50%	50% (MAA applies)
D2644 Onlay - porcelain/ceramic - four or more surfaces	50%	50% (MAA applies)
D2650 Inlay - composite/resin - one surface	50%	50% (MAA applies)
D2651 Inlay - composite/resin - two surfaces	50%	50% (MAA applies)
D2652 Inlay - composite/resin - three or more surfaces	50%	50% (MAA applies)
D2662 Onlay - composite/resin - two surfaces	50%	50% (MAA applies)
D2663 Onlay - composite/resin - three surfaces	50%	50% (MAA applies)

D2664 Onlay - composite/resin - four or more surfaces	50%	50% (MAA applies)
Crowns/Bridges		
D2710 Crown, resin-based composite (indirect)	50%	50% (MAA applies)
D2712 Crown - 3/4 resin-based composite (indirect)	50%	50% (MAA applies)
D2720 Crown - resin with high noble metal	50%	50% (MAA applies)
D2721 Crown - resin with predominantly base metal	50%	50% (MAA applies)
D2722 Crown - resin with noble metal	50%	50% (MAA applies)
D2740 Crown - porcelain/ceramic substrate	50%	50% (MAA applies)
D2750 Crown - porcelain fused to high noble metal	50%	50% (MAA applies)
D2751 Crown - porcelain fused to predominantly base metal	50%	50% (MAA applies)
D2752 Crown - porcelain fused to noble metal	50%	50% (MAA applies)
D2753 Crown - porcelain fused to titanium and titanium alloys	50%	50% (MAA applies)
D2780 Crown - 3/4 cast high noble metal	50%	50% (MAA applies)
D2781 Crown - 3/4 cast predominantly base metal	50%	50% (MAA applies)
D2782 Crown, 3/4 cast noble metal	50%	50% (MAA applies)
D2783 Crown - 3/4 porcelain/ceramic	50%	50% (MAA applies)
D2790 Crown - full cast high noble metal	50%	50% (MAA applies)
D2791 Crown - full cast predominantly base metal	50%	50% (MAA applies)
D2792 Crown - full cast noble metal	50%	50% (MAA applies)
D2794 Crown - titanium	50%	50% (MAA applies)
D2799 Provisional crown - further treatment or completion of diagnosis necessary prior to final impression	50%	50% (MAA applies)
D2910 Recement inlay, onlay, or partial coverage restoration	50%	50% (MAA applies)
D2920 Recement crown	50%	50% (MAA applies)

D2921 Reattachment of tooth fragment, incisal edge or cusp	50%	50% (MAA applies)
D2930 Prefabricated stainless steel crown - primary tooth	50%	50% (MAA applies)
D2931 Prefabricated stainless crown - permanent tooth	50%	50% (MAA applies)
D2932 Prefabricated resin crown	50%	50% (MAA applies)
D2933 Prefabricated stainless steel crown with resin window	50%	50% (MAA applies)
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth	50%	50% (MAA applies)
D2940 Protective restoration	50%	50% (MAA applies)
D2941 Interim therapeutic restoration-primary dentition	50%	50% (MAA applies)
D2949 Restorative foundation for an indirect restoration	50%	50% (MAA applies)
D2950 Core buildup, including any pins	50%	50% (MAA applies)
D2951 Pin retention - per tooth, in addition to restoration	50%	50% (MAA applies)
D2952 Cast post and core in addition to crown	50%	50% (MAA applies)
D2953 Each additional indirectly fabricated post, same tooth	50%	50% (MAA applies)
D2954 Prefabricated post and core in addition to crown	50%	50% (MAA applies)
D2955 Post removal	50%	50% (MAA applies)
D2957 Each additional prefabricated post, same tooth	50%	50% (MAA applies)
D2960 Labial veneer (laminate) - chairside	50%	50% (MAA applies)
D2961 Labial veneer (resin laminate) - laboratory	50%	50% (MAA applies)
D2962 Labial veneer (porcelain laminate) - laboratory	50%	50% (MAA applies)
D2971 Additional procedures to construct new crown under existing partial denture framework	50%	50% (MAA applies)
D2975 Coping	50%	50% (MAA applies)
D2980 Crown repair, by report	50%	50% (MAA applies)
D2999 Unspecified restorative procedure, by report	50%	50% (MAA applies)

Permanent crowns (resin-based composite – D2710 and D2712, and porcelain fused to metal (PFM) – D2751 and D2752) as follows:

1. *Limited to teeth numbers 6-11, 22 and 27 only, if dentally appropriate;*
2. *Limited to four (4) in a seven-year period. This limitation includes any replacement crowns allowed;*
3. *Only for insureds at least 16 years of age; and*
4. *Rampant caries are arrested and the insured demonstrates a period of oral hygiene before prosthetics are proposed.*

Crown replacement:

1. *Permanent crown replacement limited to once every seven years;*
2. *All other crown replacement limited to once every five years; and*
3. *Possible exceptions to crown replacement limitations due to acute trauma, based on the following factors:*
   a. *Extent of crown damage;*
   b. *Extent of damage to other teeth or crowns;*
   c. *Extent of impaired mastication;*
   d. *Tooth is restorable without other surgical procedures; and*
   e. *If loss of tooth would result in coverage of removable prosthetic.*

Endodontics

D3110 Pulp cap - direct (excluding final restoration)	50%	50% (MAA applies)
D3120 Pulp cap - indirect (excluding final restoration)	50%	50% (MAA applies)
D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	50%	50% (MAA applies)
D3221 Pulpal debridement, primary and permanent teeth	50%	50% (MAA applies)
D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	50%	50% (MAA applies)
D3230 Pulpal therapy (resorbable filling) - anterior,		

primary tooth (excluding final restoration)	50%	50% (MAA applies)
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	50%	50% (MAA applies)
D3310 Endodontic therapy, anterior tooth (excluding final restoration)	50%	50% (MAA applies)
D3320 Endodontic therapy, bicuspid tooth (excluding final restoration)	50%	50% (MAA applies)
D3330 Endodontic therapy, molar (excluding final restoration)	50%	50% (MAA applies)
D3331 Treatment of root canal obstruction, nonsurgical access	50%	50% (MAA applies)
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	50%	50% (MAA applies)
D3333 Internal tooth repair of perforation defects	50%	50% (MAA applies)
D3346 Retreatment of previous root canal therapy - anterior	50%	50% (MAA applies)
D3347 Retreatment of previous root canal therapy - bicuspid	50%	50% (MAA applies)
D3348 Retreatment of previous root canal therapy - molar	50%	50% (MAA applies)
D3351 Apexification/ recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	50%	50% (MAA applies)
D3352 Apexification/ recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	50%	50% (MAA applies)
D3353 Apexification/ recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of		

perforations, root resorption, etc.)	50%	50% (MAA applies)
D3355 Pulpal regeneration - initial visit	50%	50% (MAA applies)
D3356 Pulpal regeneration - interim medicament replacement	50%	50% (MAA applies)
D3357 Pulpal regeneration - completion of treatment	50%	50% (MAA applies)
D3410 Apicoectomy - anterior Apicoectomy/periradicular surgery - anterior	50%	50% (MAA applies)
D3421 Apicoectomy/ periradicular surgery - bicuspid (first root)	50%	50% (MAA applies)
D3425 Apicoectomy/ periradicular surgery - molar (first root)	50%	50% (MAA applies)
D3426 Apicoectomy/ periradicular surgery (each additional root)	50%	50% (MAA applies)
D3428 Bone graft in conjunction with periradicular surgery - per tooth, single site	50%	50% (MAA applies)
D3429 Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in same surgical site	50%	50% (MAA applies)
D3430 Retrograde filling - per root	50%	50% (MAA applies)
D3431 Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	50%	50% (MAA applies)
D3432 Guided tissue regeneration, resorbable barrier, per site in conjunction with periradicular surgery	50%	50% (MAA applies)
D3450 Root amputation - per root	50%	50% (MAA applies)
D3460 Endodontic endosseous implant	50%	50% (MAA applies)
D3470 Intentional reimplantation (including necessary splinting)	50%	50% (MAA applies)

D3471 Surgical repair of root restoration - anterior	50%	50% (MAA applies)
D3910 Surgical procedure for isolation of tooth with rubber dam	50%	50% (MAA applies)
D3911 Intraorifice barrier	50%	50% (MAA applies)
D3920 Hemisection (including any root removal), not including root canal therapy	50%	50% (MAA applies)
D3950 Canal preparation and fitting of preformed dowel or post	50%	50% (MAA applies)
D3999 Unspecified endodontic procedure, by report	50%	50% (MAA applies)

Endodontic therapy

For permanent teeth:

1. *Anterior and bicuspid endodontic therapy (D3310 and D3320) is covered for all insureds; and*
2. *Molar endodontic therapy (D3330) covered only for 1st & 2nd molars.*

Endodontic retreatment and apicoectomy/periradicular surgery

1. *Retrograde filling (D3430) is covered only when done in conjunction with a covered apicoectomy of an anterior tooth.*

Periodontics

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	50%	50% (MAA applies)
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	50%	50% (MAA applies)
D4230 Anatomical crown exposure - four or more contiguous teeth per quadrant	50%	50% (MAA applies)
D4231 Anatomical crown exposure - one to three teeth per quadrant	50%	50% (MAA applies)
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	50%	50% (MAA applies)
D4241 Gingival flap procedure - including root planing - one		

to three contiguous teeth or tooth bounded spaces per quadrant	50%	50% (MAA applies)
D4245 Apically positioned flap	50%	50% (MAA applies)
D4249 Clinical crown lengthening - hard tissue	50%	50% (MAA applies)
D4260 Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	50%	50% (MAA applies)
D4261 Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	50%	50% (MAA applies)
D4263 Bone replacement graft - retained natural tooth - first site in quadrant	50%	50% (MAA applies)
D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant	50%	50% (MAA applies)
D4265 Biologic materials to aid in soft and osseous tissue regeneration	50%	50% (MAA applies)
D4266 Guided tissue regeneration - resorbable barrier, per site	50%	50% (MAA applies)
D4267 Guided tissue regeneration - nonresorbable barrier, per site (Includes membrane removal)	50%	50% (MAA applies)
D4268 Surgical revision procedure, per tooth	50%	50% (MAA applies)
D4270 Pedicle soft tissue graft procedure	50%	50% (MAA applies)
D4273 Subepithelial connective tissue graft procedures, per tooth	50%	50% (MAA applies)
D4274 Mesial/distal wedge procedure single tooth (when not performed in conjunction with surgical procedures in the same area)	50%	50% (MAA applies)
D4275 Nonautogenous connective tissue graft (including recipient site and		

donor material) first tooth implant	50%	50% (MAA applies)
D4276 Combined connective tissue and double pedicle graft, per tooth	50%	50% (MAA applies)
D4283 Autogenous connective tissue graft procedure - each additional contiguous tooth, implant or edentulous tooth	50%	50% (MAA applies)
D4285 Nonautogenous connective tissue graft procedure - each additional contiguous tooth, implant or edentulous tooth	50%	50% (MAA applies)
D4341 Periodontal scaling and root planing - four or more teeth per quadrant	50%	50% (MAA applies)
D4342 Periodontal scaling and root planing - one to three teeth, per quadrant	50%	50% (MAA applies)
D4346 Scaling in presence of generalized moderate or severe gingival inflammation	50%	50% (MAA applies)
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis	50%	50% (MAA applies)
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	50%	50% (MAA applies)
D4910 Periodontal maintenance	50%	50% (MAA applies)
D4920 Unscheduled dressing change (by someone other than treating dentist or their staff)	50%	50% (MAA applies)
D4921 Gingival irrigation - per quadrant	50%	50% (MAA applies)
D4999 Unspecified periodontal procedure, by report	50%	50% (MAA applies)

Nonsurgical periodontal services – Periodontal scaling and root planing (D4341 and D4342);

1. *Allowed once every two years;*
2. *A maximum of two quadrants on one date of service is payable, except in extraordinary circumstances;*

3. *Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets 5 mm or greater:*
    a. *D4341 is allowed for quadrants with at least four or more teeth with pockets 5 mm or greater;*
    b. *D4342 is allowed for quadrants with a least one to three teeth with pocket depths of 5 mm or greater.*

Periodontal maintenance (D4910)

1. *Allowed once every six months;*
    a. *Limited to following periodontal therapy (surgical or nonsurgical) that is documented to have occurred within the past three years.*
2. *May not reimburse for procedures identified by the following codes if performed on the same date of service:*
    a. *D1110 (Prophylaxis - adult)*
    b. *D1120 (Prophylaxis - child)*
    c. *D4210 (Gingivectomy or gingivoplasty - 4 or more contiguous teeth or bounded teeth spaces per quadrant)*
    d. *D4211(Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant)*
    e. *D4341 (Periodontal scaling & root planing - 4 or more teeth per quadrant)*
    f. *D4342 (Periodontal scaling & root planing - 1 to 3 teeth per quadrant)*
    g. *D4355 (Full mouth debridement to enable comprehensive evaluation & diagnosis) - allowed once every 2 years*
    h. *D4910 (Periodontal maintenance)*

Oral Surgery

D7111 Extraction, coronal remnants - deciduous tooth	50%	50% (MAA applies)
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	50%	50% (MAA applies)
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	50%	50% (MAA applies)
D7220 Removal of impacted tooth - soft tissue	50%	50% (MAA applies)
D7230 Removal of impacted tooth - partially bony	50%	50% (MAA applies)

D7240 Removal of impacted tooth - completely bony	50%	50% (MAA applies)
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications	50%	50% (MAA applies)
D7250 Surgical removal of residual tooth roots (cutting procedure)	50%	50% (MAA applies)
D7251 Coronectomy - intentional partial tooth removal, impacted teeth only	50%	50% (MAA applies)
D7260 Oroantral fistula closure	50%	50% (MAA applies)
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50%	50% (MAA applies)
D7280 Surgical access of an unerupted tooth	50%	50% (MAA applies)
D7285 Incisional biopsy of oral tissue - hard (bone, tooth)	50%	50% (MAA applies)
D7286 Incisional biopsy of oral tissue - soft (all others)	50%	50% (MAA applies)
D7287 Exfoliative cytological sample collection	50%	50% (MAA applies)
D7288 Brush biopsy - transepithelial sample collection	50%	50% (MAA applies)
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	50%	50% (MAA applies)
D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	50%	50% (MAA applies)
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	50%	50% (MAA applies)
D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	50%	50% (MAA applies)
D7340 Vestibuloplasty - ridge extension (secondary epithelization)	50%	50% (MAA applies)

D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment)	50%	50% (MAA applies)
D7440 Excision of malignant tumor-lesion diameter up to 1.25 cm	50%	50% (MAA applies)
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm	50%	50% (MAA applies)
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	50%	50% (MAA applies)
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	50%	50% (MAA applies)
D7465 Destruction of lesion(s) by physical or chemical method, by report	50%	50% (MAA applies)
D7471 Removal of lateral exostosis (maxilla or mandible)	50%	50% (MAA applies)
D7490 Radical resection of maxilla or mandible	50%	50% (MAA applies)
D7509 Marsupialization of odontogenic cyst	50%	50% (MAA applies)
D7510 Incision and drainage of abscess - intraoral soft tissue up to 5 cm	50%	50% (MAA applies)
D7511 Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	50%	50% (MAA applies)
D7520 Incision and drainage of abscess - extraoral soft tissue	50%	50% (MAA applies)
D7521 Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	50%	50% (MAA applies)
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	50%	50% (MAA applies)

D7540 Removal of reaction-producing foreign bodies - musculoskeletal system	50%	50% (MAA applies)
D7550 Partial ostectomy/sequestrectomy for removal of nonvital bone	50%	50% (MAA applies)
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body	50%	50% (MAA applies)
D7610 Maxilla - open reduction (teeth immobilized, if present)	50%	50% (MAA applies)
D7620 Maxilla - closed reduction (teeth immobilized if present)	50%	50% (MAA applies)
D7630 Mandible - open reduction (teeth immobilized if present)	50%	50% (MAA applies)
D7640 Mandible - closed reduction (teeth immobilized, if present)	50%	50% (MAA applies)
D7650 Malar and/or zygomatic arch - open reduction	50%	50% (MAA applies)
D7660 Malar and/or zygomatic arch - closed reduction	50%	50% (MAA applies)
D7670 Alveolus - closed reduction, may include stabilization of teeth	50%	50% (MAA applies)
D7680 Facial bones - complicated reduction with fixation and multiple surgical approaches	50%	50% (MAA applies)
D7710 Maxilla - open reduction	50%	50% (MAA applies)
D7720 Maxilla - closed reduction	50%	50% (MAA applies)
D7730 Mandible - open reduction	50%	50% (MAA applies)
D7740 Mandible - closed reduction	50%	50% (MAA applies)
D7750 Malar and/or zygomatic arch - open reduction	50%	50% (MAA applies)
D7760 Malar and/or zygomatic arch - closed reduction	50%	50% (MAA applies)
D7770 Alveolus, open reduction stabilization of teeth	50%	50% (MAA applies)
D7780 Facial bones - complicated reduction with fixation and multiple approaches	50%	50% (MAA applies)

D7881 Occlusal orthotic device adjustment	50%	50% (MAA applies)
D7910 Suture of recent small wounds	50%	50% (MAA applies)
D7911 Complicated suture - up to 5 cm	50%	50% (MAA applies)
D7912 Complicated suture - greater than 5 cm	50%	50% (MAA applies)
D7920 Skin graft (identify defect covered, location and type of graft)	50%	50% (MAA applies)
D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	50%	50% (MAA applies)
D7956 Guided tissue regeneration, edentulous area - resorbable barrier, per site	50%	50% (MAA applies)
D7957 Guided tissue regeneration, edentulous area - nonresorbable barrier, per site	50%	50% (MAA applies)
D7970 Excision of hyperplastic tissue - per arch	50%	50% (MAA applies)
D7971 Excision of pericoronal gingiva	50%	50% (MAA applies)
D7979 Nonsurgical sialolithotomy	50%	50% (MAA applies)
D7977 Appliance removal (not by dentist who placed appliance), includes removal of arch bar	50%	50% (MAA applies)
D7980 Surgical sialolithotomy	50%	50% (MAA applies)
D7981 Excision of salivary gland, by report	50%	50% (MAA applies)
D7982 Sialodochoplasty	50%	50% (MAA applies)
D7983 Closure of salivary fistula	50%	50% (MAA applies)
D7990 Emergency tracheotomy	50%	50% (MAA applies)

1. *Alveoloplasty is covered without a corresponding extraction (D7320-D7321) only for Members under age 19.*
2. *Covers frenulectomy/frenuloplasty in the following situations:*
   a. *Once per lifetime per arch;*
   b. *Maxillary labial frenulectomy only for insureds age 12 through 19;*

c. *When the insured has ankyloglossia;*

d. *When the condition is deemed to cause gingival recession; or*

e. *When the frenum is placed under tension.*

3. *Covers excision of pericoronal gingival (D7971)*

Major Services	Dental Deductible applies	Dental Deductible applies
Prosthodontics (removable)		
D5110 Complete denture - maxillary	50%	50% (MAA applies)
D5120 Complete denture - mandibular	50%	50% (MAA applies)
D5130 Immediate denture - maxillary	50%	50% (MAA applies)
D5140 Immediate denture - mandibular	50%	50% (MAA applies)
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth)	50%	50% (MAA applies)
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth)	50%	50% (MAA applies)
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	50%	50% (MAA applies)
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	50%	50% (MAA applies)
D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	50%	50% (MAA applies)
D5222 Immediate mandibular partial denture - resin base	50%	50% (MAA applies)
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping material)	50%	50% (MAA applies)

D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping material)	50%	50% (MAA applies)
D5227 Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	50%	50% (MAA applies)
D5228 Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	50%	50% (MAA applies)
D5410 Adjust complete denture - maxillary	50%	50% (MAA applies)
D5411 Adjust complete denture - mandibular	50%	50% (MAA applies)
D5421 Adjust partial denture - maxillary	50%	50% (MAA applies)
D5422 Adjust partial denture - mandibular	50%	50% (MAA applies)
D5511 Repair broken complete denture base, mandibular	50%	50% (MAA applies)
D5512 Repair broken complete denture base, maxillary	50%	50% (MAA applies)
D5520 Replace missing or broken teeth - complete denture (each tooth)	50%	50% (MAA applies)
D5611 Repair resin partial denture base, mandibular	50%	50% (MAA applies)
D5612 Repair resin partial denture base, maxillary	50%	50% (MAA applies)
D5621 Repair cast partial framework, mandibular	50%	50% (MAA applies)
D5622 Repair cast partial framework, maxillary	50%	50% (MAA applies)
D5630 Repair or replace broken clasp	50%	50% (MAA applies)
D5640 Replace broken teeth - per tooth	50%	50% (MAA applies)
D5650 Add tooth to existing partial denture	50%	50% (MAA applies)
D5660 Add clasp to existing partial denture	50%	50% (MAA applies)
D5670 Replace all teeth and acrylic on cast metal framework (maxillary)	50%	50% (MAA applies)

D5671 Replace all teeth and acrylic on cast metal framework (mandibular)	50%	50% (MAA applies)
D5710 Rebase complete maxillary denture	50%	50% (MAA applies)
D5711 Rebase complete mandibular denture	50%	50% (MAA applies)
D5720 Rebase maxillary partial denture	50%	50% (MAA applies)
D5721 Rebase mandibular partial denture	50%	50% (MAA applies)
D5725 Rebase hybrid prosthesis	50%	50% (MAA applies)
D5730 Reline complete maxillary denture (chairside)	50%	50% (MAA applies)
D5731 Reline complete mandibular denture (chairside)	50%	50% (MAA applies)
D5740 Reline maxillary partial denture (chairside)	50%	50% (MAA applies)
D5741 Reline mandibular partial denture (chairside)	50%	50% (MAA applies)
D5750 Reline complete maxillary denture (laboratory)	50%	50% (MAA applies)
D5751 Reline complete mandibular denture (laboratory)	50%	50% (MAA applies)
D5760 Reline maxillary partial denture (laboratory)	50%	50% (MAA applies)
D5761 Reline mandibular partial denture (laboratory)	50%	50% (MAA applies)
D5765 Soft liner for complete or partial removable denture, indirect	50%	50% (MAA applies)
D5820 Interim partial denture (maxillary)	50%	50% (MAA applies)
D5821 Interim partial denture (mandibular)	50%	50% (MAA applies)
D5850 Tissue conditioning, maxillary	50%	50% (MAA applies)
D5851 Tissue conditioning, mandibular	50%	50% (MAA applies)
D5863 Overdenture - complete maxillary	50%	50% (MAA applies)
D5864 Overdenture - partial maxillary	50%	50% (MAA applies)

D5876 Add metal substructure to acrylic full denture (per arch) .....50%.....50% (MAA applies)
D6980 Fixed partial denture repair, necessitated by restorative material failure .....50%.....50% (MAA applies)

1. *Insured age 16 years and older are eligible for removable resin base partial dentures (D5211-D5212) and full dentures (complete or immediate, D5110-D5140).*

Resin partial dentures:

1. *Insured must have one or more anterior teeth missing or four or more missing posterior teeth per arch with resulting space equivalent to that loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth.*

Replacement of removable partial or full dentures:

Replacement of removable partial or full dentures, when it cannot be made clinically serviceable by a less costly procedure (e.g., reline, rebase, repair, tooth replacement), is limited to the following:

1. *For insureds at least 16 years and under 19 years of age - shall replace full every 10 years or partial dentures once every five years, only if dentally appropriate. This does not imply that replacement of dentures or partials must be done once every ten years, but only when dentally appropriate.*
2. *The 10-year limitations apply to the insured regardless of the insured's Enrollment status at the time insured's last denture or partial was received.*

Replacement of all teeth and acrylic on cast metal framework (D5670-D5671):

1. *Covered for insureds age 16 and older a maximum of once every 10 years, per arch.*

Denture rebase procedures:

1. *Covers rebases only if a reline may not adequately solve the problem.*

Denture reline procedures:

1. *Limited to once every three years.*

Interim partial dentures or "flippers" (D5820-D5821):

1. *Allowed if the insured has one or more anterior teeth missing.*

Tissue conditioning:

1. *Allowed once per denture unit in conjunction with immediate dentures; and*
2. *Allowed once prior to new prosthetic placement.*

Maxillofacial Prosthetics

D5986 Fluoride gel carrier.....50%.....50% (MAA applies)

1. *Fluoride gel carrier (D5986) is limited to those patients whose severity of oral disease causes the increased cleaning and fluoride treatments allowed being insufficient. The dental practitioner must document failure of those options prior to use of the fluoride gel carrier.*
2. *All other maxillofacial prosthetics (D5900-D5999) are Medical Services.*

Medically Necessary Orthodontic Services	Dental Deductible applies	Dental Deductible applies
Orthodontic Services	50%	50% (MAA applies)

Benefits for comprehensive orthodontic treatment are approved by Health Net Dental, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities, which result in physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be Prior Authorized.

Adjunctive General and Other Services	Dental Deductible applies	Dental Deductible applies
Adjunctive Services		
D9110 Palliative (emergency) treatment of dental pain - minor procedure	50%	50% (MAA applies)
D9120 Fixed partial denture sectioning	50%	50% (MAA applies)
D9210 Local anesthesia not in conjunction with operative or surgical procedures	50%	50% (MAA applies)
D9211 Regional block anesthesia	50%	50% (MAA applies)
D9212 Trigeminal division block anesthesia	50%	50% (MAA applies)
D9219 Evaluation for deep sedation or general anesthesia	50%	50% (MAA applies)
D9222 Deep sedation/general anesthesia - first 15 minutes	50%	50% (MAA applies)
D9223 Deep sedation/general anesthesia - each 15 minute increment	50%	50% (MAA applies)
D9230 Inhalation of nitrous oxide/anxiolysis analgesia	50%	50% (MAA applies)
D9239 Intravenous moderate (conscious)	50%	50% (MAA applies)
D9243 Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	50%	50% (MAA applies)
D9248 Nonintravenous conscious sedation. This includes non-iv minimal and moderate sedation.	50%	50% (MAA applies)
D9310 Consultation (diagnostic service provided by dentist or		

Physician other than practitioner providing treatment)	50%	50% (MAA applies)
D9311 Consultation with a medical health care professional	50%	50% (MAA applies)
D9410 House/extended care facility call	50%	50% (MAA applies)
D9420 Hospital or ambulatory surgical center call	50%	50% (MAA applies)
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed	50%	50% (MAA applies)
D9440 Office visit - after regularly scheduled hours	50%	50% (MAA applies)
D9610 Therapeutic parenteral drug, single administration	50%	50% (MAA applies)
D9612 Therapeutic parenteral drugs, two or more administrations, different medications	50%	50% (MAA applies)
D9613 Infiltration of sustained release of therapeutic drug per quadrant	50%	50% (MAA applies)
D9630 Office visit for observation (during regularly scheduled hours) - no other services performed	50%	50% (MAA applies)
D9920 Behavior management, by report	50%	50% (MAA applies)
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report	50%	50% (MAA applies)
D9943 Occlusal adjustment	50%	50% (MAA applies)
D9948 Adjustment of custom sleep apnea appliance	50%	50% (MAA applies)
D9961 Duplicate/copy patients records	50%	50% (MAA applies)
D9986 Missed appointment	50%	50% (MAA applies)
D9987 Cancelled appointment	50%	50% (MAA applies)
D9999 Unspecified adjunctive procedure, by report	50%	50% (MAA applies)

1. *Fixed partial denture sectioning (D9120) is covered only when extracting a tooth connected to a fixed prosthesis and a portion of the fixed prosthesis is to remain intact and serviceable, preventing the need for more costly treatment.*

Anesthesia

1. *Only use general anesthesia or IV sedation for those insured with concurrent needs: age, physical, medical or mental status, or degree of difficulty of the procedure (D9223 and D9243):*
   a. *D9223 or D9243: each 15-minute period; up to three and one-half hours;*
   b. *Each 15-minute period represents a quantity of one.*
2. *Nitrous Oxide (D9230) is per date of service, not by time.*
3. *Oral pre-medication anesthesia for conscious sedation (D9248):*
   a. *Limited to insureds under 13 years of age;*
   b. *Limited to four times a year;*
   c. *Includes payment for monitoring and Nitrous Oxide.*
4. *D9630 is limited to those oral medications used during a procedure and is not intended for "take home" medication.*

Pediatric Vision Services

This plan covers routine vision Services and Supplies for Enrolled children through the last day of the month in which the child turns 19 years of age as described on your Copayment and Coinsurance Schedule. You must utilize Participating Providers. A list of Participating Providers is available at www.healthnetoregon.com or by calling our Customer Contact Center at the phone number listed at the back of this Agreement.

Copayments and/or Coinsurance and other amounts you pay for pediatric vision benefits do not apply toward your plan's medical Deductibles.

Routine eye exam (limit: 1 per Calendar Year)

Provider selected frames (limit: 1 per Calendar Year)

Lenses (limit: 1 pair per Calendar Year) including:

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

Optional lenses and treatments, including:

- UV Treatment
- Tint (Fashion & Gradient & Glass-Grey)
- Standard Plastic Scratch Coating
- Standard Polycarbonate
- Photochromic/Transitions Plastic

- Standard Anti-Reflective Coating
- Polarized
- Standard Progressive Lens
- Hi-Index Lenses
- Blended segment lenses
- Intermediate vision lenses
- Select or ultra-progressive lenses

Provider-selected contact lenses (in lieu of eyeglass lenses):

- Daily wear: up to 3-month supply of daily disposable, single vision.
- Extended wear: up to 6-month supply of monthly or 2-week disposable, single vision.
- Conventional: 1 pair from a selection of provider-designated contact lenses.

Contact Lens Allowance: Allowances are one-time use benefits; no remaining balance.

Medically Necessary contact lenses: Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

Contact lenses may be determined to be Medically Necessary for the treatment of conditions, including, but not limited to: keratoconus, pathological myopia, aphakia, anisometropia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism.

Medically Necessary contact lenses are dispensed in lieu of other eyewear. Participating Providers will obtain the necessary Prior Authorization for these services.

Prescription Drug Benefits

This plan covers pharmacy services as described below and are subject to benefit maximums as shown in the "Professional Medical Services and Supplies" section of your Copayment and Coinsurance Schedule. Coverage is subject to the Deductible (if any), Copayments, Coinsurance as shown on the Copayment and Coinsurance Schedule in the "Outpatient Prescription Drug Benefits" section, except as stated below.

Coverage includes all Medically Necessary prescription Food and Drug Administration (FDA) approved drugs, compounded medications of which at least one ingredient is a prescription FDA approved drug, orally administered anticancer medications, preventive pharmacy medications, tobacco cessation medications, contraception methods supported by the Health Resources and Services Administration (HRSA) guidelines, diabetic supplies, insulin, and any other drug which under law may only be dispensed by written prescription of a duly licensed health care Provider. Coverage also includes prescription medications associated with an Emergency Medical Condition, including those purchased in a foreign country.

- **MAC A Plans.** When a generic form of a brand name drug exists, the generic drug will be dispensed, and in most cases, the Tier 1 Copayment and/or Coinsurance shall apply. An approved generic equivalent shall mean a generic drug that has been given an "A" therapeutic equivalent code by the Department of Health and Human Services. If a generic equivalent exists but a brand name drug is requested and approved, you may be required to pay an ancillary charge equal to the difference between the cost of the generic drug and the brand name drug in addition to the applicable Copayment and/or Coinsurance. This ancillary charge does not apply toward your plan's Out-of-Pocket Maximums.
- The amount of drug to be dispensed per filled prescription shall be for such quantities as directed by the licensed prescriber (e.g., Physician, pharmacist) as allowed by law, but in no event shall the quantity exceed a 90-day supply when filled in a pharmacy or a 90-day supply when filled through mail order. Benefits are based on FDA approved dosing guidelines. Some drugs, including, but not limited to, compounded medications, require Prior Authorization and/or may have a dosage or quantity restriction set by the Plan.
- All drugs, including insulin and diabetic supplies, must be dispensed by a participating pharmacy, except for Emergency Medical Care rendered outside the Service Area.
- Prescription Deductibles (if any), Copayments and/or Coinsurance amounts you pay for prescription drugs apply toward your plan's medical Out-of-Pocket Maximums.
- **Specialty Pharmacy.** Certain drugs identified on the Essential Drug List (EDL) are classified as Specialty Pharmacy drugs under your plan. Specialty Pharmacy drugs are high-cost biologic, injectable and oral drugs typically dispensed through a limited network of pharmacies and having significantly higher cost than traditional pharmacy benefit drugs.
- **Orally Administered Anticancer Medications.** This plan covers Medically Necessary orally administered anticancer medications used to kill or slow the growth of cancerous cells which under law may only be dispensed by written prescription of a duly licensed health care Provider. Mail order prescriptions, unless dispensed by a Specialty Pharmacy, are not covered.
- **Tobacco Cessation Medications.** Food and Drug Administration (FDA) approved prescription drugs and over-the-counter smoking cessation medications are covered when dispensed by a participating pharmacy. No Deductible, Copayment and/or Coinsurance shall apply for each prescription or refill of a generic class drug when dispensed by a participating pharmacy. If a generic class drug is not available, no Deductible, Copayment and/or Coinsurance shall apply for each prescription or refill of a brand name drug. Deductible, Copayment and/or Coinsurance will apply to brand name drugs that have generic equivalents, unless the Provider indicates the brand name drug is Medically Necessary.
- **Agents used for treatment of Substance Use Disorders.** Preferred products are covered at the Tier 1 Copayment and/or Coinsurance without requiring Prior Authorization. Nonpreferred products are covered at the Tier 3 Copayment and/or Coinsurance without requiring Prior Authorization. This includes, but is not limited to, alcohol abuse deterrents and opioid use disorder medications.

- **Preventive Pharmacy.** Preventive Pharmacy medications are limited to 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. A listing of these medications may be identified at the following USPSTF website: https://uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.

  No Deductible, Copayment and/or Coinsurance shall apply for each prescription or refill of a generic class drug when dispensed by a participating pharmacy. If a generic class drug is not available, no Deductible, Copayment and/or Coinsurance shall apply for each prescription or refill of a brand name drug. Deductible, Copayment and/or Coinsurance will apply to brand name drugs that have generic equivalents.

  Compounded medications, and prescriptions or refills dispensed by a nonparticipating pharmacy are not covered, except for Preexposure Prophylaxis (PrEP) medications for the prevention of HIV infection and post-exposure prophylactic drugs or therapies prescribed following a possible exposure to HIV.

- **Contraception Methods.** Food and Drug Administration (FDA) approved contraceptive methods, patient education and counseling for all Members with reproductive capacity are covered when dispensed by a participating pharmacy. A 12-month refill of self-administered oral hormonal contraceptive is covered after an initial 3-month supply is filled.

  This plan covers hormonal contraceptive patches, injectables, self-administered oral hormonal contraceptives, vaginal inserts and over-the-counter contraceptive methods.

  No Deductible, Copayment and/or Coinsurance shall apply for each prescription or refill of a generic class drug when dispensed by a participating pharmacy.

  If a generic class drug is not available, no Deductible, Copayment and/or Coinsurance shall apply for each prescription or refill of a brand name drug. Deductible, Copayment and/or Coinsurance will apply to brand name drugs that have generic equivalents, unless the Provider indicates the brand name drug is Medically Necessary.

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

- **Growth Hormone Drugs.** Growth hormone drugs are covered if determined to be Medically Necessary and if our medical/pharmacy policy criteria are met. Prior Authorization is required.

- The level of benefit you receive is based on the status of the drug on the Essential Drug List (EDL) at the time your prescription is filled. Only drugs listed on the EDL are covered. The EDL may be revised up to four times per Calendar Year based on the recommendations of the Pharmacy and Therapeutics Committee. Any such changes including additions and deletions from the EDL will be communicated to Participating Providers. The EDL can be found on the Health Net website at https://www.healthnetoregon.com/employers/pharmacy/commercial-group-pharmacy-information.html. Compounded medications are subject to the Tier 3 Copayment and/or Coinsurance. Brand name drugs with generic equivalents are subject to the Tier 3 Copayment and/or Coinsurance as soon as a generic becomes available.

- If a drug is not on the EDL, and is not specifically excluded from coverage, your doctor can ask for an exception. To request an exception, your doctor can submit a Prior Authorization request along with a statement supporting the request. Requests for Prior Authorization may be submitted by telephone, mail, or facsimile (fax). If we approve an exception for a drug that is not on the EDL, the nonpreferred brand tier (Tier 3) Copayment applies except for FDA approved Preventive Pharmacy medications, which would be covered at no cost. If you are suffering from a condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug that is not on the EDL, then you, your designee or your doctor can request an Expedited Review. Expedited requests for Prior Authorization will be processed within 24 hours after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make a determination.
- **Step Therapy.** Step therapy means a Utilization Review protocol, policy or program in which Health Net requires certain preferred drugs for treatment of a specific medical condition be proven ineffective or contraindicated before a prescribed drug may be reimbursed. An exception to step therapy is subject to Prior Authorization.

  Health Net will approve a request for an exception to step therapy if the prescribing Provider sufficiently demonstrates at least one of the following:

  - The prescription drug required by the step therapy is contraindicated or will cause the Member to experience a clinically predictable adverse reaction;
  - The prescription drug required by the step therapy is expected to be ineffective based on the known clinical characteristics of the Member and the known characteristics of the prescription drug regimen;
  - The Member has tried the drug required by the step therapy, a drug in the same pharmacologic class as the drug required by the step therapy or a drug with the same mechanism of action as the drug required by the step therapy, and the Member’s use of the drug required by the step therapy was discontinued due to the lack of efficacy or effectiveness, a diminished effect or an adverse reaction;
  - For a period of at least 90 days the Member has experienced a positive therapeutic outcome from the drug for which the exception is requested while enrolled in the current or immediately preceding health care coverage and changing to the drug required by the step therapy may cause a clinically predictable adverse reaction or physical or mental harm to the Member; or
  - The prescription drug required by the step therapy is not in the best interest of the Member based on Medical Necessity.
- Reimbursement (minus the Copayment and/or Coinsurance) will be made for prescriptions filled by a pharmacy other than a participating pharmacy for Emergency Medical Care rendered outside the Service Area, upon presentation of pharmacy receipts to Health Net and sufficient documentation to establish the need for Emergency Medical Care.

- Reimbursement (minus the Copayment and/or Coinsurance) will be made for coverable prescriptions filled by a licensed practitioner at a rural health Clinic for an urgent medical condition if there is not a pharmacy within 15 miles of the Clinic or if the prescription is dispensed for a patient outside of the normal business hours of any pharmacy within 15 miles of the Clinic. For these purposes, "urgent medical condition" means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems.
- Cost sharing paid on your behalf for any prescription drugs obtained by you through the use of a Drug Discount, Coupon, or Copay Card provided by a prescription drug manufacturer will not apply toward your plan Deductible or Out-of-Pocket Maximum.
- Cost sharing paid on your behalf for covered prescription drugs obtained by you, including the use of a Drug Discount, Coupon, or Copay Card provided by a prescription drug manufacturer, will apply toward your plan Deductible or Out-of-Pocket Maximum if:
  - The drug does not have a generic equivalent; or
  - The drug has a generic equivalent, and the brand name drug is either covered by Health Net without restrictions as prescribed, or you have obtained approval from Health Net for coverage.
- In accordance with state regulations, upon request, Health Net will synchronize refill dates of prescription drugs so that drugs that are refilled at the same frequency may be refilled concurrently. To request synchronization please call the Customer Contact Center at the number listed at the back of this Agreement.
- All pharmacy services covered under this Agreement must be within a pharmacist’s lawful scope of practice, as defined by the state of Oregon.

Exclusions and Limitations:

The following items are excluded from the prescription drug coverage:

- Drugs and medicines prescribed or dispensed other than as described in the "Prescription Drug Benefit" section.
- Early refills other than for changes in directions (all medications), or for medications applied directly to the eye.
- Over-the-counter drugs other than insulin and preventive pharmacy medications, tobacco cessation medications or contraceptive methods as noted above in this section.
- Any prescription drug for which an over-the-counter therapeutic equivalent is available except for preventive pharmacy medications, tobacco cessation medications or contraceptive methods.
- Diabetic supplies (other than blood glucose test strips, lancets, insulin syringes, insulin needles and continuous glucose monitors and related supplies).
- Hypodermic Syringes and Needles (other than insulin syringes and needles).
- Injectable medications other than those listed on the Essential Drug List (EDL).

- Dietary supplements, food, health and beauty aids, herbal remedies, and vitamin preparations other than prescription prenatal vitamins and prescription vitamins with fluoride, and supplements or vitamins which are prescribed for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations as described in the "Preventive Pharmacy" section above.
- Medical foods except as covered under the "Inborn Errors of Metabolism" subsection in the Group Plan Benefits section.
- Drugs for the treatment of onychomycosis (nail fungus).
- Drugs used for infertility.
- Drugs used for appetite suppression or drugs for body weight reduction.
- In the absence of a DSM mental health disorder of sexual dysfunction being the primary diagnosis, drugs used for sexual enhancement, to improve sexual performance, to treat erectile dysfunction or to increase libido are not covered.
- Drugs and medicines used for diagnostic purposes.
- Drugs dispensed by nonparticipating pharmacies.
- Supply amounts for prescriptions that exceed the FDA's or Health Net's indicated usage recommendation unless Medically Necessary and Prior Authorization is obtained from Health Net.
- Prescriptions relating to an inpatient/outpatient confinement filled at a Hospital pharmacy prior to discharge for use at home (take-home medications) except for prescriptions for a 24-hour supply or less, following an emergency room visit.
- Except as covered for the treatment of gender affirming conditions, drugs that are prescribed for cosmetic or appearance enhancement purposes, including but not limited to hair loss and anti-aging cosmetic purposes.

Preventive Care

When preventive care services, 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 nonpreventive care services are received during the same office visit, the nonpreventive 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 and/or out-of-network cost share amounts including Deductibles (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 (ACIP) of the Centers for Disease Control and Prevention (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; and
- 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/womens-guidelines-2016/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 9 and 45.
- 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. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance identified in the Copayment and Coinsurance Schedule.

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.

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

Coverage for 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. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance.

Exclusions and Limitations:

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

Reconstructive Surgery

This plan covers reconstructive surgery in the following situations:

- When necessary to correct a functional disorder; or
- When necessary, because of an accidental injury, or to correct a scar or defect that resulted from treatment of an accidental injury; or
- When necessary to correct a scar of defect on the head or neck that resulted from a covered surgery.
- For approved treatment of gender affirming conditions and gender reassignment services.
- Except when Medically Necessary, reconstructive surgery must take place within 18 months after the injury, surgery, scar, or defect first occurred. Prior Authorization is required for all cosmetic and reconstructive surgeries. For information on breast reduction, see the "Reconstructive Breast Surgery" subsection in this Group Plan Benefits section. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance.

Exclusions and Limitations:

Cosmetic procedures and procedures to improve the normal range of functions are not covered unless they are Medically Necessary. In addition, hair transplantation, hair analysis, hairpieces and cranial/hair prostheses are not covered unless Medically Necessary. Wigs are not covered except when following chemotherapy and/or radiation therapy services.

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.

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

The following 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. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance identified in the Copayment and Coinsurance Schedule.

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.

Health care services that are not rehabilitative services include, but are not limited to, Respite Care, day care, recreational care, residential treatment, social services, and Custodial Care.

Inpatient rehabilitation services are limited to:

- A maximum of 30 days per Calendar Year.
- We may also approve an additional 30 days per condition when Medical Necessity criteria are met, not to exceed 60 days total.

Outpatient rehabilitation services are limited to:

- A maximum of 30 visits per Calendar Year. We may approve an additional benefit of up to 30 visits per condition when Medical Necessity criteria are met, not to exceed 60 visits total.

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

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

Respite Care

Respite care, limited to a maximum of five consecutive days with a lifetime maximum of thirty days, is covered in connection with Hospice Care. Prior Authorization is required.

Exclusions and Limitations:

No other coverage will be provided for Respite Care.

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.

Sleep Studies

Sleep study services are covered when ordered by a pulmonologist, neurologist, psychiatrist, otolaryngologist, or certified sleep medicine specialist, and when performed at a certified sleep laboratory. Benefits are subject to any applicable Deductible, Copayments and/or Coinsurance.

Specialty Care Centers

We reserve the right to direct care to designated Specialty Care Centers which are more cost effective and provide high quality care for you.

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" portion of this Group Plan Benefits section.

Male sterilization services are covered at no cost when services are rendered by a Participating Provider. Refer to the applicable out-of-network Deductible and Coinsurance for preventive care in the Copayment and Coinsurance Schedule for services received from a Nonparticipating Provider.

Prior Authorization may be required depending on the location where the services are performed. Prior authorization requirements can be verified by contacting us as outlined in the "Prior Authorization" portion of 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 Facility 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 Behavioral Health Conditions."

Health Net will not deny benefits for a Medically Necessary treatment or service for a Substance Use Disorder 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 Disorders; or
- The fact that a court ordered the Enrollee to receive or obtain the treatment or service for a Substance Use Disorder, 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 Behavioral Health Condition shall be considered to be a distinct and specialized type of program for both Substance Use Disorder and Behavioral 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 nonemergent detoxification services. All admissions for rehabilitation are considered nonemergent 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;
- Support groups; or
- 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 Group 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 "Prescription Drug Benefits" subsection of this Group Plan Benefits section.

For purposes of this section:

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.

Wigs

Wigs following chemotherapy and/or radiation therapy services are covered. The benefits are shown on the Copayment and Coinsurance Schedule under "Prosthetic Devices/Orthotic Devices." We may utilize a Specialty Care Provider for wig services if you live in Oregon or Washington.

Exclusions and Limitations:

The maximum benefit is one wig per Calendar Year. No other coverage will be provided for wigs. Hair transplantation, hair analysis, hairpieces, and cranial/hair prostheses are not covered unless Medically Necessary.

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 and online at the www.healthnetoregon.com. 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 faxing a request to 800-495-1148. Coverage for those services will be provided only if Prior Authorization has been obtained from us.

- To obtain Prior Authorization, please call our Customer Contact Center at 888-802-7001 or fax a request to 800-495-1148. For Prior Authorization of Behavioral Health Conditions or Substance Use Disorder services, please call 800-977-8216. For Prior Authorization for Pediatric Dental Services, please call 877-410-0176.
- A Provider request for Prior Authorization of nonemergency 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 Provider. The decision to accept Health Net's recommendation on the course of treatment shall remain up to you and your Provider. Our decision in any specific instance to authorize benefits that would not otherwise be covered under this Agreement shall not commit us to cover the same or similar benefits for the same or any other Member in other instances. By authorizing alternative benefits, we shall not waive our right to enforce all terms, limitations, and exclusions of this Agreement.
- **We may revise the Prior Authorization list by making normal and customary administrative changes from time to time, as permitted by OAR 836-053-0001. Any such changes including additions and deletions from the Prior Authorization list will be communicated in advance to Participating Providers and Members and posted on the www.healthnetoregon.com website.**
- **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

All of the following benefits, accommodations, care, services, equipment, medications, or supplies are expressly excluded (not covered) or limited. Any exceptions to these exclusions are noted below.

- **Bone Bank and Eye Bank Charges.**
- **Breast Reduction or Augmentation.** Reduction or augmentation mammoplasty, except if Medically Necessary or as provided in the "Reconstructive Breast Surgery," "Reconstructive Surgery" or "Gender Reassignment Services/Gender-affirming Treatment" subsections of this Group Plan Benefits section.
- **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).
- **Cosmetic Services.** Except for treatment covered under the "Reconstructive Surgery," "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. In addition, hair transplantation, hair analysis, hairpieces and cranial/hair prostheses are not covered unless Medically Necessary. Wigs are not covered except when following chemotherapy and/or radiation therapy services.
- **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.
- **Custodial Care.**
- **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," "Dental Injury," and the "Hospital Inpatient Services" and "Pediatric Dental Services" subsections of this Group Plan Benefits section or as otherwise covered under the "Preventive Care" section. Prior Authorization may be required.
- **Diagnosis and treatment for learning disorders** in the absence of a DSM diagnosis.
- **Diagnosis and Treatment of Infertility**, except for Emergency Medical Care or as covered as outlined in the "Fertility Preservation" subsection of this Group Plan Benefits section, 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:

- Evaluation and/or treatment of an inability to conceive.
- Evaluation and/or treatment of habitual abortion, including chromosomal analysis.
- Assisted reproductive technologies and artificial insemination.

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

- **Education Related to Judicial or Administrative Proceedings.** Coverage is provided for Medically Necessary treatment or service for a Behavioral Health Condition that is evidence-based and provided by licensed mental health practitioners irrespective of court order. However, court ordered educational programs and volunteer mutual support groups that do not have a clinical basis and are not provided by licensed mental health practitioners are not a covered benefit.
- **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.
- **Experimental or Investigational Procedures.** Except as provided in the "Clinical Trials" subsection of the 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.
- **Genetic Engineering.**
- **Hair Analysis and Replacement.** Hair transplantation, hair analysis, hairpieces, and cranial/hair prostheses are not covered unless Medically Necessary. Wigs are not covered except when following chemotherapy and/or radiation therapy services.
- **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.
- **Immunizations and Inoculations.** Except as provided under the "Preventive Care" portion of 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.
- **Missed Appointments.** Charges to a Member for failure to keep a scheduled appointment are not covered.
- **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.

- **Noncovered Equipment and Supplies.** Corrective appliances and artificial aids; braces; disposable or nonprescription 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.
- **Nonlicensed Providers.** Treatment or services rendered by nonlicensed 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 nonlicensed 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.
- **Nonstandard Therapy.** Yoga, hiking, rock climbing, and any other type of sports activity are not covered.
- **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.
- **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" section (as described in the USPSTF Guidelines).
- **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," "Medical Supplies" and "Pediatric Vision Services" subsections of this Group Plan Benefits section. Hearing screening and tests except as provided in the "Diagnostic Services" provision of the "Physician and Professional Services" and the "Preventive Care" subsections of this Group Plan Benefits section. Hearing aids except as provided in the "Hearing Aids" section, masking devices, or other hearing devices or the fitting thereof.

  - **Orthodontic Services and Dental Implants.** Except for treatment covered under the "Dental Injury," "Oral and Maxillofacial Services" or "Pediatric Dental Services" subsections of this Group Plan Benefits section.

- **Orthoptics, Pleoptics.**

- **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.
- **Outside the United States.** Services provided outside the United States which are not Emergency Medical Care.
- **Personal Comfort Items.** Such as television, telephone, lotions, shampoos, meals in the home, guest meals in inpatient facilities, housekeeping services, etc.
- **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.
- **Preventive and Routine Examinations, Services, Testing, and Supplies.** Except as outlined in the "Preventive Care" subsection of this Group Plan Benefits section.
- **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.
- **Recreational or Educational Therapy; Nonmedical 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 nonmedical 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.

- **Routine Foot Care.** Including treatment for corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes.
- **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.
- **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.
- **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** for emotional or behavioral disorders which fall under special education, and/or are provided by a school district.
- **Speech Therapy for Emotional Problems and/or Disorders.** Except when the services are Medically Necessary for the maintenance, learning or improving skills and functioning for daily living as outlined in the "Habilitative Services" and "Rehabilitative Therapy" subsections of this Group Plan Benefits section.
- **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.

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.

- **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.
- **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.
- **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.
- **Unauthorized Services.** Nonemergency services without Prior Authorization, if Prior Authorization is required pursuant to the "Prior Authorization" portion of this Group Plan Benefits section.
- **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.
- **Wilderness Residential Treatment Programs.** All services provided in wilderness residential treatment programs, except for Medically Necessary evidence-based interventions provided by appropriately licensed Providers.

Health Net Health Plan of Oregon, Inc.

PPO Plan

GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT

Introduction

- This Agreement is entered into between us, and the Subscriber Group named on the attached Signature Sheet.
- We are an authorized health care service contractor in the state of 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:

"Acupuncture Services" mean services rendered by a licensed acupuncturist for treatment of Musculoskeletal and Related Disorders, nausea and pain. "Acupuncture" means the stimulation of certain points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions, including pain control, and for the management of certain types of nausea (e.g., from anesthesia, pregnancy, chemotherapy, etc.). Acupuncture includes the techniques of electroacupuncture and moxibustion.

"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 make a payment in whole or in part for a health care item or service, which 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, riders, conditions of Enrollment, underwriting assumptions, 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 PPO Plan Contract 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.

"Behavioral Health Condition" means any mental or substance use disorder covered by diagnostic categories listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)*, the *International Classification of Diseases, 10th Revision (ICD-10), or the International Classification of Diseases, 11th Revision (ICD-11)*. The exception of a disorder does not include or extend to a co-morbidity disorder accompanying the excepted disorder.

"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.

"Chiropractic Services" means the services rendered or made available to a Member by a licensed chiropractor for treatment or diagnosis of Musculoskeletal and Related Disorders.

"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 the 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" or "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, crossbite, 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 nonlicensed 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" *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* or the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*. 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;
  - A child of the Subscriber's Domestic Partner during the domestic partnership.

  "Child" does not include:

  - Foster children, wards, or children who are the subject of an Assignment of Parental Rights, even if decreed by a court.
  - Children of Dependents unless the Subscriber is a court-appointed guardian.

  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 of 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 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 (a disruption in an insured's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a Hospital to prevent a serious deterioration in the Member's mental or physical health).

"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.

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

"Expedited 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.

"Habilitative Services and Devices" means services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services and devices may include physical and occupational therapy, speech-language pathology and other services and devices for people with disabilities in a variety of inpatient or outpatient settings. The services must be based on a treatment plan authorized, as required by us or the Member's Physician.

Health care services that are not habilitative include, but are not limited to, Respite Care, day care, recreational care, residential treatment, social services and Custodial Care.

"Health Benefit Plan" means any Hospital expense, medical expense, or Hospital/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) if the Member resides within the Service Area, has a written agreement with us as an agency or organization to provide Home Health Care to Members under this Agreement.

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

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

"Hospital" means an institution which is either:

a. 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

b. 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.

"Independent 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; or
- 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 which may be less than the amount billed for those Services and Supplies. We calculate MAA as the lesser of the amount billed by the Nonparticipating Provider or the amount determined as set forth below. MAA is not the amount that we pay for a Covered Service or Supply; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles, and other applicable amounts set forth in your Copayment and Coinsurance Schedule.

- The MAA for out-of-network Emergency Medical 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 Pediatric Dental Services is calculated by us based on available data resources of competitive fees in that geographic area, including but not limited to Fair Health database, and must not exceed the fees that the dentist would charge any similarly situated payor for the same dental services. The amount is determined in accordance with our reimbursement policy guidelines. Our reimbursement policy guidelines are developed following evaluation and validation of all dental Provider billings in accordance with one or more of the following methodologies, as determined by medical or dental staff and outside medical or dental consultants: (1) as indicated in the most recent edition of the Current Dental Terminology (publication of the American Dental Association); (2) as reported by generally recognized professionals or publications; or (3) as utilized for Medicare.
- The MAA for Covered Services and Supplies, excluding Emergency Medical Care, Pediatric Dental Services 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, MAA shall be determined by Health Net as the lessor of: (1) the amount negotiated with Participating Providers for similar Covered Services or Supplies provided; (2) the amount calculated using databases of Provider charges and allowable payments maintained by entities including, but not limited to, Fair Health and Data iSight; (3) an amount based on the Medicare allowable amount for a similar Covered Services or Supplies; or (4) 50% of 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, 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 shows how MAA applies to claims payment:

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

Nonparticipating Provider's billed charge for extended office visit.....$128.00
MAA allowable for extended office visit (MAA may not always equal 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, 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 their 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.

"Musculoskeletal and Related Disorders" means conditions with associated signs and symptoms related to the nervous, muscular and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction of the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related neurological manifestations or conditions. Musculoskeletal or Related Disorders include Musculoskeletal Functional Disorders, Subluxation Only disorders and Pain Syndromes. (Musculoskeletal or Related Disorders are also known as Neuromusculoskeletal Disorders for the purposes of this Agreement).

"Myofascial Disorders" means conditions with associated signs and symptoms related to the muscular and related systems. Myofascial Disorders are conditions typically categorized as structural, spasms or inflammatory disorders or dysfunction of the muscles of the body, and/or related components of the motor unit (muscles, tendons, fascia, ligaments/capsules, discs, and synovial structures), and related manifestations or conditions.

"Naturopathic Services" means services rendered by a Provider of Naturopathic Services for the diagnosis, prevention, and treatment of disorders of the body by stimulation or support, or both, of the natural processes of the human body, as covered by the Naturopathy Plan.

"Necessary Dental Care" Dental care Services and Supplies which are determined to be appropriate, and:

- Necessary to meet the basic dental needs of the Member; and
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service; and
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national clinical, research, or health or dental care coverage organizations or governmental agencies that are accepted by us; and
- Consistent with the diagnosis of the condition; and
- Required for reasons other than the convenience of the Member or their Dentist; and
- Demonstrated through prevailing peer-reviewed medical and/or dental literature to be either:
    1. safe and effective for treating or diagnosing the condition or sickness for which their use is proposed, or
    2. safe with promising efficacy:
        a. for treating a life-threatening dental disease or condition,

b. in a clinically controlled research protocol that meets standards equivalent to those defined by the National Institutes of Health.

For the purpose of this definition, the term "life threatening" is used to describe a dental disease or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.

The fact that a Dentist has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a necessary covered dental service as defined in this Agreement. The definition of Necessary Dental Care used in this Agreement relates only to coverage and differs from the way in which a Dentist engaged in the practice of dentistry may define necessary.

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

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

"Participant" means an individual who is an employee or Member of the 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 PPO Plan with an expectation of receiving payment, other than Deductibles, Coinsurance, and Copayments, directly or indirectly from us, and such contract or other arrangement is in effect at the time such services are rendered.

Participating Provider also includes participating chiropractor, participating acupuncturist, participating provider of naturopathic services, participating provider of Therapeutic Massage Services or other licensed health care Provider acting within the scope of their license who has entered into a contract or other arrangement to provide health care services to Members of this Plan.

"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.

"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 nonemergency 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.

"Procedure in Progress" means all treatment for covered acupuncture, chiropractic, therapeutic massage, and naturopathic services that results from a recommendation and an exam by a Provider. A treatment procedure will be considered to start on the date it is initiated and will end when the treatment is completed.

"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 their license to furnish Covered Services and Supplies.

"Rating Period" means the 12-month calendar period for which premium rates established by Health Net are in effect, as determined by Health Net.

"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 state of Oregon and the state of Washington.

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

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

"Skilled Nursing Service" has the same meaning as Extended Care Service in Title XVIII of the Social Security Act and regulations except that it does not include a requirement of prior hospitalization; is

interpreted as if all Members were covered under both parts of Title XVIII; and applies only to services performed, prescribed, or directed by a participating Physician. "Post-Hospital Extended Care Service" has the same meaning as Title XVIII of the Social Security Act and regulations but applies only to services performed, prescribed, or directed by a participating Physician.

"Small Employer" is an employer that employed an average of at least one but not more than 50 employees on business days during the preceding Calendar Year, the majority of whom are employed within this state, and that employs at least one Eligible Employees on the date on which coverage takes effect under a Health Benefit Plan issued by a small employer carrier.

"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. The exception of a disorder does not include or extend to a co-morbidity disorder accompanying the excepted disorder.

"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.

"Therapeutic Massage Services" means the services rendered by a participating massage therapist within their scope of practice and for treatment of Myofascial Musculoskeletal Pain Syndromes.

"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 effective as follows. Written notice of premium rate change will be given to Subscriber Group at least 30 days prior to the effective date of the change.
    a. On any Anniversary Date for a Small Employer group that meets the definition of Oregon Small Employer in the "Definitions" section of this Group Medical and Hospital Service Agreement, or
    b. At any time for a Small Employer group that no longer meets the definition of Small Employer in the "Definitions" section of this Group Medical and Hospital Service Agreement.

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 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.

If the Subscriber Enrolled under this Agreement is under the age of 19 and has been Enrolled by the parent or legal guardian, the parent or legal guardian signing for coverage on behalf of the underage Subscriber agrees to be responsible for the administrative and premium requirements of the coverage where the Subscriber cannot do so because they are not of legal age. Dependents of the Subscriber cannot be Enrolled and cannot be Members under this Agreement. No benefits shall be payable on behalf of Dependents.

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 or a Child in Foster Care.** A newborn child or a child placed with a Member for the purpose of adoption or placed in foster care will be covered from the moment of birth or the date of adoption, placement for adoption or placement in foster care if the child is Enrolled as a Member within the first 31 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, dissolution of a domestic partnership, divorce, 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, adoption or placement for adoption or placement in foster care. In the case of marriage or domestic partnership, Enrollment is effective the first day of the following month. In the case of birth, adoption, placement for adoption, or placement in foster care, the Enrollee may elect a coverage date of the day of the birth, adoption, placement for adoption, or placement in foster care, or the first day of the month following the date of birth, adoption, placement for adoption, or placement in foster care.

c. Premium Assistance under a Medicaid plan or CHIP. 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 CHIP.

d. Permanent Move. A Participant and/or Dependents who moves into the Service Area outside of Open Enrollment can Enroll in this Agreement by submitting a completed application form within 30 days of the permanent move if such individual had minimal essential coverage for one or more days during the 60 days preceding the date of the permanent move, was living outside the United States or in a United States Territory at the time of the permanent move, or was living in a non-Medicaid expansion state at the time of the permanent move.

e. Incarceration. A Participant and/or Dependents can Enroll in this Agreement by submitting a completed application form within (60) days of being released from incarceration, (other than incarceration pending disposition of charges).

- **Late Enrollee.**

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

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

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

If a Member is confined as an inpatient in a Hospital on the Effective Date of this Agreement, and prior coverage terminating immediately before the Effective Date of this Agreement 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 nonrenewed 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 meet the participation requirement(s) as set forth in the group proposal offer.

d. When we discontinue offering or renewing, or offering and renewing, all of our Small Employer 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 d.1 above if coverage is discontinued in the entire state or, except as provided in section d.3 below, in a specified service area;

   3. May not cancel coverage for 90 days after the date of the notice required under section d.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 the Small Employer market, in this state, or in the specified service area.

e. When we discontinue offering and renewing a Small Employer 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 e.1 above; and

   3. Must offer in writing to each Subscriber Group covered by the plan, all other Small Employer Health Benefit Plans that we offer in the specified Service Area. We shall offer the plans at least 90 days prior to discontinuation.

f. When we discontinue offering or renewing, or offering and renewing, a Health Benefit Plan for all Small Employers in this state or in a specified service area within this state, other than a plan discontinued under section e. above 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.

g. 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.

h. When, in the case of a Small Employer 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.

i. When, in the case of a Health Benefit Plan that is offered in the Small Employer market 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 d. or f. above, of this Group Medical and Hospital Service Agreement. Written notice of modifications 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 their 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 their 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, except as provided in the "Continued payment of monthly premiums" section above of this Group Medical and Hospital Service Agreement.
- 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 their 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 their 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 them when their 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, dissolution of a domestic partnership, divorce or legal separation from a Subscriber may continue coverage for themselves and their Dependent children who would otherwise lose coverage due to the death, dissolution of a domestic partnership, divorce, 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.

Small Employer Coverage

- We may provide different Health Benefit Plans to different categories of employees of a Small Employer when the employer has chosen to establish different categories of employees in a manner that does not relate to the actual or expected health status of such employees or their Dependents. The categories must be based on bona fide employment-based classifications that are consistent with the employer's usual business practice.
- Except in the case of Small Employers that are not physically located in our approved Service Area, when an employee does not work or reside in our approved Service Area, or based on Provider network capacity limitations, when we offer coverage to a Small Employer, we shall offer coverage to all Eligible Employees of the Small Employer.
- If the Small Employer elects to offer coverage to Dependents of Eligible Employees, we shall offer coverage to all Dependents of Eligible Employees.

We enforce reasonable employer participation and contribution requirements on Small Employer groups applying for coverage with us. However, participation and contribution requirements shall be applied uniformly among all Small Employer groups with the same number of Eligible Employees applying for

coverage or receiving coverage from us. In determining minimum participation requirements, we shall count only those employees who are not covered by an existing group Health Benefit Plan, Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including, but not limited to, the Oregon Health Plan.

Continuation of group coverage is available to Small Employer groups with less than 20 employees. See the "Oregon State Continuation of Coverage" section of the Group Medical and Hospital Service Agreement. Continuation of group coverage is available to Subscriber Groups not required to offer continuation under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") under the "Federal Continuation of Coverage" section of the Group Medical and Hospital Service Agreement.

Participating Providers

- 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 should obtain all Medical Services from Participating Providers and in accordance with any Prior Authorization requirements, even when a Member expects payment to be made by another plan or a third party. Care furnished by a Nonparticipating Provider is generally reimbursed at a lower level. 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.
- If a Member resides outside the Service Area and is unable to receive services from Participating Providers, the Member's Coinsurance for Covered Services will be at the Nonparticipating Provider level specified in the Copayment and Coinsurance Schedule.
- 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.

- 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 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 their Physician. A Member is always entitled to obtain, at their 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," and "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, except for services covered as preventive care as outlined in the "Preventive Care" section of the Group Plan Benefits section.**
- **Nonparticipating Provider Services.** Coverage for the services of a Nonparticipating Provider is limited to and based on a Maximum Allowable Amount fee.
- **Unauthorized Benefits**. Members who are treated by a Provider 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 Schedules, 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 Nonparticipating Provider benefits 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, they shall be deemed capable of notifying us. 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

- **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 https://dfr.oregon.gov/help/complaints-licenses/Pages/file-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 nonrenewed on the basis of the status of their 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 Behavioral Health Conditions 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 Medical 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, such as 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, such as 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 a Member or a Provider first Appeals 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 the "Grievances and Appeals" section of this Group Medical and Hospital Service Agreement.
- An otherwise applicable standard for timeliness outlined in this section of this 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 Division of Financial Regulation (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 their 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 Division of Financial Regulation (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 nonmedical 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 Group Plan Benefits do not exceed 100% of the total allowable expense.
- **"Allowable expense"** is a health care expense, including Deductibles, Coinsurance and Copayments, which 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 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. 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. Some types of these 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 or 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 nonpanel 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 their 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 or 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 Subscriber or a covered Dependent(s) receives from the 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 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 their rights against a 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 must give us information about any motor vehicle insurance payments which may be available to the Member and, 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 their 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 Out-of-Network 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 they are not entitled shall be charged at the usual rates of the Provider. If any Member permits the use of their plan identification card by any other person, such card may be reclaimed by us, and all rights of such Member and their 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/or Coinsurance is limited as stated on the Copayment and Coinsurance Schedule attached hereto. It is the Member's responsibility to maintain accurate records of the Copayments and/or Coinsurance paid 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, Coinsurance, and for non-Covered Services. A Member shall not be responsible for amounts owed by us to a Participating Provider even if we are unable to pay.
- 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 their 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.
- Benefits payable under this Agreement are subject to the Deductible shown in the Copayment and Coinsurance Schedule which must be satisfied each Calendar Year before benefits will be paid.
- When this Agreement immediately replaces a Subscriber Group's previous Health Net of Oregon (HNOR) PPO Plan Agreement in the middle of a Calendar Year, we will credit amounts accumulated toward annual Deductibles 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.

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.

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.

Covered Entity Duties:

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

- The Uses or Disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the Notice

We will make any revised Notices available on the Health Net website or through a separate mailing.

https://www.healthnetoregon.com/about-us/privacy-policy.html.

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 and reviewing services for Medical Necessity.
- ***Health Care Operations*** – We may use and disclose your PHI to perform our health care operations. These activities may include providing customer services, responding to complaints and Appeals and providing care management and care coordination.

  In our health care operations, we may disclose PHI to business associates. We have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its health care operations. This includes the following:

  - Quality assessment and improvement activities;
  - Reviewing the competence or qualifications of health care professionals;
  - Care management and care coordination; or
  - Detecting or preventing health care fraud and abuse.
- ***Group Health Plan/Plan Sponsor Disclosures*** – We may disclose your protected health information 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 protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

- ***Fundraising Activities*** - We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.
- ***Underwriting Purposes*** - We may use or disclose your PHI for underwriting purposes, such as to decide 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 of 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 response to an administrative or court order. We may also be required to disclose your PHI to respond to a subpoena, discovery request, or other similar requests.
- ***Law Enforcement*** - We may disclose your relevant PHI to law enforcement when required to do so for the purposes of responding to a crime.
- ***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. We may also disclose your PHI to those who work in procurement, banking or transplantation of cadaveric organs, eyes, and 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 concerns, intelligence activities, the Department of State for medical suitability determinations, the protection of the President, and other authorized persons as may be required by law.
- ***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 interest. 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.

You have the right to revoke your authorization, in writing at any time except to the extent that we have already used or disclosed your PHI based on that initial authorization.

Individual 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 acted 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 restrictions apply. 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 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. We will also tell you 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. 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-year 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 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:1-800-537-7697**) 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.

Right to Receive a Copy of This Notice - You may request a copy of our Notice at any time by using the contact information listed 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.

Financial Information Privacy Notice

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

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

Information We Collect

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

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

Disclosure of Information

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

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

Confidentiality and Security

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

Questions about this Notice:

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

Contact Information

Health Net Health Plan of Oregon, Inc.
Attn: Compliance Department
P.O. Box 11756
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

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://www.hhs.gov/ocr/complaints/index.html, 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 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។ អ្នកអាចទទួលអ្នកបកប្រែបាន។ អ្នកអាចឱ្យសគអានឯកសារជូនអ្នក និងសុើឯញ កសារខុ៎ះជូនអ្នក ជាភាសារបេអ្ន់ នក។ េ៎ំរាប់ជំនួយ ទូរេ័ពសៅមជឈមណ្ឌ លទំនាក់ទំនងអ្តិលិជនតាមសលខេ្ញសលបើណ្ ណ ID ររបេអ្ន់ នក ឬសៅសលខ 1-888-802-7001 (TTY: 711)។

Laotian

ການ ໍ ດ ານພ າສ າ ິ ່ ທ ີ ່ ບ ເສ ຍ ິ ່ ຄ າ. ິ ່ ທ ານສ າມ າ ດ ່ ຂ ນ ຍ ແ ປພ າສ າ. ິ ່ ທ ານສ າມ າ ດ ິ ່ ອ ານເ ອ ກ ະ ສ ານ ແ ລ ະ ໍ ຈ ານ ວ ນ ິ ່ ຫ ນ ງ ໃ ້ ດ ິ ່ ສ ງ ໃ ້ ຫ ິ ່ ທ ານ ໍ ລ ະ ບ ນ ພ າສ າ ຂ ອ ງ ິ ່ ທ ານ ແ ລ ະ ໍ ລ ວ. ເ ິ ່ ພ ່ ຂ ຄ ວ າ ມ ິ ່ ຊ ວ ຍ ເ ຫ ອ, ໂ ທ ຫ າ ູ ສ ນ ິ ຕ ດ ີ ຕ ມ ກ ້ ຄ າ ໃ ້ ດ ິ ່ ທ ເ ວ ກ ຫ ມ າ ຍ ີ ່ ຢ ເ ທ ງ ໆ ັ ບ ດ ID ຂ ອ ງ ິ ່ ທ ານ ຫ ໂ ທ 1-888-802-7001 (TTY: 711).

Punjabi

ਭਾਸਾ ਸੇਵਾਵਾਂ ਲਈ ਕੋਈ ਲਾਗਤ ਨਹੀਂ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਆ ਪ੍ਾਪ੍ਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਤੁਹਾਨ ੂੰ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਦਸਤਾਵੇਜ਼ ਪ੍ਾਪ੍ਤ ਕਰ ਸਕਦ ੇ ਹੋ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸਾ ਵਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਗਏ ਹਨ। ਮਦਦ ਲਈ, ਆਪ੍ਣੇ 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).

Ukrainian

Безкоштовні послуги перекладу. Ви можете скористатися послугами перекладача.

Вам можуть прочитати документи на українській мові та надіслати переклади деяких із них. Якщо вам потрібна допомога, телефону йте у Центр обслуговування клієнтів за номером, вказаним на вашій ідентифікаційній карті, або за номером 1-888-802-7001 (лінія TTY: 711).

Vietnamese

Dịch vụ ngôn ngữ miễn phí. Quý vị có thể yêu cầu phiên dịch viên. Quý vị có thể yêu cầu đọc các tài liệu và gửi một số tài liệu cho quý vị bằng ngôn ngữ của quý vị. Để được trợ giúp, hãy gọi đến Trung tâm Liên lạc Hội viên theo số điện thoại trên thẻ nhận dạng của quý vị hoặc gọi đến số 1-888-802-7001 (TTY: 711).

FLY039497ET00 (1/21)

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

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

www.healthnetoregon.com

Effective 1/2025

Health Net Health Plan of Oregon, Inc. is a subsidiary of Health Net, LLC.

Health Net Health Plan of Oregon, Inc.

Health Net Small Group Vision Plan Contract

GROUP POLICY

Plan [ ]

2025

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Health Net Health Plan of Oregon, Inc.

Small Group Vision
Group Plan Benefits

GENERAL TERMS UNDER WHICH BENEFITS ARE PROVIDED

Throughout this Agreement, 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.

GROUP POLICY, entered into as of the effective date shown on the Signature Sheet by and between Health Net and the Subscriber Group named on the Signature Sheet. Health Net (HNOR) in consideration of the premium payments to be paid to us by the Subscriber Group, agrees to provide the Benefits of this Agreement including all endorsements issued.

The purpose of this policy is to provide vision benefits to Subscriber Groups selecting this supplemental benefit in addition to the basic benefits. This schedule is an amending attachment to the Group Plan Benefits.

This Policy is an amending attachment to the Group Medical and Hospital Service Agreement. To the extent that the terms of this Policy conflict with the terms of those documents, the terms of the Group Medical and Hospital Service Agreement will control.

Subject to all terms, conditions, exclusions and definitions in the Group Medical and Hospital Service Agreement and its attachments, you are entitled to receive benefits set forth in this Policy upon payment of the relevant premiums and Copayments.

This Agreement is delivered in and governed by the laws of the state of Oregon, and this Agreement and any attachments or endorsements constitute the entire Agreement between the Subscriber Group and us.

The initial policy term is one year, or until terminated as provided in Section Seven. For the purposes of policy effective and termination dates, all days begin and end at 12:00 midnight at the Subscriber Group's business address provided to us. This Agreement may be renewed or replaced periodically, if not terminated as provided in Section Seven. Unless we are otherwise notified within 31 days after delivery of the policy, payment of premiums due following delivery of the policy will constitute acceptance of this Agreement.

We reserve the right to modify Benefits under this Agreement at any time. Written notice of Benefit changes, including modifications to preventive Benefits, will be provided to Enrollees at least 60 days prior to the effective date of the change.

SECTION ONE - DEFINITIONS

DEFINITIONS

The following definitions will apply whenever used in this Agreement. The masculine includes the feminine and the singular includes the plural. Employee will include the Subscriber Group when covered by this Agreement.

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

ADVERSE BENEFIT DETERMINATION: An insurer's denial, reduction, or termination of a vision care item or service, or an insurer's failure or refusal to provide or make a payment in whole or part for a vision care item or service that is based on the insurer's:

a. Denial of eligibility for or termination of Enrollment in a vision benefit plan; or

b. Rescission or cancellation of a policy or certificate; or

c. Source-of-injury exclusion, network exclusion, annual Benefit limit or other limitation on otherwise covered items or services; or

d. Determination that a vision care item or service is Experimental, Investigational, not considered necessary vision care, effective, or appropriate; or

e. 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.

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

AGREEMENT: This vision policy, all attached Benefit Schedules and 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 Agreement between us and the Subscriber Group, and when distributed to a Subscriber, as the Subscriber's Evidence of Coverage (EOC) document.

APPEAL: A written or oral request submitted by or on behalf of a Member to review and reconsider an Adverse Benefit Determination.

BENEFIT SCHEDULES: The attached exhibits identified as the Benefit Schedule or Supplemental Benefit Schedules which set forth the vision and other Benefits provided under this Agreement.

BENEFITS: Payments by us, which, under the terms of this Agreement, constitute allowances toward charges for Covered Services.

CALENDAR YEAR: The period of time beginning January 1 and ending December 31. Each succeeding January 1 will start a new Calendar Year.

CLAIM DETERMINATION PERIOD: A Calendar Year, or portion thereof.

COPAYMENT: 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.

COSMETIC PROCEDURES: Services, including surgery, performed to improve appearance and not primarily to restore impaired function of the body.

DEPENDENT: Any member of an Employee's immediate family who is one of the following:

a. The spouse or Domestic Partner of the Subscriber.

b. A Child of the Employee 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 Employee to provide health coverage for the child. Proof of compliance with this requirement must be furnished annually.

"Child" means a natural child of the Employee, an adopted child of the Employee, or a stepchild of the Employee during the marriage or Domestic Partnership of the Employee and the natural parent, or a child of the Employee'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. Coverage of any Dependent child of an Employee shall not be terminated by the child's attaining the age of 26 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.

DISABLED: 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: A person who is in a "domestic partnership" with the Subscriber. A domestic partnership is defined as:

a. A relationship of two people 18 years of age or older that were mentally competent to consent to contract when the domestic partnership began, neither of whom is married to anyone else and neither of whom has had another domestic partnership within the most recent six months.

b. A relationship of two people who are not related by blood closer than first cousins.

ELIGIBLE EMPLOYEE: means an employee who is eligible for coverage under a group health benefit plan.

ENROLLMENT or ENROLL or ENROLLED: The completion and signing of the necessary Enrollment forms by or on behalf of an eligible person and acceptance by us.

EXPERIMENTAL OR INVESTIGATIONAL: Services which a reasonably substantial, qualified, responsible, relevant segment of the medical or vision 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 or vision 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:

a. 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:
   1. in writing, for an Internal Appeal or an external review; or
   2. in writing or orally, for an expedited response or an expedited external review; or

b. A written complaint submitted by an Enrollee or an authorized representative of an Enrollee regarding the following:
   1. availability, delivery or quality of a vision care service;
   2. claims payment, handling or reimbursement for vision 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
   3. matters pertaining to the contractual relationship between an Enrollee and an insurer.

INITIAL ENROLLMENT PERIOD: The initial period of time, determined by us and the Subscriber Group, during which Employees may Enroll themselves and Dependents under the Agreement.

INTERNAL APPEAL: A review by us of an Adverse Benefit Determination made by us.

LATE ENROLLEE: An individual who Enrolls in a group vision 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:

a. The individual applies for coverage during an open Enrollment period;
b. A court has ordered that coverage be provided for a spouse, Domestic Partner or minor child under a covered Participant's vision benefit plan and request for Enrollment is made within 31 days after issuance of the court order;
c. The individual is employed by a Subscriber Group who offers multiple vision benefit plans and the individual elects a different vision benefit plan during an open Enrollment period agreed upon by Subscriber Group and us;
d. The individual qualifies for Special Enrollment under Section 2.B.4.

MEDICAL DIRECTOR: A Medical Director of our plan or designee. A decision of the Medical Director which substantially affects a Member is subject to Section 8.D. – Grievances and Appeals, and will be made in the exercise of the Medical Director's reasonable judgment, subject to all terms and conditions of this Agreement.

MEDICARE: Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act. As amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

MEMBER or ENROLLEE: 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.

MEDICALLY NECESSARY CONTACT LENSES means:

a. Keratoconus where the Member is not correctable to 20/25 in either or both eyes using standard spectacle lenses, or the Provider attests to the specified level of visual improvement;

b. High Ametropia exceeding -10D or +10D in spherical equivalent in either eye;

c. Anisometropia of 3D in spherical equivalent or more; or

d. vision for a Member can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle.

NONPARTICIPATING PROVIDER, or OUT-OF-NETWORK PROVIDER: Any Provider who is not a Participating Provider at the time services are rendered to a Member.

OPTOMETRIST: An Optometrist is a doctor of optometry (OD). They are trained to examine, diagnose, treat, and manage some diseases and disorders of the eye and visual system.

PARTICIPANT: An individual who is an employee or Member of Subscriber Group and is entitled, in accordance with the Group's established eligibility rules, to participate in the vision 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 vision plan sponsored by Subscriber Group.

PARTICIPATING PROVIDER: A licensed Optometrist or other Provider acting within the scope of their license who has entered into a contract or other arrangement to provide vision care services to Members of this Plan with an expectation of receiving payment, other than Deductibles, Coinsurance, directly or indirectly from us, and such contract or other arrangement is in effect at the time such services are rendered.

PROCEDURE IN PROGRESS: All treatment for covered services that results from a recommendation and an exam by Vision Provider. A treatment procedure will be considered to start on the date it is initiated and will end when the treatment is completed.

PROVIDER: A licensed Optometrist or other Provider acting within the scope of their license.

SERVICE AREA: The state of Oregon.

SUBSCRIBER: 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: The entity, such as employer, trust or association, sponsoring health and welfare plan pursuant to which the Benefits of this Agreement are made available to Members. A Subscriber Group is limited to an entity that would, under Oregon law, be eligible for a group vision

policy or Agreement. In order to qualify as a Subscriber Group, an entity must meet our current underwriting standards for the product sought.

VISION PROVIDER: A licensed Optometrist or other Provider acting within the scope of their license.

VISION SERVICES: Services for which Benefits are provided under this Agreement.

SECTION TWO - ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

A. ELIGIBILITY

1. 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 must meet the Subscriber Group's eligibility criteria.
2. 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.
3. 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.
4. 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.
5. 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.

B. ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

1. 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.

2. 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.
3. 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.
4. Special Enrollment.
    a. Loss of Other Coverage. A Participant and/or Dependents who previously declined coverage under this Agreement because of coverage under another vision 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, dissolution of a domestic partnership, divorce, 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.
    c. Premium Assistance under a Medicaid plan or CHIP plan. A Participant and/or Dependents can Enroll in this Agreement by submitting a completed application form within 60 days of becoming eligible for premium assistance under a Medicaid or CHIP plan.
    d. Permanent Move. A Participant and/or Dependents who moves into the Service Area outside of Open Enrollment can Enroll in this Agreement by submitting a completed application form within 30 days of the permanent move if such individual had minimal essential coverage for one or more days during the 60 days preceding the date of the permanent move, was living outside the United States or in a United States Territory at the time of the permanent move, or was living in a non-Medicaid expansion state at the time of the permanent move.
    e. Incarceration. A Participant and/or Dependents can Enroll in this Agreement by submitting a completed application form within (60) days of being released from incarceration, (other than incarceration pending disposition of charges).
5. Late Enrollee. 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. Employee eligibility wait periods established by the Subscriber Group may apply.
6. Late Enrollees do not include those who experience a qualifying event, and are eligible for Enrollment during a Special Enrollment period.
7. Subscriber Group shall notify us no later than the next billing cycle of any changes which may affect Member eligibility.

8. 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.
9. 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.

C. MEDICAID NOT CONSIDERED

The availability or eligibility for assistance under Medicaid, in any state, is not considered when considering eligibility for coverage or paying Benefits for eligible Members under this Agreement.

D. IMPORTANT INFORMATION REGARDING MEDICARE

Enrollment under this Agreement is not intended to supplement any coverage provided by Medicare, but in some circumstances Members who are eligible for or enrolled in Medicare may also be Enrolled under this Agreement. If you are eligible for or enrolled in Medicare, please read the following information carefully.

If, in addition to being Enrolled under this Agreement, you are enrolled in a Medicare Advantage (Medicare Part C) plan, you must follow all rules of that plan that require you to seek services from that plan's Participating Providers. When we are the secondary payer, we will pay any benefit available to you under this Agreement as if you had followed all rules of the Medicare Advantage plan. If we are the secondary plan and you don't follow the rules of the Medicare Advantage plan, you will incur a larger out-of-pocket cost for Vision Services.

SECTION THREE - PREMIUMS

A. PREMIUM RATES

Monthly premium rates are included in the premiums indicated on the medical Signature Sheet.

B. PAYMENT OF PREMIUMS

Each monthly premium shall be calculated on the basis of our records reflecting the number of Subscribers and Dependents in each coverage classification, as indicated on the medical 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. Subscriber Group assumes responsibility for collection of the contributory portion of the premium, if any, from each Subscriber.

C. REQUIRED PREMIUM NOT RECEIVED

Only Members for whom the premium is actually received shall be entitled to Benefits, and then only for the period to which such premium is applicable.

If 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. We may charge a fee to reinstate the Agreement after termination.

D. CHANGES TO TOTAL PREMIUM

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.

E. PREMIUM ADJUSTMENTS

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 30 days prior to the effective date of the change.

SECTION FOUR - PARTICIPATING PROVIDERS

A. ID CARDS

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 vision care Provider at the time of service.

B. ENSURE MAXIMUM AVAILABLE BENEFITS

To receive maximum benefits, you must utilize Participating Providers. A list of Participating Providers is available at www.healthnetoregon.com or by calling our Customer Contact Center at the number on the back of this Agreement. When services are received from a Participating Provider, we make payment directly to the Provider. You are responsible for paying the Copayment to the Provider.

C. REFUSAL OF PROCEDURE OR TREATMENT

For personal reasons, a Member may refuse to accept a procedure or treatment recommended by the Provider.

SECTION FIVE - PAYMENT OF BENEFITS

We will provide Benefits for vision care required by a Member covered under this Agreement. This provision of Benefits is subject to all of the terms and provisions of this Agreement.

Services rendered before the effective date of this Agreement will not be covered. The expense of such services will not apply towards any Deductible whether or not such services would have been covered by the policy.

A. BENEFIT AMOUNTS

To receive maximum benefits, you must utilize Participating Providers. A list of Participating Providers is available at www.healthnetoregon.com or by calling our Customer Contact Center at the number at the back of this Policy. When services are received from a Participating Provider, we make payment directly to the Provider. You are responsible for paying the Copayment to the Provider.

B. MAXIMUM CALENDAR YEAR BENEFIT

The maximum Benefit payable for all covered services in any Calendar Year is shown on the Supplemental Benefit Schedules of this Agreement.

C. RECOVERY OF BENEFITS PAID BY MISTAKE

We will have the right to recover the payment from the person paid or anyone else who benefited from it, including a Provider of services if:

1. We make a payment to which a Member is not entitled under this Agreement; or
2. We pay a person who is not eligible for Benefits at all.

D. ASSIGNMENT OF BENEFITS

No Benefit, right or interest of either Subscriber Group or any Member under this Agreement can be assigned or transferred. Any attempted assignment or transfer will be invalid and void. We may, however, in our discretion, make payments directly to a Provider of service.

Checks for payment for claims will be made out to the Provider submitting the claim for Benefits. Payment will be made to the Member only if the Member received services from a Nonparticipating Provider and furnishes evidence of prepayment to us.

E. SUBMISSION OF CLAIMS

Members must submit claims to us for all services provided within 90 days from the date the services were rendered or as soon as reasonably possible, but in no event later than one year from the date services were rendered unless the Member is legally incapacitated throughout that year. Claims must include a statement describing the services rendered, date of services, and charges.

We will respond to submitted claims as follows:

- 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.

F. FINAL REVIEW BEFORE PAYMENT OF BENEFITS

Any payment of Benefits under this policy is subject to:

1. Actual submission of the claim;

2. Review of the services performed and determination of necessary vision care;
3. Existing Group Plan Benefits; and
4. All eligibility provisions, conditions, limitations and exclusions of this plan.

SECTION SIX - LIMITATIONS AND EXCLUSIONS

A. LIMITATIONS

Vision Examination and Vision Materials - Fees charged by a Provider for services other than Vision Examination or covered Vision Materials must be paid in full by the Member to the Provider. Such fees or materials are not covered under this Policy.

Benefits may not be combined with any discount, promotional offering, or other group benefits plans. Allowances are one-time use benefits; no remaining balance.

B. EXCLUSIONS

There is no benefit for professional services or materials connected with:

1. Orthoptics or vision training, subnormal vision aids and any associated supplemental testing.
2. Aniseikonic lenses.
3. Medical or surgical treatment of the eyes or supporting structures.
4. Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under this plan.
5. Services for any illness, condition or injury occurring in or arising out of the course of employment for which there is an approved workers' compensation claim.
6. Plano nonprescription lenses and nonprescription sunglasses.
7. Lost or broken materials except at normal intervals when services are otherwise available.
8. Any procedure not performed in a vision setting.
9. Benefits not stated; services and supplies not specifically listed as covered; Benefits in excess of the stated limits under this Agreement.
10. Hospitalization or other facility charges.
11. 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 vision coverage; services and supplies for which the Member is not billed by a Provider or for which we are billed a zero dollar charge.
12. Services and supplies rendered by an immediate family member (spouse, Domestic Partner, parent, child, grandparent or sibling related by blood, marriage or adoption) or 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.
13. Cosmetic Procedures.
14. Nonemergency services provided outside the United States.

15. Reconstructive surgery, regardless of whether or not the surgery is incidental to a vision disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
16. Procedures that are considered to be Experimental or Investigational. The fact that an Experimental or Investigational service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental or Investigational for that particular condition.
17. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
18. Drugs and medications obtainable with or without a prescription, unless dispensed and utilized in the vision office during the patient visit.
19. Acupuncture, acupressure, and other forms of alternative treatment.
20. Charges for failure to keep a scheduled appointment.
21. 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.
22. Treatment or services rendered by nonlicensed 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 nonlicensed Provider under the supervision of a licensed physician.

SECTION SEVEN - TERM AND TERMINATION

A. POLICY TERM

This policy will remain in effect for the term specified on the Signature Sheet. The policy will be renewed automatically, from year to year thereafter, until terminated as provided in this Section.

B. MODIFICATION OF POLICY

We may change or amend this Agreement by giving written notice to the Subscriber Group at least 30 days prior to the effective date of the renewal. The 30-day notice requirement does not apply to normal and customary administrative changes that do not have an actuarial impact, such as a decrease or increase required by state or federal law. Payment of premiums after notice of change to the Subscriber Group by us constitute acceptance of change by the Subscriber Group. Failure to pay the premium after notice of change constitutes termination of the policy as of the effective date of the change. Any monies from prepaid premiums will be refunded on termination.

C. CONTINUITY OF COVERAGE AND GUARANTEED RENEWABILITY

This Agreement is renewable with respect to all Members at the option of the Subscriber Group except it may be discontinued or nonrenewed based on the following circumstances:

1. For nonpayment of the required premiums by the Subscriber Group.

2. For fraud or intentional misrepresentation by the Subscriber Group, or with respect to the coverage of a Member by the Member or the Member's representative.
3. Failure of the Subscriber Group to meet the participation requirement(s) as set forth in the group proposal offer.
4. When we discontinue offering or renewing, or offering and renewing, all of our group vision in this state or in a specified service area within this state. In order to discontinue plans under this Article, we:
    a. 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;
    b. May not cancel coverage under the plans for 180 days after the date of the required notice;
    c. 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.
5. When we discontinue offering or renewing, or offering and renewing, a vision plan for all groups in this state or in a specified service area within this state. With respect to plans that are being discontinued, we must:
    a. Offer in writing to each Subscriber Group covered by the plan, all other vision plans that we offer in the specified service area.
    b. Offer the plans at least 90 days prior to discontinuation.
    c. Act uniformly without regard to the claims experience of the affected Subscriber Groups or the health status of any current or prospective Enrollee.
6. Material breach of the policy.
7. Change or implementation of federal or state laws that no longer permit the continued offering of such coverage.

Upon 30 days written notice to us, Subscriber Group can terminate this policy for any reason on the first anniversary of the effective date of this Agreement or on the first day of any month thereafter. No continuation privileges are available when the Agreement is terminated.

D. RESCISSION

Notwithstanding any provision in Section 7.C. to the contrary, we may rescind an Agreement for fraud or intentional misrepresentation of material fact or concealment by a Subscriber Group, and the coverage of a Member may be rescinded for fraud or intentional misrepresentation of material fact or concealment by the Member.

E. TERMINATION OF AGREEMENT

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 regardless 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 Subscriber Group, 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 shall notify Subscriber Group by mail within 10 days after this Agreement is terminated and not replaced by the Subscriber Group. This provision shall apply when an employer terminates participation in a multiple employer trust as well as in the event of termination of this Agreement when held by a multiple employer trust. If notice is not given as required by this Article, 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.

F. LIABILITY AFTER TERMINATION

1. If this policy is terminated because of:
    a. Failure to pay monthly premiums; or
    b. Termination by Subscriber Group, with our consent, without giving the required 30 days' notice;

Subscriber Group must repay us:

    a. For Benefits paid by us for claims incurred after the policy termination date; and
    b. For any administrative costs incurred in paying such Benefits.

2. We are relieved of all claims of liability for payment of Benefits incurred after the effective date of termination of this policy.
3. Benefits are limited solely to those Benefits for procedures completed or supplies provided prior to termination. We are relieved of liability for payment of Benefits for procedures completed or a supply provided after the policy has terminated. This includes, but is not limited to, Benefits, which may be paid as a global fee.

G. EMPLOYEE LEAVING THE EMPLOY OF SUBSCRIBER GROUP

Coverage for Members will continue until the end of the month for which premiums are paid, even though eligibility may terminate prior to the end of the month. Procedures completed and supplies received after the end of the month for which premiums are paid are not covered.

See Section 9 for provisions for continuation of group coverage.

SECTION EIGHT - MISCELLANEOUS PROVISIONS

A. GROUP QUALIFICATION

During the life of this Agreement, the group must maintain the minimum participation requirements specified on the Signature Sheet.

During the life of this Agreement, we must be notified if Subscriber Group enters into any additional group vision Benefits policies it is not a party to at this time.

B. SUBSCRIBER GROUP IS THE AGENT

Subscriber Group is the agent of the Employee and Dependent for all purposes under this Agreement and not our agent.

C. PARTIES DO NOT LOSE THEIR RIGHTS

The fact that either party to this Agreement ignores any violation of this Agreement will not prevent that party from insisting on strict observance of all provisions of the Agreement in the future.

D. GRIEVANCES AND APPEALS

1. **Grievance Process**. 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 the availability, or delivery, or quality of vision 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.
2. **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 Appeals and Grievance 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 Grievance within 7 calendar days and report its decision and rationale within 30 days (72 hours for Expedited Claims). 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.
3. **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) considered necessary vision care; (ii) Experimental or Investigational; (iii) an active course of treatment for purposes of continuity of care; or (iv) delivered in an appropriate health care setting and with the appropriate level of care. A Member can apply in writing for external review of an Adverse Benefit Determination by us no later than the180th day after receipt of our final written decision following our internal review through our Grievance and Appeal process. We will notify the Oregon Division of Financial Regulation of your request for an external review no later than the second business day after receipt of the request. A Member is eligible for External Review once the Member has exhausted the Internal Appeals process shown above.

Health Net will pay the cost for external review. 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 Member who applies for External Review of an Adverse Benefit Determination must provide complete and accurate information to the IRO in a timely manner. A Member may submit additional information to the IRO no later than 5 business days after the receipt of notice of the appointment of the IRO or 24 hours in the case of an expedited review. The IRO will make its review and report its decision within 30 days (72 hours for expedited reviews). **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.

4. A Subscriber Group or Member aggrieved by any action by us must first exhaust the Grievance Process as set forth above. When the Grievance Process is exhausted, an aggrieved Subscriber Group or Member may submit their 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. 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.

E. RIGHT TO EXAMINE RECORDS

We have the right to examine all pertinent medical, vision, or other records of a Member pertaining to any cases for which Benefits are claimed and discuss matters pertaining to those cases with the Member's Providers. If the Member does not consent to the release of records or discussions with Providers, we will be unable to determine the proper payment of any Benefits and will deny the claim accordingly.

Consent to the release of records and discussion with Providers is our condition of payment of any Benefits. Neither the consent to nor the actual examination of the records or discussion with Providers will constitute a guarantee of payment.

F. LEGAL ACTIONS

No legal or equitable action will be brought to recover on this Agreement until 60 days after written proof of loss has been furnished. No such action will be brought more than three years after the time written proof of loss is required to be furnished. If the time limit of the Policy is less than allowed by the

laws of the state where the Insured Person resides, the limit is extended to meet the minimum time allowed by such law.

G. LIMITATIONS ON LIABILITY

Nothing in or omitted from this Agreement will be construed as a promise by us to perform any services hereunder. In no case will we be liable for the negligence or other wrongful act or omission of any Vision Provider or other Provider or practitioner, or any institution, or their employees, or any other person. Our liability will in any event be limited to the reasonable cost of covered Vision Services and will not include any liability for pain and suffering or general damages.

H. TRANSFER BENEFITS

A Member transferring to this Agreement from another Health Net Agreement will be provided further Benefits under the prior policy only to the extent of its accrued liabilities and extensions of Benefits, if any. Otherwise, the Member will be subject to the provisions of this Agreement immediately upon transfer.

I. WORK STOPPAGE

If compensation is suspended or terminated because of a strike, lockout, or other labor dispute, this Agreement will continue for Employees and Dependents for 6 months after compensation stops. The following requirements must first be met:

1. Any premium due but unpaid on the date of compensation suspension or termination must be paid to us before the next monthly premium becomes due; and
2. Monthly premiums for Members must be paid to us in one payment, either by the Subscriber Group or by the Employees' union.

Members covered at the beginning of a compensation suspension or termination may continue to be insured while the group policy remains in effect as stated above. Coverage for Members under the policy during a compensation suspension or termination will cease when the Employee becomes a full-time employee of another employer.

This Agreement will end on the last day of the month during a compensation suspension or termination when any of the above requirements are not met.

J. ENDORSEMENTS

Any endorsement or rider changing the Benefits or provisions of this Agreement will be subject to all other terms and conditions of this Agreement which are not specifically changed by the endorsement or rider.

K. MEMBER RESPONSIBILITY

It is the responsibility of the Member to know and to understand the terms of this Agreement. We will have no liability whatsoever for a Member's misunderstanding, misinterpretation or failure to read the terms, provisions and Benefits of this Agreement.

L. REPRESENTATIONS NOT WARRANTIES

In the absence of fraud, all statements made by applicants, the Subscriber Group or a Member shall be deemed representations and not warranties and no statement made for the purpose of effective insurance shall avoid the insurance or reduce Benefits unless contained in a written instrument signed by the Subscriber Group or the Member, a copy of which has been furnished to the Member or the Member's beneficiary.

M. CLAIM FORMS

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

N. PROOFS OF LOSS

Written proof of loss must be furnished to the insurer at its office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

SECTION NINE - CONTINUATION OF GROUP COVERAGE

. FEDERAL CONTINUATION OF COVERAGE

1. **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 14 days of a Member's election to continue coverage and the applicable maximum coverage period; and (d) notifying us of any event which terminates Subscriber Group's obligation to provide the Member with COBRA continuation coverage before the end of the maximum coverage period.

c. A Member must apply for COBRA continuation coverage within 60 days of the termination date of coverage, or the date the Member receives specific notice of their 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.

B. OREGON STATE CONTINUATION OF COVERAGE

1. 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.
2. A Member who would otherwise lose coverage under this Agreement, or similar predecessor Agreement, may continue uninterrupted coverage hereunder upon payment of applicable monthly premiums if:
   a. The Member was covered under this 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.
3. 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 them when their eligibility under this Agreement ended
4. 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.

5. 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.
6. 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.
7. 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.
8. 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.
9. A Member age 55 or older who would otherwise lose coverage due to the death of a Subscriber, dissolution of a domestic partnership, divorce or legal separation from a Subscriber may continue coverage for themself and their Dependent children who would otherwise lose coverage due to the death, dissolution of a domestic partnership, divorce 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 Policy.

C. FAMILY AND MEDICAL LEAVE CONTINUATION

Coverage for Employees and Dependents will be continued during a leave of absence taken in accordance with the federal Family and Medical Leave Act. The following provisions apply:

1. The Subscriber Group and Employee must continue to pay their respective shares of all required premiums on or before the date those premiums are due. Failure to make continued premium payments when due or before the end of the grace period allowed by the Family and Medical Leave Act will result in a lapse of coverage effective as of the last day of the last period for which premiums were paid.
2. The Subscriber Group and Employee must follow all the requirements of the policy during the period of continued coverage. The Employee must notify the Subscriber Group and us of any new Dependents within the period allowed or the Dependent will be subject to the late Enrollment rules.
3. When the Employee returns to active work at the end of a family or medical leave of absence, the Employee's coverage will resume as if there was no period away from work, provided that there was no lapse in coverage. If a lapse in coverage occurred, coverage will resume from the date the Employee returns to work.
4. Coverage under this endorsement will be continued only for the length of time the Employee is away from work as provided under the Family and Medical Leave Act. If the Employee fails to return to work after a family or medical leave of absence, coverage will terminate, effective as of the last day of the last period for which the required premiums were paid. We must be reimbursed for any claims paid for services received after the coverage termination date. If coverage terminated, and the Employee later returns to work and applies for coverage, Enrollment will be in accordance with the terms and provisions of the policy at that time.
5. In the event coverage lapses during a family or medical leave of absence, the Subscriber Group will hold us harmless and will be responsible and reimburse us for the cost of any coverage provided or Benefits paid on behalf of the Employee after the coverage lapse date.

SECTION TEN – VALUE ADDED DISCOUNTS

CONTACT LENSES: Participating Providers offer preferred pricing and direct delivery on annual supplies of select brands of disposable contact lenses.

LASKIK OR PRK: You may have a discount available for these services. Please contact our Customer Contact Center for more information.

CONTINUED EYEWEAR SAVINGS. After your initial benefits have been utilized, you may be able to receive ongoing discounts on additional eyewear purchases at Participating Provider locations. Please contact our Customer Contact Center for more information.

Health Net Health Plan of Oregon, Inc.
13221 SW 68th Parkway
Suite 315
Tigard, Oregon 97223
888-802-7001
www.healthnetoregon.com

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

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

Customer Contact Center
Health Net Vision
866-392-6058

Effective 1/2025