Group Enrollment Agreement

Issued by

Health Net of Arizona, Inc.

Issuer:

Health Net of Arizona, Inc.
1230 W. Washington St #401 Tempe, Arizona 85281
Attention: SHERRIE SERVENTI

Group: PAYPAL, INC.
Group ID: AJ889A, B, C, D
Group Coverage Code: 2TPS
Group Plan Code: E87
Product: HMO

Effective Date: January 1, 2017

Term Of Agreement
The initial term of this Agreement shall be from January 1, 2017 at 12:00 a.m. local time in Tempe, Arizona and will remain in effect for a term of twelve consecutive months. Thereafter, this Agreement shall automatically renew on the Anniversary Date of the Agreement in accordance with the "Renewal of Agreement" section of the Agreement.

IN WITNESS WHEREOF, Issuer has caused this Agreement to be signed by a duly authorized officer as of the Effective Date hereof and the parties enter into this Agreement through payment of the Premiums set forth herein. Payment of Premium by the Group shall constitute acceptance of this Agreement and will cause this document to be in full force and effect.

Health Net of Arizona, Inc.
By:

Name: Paul Barnes
Title: President Health Net of Arizona, Inc.

THIS AGREEMENT IS EXECUTED IN TUCSON, ARIZONA, ON THE DATE SET FORTH ABOVE.

ADDENDUMS TO THIS AGREEMENT

The following documents are hereby incorporated by reference as if fully set forth herein.

- Underwriting Requirements
- Schedule of Benefits
- Evidence of Coverage

DEFINITIONS

Defined terms used in this Agreement are as set forth in the Evidence of Coverage.

PREMIUMS AND CHARGES

- **Premium Fees.** Group agrees to pay Issuer the Premium fees set forth below for each Member eligible and enrolled for Coverage hereunder. Premium payments are due on the last day of the month preceding the next month's benefit Coverage (the "Premium Due Date"). Premium payments must be made by check, money order or wire transfer.

MONTHLY CHARGES

Monthly Rates for AJ889A

Individual Employee:	664.51
Employee and Spouse:	1,461.88
Employee with Spouse and Child(ren):	2,126.37

Monthly Rates for AJ889B

Employee (No Spouse) and Child(ren):	1,328.98

Monthly Rates for AJ889C

Individual COBRA Subscriber:	664.51
Subscriber and Spouse:	1,461.88
Subscriber with Spouse and Child(ren):	2,126.37

Monthly Rates for AJ889D

COBRA Subscriber (No Spouse) and Child(ren):1,328.98

Groups that are exempt from the requirements of COBRA are prohibited from offering COBRA continuation Coverage.

- **Issuer's 15-Day Rule Policy.**

  Enrollment: Unless otherwise agreed to by Group and Issuer, in the event that a Member enrolls for Coverage hereunder on or before the 15th day of a month, Group agrees to remit to Issuer on or before the next Premium Due Date an additional total monthly Premium for such Member(s) for the month in which the Member enrolled. In the event a Member enrolls for Coverage hereunder after the 15th day of the month, no additional Premium payment will be due with respect to such Member(s) for the month in which the Member enrolled.

  Termination: Unless otherwise agreed to by Group and Issuer, Premium payments for terminated Members shall be calculated as follows:

  1. In the event a Member is terminated on or before the 15th day of a month, Issuer shall credit to Group the total paid monthly Premium for such Member for that month. If, however, the Group provides Coverage for such terminated Member through the last day of the month in which the qualifying event for termination occurs, then Group shall not be entitled to any Premium adjustment from Issuer.

     Dependent Reaches Limiting Age. Dependents who reach the limiting age are covered through the end of the month in which the Dependent reaches the limiting age. Therefore, Group shall not be entitled to any Premium adjustment from Issuer for the month in which a Dependent reaches the limiting age.

  2. In the event a Member's Coverage is terminated after the 15th day of a month, Group shall not be entitled to any Premium adjustment from Issuer.

- **Grace Period.** Issuer shall permit a Grace Period of 10 days following the Premium Due Date during which Premium fees may be made to Issuer without a lapse of Coverage. If Premium fees are not received by Issuer within the allowed Grace Period, Coverage for the Group may be cancelled in accordance with the termination provisions described in this Agreement.
  In the event that Group fails to pay premiums timely, Issuer may at its sole option reinstate Group with no loss in coverage upon Group's payment of all arrearages and a $100 administrative fee. Nothing herein shall be construed as any limitation or waiver of Issuer's right to terminate Group for non-payment or untimely payment of premium.

- **Non-Sufficient Funds Charge.** A fee of $25.00 may be charged to the Group for any check returned to Issuer marked "non-sufficient funds."

- **Change in Premium Fees.** The issuer reserves the right to increase the Premium fees set forth above in accordance with the "Premium Increase" subsection of the "Premiums and Charges" section of the Agreement. A 60 day written notice to the Group will be provided by Issuer, except as otherwise indicated. Payment of adjusted monthly Premium fees on or after the Effective Date shall constitute acceptance of continued Coverage at such Premium fee rate.

- **Subscriber Contributions.** Subject to approval by Issuer, Group shall contribute a portion of the Premium fee as stated in the attached Underwriting Requirements. Group is responsible for the collection of employee contributions.

- **Eligibility Information.** Group shall furnish accurate, current eligibility information to Issuer within 31 days of the date such individual(s) first becomes eligible (including Medicare eligibility related information). Issuer may rely upon the latest information received as correct without further verification. If Group submits inaccurate information to Issuer, Group is responsible for Premium fees associated with the periods of time and Coverage's extended based on the inaccurate information. Issuer will not refund any Premium to Group paid for an ineligible person if: (1) the request for such refund is made later than 30 days after the receipt of payment by Issuer for said ineligible person; OR (2) Covered Services were received by the ineligible person during such period. Issuer reserves the right to verify eligibility data maintained by Group and to review all Member records maintained by Group as they relate to establishment and maintenance of eligibility for Issuer membership, provided, however, that such right shall be limited to the extent permitted by the law and requirement for confidentiality of Employee and Member information is upheld.

- **COBRA Enrollees.** Group agrees to notify Issuer within 31 days of the date a Member elects continuation Coverage under COBRA. Groups that are exempt from the requirements of COBRA are prohibited from offering COBRA continuation Coverage.

- **Retired Employees.** Group agrees to notify Issuer within 31 days of the date an Eligible Employee elects retirement.

- **Change in Status – Notice Required.** Group agrees to notify Issuer within 31 days of any event that may affect Coverage for a Subscriber or Dependent. Such events may include, but are not limited to, changes in enrollment, disenrollment, termination of employment and other losses of Subscriber or Dependent eligibility. If the Group fails to notify Issuer of a Member's termination of employment or loss of eligibility within the required time period, then Group agrees to pay the Premium amount for such individual through the date Coverage ceases for that terminated Member.

- **Eligibility Changes Requested by Group.** All eligibility provision changes that are requested by Group to be implemented prior to the Anniversary Date of this Agreement are subject to Issuer's prior written consent, which may be withheld for any reason at the sole discretion of Issuer. The parties acknowledge that there may be a resulting concomitant increase to the Premium fees required under this Agreement if the eligibility change would increase the size of the Group's risk pool or otherwise change the nature of the risk from that which the original rates were contemplated.

- **Premium Increase**. Issuer reserves the right to increase the Premium rates described in this Agreement upon occurrence of any of the following events. Except as otherwise stated, Issuer agrees to provide a 60 day written notice of Premium adjustment to the Group.

    1. Renewal of Agreement. At least 60 days prior to the Anniversary Date, Issuer shall provide written notice to the Group of the Premium fees under which Issuer will renew the Agreement.
    2. Material Change in Group's Business. If at any time during the term of this Agreement there is a material change in the nature of the Group's business that would place the Group in a higher risk

category than that shown in the Group's original Application, or a change in the Group's industry requirement for Coverage, the Premium may be adjusted without cancellation of this Agreement.

3. Regulatory Changes. If at any time during the term of this Agreement the Issuer is required to provide Medical Services in addition to those Covered Services described in the Evidence of Coverage , resulting from a change in state, local or federal laws or regulations or if the Issuer's financial obligation or administrative burdens are increased as the result of a change in state, local or federal laws or regulations, the Premium may be adjusted without cancellation of this Agreement.
4. Failure to Meet Underwriting Requirements. If at any time during the term of the Agreement Group fails to meet any Underwriting Requirements, or contingencies defined in a notice of renewal, the Premium may be adjusted without cancellation of this Agreement. Nothing herein limits Issuer's right to terminate this Agreement pursuant to any provisions of the "Termination of Agreement" section.

- **Tax and Assessment Charges**. The Premium rate described in the Agreement includes all taxes and assessments in effect on the Effective Date or the Anniversary Date of this Agreement. In the event that additional taxes or assessments are levied upon Issuer during the term of the Agreement by any federal, state or local governmental entity with such authority, Group will reimburse Issuer for the liability imposed by the additional tax or assessment. If a tax or assessment is based on Premiums, the Premium rate for the Group will be adjusted to reflect the tax. In the event that the tax or assessment is in the form of a lump sum, Group will be responsible on a per Member basis for a pro rata share of the assessment.

  Payment of Premium following the Effective Date of any modification shall constitute Group's acceptance thereof.

RENEWAL OF AGREEMENT

This Agreement shall automatically renew on the Anniversary Date of the Agreement for successive periods of 12 consecutive months, unless terminated by either party pursuant to this Agreement. The Anniversary Date is the date that is one year from the Effective Date as set forth on page 1 of this Agreement. At least 60 days prior to the Anniversary Date, Issuer shall provide written notice to the Group of the terms and conditions under which Issuer will renew the Agreement. Such terms and conditions may include a change in Premium fees, Copayments, Coinsurance, Deductibles and type of package plan. If the Group fails to notify Issuer at least 10 days prior to the Anniversary Date of its intention to terminate the Agreement at the end of the term, Issuer shall automatically renew.

ELIGIBILITY AND ENROLLMENT

- **Eligibility**. Persons satisfying the eligibility requirements may enroll for Coverage in the Health Plan in accordance with the enrollment procedures described in the Evidence of Coverage. Group shall be responsible for determining whether an individual satisfies the eligibility requirements as described in the Evidence of Coverage or as agreed upon between Issuer and Group. Group shall be responsible for determining whether Subscriber, and Subscriber's Dependents, are eligible for Coverage hereunder, which also includes monitoring the limiting age for enrolled Dependents. Failure to determine Subscriber and Dependent eligibility pursuant to this Agreement shall constitute a breach of the Agreement.

In addition to the requirement as described in the Evidence of Coverage, Eligible Employees of the group must be full-time, non-seasonal employees working the minimum number of hours per week as specified in the Group application, unless otherwise specifically agreed to by Issuer.

- **Notification of Eligibility Information**. Group shall furnish accurate, current eligibility information to Issuer within 31 days of the date an individual becomes eligible for Coverage under the Agreement (including Medicare eligibility related information). Issuer may rely upon the latest information received as correct without further verification. Issuer reserves the right to verify eligibility data maintained by the Group and to receive all Member records maintained by the Group as they relate to establishment and maintenance of eligibility for Issuer membership, provided however, that such right shall be limited to the extent permitted by law and requirement for confidentiality of Employee and Member information is upheld.

- **Change in Status - Notice Required**. Any event that may affect Coverage for a Subscriber or Dependent must be reported to Issuer within 31 days of the event. Such events may include, but are not limited to, the following:

  1. Eligibility Changes. Changes in enrollment, disenrollment, termination of employment and other losses or changes of Subscriber or Dependent eligibility.
  2. Dependent Reaches Limiting Age. A Dependent reaches the limiting age as described in the Evidence of Coverage.
  3. Retiree Eligibility. A Subscriber retires from the Group's employment this provision.
  4. COBRA Eligibility. A Member elects continuation Coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. Group further agrees to notify Issuer when an individual no longer qualifies for continuation Coverage under COBRA, when the Member's maximum period for continuation Coverage has been exhausted, or when the Member's length of eligibility under COBRA changes.

- **Waiting Period**. Every new employee who is eligible to enroll must satisfy the probationary or waiting period established by Group prior to enrollment. A part-time employee who has been employed for as long (or longer) than the applicable probationary or waiting period, does not need to satisfy a new probationary or waiting period if the employee becomes eligible for enrollment because they have been hired as a full-time employee, as defined herein. An employee who was covered under the Health Plan who is rehired by Group within 90 days of termination of employment with Group need not satisfy a new probationary or waiting period.

- **Eligibility Changes Requested by Group**. All eligibility provision changes that are requested by the Group to be implemented prior to the Anniversary Date of the Agreement are subject to Issuer's prior written consent, which may be withheld for any reason at the sole discretion of Issuer.

- **Loss of Eligibility**

  1. Employee Eligibility. Coverage for an Employee who ceases to be eligible according to the provisions of this Agreement shall terminate for the Employee and any of his or her enrolled Dependents on midnight of the End of Month on which loss of eligibility occurs.
  2. Dependent Eligibility. Coverage for an individual Dependent, who ceases to be eligible according to the provisions of this Agreement, shall terminate for the Employee and any of his or

her enrolled Dependents on midnight of the End of Month on which loss of eligibility occurs. Dependent who reaches the limiting age as described in the Evidence of Coverage will be automatically terminated on midnight of the End of Month on which loss of eligibility occurs.

3. Relocation Outside of Service Area. Members who relocate outside of the Issuer's Service Area will be terminated on the date of relocation.

- **Open Enrollment Period**. Group agrees to offer an annual Open Enrollment Period of no less than 31 days prior to the Anniversary Date, for enrollment effective on the Anniversary Date. The Open Enrollment Period shall occur at least 31 days prior to the Anniversary Date.

TERMINATION OF AGREEMENT

- **Termination of Agreement by Issuer**. This Agreement may be terminated by Issuer upon occurrence of any of the following events. Except as otherwise stated, Issuer agrees to provide a 60 day written notice of termination to the Group and each Subscriber.

1. Non-Payment of Premium. Upon written notice, if the Group fails to pay the required Premium fees as outlined herein. The date of termination shall be the last day of the month for which full Premiums have been received and accepted by Issuer's Accounts Receivable Department. The Group shall not be permitted to unilaterally reinstate Coverage through the submission of Premium after the date on which termination under this provision occurs. A 60 day notice of termination is not required under this provision and failure by Issuer to provide such notice shall not invalidate termination of this Agreement.
2. Fraud or Intentional Misrepresentation. Upon written notice, if the Group performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of the Health Plan. The date of termination shall be the last day of the month for which Premiums have been received and accepted by Issuer's Accounts Receivable Department. A 60 day notice of termination is not required under this provision if the termination is based on fraud or intentional misrepresentation in the application or other enrollment documents and failure by Issuer to provide such notice shall not invalidate termination of this Agreement.
3. Violation of Participation or Contribution Requirements. Upon 60 days written notice, if the Group violates the participation or contribution rules set forth in the attached Underwriting Requirements. Termination shall be effective on the last day of the month in which termination occurs, or on the last day of the month for which Premiums have been received and accepted by Issuer's Accounts Receivable Department, whichever is the first to occur. The Group shall not be permitted to unilaterally reinstate Coverage by complying with the participation requirements after the notice of termination has been issued. The Group must reapply for membership if termination occurs under this provision.
4. Failure of the Group to maintain minimum participation requirements as follows: where coverage is offered on a contributory basis, health plan enrollment represents the greater of 75% of the eligible active employee population or 38 enrolled active employees; if more than one health plan is offered, Health Net's enrollment represents the greater of 38% of the eligible active employee population or 19 enrolled active employees; if coverage is offered on a non-contributory basis, health plan enrollment will be 100% of the eligible employee population.
5. Group Ceases to Qualify for Group Coverage. If the Group ceases to qualify for Group Coverage, including but not limited to the Group's failure to maintain the minimum participation requirements as defined in the attached Underwriting Requirements. Termination shall be

effective on the last day of the month in which termination occurs, or on the last day of the month for which Premiums have been received and accepted by Issuer's Accounts Receivable Department, whichever is the first to occur.

6. No Enrollees in Service Area. If the Group no longer has any enrollee who lives, works or resides in Issuer's Service Area. Termination shall be effective on the last day of the month in which termination occurs, or on the last day of the month for which Premiums have been received and accepted by Issuer's Accounts Receivable Department, whichever is the first to occur.
7. Issuer Ceases to Offer Coverage in the Group Market
   a. If Issuer ceases to offer all Coverage in the Group market, Coverage for the Group may be terminated. Issuer will notify the Group 180 days in advance of its intent to discontinue Coverage upon expiration of the Group's current Plan Year.
   b. If Issuer ceases to offer this particular Health Plan in the Group market, Coverage for the Group may be terminated. Issuer will notify the Group 90 days in advance of its intent to discontinue Coverage upon expiration of the Group's current Plan Year.
8. Automatic Termination for Failure to Pay Premium Fees. Notwithstanding the above, this Agreement will automatically terminate in the event Group fails to pay Premium fees due hereunder within 60 days of the Premium Due Date.

- **Termination of Agreement by Group**. Upon written notice to Issuer, the Group may terminate this Agreement upon occurrence of any of the following events. If termination occurs under this provision, Group agrees to provide written notice to each Subscriber enrolled under the Health Plan.

  1. Insolvency or Bankruptcy of Issuer. In the event of insolvency or bankruptcy of the Issuer.
  2. Revocation of Issuer's Certificate of Authority. In the event of revocation of Issuer's Certificate of Authority or license, as applicable.
  3. Material Breach of Agreement. Upon 60 days written notice, in the event Issuer materially breaches any of the terms and provisions of this Agreement, provided however, that Issuer has not substantially cured the breach during the 60 day notice period and except as otherwise provided herein.
  4. Upon Written Notice: This agreement may be terminated by the Group with a 30 day written notice to Issuer.

- **Termination of Coverage for Individual Members**. Coverage for individual Members may be terminated upon occurrence of the following events.

  1. Termination of Group Agreement. By Group or Issuer termination of this Agreement upon written notice to the Subscriber in accordance with the "Termination of Agreement by Issuer" and "Termination of Agreement by Group" subsections above provided herein.
  2. Failure to Pay Premium. If the required Premium for a Subscriber, and Subscriber's enrolled Dependents, is not received by Issuer in the manner, amount, and at the times specified in this Agreement, Coverage for that Subscriber will terminate. Neither the Subscriber nor the Group may be permitted to unilaterally reinstate Coverage through the submission of Premium after the date on which termination under this provision occurs. A 60 day notice of termination is not required under this provision and failure by Issuer to provide such notice shall not invalidate termination of Coverage for such Subscriber.

3. Loss of Eligibility. If a Member fails to meet the eligibility requirements set forth in the Evidence of Coverage, Coverage for that Member will terminate. A 60 day notice of termination is not required under this provision and failure by Issuer to provide such notice shall not invalidate termination of Coverage for such Member.
4. Loss of Eligibility at End of Leave of Absence. If the Group permits a leave of absence extending beyond 90 days, Coverage for that Subscriber may terminate. The date of termination will be the last day of the month in which the 90th day occurs.

- **Miscellaneous Termination Provisions.**

1. Group shall notify Issuer immediately upon occurrence of any event that gives rise to Issuer's right to terminate this Agreement or any individual Member's Coverage, including events which would result in a Member's loss of eligibility. When Group requests retroactive termination of a Member, such termination shall not be prior to any date on which any services or supplies were provided to Member under this Agreement. And in no event shall such termination occur more than 31 days retroactively from Issuer's receipt of the termination request. In such instances, the date of termination will be the first day of the calendar month following the month in which services or supplies were provided, or the first day of the calendar month following the 31st day prior to the receipt of the request for termination, whichever is later.
2. Upon Issuer's notice to terminate Group, Issuer shall immediately mail to each Subscriber a notice of termination. Upon Group's notice to terminate this Agreement, Group shall immediately provide written notice to each Subscriber of such termination. Group is responsible for notifying Members of any applicable rights Members may have under COBRA.
3. Termination of Group Coverage for a Subscriber shall automatically terminate Coverage for that Subscriber's enrolled Dependents.
4. Failure of Issuer to provide 60 days written notice to Group or individual Members shall not invalidate termination of Coverage for the following:
    a. failure to pay the required Premium payments in a timely manner.
    b. fraud or intentional misrepresentation in the application or enrollment documents.
5. Group shall be responsible for the payment of all Premium fees due through the date on which Coverage ceases. The Subscriber shall be liable for health care services rendered after the termination date.
6. Issuer acknowledges and agrees to comply with all limitations and notice requirements prescribed by law relating to termination of this Agreement or the Coverage of individual Members.

CONTINUATION OF GROUP COVERAGE UNDER COBRA

- **Applicability**. This section applies only if Group is subject to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. Issuer is only responsible to provide coverage, including any continuation or conversion coverage, to eligible beneficiaries of Group. Issuer is expressly not responsible or obligated to provide coverage to employees, or former employees (or the dependents of either), of any other entity affiliated with Group. Including any entity that owns any shares in Group, or has any other relationship, affiliation or construct with Group that could be categorized as a "controlled group" under COBRA regulations. If Group is exempt from the requirements of COBRA, Group is prohibited from offering continuation Coverage.

- **COBRA Provisions**. Generally, COBRA requires employers with 20 or more employees, as defined in applicable laws and regulations, to offer continuation Coverage to Members who lose Group Coverage due to a qualifying event. The types of qualifying events and the maximum allowable periods for continuation Coverage are described in the Evidence of Coverage. For purposes of COBRA administration, Group acknowledges and agrees:

  1. that Group shall be the designated plan administrator or fiduciary as those terms are used in the Employment Retirement Income Security Act (ERISA).
  2. that Group agrees to perform all obligations required of a plan administrator under COBRA. Such obligations include, but are not limited to, notifying eligible qualified beneficiaries in a timely manner of a Member's right to elect continuation Coverage and notifying Issuer in a timely manner of a Member's election to continue Group Coverage.
  3. that all notification and other compliance responsibilities are the sole obligation of Group, and that Issuer does not undertake to perform, or assume any responsibility for, any obligations of Group in connection with COBRA.
  4. that if Group fails to perform its responsibilities under federal law or this Agreement, Issuer is not obligated to provide continuation Coverage.
  5. that Group will notify Issuer within 31 days of the date a Member elects continuation Coverage under COBRA.
  6. that Group will notify Issuer within 31 days of a qualifying event for termination of continuation Coverage. Qualifying events for termination include the following:
     a. the Member no longer qualifies for continuation Coverage;
     b. the Member has exhausted the maximum allowable period for continuation under federal law.
  7. that Issuer will provide continuation Coverage only for the time periods mandated by federal law, subject to all other provisions of the Agreement.
  8. that Issuer's continuation of Group Coverage under COBRA is subject to payment of the Premium fees described in this Agreement.
  9. that if Group fails to notify Issuer within 60 days of the date a qualified beneficiary elects continuation Coverage, changes Coverage to Health Net as a COBRA beneficiary, or becomes eligible for a longer COBRA benefit period, Issuer is not responsible for providing continuation Coverage to the qualified beneficiary.
  10. that if Group fails to provide proper notice to a qualified beneficiary and the qualified beneficiary chooses to elect continuation Coverage after the election period has expired, Issuer is not responsible for providing continuation Coverage to that qualified beneficiary.
  11. that when a qualified beneficiary receiving continuation Coverage pursuant to COBRA has received such Coverage for the amount of time for which they are entitled under COBRA, the qualified beneficiary is no longer eligible for Coverage by Issuer and Coverage through Issuer will be terminated.

CONVERSION COVERAGE FOR INDIVIDUAL MEMBERSHIP

Issuer agrees to offer an individual conversion policy to any Member whose Group Coverage under this Agreement terminates, subject to the conditions set forth in the Evidence of Coverage. Group acknowledges that benefits provided under Issuer's conversion policy may be different than the benefits provided under this Agreement.

COVERED SERVICES AND COPAYMENTS

In consideration of Premium payments by Group, Issuer shall provide Covered Services as set forth in the Evidence of Coverage and Schedule of Benefits. Covered Services are subject to applicable Copayments, Coinsurance, Deductibles, limitations, exclusions and all other terms and conditions described in the Evidence of Coverage and Schedule of Benefits.

GENERAL PROVISIONS

- **Workers' Compensation Insurance**. Group acknowledges and agrees that the Health Plan provided by Issuer is not in lieu of and does not affect any requirements of coverage by workers' compensation insurance. However, any benefits payable are subject to all provisions of the Evidence of Coverage. Group shall obtain and provide workers' compensation insurance which covers industrial injuries to all Eligible Employees.

- **Relationship of Parties**. The relationship between Issuer, its Participating Providers, the Group and the Members is as follows:

    1. **Issuer's Relationship with Participating Providers**. The relationship between Issuer and its Participating Providers is that of an independent contractor relationship. Providers are not agents or employees of Issuer, nor is Issuer or its employees an employee or agent of any Provider. Providers maintain the Provider-patient relationship with Members and are solely responsible to Members for all of their services. In no event shall Issuer be liable for the negligence, wrongful acts or omissions of Providers.
    2. **Issuer's Relationship with Group**. Group is not the agent or representative of Issuer nor is Issuer, its agents or employees liable for any acts or omissions of Group, its agents or employees. Group is not liable for any act or omission of Issuer, its agents or employees or of any Provider, or any other person or organization with which Issuer has made or hereafter makes arrangements for the performance of services hereunder.
    3. **Issuer's Relationship with Members**. No Member is the agent or representative of Issuer and no Member is liable for any acts or omissions of Issuer, its agents or employees, or of any Provider, or any other person or organization with which Issuer has made or hereafter makes arrangements for the performance of services hereunder.

- **Notices**. Any notice required hereunder shall be deemed sufficient if mailed to Group and/or Issuer at the address set forth on page 1 of this Agreement or at such other address as the parties may designate in writing from time to time. Group agrees to cooperate with Issuer in disseminating to Subscribers any disclosure forms or other material that may be required to be disseminated to Members.

- **Identification Cards**. Issuer will issue identification cards to Subscribers for identification purposes only. Possession of an identification card in and of itself does not, however, confer any rights to Covered Services hereunder. To be entitled to Covered Services, the holder of the identification card must, in fact, be a Member on whose behalf all applicable Premiums have actually been paid. Any person receiving Covered Services who is not entitled to such services is liable for payment of billed charges to the Provider of such service, and/or for reimbursement to Issuer. In addition, the Member will be charged the entire cost of any health services received by the Member from Issuer, from the date of termination.

- **Representation of Information Provided**. A person who meets the eligibility and other requirements may enroll by completing the membership application forms provided by Issuer to the Group. Members represent that all information contained in such applications, forms or statements submitted to Issuer pursuant to enrollment hereunder or the administration hereof is true, correct and complete, and all rights to Covered Services are subject to the condition that all such information is true, correct and complete.

- **Amendment and Modification.**

  1. **Amendment by Issuer**. Issuer reserves the right to modify this Agreement by providing 30 days written notice to Group. Payment of Premium following the Effective Date of any modification shall constitute Group's acceptance thereof. Any such modification shall be final and binding on the Group and all persons covered under the terms and conditions of this Agreement.
  2. **Mutual Agreement**. Any amendments to this Agreement, other than modifications described above, shall be in writing and mutually agreed to by both Group and Issuer. Such amendments shall not be effective unless accepted by Issuer. Payment of Premium following the Effective Date of any modification shall constitute acceptance thereof by the Group. Any such amendment shall be final and binding on the Group and all persons covered under this Agreement.
  3. **Compliance with local, State or federal law**. This Agreement shall be deemed automatically modified, as necessary, to comply with any local, state or federal law currently in effect or which shall become effective following the Effective Date of this Agreement.

- **Acceptance of Agreement**. Group, on behalf of Members, accepts this Agreement by making payment to Issuer, and such acceptance renders all terms and provisions hereof binding on Group.

- **Agreement Binding on Subscribers and Family Members**. By this Agreement, Group makes Issuer Coverage available to persons who are eligible and enroll in accordance with the eligibility requirements as described in the Evidence of Coverage. However, this Agreement is subject to amendment, modification or termination by Group and Issuer, and, with respect to any Member, by mutual agreement between Issuer and any Subscriber without the consent or concurrence of his or her eligible Dependents. By electing Coverage or accepting benefits hereunder, all Members agree to all terms, conditions and provisions hereof.

- **Administration of Health Plan**. Issuer may adopt reasonable policies, procedures, rules and interpretations to promote orderly and efficient administration of this Health Plan.

- **Governing Law, Regulation and Severability.**

  1. **Governing Law**. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of Arizona.
  2. **Regulation**. Issuer is subject to regulation by the Arizona Department of Insurance. This Agreement, the Evidence of Coverage and Schedule of Benefits, and administration of the Health Plan shall be subject to regulation of the Arizona Department of Insurance.
  3. **Severability**. If any provision of this Agreement is rendered invalid or unenforceable by any local, State or federal law, rule or regulation, or declared null and void by any court of competent jurisdiction, the remainder of this Agreement shall remain in full force and effect. This

Agreement shall be deemed automatically amended to comply with any new local, State or federal law, rule or regulation that becomes effective after the Effective Date of this Agreement.

- **Limitation on Services**. If, due to circumstances not within the control of Issuer (including but not limited to a major disaster, epidemic, the complete or partial destruction of Facilities, riot, civil insurrection, disability of a significant part of Participating Provider's personnel or similar cause) the rendition of Medical and Hospital Services provided hereunder is delayed or rendered impractical, Issuer shall make a good faith effort to arrange for an alternative method of providing Coverage. In such event, Issuer and Participating Providers shall render Hospital and Medical Services provided hereunder insofar as practical, and according to their best judgment. However, Issuer and Participating Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

- **Issuer's Underwriting Requirements**. Group must continually adhere to Issuer's Underwriting Requirements, such as, but not limited to, minimum Group financial contribution requirements, minimum participation size requirements and eligibility provisions. Issuer's Underwriting Requirements are attached to this Agreement and may be changed by Issuer upon 60 days written notice prior to the renewal date. Continued payment hereunder shall constitute acceptance of the revised underwriting requirements.

- **Assignment**. Group agrees to immediately notify Issuer in the event of a sale, merger or acquisition involving Group. This Agreement is not assignable by Group without the written consent from Issuer. The Coverage and any benefits under this Agreement are not assignable by any Covered Person without the written consent of Issuer.

- **Group's Affirmative Obligation to Provide Issuer Notice of Important Events**. Group shall immediately notify Issuer as to any event which gives rise to Issuer's right to terminate this Agreement or any individual Member's Coverage, including events which would result in a Member's loss of eligibility.

- **Arizona Revised Statute § 20-2304 Notice**. Group acknowledges that Issuer is not required to pay taxes on Premiums received from small employers. A Group is a small employer if it employs at least 2 but not more than 50 Eligible Employees on a typical business day during any one Calendar Year.

- **Special Taxes and/or Assessments**. Group agrees to pay any special health care taxes or assessments imposed by a taxing authority or local, state or federal government.

ARBITRATION

Group and Issuer agree to arbitrate problems or disputes that may arise under this agreement. Prior to filing for arbitration, Group and Issuer agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement. Such negotiation shall be a condition precedent to the filing of any arbitration demand by either party, and no arbitration demand may be filed until the exhaustion of Issuer's internal appeal procedures. If the parties are unable to informally resolve the dispute within 30 days, the aggrieved party may send written notice to the other party demanding arbitration under the terms of the Agreement. Such notice shall specifically set forth the precise

nature of the dispute. Such arbitration shall be conducted under the rules of commercial arbitration as set forth by the American Arbitration Association (AAA). In no event may arbitration be initiated more than one year following the sending of written notice of the dispute. The arbitrator may construe or interpret, but shall not ignore or vary the terms of this Agreement and shall have no authority to award exemplary or punitive damages, and shall be bound by controlling laws. Any arbitration shall be conducted in Tucson, Arizona. The parties expressly agree to be bound by the decision of the arbitrator(s). The parties further agree that each party shall bear the cost of its own attorney's fees and related expenses and arbitration costs. Fees charged by the arbitrator or the AAA shall be shared equally by the parties.

ENTIRE AGREEMENT

This Agreement, including the documents referenced herein, and the application of the Group, constitute the entire Agreement between the parties (together the "Group Agreement"). This Group Agreement supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this Agreement shall be valid or binding.

CLERICAL MISTAKE

Clerical mistake, whether of the Group or the Issuer in keeping any record pertaining to the Coverage under this Agreement, will not invalidate Coverage otherwise validly in force or continue Coverage otherwise validly terminated subject to the provisions of this Agreement, regarding ineligible persons.

GENDER

The use of any gender herein shall be deemed to include the other gender and, whenever appropriate, the use of singular herein shall be deemed to include the plural (and vice versa).

INCONSISTENCY

In the event of any inconsistency between this Agreement and the Evidence of Coverage or Schedule of Benefits, the terms of this Agreement shall govern.

HEADINGS

The headings of articles and paragraphs contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

WAIVER

The failure of Issuer to enforce its rights hereunder on one or several occasions shall not operate as a waiver and shall not have the effect of amending or otherwise modifying this Agreement.

UNDERWRITING REQUIREMENTS
ATTACHMENT TO RATES

Eligible Employees include full-time non-seasonal employees working a minimum number of hours as stated on the Group Application.

- Employer group must provide workers' compensation to all eligible employees.
- No retiree coverage is available.
- The employer contribution toward Health Net's premium must be equal to or greater than fifty percent (50%) of the single premium.
- Health Net minimum standard participation assumes where coverage is offered on a contributory basis, health plan enrollment represents the greater of 66% of the eligible active employee population or 38 enrolled active employees; If more than one health plan is offered, Health Net's enrollment represents the greater of 38% of the eligible active employee population or 19 enrolled active employees; If coverage is offered on a non-contributory basis, health plan enrollment will be 100% of the eligible employee population. Failure to maintain these minimum contribution and minimum participation requirements may result in termination or non-renewal.
- Health Net must be the sole medical carrier in all areas where Health Net's plan is offered.
- An employer/employee relationship must exist. As evidence of this relationship, the employer is required to provide Worker's Compensation for all employees as required by law.
- Health Net does not cover employees who are routinely out of the country, i.e. at least 90 days per year.
- Groups with Arizona branch offices (Arizona employees/dependents of a subsidiary or branch office location of the company based outside of Arizona) will only be renewed if:
    1. they supply a Quarterly Wage and Tax Statement from Arizona;
    2. they have signature authority in Arizona;
    3. they have check authority in Arizona; and
    4. the billing must be sent to an office in Arizona.
- Rating is based on demographics, industry and anticipated cost of health care.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

Regulations under the federal Patient Protection and Affordable Care Act[1] (SBC Regulations) require that Health Net (a group health insurance issuer) and Group (a group health plan) provide a Summary of Benefits and Coverage (SBC), notice of modification of the SBC, and, upon request, a uniform glossary to Participants and Beneficiaries who are enrolled in the group health plan (Covered Persons) as well as to Participants and Beneficiaries who are eligible for but not enrolled in the group health plan (Eligible Persons). These documents must be available without charge to individuals who enroll or re-enroll in group health coverage during an open enrollment period (including former employees with COBRA continuation coverage) or other than through an open enrollment period (including individuals who are newly eligible for coverage or special enrollees[2]).

Group and Health Net, in accordance with the responsibilities assigned to each party as set forth herein below, agree to undertake their respective assignments to satisfy all timing, form and content requirements that pertain to the distribution of SBCs and the uniform glossary to Covered and Eligible Persons. Both Group and Health Net shall cooperate with each other in good faith and to the extent reasonably necessary to ensure that the parties fully comply with requirements of the SBC Regulations.

DEFINITIONS

This section defines words that will help you understand this Addendum. The terms used within this Addendum have certain meanings that are specific to this document.

- "Beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.
- "Covered Persons" means Participants and Beneficiaries who are enrolled in the group health plan.
- "Eligible Persons" means Participants and Beneficiaries who are eligible for but not enrolled in the group health plan.
- "Group" is the business organization (usually an employer or trust) to which Health Net has issued the agreement to provide the benefits to Covered Persons.
- "Participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

[1] 26 CFR §54.9815-2715; 29 CFR §2590.715-2715; and 45 CFR §147.200.

[2] Regulations regarding special enrollment are available at 45 CFR §146.117 and 26 CFR §54.9801-6, and 29 CFR §2590.701-6.

PREPARATION OF SBCS.
Health Net shall prepare and deliver to Group, a SBC for each Health Net health benefit plan which Group offers to Covered and Eligible Persons. Health Net shall use reasonable commercial efforts to provide required SBCs to Group before Group's open enrollment process. Health Net shall prepare and deliver a modified SBC to Group whenever Health Net determines that material modifications must be made to a previously delivered SBC.

DISTRIBUTION OF SBCS
Group shall provide Covered and Eligible Persons with SBCs in the exact and unmodified form (including appearance and content) in which Health Net provides the SBCs to Group pursuant to the provisions of this section and as described here below.

TIMING
Group shall provide a SBC to an Eligible or Covered Person:

- Upon application for enrollment:
  a) along with any written application materials, or if the Group does not distribute written application materials for enrollment, then no later than the first date the Eligible or Covered Person is eligible to enroll in coverage for the participant or any beneficiaries, and by the first day of coverage, if Health Net provides a modified SBC between the date an Eligible or Covered Person applied for coverage and the first day of coverage; or
  b) within ninety (90) days following enrollment, if the Eligible or Covered Person is a special enrollee.
- Upon renewal or reissuance of this Agreement:
  a) no later than the date on which application materials (including, but not limited to, open enrollment materials) are distributed, if written application (or active election) is required for renewal; or
  b) if renewal is automatic, no later than 30 days prior to the first day of the new plan or policy year. If the Agreement is not issued or renewed before this 30 day period, Group shall provide the SBC as soon as practicable but not later than 7 business days after the Agreement is issued or Health Net receives your Group's written confirmation of its intent to renew the Agreement, whichever is earlier.

  The Group is not required to provide a SBC to a Covered Person automatically upon renewal for benefit packages in which the Covered Person is not enrolled. However, if a Covered Person requests a SBC for a benefit package in which he or she is not enrolled, such SBC must be provided as soon as practicable, but in no event later than 7 business days following receipt of the request.
- At any time, upon request for a SBC or summary information about any Health Net health benefit package for which an Eligible or Covered Person is eligible. The SBC must be provided as soon as practicable, but within 7 business days following receipt of the request.

NUMBER
A single SBC may be provided to a participant and any beneficiaries at the participant's last known address, unless any beneficiary is known to reside at a different address. In that case, a separate SBC must be provided to any beneficiary at his or her last known address.

FORM AND MANNER
Group shall provide the SBC to an Eligible or Covered Person in paper form or, alternatively, electronically (such as by email or an Internet posting) if the followed conditions are met:

- SBCs reproduced and distributed in paper form must be in the uniform format provided by Health Net; they must be copied on four, double-sided pages in length and not include print smaller than 12-point font.
- SBCs displayed electronically may be on a single webpage, so the viewer can scroll through the information required to be on the SBC without having to advance through pages. However, columns or rows may not be deleted when displaying a complete SBC.
- For Covered Persons who are already covered under a benefit package provided under this Agreement, Group may provide the required SBCs electronically if the requirements of the U.S. Department of Labor's regulations at 29 CFR 2520.104b-1 are met. This regulation contains fiduciary disclosure requirements as well as an electronic distribution safe harbor.
- For Eligible Persons, Group may provide SBCs electronically if (1) the format is readily accessible (such as in an html, MS Word, or pdf format) and can be electronically retained and printed, (2) paper copies are provided free of charge upon request, and (3) if the electronic form is an Internet posting, the Group timely advises Eligible Persons in paper form (such as a postcard) or by email that the SBCs are available on the Internet, provides the Internet address, and notifies the Eligible Persons that the documents are available in paper form upon request.

Model language for an e-card or postcard in connection with a website posting of a SBC follows:

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the web at: www.**healthnet**.com. A paper copy is also available, free of charge, by calling
1-800-289-2818 (a toll-free number).

NOTICE OF MODIFICATION OF A SBC DURING THE PLAN OR POLICY YEAR

Upon receipt of timely notice from Health Net of material changes to the contents of a SBC and an updated SBC which reflects such changes, and that occurs other than in connection with a renewal or reissuance of coverage under this Agreement, Group shall provide notice of the material changes to Covered Persons no later than 60 days prior to the date on which material changes will become effective. Group shall distribute such notice to Covered and Eligible Persons in the same number, form and manner (so as to comply with the SBC Regulations) in which Group provided the original SBC which was subsequently updated.

UNIFORM GLOSSARY

The SBC informs the reader that he or she can view a Glossary of bolded terms used in the SBC at www.cciio.cms.gov or can call a Health Net 1-800 number to request a copy. Health Net shall provide a written copy of the Glossary to a Covered or Eligible Person who requests a written copy within 7 business days after Health Net receives the request.

PARTIES TO BEAR THEIR OWN COSTS

Health Net and Group shall each bear its own costs in connection with the execution of the respective party's responsibilities under this Agreement, as amended, including but not limited to the production, reproduction and distribution of SBCs and the Glossary.

ADVICE OF COUNSEL

Group and Health Net each acknowledge that they have consulted with and have had appropriate advice and legal counsel to determine their responsibilities under the SBC Regulations. Group and Health Net have executed this Agreement, as amended, knowingly and voluntarily.

DELAYED DISTRIBUTION

In the event that Health Net determines that the Group failed to distribute the SBCs to Covered Persons or Eligible Persons as required herein, Health Net will contact the Group and assure the immediate distribution of the SBCs to comply with applicable federal statutes and regulations. In such case, the Group agrees to reimburse Health Net for any costs incurred by Health Net to assure distribution of the SBCs.

WELCOME TO HEALTH NET

Thank you for selecting Health Net to provide your health care benefits. We want your experiences with Health Net to be positive. If you have any questions about the information in this packet please contact us at the numbers below.

Enclosed you will find information about your coverage including Health Net's policies to safeguard your personal information, a Schedule of Benefits and other coverage documents that describe your medical benefits. The Schedule of Benefits shows what your out-of-pocket costs and specific coverage levels are. The other coverage documents tell you how your plan works, as well as what is and is not covered under the plan.

This information will help you become familiar with the details of your coverage before you need medical care. Please take a few moments to review the enclosed information and then put this packet in a convenient place for future reference.

Please note that Health Net of Arizona does not provide coverage for out of network benefits except in emergent situations. Services that are not available through the Health Net physician and provider network must be authorized in advance to be covered. Your PCP or a participating specialist must call Health Net for prior authorization and review before you receive non-emergent services outside of Health Net of Arizona's Network. This request, submitted by your doctor, must confirm that these services are not available through the Health Net Network. Members are responsible for full payment when prior authorization has not been obtained or has been denied.

If your plan includes pharmacy benefits, you will find written information on how this benefit works in this packet and on the website at www.healthnet.com under "View Pharmacy Information."

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

Customer Contact Center: 1-800-289-2818
Hearing Impaired Assistance: TTY 1-800-977-6757
MHN (Behavioral Health Services): 1-800-977-0281

In most cases your contracted Health Net providers will take care of submitting claims. However, if you need to submit a claim, send it to:

Health Net of Arizona
P. O. Box 14225
Lexington, KY 40512-4225

Thank you for choosing Health Net.

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NOTICE OF PRIVACY PRACTICES

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

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

We are required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information, and notify you in the event of a breach of your unsecured protected health information. We must follow the terms of this Notice while it is in effect. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your protected health information we already have as well as any of your protected health information we receive in the future. We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your rights, our legal duties, or other privacy practices stated in the Notice. This will include, but may not be limited to updating the Notice on our web site. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

I. How We May Use and Disclose Your Protected Health Information: We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment:

- **Payment.** We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims, to be reimbursed by another insurer that may be responsible for payment or for premium billing.
- **Health Care Operations.** We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or customer service.
- **Treatment.** We may use and disclose your protected health information to assist your health care providers (doctors, pharmacies, hospitals, and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.
- **Plan Sponsor.** 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).
- **Person(s) Involved in Your Care or Payment for Your Care.** We may also disclose protected health information to a person, such as a family member, relative, or close personal friend, who is involved with your care or payment. We may disclose the relevant protected health information to these persons if you do not object or we can reasonably infer from the circumstances that you do not object to the disclosure; however, when you are not present or are incapacitated, we can make the disclosure if, in the exercise of professional judgment, we believe the disclosure is in your best interest.

II. Other Permitted or Required Disclosures:

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.
- **Public Health Activities.** We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury, or disability.
- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose protected health information to government agencies about abuse, neglect, or domestic violence.

- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g., California Department of Health Services) for activities authorized by law.
- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request, or other lawful process.
- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Coroners, Funeral Directors, Organ Donation.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
- **Research.** Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Special Government Functions**. We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.
- **Fundraising Activities.** We may use or disclose your protected health information for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.
- **Underwriting Purposes.** If applicable, we may use or disclosure your protected health information for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your protected health information for underwriting purposes, we are prohibited from using or disclosing your protected health information that is genetic information in the underwriting process.

III. Other Uses or Disclosures that Require Your Written Authorization: We are required to obtain your written authorization to use or disclose your protected health information, with limited exceptions, for the following reasons:

- **Marketing.** We will request your written authorization to use or disclose your protected health information 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.
- **Sale of Protected Health Information.** We will request your written authorization before we make any disclosure that is deemed a sale of your protected health information, meaning that we are receiving compensation for disclosing the protected health information in this manner.
- **Psychotherapy Notes**. We will request your written authorization to use or disclose any of you psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.
- **Other Uses or Disclosures.** All other uses or disclosures of your protected health information not described in this Notice will be made only with your written authorization, unless otherwise permitted or required by law.
- **Revocation of an Authorization.** You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

IV. Your Rights Regarding Your Protected Health Information: You have certain rights regarding protected health information that the Plan maintains about you.

- **Right to Access Your Protected Health Information.** You have the right to review or obtain copies of your protected health information contained in a designated record set, with some limited exceptions. You may request that we provide copies of this protected health information in a format other than photocopies, such as providing them to you electronically, if it is readily producible in such form and format. Usually the protected health information contained in a designated record set includes enrollment, billing, claims payment, and case or medical management records.

  Your request to review and/or obtain a copy of this protected health information must be made in writing. We may charge a fee for the costs of producing, copying, and mailing or sending electronically your requested information, but we will tell you the cost in advance. If we deny your request for access, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

- **Right to Amend Your Protected Health Information.** If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we amend, or change, the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by the Plan, as is often the case for health information in our records, or you ask to amend a record that is already accurate and complete.

  If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision, and we have the right to rebut that statement.

  Right to an Accounting of Disclosures by the Plan. You have the right to request an accounting of certain disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

  Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.

- **Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. *We may not agree to your request.* If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

- **Right to Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Notice in the Event of a Breach.** You have a right to receive a notice of a breach involving your protected health information (PHI) should one occur.

- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.

- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting our Privacy Office. See the end of this Notice for the contact information.

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

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

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

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

VIII. Contact the Plan:

If you have any questions about this Notice or you want to submit a written request to the Plan as required in any of the previous sections of this Notice, please contact:

Address:

Health Net Privacy Office:
Attention: Privacy Officer
P.O. Box 9103
Van Nuys, CA 91409

You may also contact us at:

Telephone: 1-800-522-0088
Fax: 1-818-676-8314
Email: Privacy@healthnet.com

FINANCIAL INFORMATION PRIVACY NOTICE

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

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

Information We Collect:

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

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

Disclosure of Information:

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

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

Confidentiality and Security:

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

Questions about this Notice:

If you have any questions about this notice:

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

HEALTH NET OF ARIZONA MEMBER RIGHTS & RESPONSIBILITIES

Your Rights	***Your Responsibilities***
As a Health Net member, you have the right to:	***As a Health Net member, it is your responsibility to:***
• Receive information about the organization, its services, its practitioners and providers and members' rights and responsibilities. • Be treated with respect and Recognition of your dignity and right to privacy • Participate with practitioners in making decisions about your health care. • A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage. • Voice complaints or appeals about the organization or the care it provides. • Make recommendations regarding the organization's members' rights and responsibilities policies.	• Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care. • Follow plans and instructions for care that you have agreed on with your practitioners. • Understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

HEALTH NET OF ARIZONA DERECHOS Y RESPONSABILIDADES DE LOS MIEMBROS

Sus derechos ***Como miembro de Health Net, tiene derecho a:***	***Sus responsabilidades*** ***Como miembro de Health Net, es su responsabilidad:***
• Recibir información acerca de la organización, sus prestaciones, susmédicos y proveedores, y respecto a los derechos y responsabilidades de los miembros. • Ser tratado con respeto y reconocimiento de su dignidad y derecho a la privacidad. • Participar junto a los médicos en la toma de decisiones acerca de la atención de su salud. • Un debate franco sobre las opciones de tratamiento médicamente indicadas o necesarias según su afección, independientemente del costo o de la cobertura de las prestaciones. • Presentar reclamos o apelaciones contra la organización o relacionadas con la atención que ésta provee. • Ofrecer sugerencias acerca de las políticas de la organización con respecto a los derechos y obligaciones de los miembros.	• Proporcionar la información (dentro de sus posibilidades) que necesiten la organización y sus médicos y proveedores para poder prestar sus servicios. • Cumplir con aquellos programas e instrucciones acordados con su médico en relación con su salud. • Conocer sus problemas de salud y participar, en la medida de lo posible, del desarrollo de las metas de tratamiento acordadas con su médico.

EVALUATING NEW TECHNOLOGY

Health Net of Arizona (HNAZ) utilizes the Hayes Technology Assessment Manual to evaluate new technology used in providing a covered benefit.

New technology with a Hayes policy rating of A or B will be deemed acceptable for use in providing a covered benefit. If the technology is rated D, then it is considered investigational. If the rating is C other sources are referenced including:

- At least two well-designed and well-conducted prospective, randomized, controlled trials with statistically significant results that demonstrate the safety and effectiveness of the new technology, as reported in peer-reviewed journals.
- Opinions and assessments by nationally recognized medical associations including Physician Specialty Societies, consensus panels, or other nationally recognized research or technology assessment organizations.
- Reports and publications of government agencies.
- External review organization recommendations.

If there is no Hayes rating in existence, the technology is referred to Health Net, Inc.'s (HNI) Medical Advisory Council (MAC) for evaluation of experimental/investigational status.

If the MAC determines that the technology is not experimental/investigational, then its use may be considered acceptable pending coverage limitations.

The highest priority will be given to inquiries related to open cases pending authorization, expedited appeals and requested originating from providers or members via medical directors. Response will be provided within 24 hours.

A response to inquiries from providers, vendors, manufacturers, pharmaceutical companies or other persons or groups promoting a specific service or requests for informational purposes only will be provided within 72 hours.

SCHEDULE OF BENEFITS

This Schedule has been prepared to assist you in identifying Copayments, Coinsurance, maximum benefits and other important information about your Health Plan with Health Net of Arizona, Inc. ("Health Net"). This Schedule should be used with your Evidence of Coverage for a complete description of your benefits, exclusions, limitations and plan provisions. If you need help understanding a benefit, please call Health Net's Customer Contact Center at 1-800-289-2818.

When Telemedicine coverage is available, it is subject to the same Deductible, Copayment or Coinsurance that would apply to a comparable health care service provided in person, as shown in this Schedule of Benefits.

BASIC INFORMATION

Maximum Lifetime Benefit for all Covered Services

Selected benefits under this Health Plan contain an annual or Lifetime Maximum benefit. Refer to the Evidence of Coverage and/or benefit descriptions contained within this Schedule for benefit details	Unlimited
Coinsurance	Subject to applicable coinsurance amounts, as stated herein
Deductible per Calendar Year	None
Maximum Out-of-Pocket Expense per Calendar Year	Limited to stated Coinsurance $2000 single, $4000 family per Calendar Year

Your Group Enrollment Agreement is based on a Calendar Year

This Schedule of Benefits has been prepared as a summary of the health care benefits that are currently provided under your Health Plan with Health Net. *It is a summary only*. For a complete description of the health care benefits, exclusions and limitations applicable to your Health Plan, we refer you to the Evidence of Coverage and the Group Enrollment Agreement entered into between your employer and Health Net, including any amendments thereto. In the event this Schedule of Benefits conflicts with the Group Enrollment Agreement, the Group Enrollment Agreement shall prevail.

HOSPITAL SERVICES

Inpatient ..... $250 Copayment per admission.

Outpatient (including Outpatient Surgical Facility) including surgical or ambulatory services) ..... $50 Copayment per visit

Injectable Medication purchased and billed by the Physician or Provider ..... $0 Copayment per visit

Note

Includes Physician services while hospitalized, maternity care and ambulatory surgical facility

OFFICE VISITS

Includes maternity visits◆, allergy testing/serum■ and visits for injury or illness.

Primary Care Physician visit..... $20 per visit
Specialist Physician visit ..... $35 per visit
Home visit at Physician's discretion..... $20 per visit
Injectable Medication purchased and billed by the Physician or Provider ..... $0 Copayment per visit

Note

- ◆ Copayment and/or Coinsurance applies to the initial office visit. Once diagnosis is confirmed, Outpatient pre-natal and post-partum office visit Copayments and/or Coinsurance will be waived.
- ■ Copayment waived for allergy injections received in the Physician's office and performed by non-Physician personnel.

Benefits are provided under this section regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital. Benefits may be subject to the Facility Plan Deductible and Coinsurance or Copayment in addition to the office visit Copayment.

PREVENTIVE CARE

Preventive Care..... No charge

Note

Preventive Services are those services performed for screening purposes when the member does not have active signs or symptoms of a condition and does not include diagnostic tests performed because the member has a condition or an active symptom of a condition. Whether something is preventive is determined by the diagnosis submitted by the provider.

Includes preventive health exams, immunizations, gynecological examinations, well-baby care, hearing screening◆, vision screening◆, flu shot■ and Women's Preventive Services✱ colorectal screening ○, Mammograms and preventive lab and X-ray.

- ◆ Hearing and Vision screenings by the Primary Care Physician are covered for all Members at the Office Visit *Copayment and/or Coinsurance* indicated. Referrals to Specialists for injury or illness related conditions are covered at the Office Visit *Copayment and/or Coinsurance* indicated.
- ■ Copayment waived for an annual flu shot when performed by non-Physician personnel in the Primary Care Physician's office, or when received at an affiliated flu shot clinic sponsored by the Primary Care Physician or Health Net.

❋ Women's Preventive Services include:

- 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 sterilization procedures, and contraceptive counseling for women with reproductive capacity;
- Breastfeeding support, supplies, and counseling (one breast pump and the necessary supplies to operate it (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 contacting our Customer Contact Center at 1-800-289-2818 (TTY/TDD 1-800-977-6757); and
- Interpersonal and domestic violence screening and counseling.

○ Colorectal Cancer Screening: Screening colonoscopy and sigmoidoscopy procedures (for the purposes of colorectal cancer screening) will be covered under the preventive care services. Diagnostic endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an outpatient facility require the Copayment or Coinsurance applicable for outpatient facility services.

- Preventive Lab and X-ray
- Counseling Services: counseling for alcohol misuse, smoking cessation, breastfeeding/lactation, depression/psychological, genetic, healthy diet/ nutrition, obesity in adults and children, preventative medication, sexually transmitted infections, skin cancer, behavioral and tobacco use.

Benefits are provided under this section regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital. Benefits may be subject to the Facility Plan Deductible and Coinsurance or Copayment in addition to the office visit Copayment.

Preventive Health Exams and Immunizations

The coverage described above shall be consistent with the requirements of the Patient Protection and Affordable Care Act (PPACA) of 2009. Recommended preventive care services include the following:

- United State Preventive Services Task Force (USPSTF) recommended type "A" and "B" services
- Immunizations and inoculations as recommended by the Advisory Committee on immunization Practices of the Center for Disease Control (CDC)
- Pediatric preventive care and screening, as supported by the Health Resources and Services Administration (HRSA) guidelines
- Women's health care services as supported by HRSA guidelines. Other USPSTF recommendations for breast cancer screening, mammography and prevention.

AMBULANCE

Ambulance..... $0 Copayment

Note

Emergency Services are covered without Prior Authorization. Non-Emergency Services are covered when authorized by a Plan Physician.

CHIROPRACTIC SERVICES

Chiropractic services ..... $35 Copayment per visit

Note

Services are provided through American Specialty Health Network (ASHN). For a list of participating Providers, call ASHN at 1-800-848-3555.

DENTAL SERVICES

Dental services..... Copayment and/or Coinsurance will correspond to the Facility in which services are received

(Dental services under the *medical* portion of your Health Plan are limited to accident or injury related conditions as defined in the Evidence of Coverage.)

DIABETIC SUPPLIES, EQUIPMENT AND DEVICES

Diabetic supplies, equipment and devices are covered under your Health Plan. Refer to the Evidence of Coverage for a description of Covered Services and the limitations that apply.

Note

Diabetic *medications and supplies* are subject to the Copayment and/or Coinsurances described in the Outpatient Prescription Drug Benefit.

Diabetic *equipment*, other than Blood glucose monitors, is covered under the *Durable Medical Equipment* benefit. Covered equipment is subject to applicable DME *Copayment and/or Coinsurance*.

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment..... 20% of eligible expenses

A manual adult size or pediatric size wheelchair is covered when determined to be Medically Necessary. If a Member requires an electric or specialized wheelchair, then the Member may receive reimbursement for a manual adult size or pediatric size wheelchair to use towards the cost of the electric or specialized wheelchair in accordance with Health Net's rules and regulations.

Note

Deluxe, electric, model upgrades, specialized, customized or “sport” equipment are not covered under your Health Plan.

EMERGENCY SERVICES

Emergency Services..... $100 Copayment per visit

Note

Copayment and/or Coinsurance will be waived if hospitalized; Inpatient Hospital Copayment and/or Coinsurance will then apply

FAMILY PLANNING SERVICES

Abortions which are determined Medically Necessary to save the life of the woman are covered; applicable *Copayment and/or Coinsurance* will correspond to the Facility in which Covered Services are received.

Elective abortions are covered; applicable *Copayment and/or Coinsurance* will correspond to the Facility in which Covered Services are received. Lifetime Maximum benefit for elective abortions performed during the first trimester is limited to 2 per Member.

Women's contraception methods and contraceptive counseling, as supported by the Health Resources and Services Administration (HRSA) guidelines, are covered under the Preventive Care benefit. Refer to the Preventive Care section for the applicable *Copayment and/or Coinsurance*.

HEALTH EDUCATION/DISEASE MANAGEMENT SERVICES

Selected Health Education and Disease Management ..... $0 Copayment
Services may require a materials fee.

- Including Diabetic Education

HEARING SERVICES

Primary Care Physician visit..... $20 Copayment per visit
Specialist Physician visit ..... $35 Copayment per visit
Benefit for hearing aid(s) is 1 hearing per ear ..... $0 Copayment, every 24 months

Note

Hearing screenings by the Primary Care Physician are covered.

Referrals to Specialist for Members over the age of 18 years, are limited to injury or illness related conditions.

Members age 18 or younger may be referred to a Specialist when determined to be Medically Necessary by the Primary Care Physician.

HOME HEALTH SERVICES

Home Health Services. ..... $0 Copayment per visit

Limited to part-time and intermittent care. This may include 8 hours of reasonable and necessary care per day for up to 21 consecutive days or longer when preauthorized.

HOSPICE CARE

Inpatient Facility for life expectancy of 6 months or less. ..... $250 Copayment per admission

Home Hospice for life expectancy of 6 months or less. ..... $0 Copayment per admission

MAMMOGRAMS

Performed at a Physician's office ..... $0 Copayment per visit

Performed at an independent, freestanding Facility..... $0 Copayment per visit

Performed at a Hospital ..... $0 Copayment per visit

Note

Routine and diagnostic mammograms to reduce the risk or determine the presence of breast cancer are a combined benefit. Refer to the *Mammograms benefit* in the Evidence of Coverage for a description of Covered Services.

MATERNITY SERVICES

Coverage includes Medically Necessary services relating to prenatal, delivery and post-partum care.

Office Visit Copayment and/or Coinsurance applies to the initial outpatient office visit only. Once diagnosis is confirmed, obstetrical pre-natal and post-partum office visit Copayments and or Coinsurance will be waived.

Prenatal screenings as outlined in the USPSTF recommendations A&B are covered under the Preventive Care benefit shown in this Schedule of Benefits.

Note

Copayment and/or Coinsurance will correspond to the charge associated with the facility in which the services are received.

MEDICAL SUPPLIES

Medical Supplies are issued when Medically Necessary, as determined by Us ..... $0 Copayment

Covered Services include:

- casting materials.
- surgical dressings only when provided under the supervision of a Home Health Agency and prescribed by the Primary Care Physician.
- ostomy supplies and urinary catheters (are limited as defined by Medicare guidelines).
- medical supplies that are necessary to operate and/or maintain a covered prosthesis or item of Durable Medical Equipment, subject to the limitations stated herein.
- most medical supplies are issued for a 31 day supply as defined by Medicare guidelines.

MEDICAL FOOD

For Members with an Inherited Metabolic Disorder ..... 50% Coinsurance

Members with an Eosinophilic Gastrointestinal Disorder ..... 25% Coinsurance

MENTAL HEALTH SERVICES

Mental Health Services are managed by MHN. Selected services and treatments that are covered under the Mental Health Service Benefit require Prior Authorization by MHN, the designated behavioral health representative for this Health Plan. Outpatient office and home visits do not require prior authorization.

Inpatient Services..... $250 Copayment per admission

Outpatient Consultant/Office Visit ..... $20 Copayment per visit

Individual Therapy..... $20 Copayment per visit

Group Therapy..... $20 Copayment per visit

Outpatient Services other than Consultant/Office visits (including medically Necessary Behavioral Therapy in relation to Autism Spectrum Disorder)..... $0 Copayment per visit

Note

Call MHN at 1-800-977-0281 to access these services. Refer to the *Mental Health Services Benefit* following this Schedule for a description of Covered Services.

Psychiatric medication follow-ups (med-checks) are subject to the mental health outpatient *Copayment and/or Coinsurance* for individual therapy. Med checks do not count towards the maximum visit limitations.

Covered Services include marriage counseling, subject to all other provisions of the *Mental Health Services Benefit.*

OUTPATIENT LABORATORY SERVICES

Performed at a Physician's office ..... $0 Copayment per visit
Performed at an independent, freestanding facility..... $0 Copayment per visit
Performed at a hospital, outpatient surgery or ambulatory surgical facility ..... $0 Copayment per visit

Note

Copayment and/or Coinsurance may vary depending on where services are rendered

You may be charged a *Copayment and/or Coinsurance* for services performed at your Physician's office and sent to another facility for processing. In such cases, the corresponding *Copayment and/or Coinsurance* would apply.

OUTPATIENT X-RAY SERVICES

Performed at a Physician's office ..... $0 Copayment per visit
Performed at a hospital, outpatient surgery or ambulatory surgical facility ..... $0 Copayment per visit

Note

Copayment and/or Coinsurance may vary depending on where services are rendered

You may be charged a *Copayment and/or Coinsurance* for services performed at your Physician's office and sent to another facility for processing. In such cases, the corresponding *Copayment and/or Coinsurance* would apply.

OUTPATIENT IMAGING AND TESTING SERVICES

Performed at a physician's office ..... $25 Copayment per visit

Note

You may be charged a *Copayment and/or Coinsurance* for services performed at your Physician's office and sent to another facility for processing. In such cases, the corresponding *Copayment and/or Coinsurance* would apply.

Performed at a hospital, outpatient surgery or ambulatory surgical facility ..... $200 Copayment per visit
(Including but not limited to CT scans, MRIs, MRAs, and PET/SPECT scans)

OUTPATIENT DIALYSIS CHEMOTHERAPY AND RADIATION THERAPY SERVICES

Outpatient Dialysis. ..... $35 Copayment per visit

(Out-of-area dialysis is limited to 6 treatments per Calendar year with preauthorization)

Outpatient Chemotherapy and Radiation Therapy..... $35 Copayment per visit

Note

You may also be responsible for the *Copayment and/or Coinsurance* corresponding to the facility where services are rendered.

PROSTHETICS AND SUPPORT DEVICES

Prosthetics and support devices. ..... 20% of eligible expenses

(Mastectomy bras are limited to 1 per calendar year)

RECONSTRUCTIVE SURGICAL SERVICES

Reconstructive surgical services. ..... Copayment and/or Coinsurance will correspond to the charge associated with the Facility in which services are received

(Limited to illness or injury related conditions as defined in the Evidence of Coverage)

REHABILITATION SERVICES

Includes Speech and Language Services

Copayment and/or coinsurance will correspond to the charge associated with the Facility in which Services are received.

Inpatient..... $250 Copayment per admission. Limited to 60 days per member per Calendar year.

Outpatient. ..... $35 Copayment per visit. Limited to 60 visits per member per Calendar year.

Note

Rehabilitation Services and Speech and Language Services are a combined benefit per Calendar Year, all therapies combined (physical, occupational, speech and language, etc.).

SKILLED NURSING SERVICES

Inpatient services ..... $250 Copayment per admission

Note

Inpatient services are limited to 100 days per Calendar Year.

SUBSTANCE ABUSE SERVICES

Substance Abuse Services are managed by MHN. Selected services and treatments that are covered under the Substance Abuse Service Benefit require Prior Authorization by MHN, the designated behavioral health representative for this Health Plan. Outpatient office and home visits do not require prior authorization.

Call MHN at 1-800-977-0281 to access these services. Refer to the *Substance Abuse Services Benefit* following this Schedule for a description of Covered Services.

Inpatient Services..... $250 Copayment per admission

Outpatient Consultant/Office Visit ..... $20 Copayment per visit

Individual Therapy..... $20 Copayment per visit

Group Therapy..... $20 Copayment per visit

Outpatient Services other than Consultant/Office Visits ..... $0 Copayment per visit

TELEMEDICINE SERVICES

Telemedicine healthcare services are provided for, but not limited to, the following conditions:

Copayment and/or Coinsurance will correspond to the Facility in which services are received.

- Trauma
- Burn
- Cardiology
- Infectious Diseases
- Mental Health Disorders
- Neurologic Diseases including Strokes
- Dermatology

TRANSPLANT SERVICES – ORGAN AND TISSUE

Copayment and/or Coinsurance will correspond to the Facility in which services are received.

URGENT CARE SERVICES

Urgent care services..... $50 Copayment per visit

VISION SERVICES

Services are provided through EyeMed. For a list of participating EyeMed providers, call EyeMed at 1-866-392-6058.

Eye Exam every 24 months ..... $0 Copayment per visit

Enhanced Vision Services
Refer to the Vision Services Benefit following this Schedule for a description of Covered Services.

Questions about this Schedule can be directed to Health Net's Customer Contact Center at 1-800-289-2818.

OUTPATIENT PRESCRIPTION DRUG BENEFIT

THIS RIDER is made part of the Health Net of Arizona, Inc. ("Health Net") Evidence of Coverage ("EOC"). Unless otherwise indicated herein, all terms initially capitalized herein shall have the same meaning attributed to such terms in the EOC and references to applicable sections are to sections of the EOC. This Rider combined with your EOC and Schedule of Benefits explain the details of your health care coverage. **This benefit applies only to Prescription Drugs that are prescribed on an Outpatient basis.**

Preventive Pharmacy medications require a prescription and 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: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.

DEFINITIONS

The following terms are used in this Outpatient Prescription Drug Benefit:

- **Brand Name Drug** means a prescription drug that has been given a brand name or trade name by its manufacturer and is advertised and sold under that name or is classified as such by a nationally recognized drug database company.
- **Eosinophilic Gastrointestinal Disorder** means a disorder that selectively affects the gastrointestinal tract with eosinophil-rich inflammation in the absence of known causes for eosinophilia (e.g., drug reactions, parasitic infections, and malignancy). These disorders include, but are not limited to, eosinophilic esophagitis, eosinophilic gastritis, eosinophilic gastroenteritis, eosinophilic enteritis, and eosinophilic colitis.
- **Enteral Nutrition** means formulas consisting of semi-synthetic intact proteins or protein isolates that can be used for enteral feeding in the majority of patients who meet criteria for enteral feeding.
- **Generic Drug** means a prescription that:
  1. is available from multiple manufacturers;
  2. complies with the Food and Drug Administration's (FDA) standards;
  3. has never been under patent protection; and
  4. is classified as such by a nationally recognized drug database management company.
- **Inherited Metabolic Disorder** means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program (heel prick).
- **Medical Food** means modified low protein foods and metabolic formulas which are not Over-the-Counter and are FDA approved. Low protein foods and metabolic formulas must be: formulated to be consumed or administered enterally under the supervision of a Physician or registered nurse practitioner; administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; essential to a member's optimal growth, health and metabolic homeostasis. Metabolic formulas must also be processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs. Low protein food must also be processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein.
- **National Pharmacy Network** means a national network of pharmacies that have contracted with Health Net Pharmaceutical Services or our pharmacy claims processor. These pharmacies will honor your Health Net identification card and dispense prescription medications in accordance with your benefit.
- **Non-Formulary (NF) Drug** means a prescription drug, with a generic, therapeutic, OTC, or other equivalent formulary alternative, which requires prior authorization for coverage.
- **Participating Pharmacy** means a retail pharmacy, a mail order pharmacy, or a specialty pharmacy, that has contracted with Health Net Pharmaceutical Services or our pharmacy claims processor to dispense covered Prescription Drugs or supplies to Members of this Health Plan. Health Net contracts with many pharmacies, including some specific pharmacies within chains. That does not mean that all pharmacies within that chain are Participating Pharmacies. Refer to Health Net's listing of Participating Pharmacies to determine which pharmacies are contracted with Health Net.
- **Preferred Drug List** means a listing of drugs eligible for certain levels of coverage under this benefit. A team of doctors and pharmacists developed and reviews this list of drugs for effectiveness, safety and value. The list is periodically updated and is available to Participating Providers (Pharmacies and Physicians). Depending on your plan, drug coverage may be limited to those drugs on the Preferred Drug List and can change at any time without notice. Your doctor must request a patient specific authorization for select drugs on the Preferred Drug List. Requests for these drugs are evaluated

by Health Net to determine if the established approval criteria are met. If approved, you will be responsible for your Copayments, Deductibles, Coinsurance amounts, any non-Covered or Excluded Charges, and amounts over specifically limited benefits. If the drug is not approved you will be responsible for the entire cost of the drug. The Health Net P&T committee, comprised of actively practicing physicians and pharmacists, reviews medications based on clinical efficacy, safety, side effects, quality outcomes, and comparisons to existing products, and develops protocols for medications requiring prior authorization through consideration of benefit plans, step-care protocols, quantity or duration limits, benefit exclusions, potential for misuse, potential usage indications that do not meet Food and Drug Administration (FDA) criteria, experimental or off-label use, and required level of laboratory or safety monitoring. The HNPS Strategic Development Committee may recommend cost-based tier placement in the Preferred Drug List PDL for medications determined to be clinically equivalent by the P&T committees. The Preferred Drug List is reviewed in its entirety no less than annually and updated quarterly by our P&T Committees. The HNAZ Pharmacy Department makes monthly non-clinical updates to the Preferred Drug List as new drugs become available. The Preferred Drug List is available on the Health Net website at www.healthnet.com.

- **Prescription Drug** means any of the following:
  1. A Federal Legend Drug (a medication that is required by the U.S. Food, Drug and Cosmetic Act to include a label that reads: "Caution: Federal law prohibits dispensing without a prescription").
  2. A Drug that requires a prescription under State law but not under Federal law.
  3. A compound Drug that has more than one ingredient, one of which must be a Federal Legend Drug or a Drug that requires a prescription under State law.
- **Stay Healthy Drug** means certain generic and brand name medications used for specifically identified medical conditions, as determined by Health Net, which contribute to the long term health and wellness of a member.

SPECIFIC REQUIREMENTS FOR COVERAGE

The following provisions apply to this Prescription Drug Benefit:

- Prescriptions must be included on Health Net's Preferred Drug List. For select Drugs, your doctor must request authorization. Requests for these Drugs are evaluated to determine if the established approval criteria are met.
- All Prescription Drugs must be written by a Participating Physician
- All Prescription Drugs must be obtained from a Participating Pharmacy
- Participating retail and specialty pharmacies will dispense prescriptions for up to a 30 day supply.
- Mail Order prescriptions will be dispensed for up to a 90 day supply.
- Some medications may be dispensed in quantities less than those stated above due to prepackaging by the pharmaceutical manufacturer
- Insulin, diabetic supplies and inhalers have quantity per Copayment limitations other than 30 days.
- Refills are covered only when authorized by a Participating Physician
- You will be financially liable for the cost of medications obtained after you are no longer eligible for Coverage under this Health Plan.
- Medications for weight loss may be covered with Prior Authorization
- Medications for sexual dysfunction may have quantity per Copayment limitations prescribed in the Essential Rx Drug List

SPECIALTY PHARMACIES

As part of our Specialty Pharmacy program, certain Specialty Drugs are only available through a specialty pharmacy designated by Health Net. You and your Physician will be contacted if a specialty pharmacy will now be dispensing a particular Drug for You. Health Net will work with You, your Physician and the specialty pharmacy to coordinate services such as ordering, delivery and *Copayment and/or Coinsurance* collection. If Your Specialty Drug is available at a contracted retail Pharmacy, and You do not want to use Our Specialty Pharmacy program, You may obtain the Specialty Drug at a contracted retail Pharmacy. You, Your Physician, or the contracted retail Pharmacy will need to contact Health Net to coordinate this.

MAIL ORDER FOR MAINTENANCE PRESCRIPTIONS

Mail order prescriptions are limited to Health Net's mail service Provider. Prescriptions, either initial or refills, will be allowed for up to a 90 day supply. Supply restrictions may be applied to Members whose coverage is scheduled to terminate

in less than 90 days from the date of receipt of the order by the mail service Provider. Contact Health Net's Customer Contact Center at 1-800-289-2818 for mail order forms.

INFORMED CHOICE - STAY HEALTHY PROGRAM

As part of our pharmacy wellness program, certain Drugs are eligible for a reduced copayment and/or coinsurance reductions if all provisions of the Informed Choice – Stay Healthy Program (hereinafter called the program) are met. Positive compliance leads to better outcomes and a healthier life and a reduced copayment or coinsurance. The following provisions apply to this program:

1. The program only applies to select generic and brand name medications taken for medical conditions, including, but not limited to, High Cholesterol, Diabetes, and High Blood Pressure, specifically identified by Health Net.
2. Maintaining a healthy lifestyle and taking medication correctly, as prescribed, is the member's responsibility (choice).

HOW THE THREE-TIER PHARMACY BENEFIT WORKS

Preferred Generic Drugs are available at the lowest Copayment and/or Coinsurance level. Preferred Brand Name Drugs are available for a slightly higher Copayment and/or Coinsurance. Unless otherwise excluded, Non-Preferred Drugs are available at the highest Copayment and/or Coinsurance level and Specialty Drugs are available at the highest Copayment and/or Coinsurance levels. Prior Authorization may be required for select Drugs. Your prescription will be filled with a generic medication when available. If you or your Physician requests a Brand Name Drug when the generic is available, it will be available at the highest Copayment and/or Coinsurance level. Prior Authorization may be required for select Drugs. Determination as to whether a Drug is classified as a Generic or Brand Name Drug is made by a nationally recognized Drug database management company.

COPAYMENT, COINSURANCE, AND QUANTITY LIMITATIONS

Copayment and/or Coinsurance. The Member is required to pay a predetermined Copayment and/or Coinsurance for each prescription dispensed.

Medication Synchronization. In accordance with state regulations, upon request, a Member taking two or more chronic prescription Drugs may ask a Participating Provider pharmacy to synchronize refill dates so that Drugs refilled at the same frequency may be refilled concurrently. This will allow the copayment(s) to be prorated based on the synchronized days supply. For questions about this process, please call the Customer Contact Center at the number listed at the back of Your ID Card.

OUTPATIENT PRESCRIPTION DRUG SCHEDULE

Out-of-Pocket Outpatient Prescription Drug Maximum	$1000 per Member per Calendar Year, not to exceed $2000 for all Members in a family

Retail Pharmacy ❶❷❸

Copayment and/or Coinsurance required per prescription or refill up to a 30 day supply

Tier 1	$10 Copayment per prescription
Tier 2	$25 Copayment per prescription
Tier 3	$40 Copayment per prescription
Informed Choice – Stay Healthy Program	$0 Copayment per prescription

Specialty Drugs ❶❷❸

Copayment and/or Coinsurance required per prescription or refill up to a 30 day supply

TierS-1	$75 Copayment per prescription
TierS-2	$100 Copayment per prescription
TierS-3	$150 Copayment per prescription
TierS-4	$300 Copayment per prescription
Self-injectable drugs	Tier 2 Copayment and/or Coinsurance will apply to Preferred insulin

Oral or patient administered cancer treatment medications ..... $0 Copayment, subject to deductible per member per prescription or refill, up to 30 day supply. Prior Authorization and Quantity limitations may apply to specific drugs.

Health Net Mail Order Pharmacy Program ❶❷❸

Copayment and/or Coinsurance required per mail order prescription or refill up to a 90 day supply.

Tier 1..... $20 Copayment per prescription
Tier 2..... $50 Copayment per prescription
Tier 3..... $80 Copayment per prescription

❶ *The following applies to 3-Tier benefits: Preferred generic drugs are available at the lowest Copayment and/or Coinsurance level. Preferred brand name drugs are available for a slightly higher Copayment and/or Coinsurance. Unless otherwise excluded, Non-Preferred drugs are available at the highest Copayment and/or Coinsurance level. Prior Authorization may be required for select drugs. Your prescription will be filled with a generic medication when available. If you or your physician requests a brand name drug when the generic is available, it will be available at the highest Copayment and/or Coinsurance level. Prior Authorization may be required for select drugs and Specialty Drugs.*

❷ Insulin, diabetic supplies and inhalers have quantity per Copayment and/or Coinsurance limitations. These limitations apply to both retail pharmacies and Health Net's Mail Order Program.

❸ Although most prescriptions are provided up to a 30 day supply, some medications may be dispensed in quantities less than 30 days due to prepackaging by the pharmaceutical manufacturer.

Quantity Limitations

The following quantity limitations apply to both retail pharmacy and mail order prescriptions. It should be noted that insulin, diabetic supplies and inhalers have quantity per Copayment and/or Coinsurance limitations in addition to the 30 day supply limitation.

Diabetic Supplies and Medications	***Quantity Limitations***
Preferred Insulin vials/pens	Up to 2 vials/packages per Copayment and/or Coinsurance
Drawing up devices (syringes)	Up to 100 per Copayment and/or Coinsurance
Insulin cartridges for the legally blind (requires Prior Authorization)	One commercial package per Copayment and/or Coinsurance
Glucose test strips	Up to 100 per Copayment and/or Coinsurance
Visual reading testing strips	Up to 100 per Copayment and/or Coinsurance
Urine testing strips	Up to 100 per Copayment and/or Coinsurance
Lancets	Up to 100 per Copayment and/or Coinsurance
Automatic lancing devices	1 every 6 months per Copayment and/or Coinsurance
Insulin aids (when medically necessary)	1 every 6 months per Copayment and/or Coinsurance
Glucagon (requires Prior Authorization)	1 per Copayment and/or Coinsurance
Plan approved standard blood glucose monitors are covered for both insulin-dependent and non-insulin-dependent Members when necessary for medical management as determined by Health Net in consultation with your Physician. Blood glucose monitors require a written prescription from a Physician and must be obtained at a Participating Pharmacy	Up to one per Year
Plan approved blood glucose monitors for the legally blind are covered when medically necessary and the Member has been diagnosed with diabetes. Blood glucose monitors require a written prescription from a Physician and must be obtained at a Participating Pharmacy	Up to one per Year
Other devices, medication, equipment or supplies that Medicare adds to its list of covered diabetic supplies will become eligible for coverage under this Health Plan within 6 months following Medicare's inclusion of such item for coverage.	

❶ Covered Diabetic medications and supplies, including oral agents are subject to Health Net's Preferred Drug List and are available to all Health Net Members covered under this Health Plan. To access benefits, simply present your member identification card to a Participating Pharmacy and pay the required Copayment and/or Coinsurance at the time the prescription is filled. Health Net's Provider Directory includes a list of contracted pharmacies. Refer to the Schedule of Benefits to determine your required Copayment and/or Coinsurance.

If determined to be Medically Necessary, quantity limitations are two commercial packages of vials, pens, syringes or one commercial package of cartridges per Copayment and/or Coinsurance payment.

For member submitted claims; Covered Charges for prescription medications will be reimbursed at a rate that is equivalent to 95% of the Average Wholesale Price of the medication as determined by Us or the submitted amount, whichever is less, subject to the Member's applicable Copayment, Coinsurance and Deductible.

MISCELLANEOUS SUPPLIES AND MEDICATIONS

- Spacers and holding chambers for inhaled medications are limited to 1 per 6 months per Copayment and/or Coinsurance.
- Up to 2 inhalers (nasal or oral), or up to a 30 day supply, whichever is less, per Copayment and/or Coinsurance.

CONTRACEPTIVES AND PREVENTIVE PHARMACY

Contraceptive drugs and devices are covered and require a prescription from your Physician.

Preferred oral contraceptives and diaphragms included on Health Net's Preferred Drug List are covered.

Generic class Food and Drug Administration approved contraceptive methods for all women with reproductive capacity are covered. FDA approved over-the-counter contraceptive methods for women are covered when prescribed by a Participating Physician. No deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a generic class drug when dispensed by a Participating Pharmacy, unless the Provider indicates the brand name drug is Medically Necessary. 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.

No deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a generic class drug when dispensed by a Participating Pharmacy, unless the Provider indicates the brand name drug is Medically Necessary. 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.

SMOKING CESSATION MEDICATIONS

Smoking cessation medications including Over the Counter medications that have been approved by Health Net's Pharmacy and Therapeutic Committee are a covered benefit

- Smoking cessation medications that have been approved by Health Net's Pharmacy and Therapeutic Committee are eligible for coverage. Medications eligible for coverage may be subject to applicable prescription Copayment and/or Coinsurance. One Copayment and/or Coinsurance payment will apply for each monthly supply of approved medication, or partial monthly supply.

For more information regarding the smoking cessation program available through Health Net, contact Health Net's Customer Contact Center at 1-800-289-2818 or 1-888-926-1692.

RESIDENTIAL ENTERAL TUBE FEEDING

Medically Necessary Enteral Nutrition is a Covered Expense when all of the following apply:

- ***Prescribed by a Participating Physician;***
- ***for use in the home through enteral feeding tubes;***
- ***feedings exceed 750 kilocalories a day in order to maintain weight and strength commensurate with the Member's overall health status.***

If the requirements above for Enteral Nutrition are met, supplies, including but not limited to bags, tubing, syringes, irrigation solution, dressings, and tape are also a Covered Expense.

Please note Residential Enteral Tube Feeding is covered under the Medical Supplies benefit for Groups with a Health Net supplemental Outpatient Prescription Drug Benefit. Refer to the Medical Supplies benefit in the Evidence of Coverage and Schedule of Benefits for a description of Covered Services and limitations that apply.

EXCLUSIONS AND LIMITATIONS

Prescription Medications

Outpatient prescription medications except as specifically described in the benefit description titled *Diabetic Supplies, Equipment and Devices*, or as otherwise listed as a Covered Service herein or in the *Schedule of Benefits*. Non-Covered Services include:

- Drugs obtained out of the Service Area
- Take home prescription drugs and medications from a Hospital or other Inpatient or Outpatient Facility;
- Supplies, medications and equipment dispensed by Non-Participating Providers; unless Preauthorized by Us;
- Supplies, medications and equipment labeled "Caution - Limited by Federal Law to Investigational Use";

- Drugs or dosage amounts determined by Health Net to be ineffective, unproven or unsafe for the indication for which they have been prescribed, regardless of whether the drugs or dosage amounts have been approved by any governmental regulatory body for that use.
- Supplies, medications and equipment deemed Experimental, Unproved or Investigational by Us, except for covered Preventive Medications (as determined to be preventive as recommended by the United States Preventive Services Task Force (USPSTF) A and B recommendations (medications listed at www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm) any non-prescription or over-the-counter drugs, devices and supplies that can be purchased without a prescription or physician order is not covered, even if the physician writes a prescription or order for such drug. Additionally, any prescription drug for which there is a therapeutic interchangeable non-prescription or over-the-counter drug or combination of non-prescription or over-the-counter drugs is not covered, except as prescribed for treatment of diabetes and for smoking cessation. supplies, medications and equipment for other than FDA approved indications("off labels");
- Except for certain FDA approved drugs used:
  1. for the treatment of cancer in accordance with state law provided that the drug is not contraindicated by the FDA for the off-label use prescribed; or
  2. for the treatment of other specific medical conditions provided the drug is not contraindicated by the FDA for the off-label use prescribed and such use has been proven safe, effective and accepted for the treatment of the condition as evidenced by supporting documentation in any one of the following: (a) the American Hospital Formulary Service Drug Information or the United States Pharmacopeia Drug Information; or (b) results of controlled clinical studies published in at least two peer-reviewed national professional medical journals;
- Any Drug consumed at the place where it is dispensed or that is dispensed or administered by the Physician;
- Supplies, medications and equipment that are not Medically Necessary; as determined by Us;
- Replacement prescriptions for any reason;
- Mail order Drugs
- Medications for sexual dysfunction;
- Medications for infertility, unless otherwise specifically stated as covered in the Schedule of Benefits;
- Medications purchased before a Member's Effective Date of Coverage or after the Member's termination date of Coverage;
- Medications used for cosmetic purposes as determined by Us;
- Vitamins, except those included on Health Net's Preferred Drug List;
- Drugs, weight reduction programs and related supplies to treat obesity, except as covered under Preventive Care;
- Human Growth Hormone except for children or adolescents who have one of the following conditions:
- Documented growth hormone deficiency causing slow growth
- Documented growth hormone deficiency causing infantile hypoglycemia
- Short stature and slow growth due to:
  1. Turner syndrome
  2. Prader-Willi syndrome
  3. Chronic renal insufficiency prior to transplantation
  4. Central nervous system tumor treated with radiation
- Documented growth hormone deficiency due to a hypothalamic or pituitary condition
- Enteral Nutrition in situations involving temporary impairments;
- Enteral Nutrition for Members with a functioning gastrointestinal tract whose need for Enteral Nutrition is due to anorexia, nausea associated with mood disorder, end-stage renal disease, or other impairments unrelated to the gastrointestinal tract;
- Enteral Nutrition when adequate nutrition is possible by dietary adjustment, counseling and/or oral supplements;
- Drugs that require a prescription by their manufacturer, but are otherwise regulated by the FDA as a medical food product and not listed for a covered indication listed in this document.

IDENTIFICATION CARD

Members must use identification cards when filling prescription medications. This card must be presented to the pharmacist when prescriptions are filled or refilled. If this identification card is used after Coverage under this Health Plan terminates, the Subscriber and/or his/her Employer may be held responsible for all Drug Claims made after the date of termination, including Drug Claims paid on behalf of a Subscriber's covered Dependents.

GENERAL PROVISIONS

Health Net reserves the right to waive any of the program limitations or provisions, if in the opinion of the Provider, it is necessary for the Member's welfare. All other provisions of the Group Enrollment Agreement and Evidence of Coverage, including any amendments thereto, shall apply to this Outpatient Prescription Drug Benefit. This Outpatient Prescription Drug Benefit will terminate upon termination of the Group Enrollment Agreement. Nothing in this Outpatient Prescription Drug Benefit shall vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, exclusions or limitations of the Group Enrollment Agreement or Evidence of Coverage.

DOMESTIC PARTNERSHIP ADDENDUM

Your Group Enrollment Agreement includes the following Dependent eligibility criteria for domestic partners and children of domestic partners as part of section II of the Group Enrollment Agreement.

Domestic partners: Subscriber's domestic partner, who lives or resides in the Service Area, for whom all of the following apply:

1. The Subscriber and domestic partner are each other's sole domestic partner and intend to remain so indefinitely.
2. The Subscriber and domestic partner reside together and intend to reside together indefinitely.
3. The Subscriber and domestic partner are jointly responsible for each other's common welfare and are financially interdependent.
4. The Subscriber and domestic partner are both at least 18 years of age, are competent to enter into a binding contract, and are not related to each other by blood so as to bar marriage under Arizona law.
5. Neither the Subscriber nor domestic partner is legally married to anyone else.
6. The Subscriber has not enrolled a different domestic partner in the previous 6 months.

Children of Domestic partners: Subscriber's domestic partner's unmarried child, including any stepchild, legally adopted child, child who has been placed for adoption with Subscriber's domestic partner or a child for whom Subscriber's domestic partner is obligated to provide Coverage pursuant to a qualified medical child support order, under the limiting age of 26 years of age.

GENERAL

All provisions of the Group Enrollment Agreement apply to this Employee Eligibility Criteria for domestic partners and children of domestic partners. Eligibility for domestic partners and children of domestic partners will terminate upon termination of the General Enrollment Agreement.

FERTILITY AND INFERTILITY SERVICES BENEFIT

THIS RIDER is made part of the Health Net of Arizona, Inc. ("Health Net") Evidence of Coverage ("EOC"). Unless otherwise indicated herein, all terms initially capitalized herein shall have the same meaning attributed to such terms in the EOC and references to applicable sections are to sections of the EOC. This Rider, combined with your EOC and Schedule of Benefits explain the details of your health care coverage.

COVERED SERVICES

Fertility and Infertility Services are covered as provided below, with respect to Subscriber's family only, and when determined to be Medically Necessary due to physiological dysfunction. Covered Services include:

- Physical examinations and/or medical history
- Sperm count, to determine the cause of infertility
- Diagnostic laparoscopy, laboratory or x-ray procedures or services
- Endometrial biopsy
- Hysterosalpingography
- Surgery or other treatment for endometriosis, diagnosed or identified in the course of fertility or infertility treatment
- Medications used to treat infertility
- Injections related to fertility services
- Confinement for infertility services
- Artificial insemination is covered at 50% of eligible expenses.
- Lifetime Maximum benefit for artificial insemination is 1 treatment period of up to 6 cycles.

LIMITATIONS AND EXCLUSIONS

In addition to the Exclusions and Limitations listed in the Evidence of Coverage, the following procedures and services are not covered under this Fertility and Infertility Services Benefit:

- *In-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT)*
- Embryo or ovum transfer
- Reversal of elective sterilization
- Medications whose primary purpose is to achieve pregnancy
- Artificial insemination services which exceed the Lifetime Maximum benefit as described above
- The collection, storage or purchase of sperm.
- Other services or supplies that are intended to impregnate a woman, such as the collection, storage or purchase of sperm or ova.

GENERAL PROVISIONS

All provisions of the Group Enrollment Agreement and Evidence of Coverage, including any amendments thereto, shall apply to this Fertility and Infertility Services Benefit. This Fertility and Infertility Services Benefit will terminate upon termination of the Group Enrollment Agreement.

EVIDENCE OF COVERAGE

Contents

INTRODUCTION

Welcome to Health Net of Arizona, Inc. ("Health Net"). This booklet is your Evidence of Coverage. It explains what your benefits are, how you can access these benefits, and the limitations and exclusions that apply to Covered Services. For your convenience, We have included a Glossary, which will explain the meaning of special words and phrases used throughout this Evidence of Coverage. Be sure to check these definitions as they may differ from other Health Plans.

If you have questions regarding any information contained within this Evidence of Coverage, please call Health Net's Customer Contact Center at 1-800-289-2818 or go to www.healthnet.com. One of our Customer Contact Center Representatives will be happy to assist you.

UNDERSTANDING YOUR HEALTH PLAN

Each Member covered under this Health Plan is entitled to receive the benefits and services described in this Evidence of Coverage.

Although We encourage you to read this entire document to familiarize yourself with your health Coverage, the following sections should be reviewed immediately upon enrollment:

- *Description of Benefits.* This section describes the services and treatments, which are covered under your Health Plan, including general health physicals.
- *Limitations and Exclusions.* This section identifies services and treatments that are not covered under your Health Plan, or are limited in Coverage.
- *Schedule of Benefits.* This section describes your out-of-pocket expenses, such as Copayment and/or Coinsurance amounts you are required to pay when receiving Covered Services. This section also details benefit maximums, such as visit and/or day limits, which may be included in your Health Plan. This Schedule is a separate booklet and is included in your enrollment packet.

PARTICIPATING PROVIDERS

Health Net has contracted with Physicians, Hospitals, Facilities and other Health Professionals to provide Medical Services and treatments to Members covered under this Health Plan. These Physicians, Hospitals and Facilities are referred to as *Participating Providers*.

YOUR PRIMARY CARE PHYSICIAN

Every Member of Health Net must have a Primary Care Physician. These Primary Care Physicians are sometimes referred to as a *PCP*. Your PCP is the person who will provide and coordinate Medical Services and treatments you may require while covered by Health Net. At some time, you may need to see a Physician who is a Specialist. Your Primary Care Physician will refer you to one. If you are hospitalized, your Primary Care Physician will coordinate the care and services you need with the Hospital and any other Physicians, including Hospitalists, who may be involved.

Your Primary Care Physician's office is available 24 hours a day 7 days a week.

During regular office hours:

- Call the office and identify yourself as a Health Net Member
- Your Primary Care Physician has a staff that can schedule an appointment or help answer your medical questions.

After regular office hours:

- Call the office and identify yourself as a Health Net Member
- Describe the medical condition you are experiencing
- Your Primary Care Physician's office will have your Physician, or another Health Professional, contact you. He or she will discuss the illness or injury in question and give you direction. Each case is different. You may receive advice over the telephone or you may be asked to come into the office. In Emergency or Urgent situations, you may be directed to the nearest Emergency or Urgent Care Facility.
- Always remember that you can call your Primary Care Physician's office 24 hours a day. You do not have to wait for regular office hours to obtain medical advice.

Each member of a family who is covered by Health Net has the right to select his or her own Primary Care Physician. This means that a parent who desires to have a Primary Care Physician close to their office may select a different Primary Care Physician for their children closer to home. In addition, you may select a Physician specializing in pediatrics as the Primary Care Physician for each child under the age of 19, even if the pediatric Physician is not identified by Health Net as a Primary Care Physician. Please make sure that you have selected a Primary Care Physician for yourself and each of your Dependents that are enrolled under this Health Plan. Until you make this selection, Health Net will designate one for you. Refer to Health Net's Provider Directory for a list of Primary Care Physicians, or you can visit our Internet website at www.healthnet.com. This information is available to you at no charge. If you need help in choosing a Primary Care Physician, call Health Net's Customer Contact Center at 1-800-289-2818.

CHANGING PRIMARY CARE PHYSICIANS

You, and each of your enrolled Dependents, may select a new Primary Care Physician by contacting Health Net's Customer Contact Center. The following are some general guidelines to follow if you need to change your Primary Care Physician:

- You can switch your PCP only one time per month.
- If we receive your request for a transfer on or before the 15th day of the month, the transfer will occur on the first day of the following month. For example, if your request is received March 12th, your PCP transfer will be effective April 1st.
- If we receive your request for transfer on or after the 16th day of the month, the transfer will occur on the first day of the second following month. For example, if your request is received March 17th, your PCP transfer will be effective May 1st.
- If your new PCP is outside of your existing Network, you must renew all existing authorizations through your new Primary Care Physician.
- A Network may request that a Member be transferred out of their Network for cause.

NETWORK AFFILIATIONS

Your Primary Care Physician and other Health Professionals have contracted with Health Net to provide Medical Services and treatments to you. They have contracted either individually, or through a group of providers called a *Network*. If your Primary Care Physician is contracted with a Network, you may be required to obtain services from Specialists and other providers who belong to that Network. If you are unsure whether your Primary Care Physician is contracted with a Network, check your Health Net Provider Directory or call Health Net's Customer Contact Center.

SPECIALIST PHYSICIANS

Specialist Physicians may also be part of your Network. If your Primary Care Physician determines that you need care from a Specialist, your Primary Care Physician will refer you to the appropriate Specialist within your Network. If an appropriate Specialist does not exist within your Network, your Primary Care Physician will refer you to a Specialist outside of your Network.

If you receive services from a Specialist before your Primary Care Physician has informed you that the Referral has been Approved, the services will not be covered, unless specifically stated otherwise in this Evidence of Coverage. Services and treatments by Specialists are covered only when a Referral is Approved even if the Specialist is part of your Network. Always remember that your Primary Care Physician is the person responsible for coordinating your care and will refer you to an appropriate Specialist when it is Medically Necessary.

AVAILABILITY OF PROVIDERS

Health Net cannot guarantee the continued availability of any particular Physician, Network, Facility or other Health Professional. Consequently, if a Primary Care Physician terminates his or her relationship with Health Net, you will be required to select another Primary Care Physician, who will be responsible for providing and coordinating your total health care. **Covered Services must be obtained from Participating Providers who are under contract with Health Net at the time Medical Services are received.**

PRIOR AUTHORIZATION

Selected services and treatments that are covered under your Health Plan require Health Net's approval before you receive them in order for them to be covered by Health Net. This approval is referred to as Prior Authorization. This means that even though a service or treatment may be a covered benefit, Prior Authorization must be obtained before the service or treatment can be received. Even those services that are determined to be Medically Necessary by Us must have Prior Authorization in order to be covered. Physicians and Networks cannot deny a service or treatment for failure to obtain Prior Authorization. Only Health Net can deny Coverage for Medical Services for failure to obtain Prior Authorization. Questions concerning Prior Authorization can be directed to your Primary Care Physician, or you can call Health Net's Customer Contact Center. Prior Authorization does not guarantee coverage. Circumstances in which the service will not be covered include, but are not limited to:

- Other plan provisions are not satisfied (for example, the Member is not enrolled or eligible for service on the date the service is received or the service is not a Covered Benefit),
- Fraudulent, materially erroneous or incomplete information is submitted, or
- A material change in the Member’s health condition occurs between the date that the Prior Authorization was provided and the date of the treatment that makes the proposed treatment no longer Medically Necessary for such Member.

In the event that Health Net certifies the Medical Necessity of a course of treatment limited by number, time period or otherwise, a request for treatment beyond the certified course of treatment shall be deemed to be a new request.

As a general rule, please remember that, except for Emergency Services, all Medical Services and treatments must be provided through the direct coordination of the Primary Care Physician and received within the Service Area. If they are not, your Health Plan may not cover these services.

PAYMENT OF BENEFITS

Subject to the Limitations and Exclusions that follow, and all applicable provisions of this *Evidence of Coverage* and any attached riders, Health Net will pay for Covered Expenses incurred by a Member while covered under this Health Plan.

Covered Expenses will only include Covered Services shown in this *Evidence of Coverage*, up to the Maximum Annual and Lifetime Benefit amounts shown in the *Schedule of Benefits*.

Each Member must satisfy certain Deductibles and/or Copayments/Coinsurance (if applicable), as shown in the *Schedule of Benefits*, before any payment is made by Health Net for certain Covered Expenses. Then the Health Plan pays the percentage of Covered Expenses as shown in the *Schedule of Benefits*.

OUT OF POCKET MAXIMUM

This is the total dollar amount of Copayment, Coinsurance and Deductibles that a Member or family unit is required to pay for Covered Services during any given Calendar Year. Out-of-Pocket Maximums are determined for Covered Services only and do not apply to any Medical Services or treatments that are not Covered Services.

Individual

The Covered Expenses that you pay, except as described below, are counted towards the Individual Out-of-Pocket Maximum. The amount of the Out-of-Pocket Maximum is listed in the *Schedule of Benefits*. When this amount is reached for an Individual in a Year, Covered Expenses, except as described below, are payable at 100% for the remainder of the Year.

Family

The Covered Expenses that covered Members in a Family Unit pay, except as described below, are counted towards the Family Out-of-Pocket Maximum. The amount of the Out-of-Pocket Maximum is listed in the *Schedule of Benefits*. When this amount is reached for a Family Unit in a Year, Covered Expenses, except as described below, are payable at 100% for the remainder of the Year.

The following are not counted toward the Individual or Family Out-of-Pocket Maximums and will not be paid at 100% once the Out-of-Pocket Maximum is met. They will be subject to the Copayment, Coinsurance and/or Deductible as shown in the *Schedule of Benefits*:

Your Mental Health and Substance Abuse Services are provided by MHN. Any amounts paid to MHN for Mental Health and Substance Abuse Services that are the Member's responsibility may be counted toward the Maximum Out-of-Pocket Expense for this Health Net plan.

1. Any percentage of Covered Expenses that a Member must pay due to failure to follow any requirements of Precertification;
2. Limitations and Exclusions;
3. Use of Emergency room for non-Emergent Services;
4. Covered Expenses for Prescription Drugs;

EMERGENCY SERVICES AND CARE

Members requiring Emergency Services will **not** be required to obtain Precertification from Health Net prior to receiving an initial medical or psychiatric screening examination and any immediate treatments or services necessary to stabilize a condition. This applies to both Participating Providers and Out-of-Network Providers.

If You are faced with a medical or psychiatric Emergency, call 911 or go to the Emergency room.

It is the responsibility of the Member to contact Health Net to obtain any required Precertification within 48 hours after Emergency admission, or as soon as medically possible. Health Net will not, however, deny Coverage for Emergency admission due to failure to contact Health Net because of the Member's Emergent medical or psychiatric condition.

In the case of post-stabilization care, if Health Net has given Precertification for specific care by a Provider, Health Net will not rescind or Modify the Precertification after the care has been given in good faith, and pursuant to the Precertification and subject to the terms of your Coverage document.

Emergency Services do not include use of a Hospital Emergency room or other Emergency medical Facility for Routine Medical Care, or follow-up or continuing care, unless Precertification has been obtained from Health Net. The Member will be financially responsible for any Emergency room charges for any non-Emergency Services, as determined by Health Net.

WHAT TO DO WHEN URGENT CARE IS REQUIRED

Urgent Care Situations include cases of high fevers, severe vomiting, sprains, fractures, or other injuries. In such cases, call your Primary Care Physician. The PCP's office is available 24 hours a day, 7 days a week by telephone. You will be given direction on how to obtain care for your condition. All follow-up and continuing care must be provided or arranged through your Primary Care Physician in order to be covered by Health Net.

MEMBER IDENTIFICATION CARD

It is important to have your Member Identification Card with you whenever you need Medical Services or treatment. This card will identify you as a Health Net Member. If you lose your card, contact Health Net immediately and We will send you a new one.

Do not give your Member Identification Card to another person at any time. Use of your I.D. Card by a person other than you is fraud. Having an I.D. Card does not guarantee eligibility in this Health Plan.

COPAYMENT / COINSURANCE

Your Health Plan may require its Member to pay a Copayment and/or Coinsurance when receiving Covered Services. Copayments and Coinsurance are the Subscriber's responsibility and are due to the Provider. Appointments made by a Member that are not cancelled 24 hours in advance may also be subject to Copayment, Coinsurance and/or a late cancellation fee. The Copayment and/or Coinsurance amounts applicable to your Health Plan are described in the *Schedule of Benefits*. If you need another copy of the Schedule, please call Health Net's Customer Contact Center.

PREMIUM

Your employer collects any contributions (Premiums) for which you are responsible and submits the total Premium due to Health Net. The Premium amounts for Subscribers and any enrolled Dependents are contained in the Group Enrollment Agreement. Premiums are not changed unless a 60-day notice is provided to your employer.

UTILIZATION MANAGEMENT

Health Net reviews certain requests for medical procedures, specialty consultations and hospitalizations to determine whether the treatment is Medically Necessary, as determined by Us, and to verify that the services are covered under this Health Plan. The determination of the reviewer or professional review organization is not a substitute for the independent judgment of the treating

provider as to the course of treatment. **Utilization Management decisions do not prevent treatment or hospitalization but do determine whether or how the treatment or hospitalization is covered by Health Net.**

APPEAL PROCEDURES

If a Member disagrees with any determination made by Health Net during the Prior Authorization or claim review process, he or she can appeal Health Net's decision. A summary of the appeal procedures is contained in the section titled *Contract Provisions for Coverage*. If you have questions about filing an appeal or need another copy of the brochure, please call Health Net's Customer Contact Center.

YOUR COOPERATION

It is the Member's responsibility to complete and submit to Health Net such consents, releases, assignments, and other documents as may be requested by Health Net in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other insurance coverage. Any Member who fails to comply with this requirement may be liable for the costs of the services rendered.

DESCRIPTION OF BENEFITS

Subject to the Limitations and Exclusions provision of this *Evidence of Coverage*, and any attached riders, the following Covered Services will be considered Covered Expenses under the Evidence of Coverage.

HOSPITAL - INPATIENT AND OUTPATIENT SERVICES

Emergency Services and the minimum Hospital stay requirements for maternity do not require Prior Authorization. All other Hospital Services, whether Inpatient or Outpatient, must be arranged through the Primary Care Physician. Any Member who receives Emergency Services must contact his or her Primary Care Physician for follow up services, and contact Health Net within 24 hours of treatment if admitted, or as soon thereafter as is medically possible.

Inpatient Services

Covered Services include:

- Semiprivate room and board (private room when Medically Necessary, as determined by Us)
- Hospital and Physician services, including supplies and consultation
- ICU, CCU and other special care units
- Operating room and related Facilities
- Medications and biologicals ◆
- Diagnostic services, including x-ray and laboratory
- General nursing care (special duty nursing when Medically Necessary, as determined by Us, and Preauthorized by Health Net)
- Surgical procedures ❋, including anesthesia
- Oxygen and related services
- Inhalation treatment
- Meals, including special diets when Medically Necessary, as determined by Us
- Whole blood and blood plasma and its administration
- Physician visits■
- Radiation therapy and chemotherapy

◆ Medications and biologicals are covered while confined in the Hospital. Take home medications from an Inpatient Facility are not covered. Medications prescribed for use after discharge from an Inpatient Facility will be covered only if an Outpatient Prescription Drug Benefit has been purchased by your Group and in accordance with any restrictions and limitations that may apply, including Preferred Drug List restrictions. Refer to the Schedule of Benefits to determine whether your Group has purchased an Outpatient Prescription Drug Benefit, and the restrictions and limitations that apply.

■ Medically Necessary services of a Physician, including office visits and consultations, Hospital and Skilled Nursing Facility visits, and visits to your home.

Selected services and treatments require Preauthorization in order to be covered. Questions concerning Prior Authorization can be directed to the Primary Care Physician or Health Net's Customer Contact Center at 1-800-289-2818.

❋ All covered surgical procedures, including the services of the surgeon or Specialist, assistant surgeon and anesthetist or anesthesiologist, together with preoperative and postoperative care. Health Net uses Medicare guidelines to determine the circumstances under which Claims for assistant surgeon services and co-surgeon and team surgeon services will be eligible for reimbursement, in accordance with Health Net's standard Claims filing requirements. Surgery includes surgical reconstruction of a breast incident to a mastectomy, including surgery to restore symmetry; it also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema.

When adjudicating Claims for Covered Services for the postoperative global period for surgical procedures, Health Net applies Medicare's global surgery periods to the American Medical Association defined Surgical Package. The Surgical Package includes typical postoperative care. These criteria include consideration of the time period for recovery following surgery and the need for any subsequent services or procedures which are part of routine postoperative care.

Health Net uses Medicare guidelines to determine which procedures billed by a Provider are eligible for separate professional and technical components.

Outpatient Surgery and Ambulatory Surgical Facilities

Covered Services include:

- Medications and biologicals ◆
- Surgical procedures ■, including anesthesia
- Therapeutic services including chemotherapy, radiation therapy and inhalation treatment
- Diagnostic services, including x-ray and laboratory☐
- Oxygen and related services
- Emergency Services as defined in this Evidence of Coverage
- Whole blood and blood plasma and its administration

◆ Medications and biologicals are covered while undergoing treatment in an Outpatient Facility. Take home medications from an Outpatient Facility are not covered. Medications prescribed for use after discharge from an Outpatient Facility will be covered only if an Outpatient Prescription Drug Benefit has been purchased by your Group and in accordance with any restrictions and limitations that may apply, including Preferred Drug List restrictions. Refer to the Schedule of Benefits to determine whether your Group has purchased an Outpatient Prescription Drug Benefit, and the restrictions and limitations that apply.

■ Based on national billing guidelines for Providers, multiple surgical procedures performed during a single operative session will be reviewed to determine appropriate benefit payment levels. In general, secondary and tertiary procedures are reimbursed at lower levels.

☐ The Copayment or coinsurance for diagnostic services, including x-ray and laboratory services, obtained at an Outpatient Surgery or Ambulatory Surgical Facility may be different than the Copayment or Coinsurance if the service is obtained at a physician's office or at an independent, freestanding facility. Please refer to the Schedule of Benefits to determine your Copayment or Coinsurance amount.

TRAVEL REIMBURSEMENT

Health Net may reimburse you for Qualified Travel Expenditures.

Travel reimbursement will be made in accordance with the following provisions:

- The Member must satisfy any applicable plan Deductible amount, as shown in the Schedule of Benefits, before any reimbursement for Qualified Travel Expenditures will be made by Health Net.
- The Member will be required to prepay travel expenditures and submit a reimbursement request to Health Net.
- Travel reimbursement is provided on a per diem basis at a rate of $150 with a Calendar Year maximum of $3,000. Qualified Travel Expenditures are paid at 100% up to the per diem rate and do not accumulate toward any applicable Out of Pocket Maximum.
- For purposes of reimbursement, Qualified Travel Expenditures will begin accumulating on the date you depart the Service Area for Preauthorized treatment.

OFFICE VISITS

Covered services include:

- Office visits to Physicians, including Specialists◆
- Treatment for an injury or illness
- Allergy testing, allergens and their administration in accordance with accepted medical practice, or as otherwise determined to be Medically Necessary, as determined by Us.

◆ Specialist visits may require the Member to obtain a referral through the Primary Care Physician, referring Provider or Health Net. **Except as provided below, specialty care services must have Prior Authorization or an Approved Referral before Medical Services are received in order to be covered by Health Net**. If You are an HMO Self-referral member, your plan allows You to receive most care from In-Network Specialists without an Authorization or referral from a Primary Care Physician. Only services from In-Network Physicians and facilities will be covered.

Preventive Health Exams and Immunizations

The coverage described below shall be consistent with the requirements of the Patient Protection and Affordable Care Act (PPACA) of 2009.

- United State Preventive Services Task Force (USPSTF) recommended type "A" and "B" services
- Immunizations and inoculations as recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control (CDC)
- An annual flu shot, when received in a Physician's office, at a network pharmacy participating in the vaccine network, or at a contracted flu clinic sponsored by the Member's Physician or Health Net.
- Pediatric preventive care and screening, as supported by the Health Resources and Services Administration (HRSA) guidelines
- Women's health care services as supported by HRSA guidelines
- Other USPSTF recommendations for breast cancer screening, mammography and prevention.

Selected services and treatments require Preauthorization in order to be covered. Questions concerning Prior Authorization can be directed to the Primary Care Physician or Health Net's Customer Contact Center at 1-800-289-2818.

Prostate specific antigen (PSA) screening and digital rectal examination (DRE) are covered annually if the following criteria are met:

1. If you are under 40 years of age and are at high risk because of any of the following:
   a. Family history (i.e., multiple first-degree relatives diagnosed at an early age)
   b. African-American race
   c. Previous borderline PSA levels
2. If you are age 40 and older.

Preventive physical examinations and immunizations will be covered by Health Net when obtained from or through your Primary Care Physician according to the guidelines and policies adopted by Health Net. Additional examinations and immunizations will be covered if determined to be Medically Necessary by your Primary Care Physician.

Self-Referral Benefits
The following services are provided as self-referral benefits. They do not require a Referral from the Primary Care Physician, referring Provider or Health Net

- Members may self-refer to a Doctor of Chiropractic contracted with the designated Chiropractic Provider as shown in the *Schedule of Benefits*. Chiropractic Services and treatments are covered for Covered Services for the number of visits as shown in the *Schedule of Benefits*.
- Female Members may self-refer to an OB/GYN Specialist, Physician or Provider within their Network, or a Health Net contracted OB/GYN Specialist, Physician or Provider if none is available within the Member's Network, for any OB/GYN preventive, obstetric, or gynecology related Covered Services. The OB/GYN Specialist, Physician or Provider will consult with the Member's Primary Care Physician regarding the Member's condition, treatment and any need for follow-up care.
- Once each Year, diabetic Members may self-refer to an eye care Specialist within their Network, or a Health Net contracted ophthalmologist if none is available within the Member's Network, for the purpose of receiving an eye exam for the detection of eye disease. Continued or follow-up care from the eye care Specialist will, however, require a Referral through your Primary Care Physician.

Self-referrals under this provision are limited to Health Net contracted Specialists who are contracted with the Member's Network or Primary Care Physician. To ensure Coverage, refer to Health Net's Provider Directory or check our internet website at www.healthnet.com. You may also contact your Primary Care Physician, Network or Health Net's Customer Contact Center to verify the name of an appropriate Specialist. Your Primary Care Physician or Network can direct you to a Health Net contracted Specialist if none exists within the Network. **Services received from non-contracted Specialists may be denied by Health Net and the Member may be held financially responsible for the charges.**

AMBULANCE SERVICES

Covered Services include:

- Emergency transportation from the site of an accidental injury or acute illness to the nearest facility capable of providing appropriate treatment.
- Air and water evacuation will be considered Medically Necessary if the patient's condition is of an Emergency nature, the location where the accidental injury and/or illness occurred is inaccessible by ground vehicles, or transport by ground ambulance would be detrimental to the patient's health.

Covered Services for ground, water, or air ambulance travel must be provided by a duly licensed vehicle specifically designed and equipped for transporting the sick and/or injured.

Covered Services **do not include** transportation for Non-Emergent treatment unless preapproved by Health Net.

AUTISM SPECTRUM DISORDERS

Subject to the terms and conditions of the Evidence of Coverage ("EOC"), Health Net covers the diagnosis and treatment of Autism Spectrum Disorders (ASD) as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. ASD includes:

- Autistic disorder;
- Asperger's syndrome and
- Pervasive development disorder; not otherwise specified.

Covered Services must be Prior Authorized by Health Net in accordance with the Precertification provisions in your EOC. If multiple services are provided on the same day by different Providers a separate co-payment will apply to each Provider.

Medically Necessary Behavioral Therapy will be provided when prescribed by the Member's treating Participating Provider in accordance with an approved Behavioral Therapy treatment plan. Covered Services must be provided or supervised by a licensed or certified Participating Provider. Please note that whenever you obtain Covered Services from an Out-Of-Network Provider, you are responsible for applicable Deductibles, Copayment and Coinsurance. To access these benefits, please contact Managed Health Network directly at 1-800-977-0281.

Behavioral Health Treatment for pervasive developmental disorder or autism spectrum disorders: 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.

The treatment must be prescribed by a licensed Physician or developed by a licensed psychologist, and must be provided under a documented treatment plan prescribed, developed and approved by a Qualified Autism Service Provider providing treatment to the Member for whom the treatment plan was developed. The treatment must be administered by the Qualified Autism Service Provider, or by

qualified autism service professionals and paraprofessionals who are supervised and employed by the treating Qualified Autism Service Provider.

A licensed Physician or licensed psychologist must establish the diagnosis of pervasive development disorder or autism spectrum disorders. In addition, the Qualified Autism Service Provider must submit the initial treatment plan to the Managed Health Network.

The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated, and must be reviewed by the Qualified Autism Service Provider at least once every six months and modified whenever appropriate. The treatment plan must not be used for purposes of providing or for the reimbursement of respite, day care or educational services, or to reimburse a parent for participating in a treatment program.

The Qualified Autism Service Provider must submit updated treatment plans to Health Net for continued behavioral health treatment beyond the initial six months and at ongoing intervals of no more 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.

CHIROPRACTIC SERVICES

Members may self-refer to a Doctor of Chiropractic contracted with the designated Chiropractic Provider as shown in the *Schedule of Benefits*. Chiropractic Services and treatments are covered for Covered Services for the number of visits as shown in the *Schedule of Benefits*.

Covered Services are those within the scope of chiropractic care which are necessary to help Members achieve the physical state enjoyed before an illness or injury, and which are determined to be Medically Necessary and generally furnished for the diagnosis and/or treatment of neuromusculoskeletal condition associated with an injury or illness, including:

- Chiropractic manipulations, adjustments and physiotherapy
- Diagnostic radiological services generally provided by Participating Chiropractors
- Examination and treatment for the Aggravation of an illness or injury
- Examination and treatment for the Exacerbation of an illness or injury

This Health Plan will provide chiropractic benefits to Members in accordance with the following provisions:

- *Chiropractic benefits will be provided through a contract between Health Net and the designated Chiropractic Provider as shown in the Schedule of Benefits*
- *Covered Services may be obtained from Participating Chiropractors who are contracted with the designated Chiropractic Provider as shown in the Schedule of Benefits.*
- The Member does not need a referral from a Primary Care Physician to make an appointment with a Participating Chiropractor.

Initial Evaluation Visit. To obtain chiropractic services, the Member must schedule an initial evaluation appointment with a Participating Chiropractor. The Member may select any chiropractor listed in the Provider Directory. Please call the chiropractor to verify that he or she is a Participating Chiropractor, as provider status may change occasionally. Services rendered from non-Participating Chiropractors are not covered. Only one initial evaluation visit is provided without authorization for each illness or injury requiring chiropractic treatment.

Pretreatment Authorization. Before a Member can receive additional Covered Services after the initial 12 visit limit, the Participating Chiropractor must obtain a pretreatment authorization from the designated Chiropractic Provider as shown in the *Schedule of Benefits*. Once treatment has been authorized, the Member may receive those services from the Participating Chiropractor. If the Member completes the treatment plan and the chiropractor believes additional visits are necessary, these visits may be authorized through the designated Chiropractic Provider as shown in the *Schedule of Benefits*.

Copayment. The Member is required to pay a predetermined Copayment for each chiropractic visit. Refer to the *Schedule of Benefits* to determine the applicable Copayment under your Health Plan.

Maximum Benefits. The maximum allowable visit limitations are described in the *Schedule of Benefits.* The Member will be required to pay the full amount of charges incurred for services received after the maximum allowable benefit has been exhausted.

CLINICAL TRIALS

Routine patient costs for items and services furnished in connection with participation in approved clinical trials are covered as required by state and federal law. Health Net will not exclude, limit or impose special conditions on such coverage and Health Net will not include provisions that discriminate against an individual on the basis of the individual's participation in an approved clinical trial. You must pay any Deductibles, Copayments or Coinsurance that apply to the items and services whether or not you receive the items and services in connection with Clinical Trial. Prior Authorization is required. The following provisions apply:

- Routine patient costs include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial.

Routine patient costs do not include:

a. The cost of Investigational services, drugs or devices, whether or not you receive the items and services in connection with clinical trial;
b. Items and 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;
c. The cost of any non-health services;
d. The cost of managing research; or
e. Items or services that would not otherwise be covered

- Approved clinical trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening condition and is approved or funded by at least one of the following:

a. One of the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, or 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 cooperative group or center of any of the entities described above;
c. The FDA in the form of an investigational new drug application or if the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
d. A qualified research entity that meets the criteria of the NIH for grant eligibility; or
e. A panel of qualified recognized experts in clinical research within academic health institutions in this state.

For purposes of clinical trials, the term "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.

DENTAL SERVICES

Preventive and Restorative Services - General Dental Services
Preventive, restorative and general dental services are not covered under this Health Plan, unless your Group employer has purchased a Dental Benefit. Refer to the *Schedule of Benefits* to determine whether your particular Health Plan contains supplemental Dental Benefits, and the restrictions and limitations that apply.

Dental Services Under Your Health Plan's Medical Benefit
Dental services under the *medical* portion of your Health Plan are limited to services and treatments which are received in connection with an injury or as a direct result of a Congenital Defect. Services normally associated with routine or general dental care are not covered. Covered Services under the *medical* portion of your Health Plan are limited to services or treatments that are determined to be related to a medical condition or injury and are determined to be Medically Necessary by Us and include:

- The repair, but not replacement of Sound Natural Teeth damaged as a result of an Accident;
- The reduction or manipulation of fractures of facial bones including the jawbone and supporting tissues due to an accidental injury;
- Oral surgery for the excision of lesions, cysts, or tumors;
- Reconstruction or repair of the palate or cleft lip.

Dental Services under the *medical* portion of your Health Plan **do not include**:

- Medical treatments relating to orthognathic and/or arthroplastic surgery;
- General anesthesia for routine dental work;
- Routine or general care of teeth or dental structures;
- Extraction of impacted or abscessed teeth and services related to malocclusion or malposition of the teeth or jaw;
- Temporomandibular Joint Disorder (TMJ) except for Medically Necessary services in connection with Acute dislocation of the mandible. See the Exclusions and Limitations section for more details;

- Accidental injury to the teeth or gums caused by chewing;
- Treatment of problems or complications relating to TMJ, including the removal of TMJ implantation devices;
- Dental splints, dental implants, dental Prostheses or dentures;
- Medications needed prior to non-covered dental surgery; and
- Prescription drugs.

DIABETIC CARE MANAGEMENT

The following is covered in relation to Members who have been diagnosed with diabetes:

- Diabetes outpatient self-management training and education, including a wellness health coaching program that guides an individual to change unhealthy behaviors and adopt positive lifestyle changes in order to promote the life-long practice of good health behavior. Refer to the Schedule of Benefits Health under Health/Education and Disease Management for applicable Copayment, Coinsurance or Deductibles.
- Supplies and equipment related to Diabetes Management as described in the Outpatient Prescription Drug Benefit and Diabetic Supplies, Equipment and Devices provision of this section.
- Nutritional counseling services are covered and not subject to the lifetime limit as shown in the Nutritional Counseling Services provision of this section.
- Routine foot care in connection with the treatment of diabetes.
- Self-referral once each Year to an eye care Specialist for the purpose of receiving an eye exam for the detection of eye disease as described in the Vision Services provision of this section.

DIABETIC SUPPLIES, EQUIPMENT AND DEVICES

Diabetic supplies are covered when determined to be Medically Necessary, as determined by Us and in accordance with the guidelines established by the Centers for Medicare and Medicaid Services (CMS). The following are specific requirements for Coverage:

- Diabetic supplies must have a written prescription from a Participating Provider, when Medically Necessary, as determined by Us;
- Refills are covered only when Authorized by a Participating Provider, when Medically Necessary, as determined by Us;
- Covered supplies and equipment must be obtained from a Participating Provider unless otherwise Preauthorized by Us;
- Plan approved standard blood glucose monitors are covered for both insulin-dependent and non-insulin-dependent Members when necessary for medical management as determined by Health Net in consultation with your Physician. Blood glucose monitors require a written prescription from a Physician and must be obtained at a Participating Pharmacy;
- Plan approved blood glucose monitors for the sighted and the legally blind are covered when medically necessary and the Member has been diagnosed with diabetes. Blood glucose monitors require a written prescription from a Physician and must be obtained at a Participating Pharmacy.

Selected services and treatments require Preauthorization in order to be covered. Questions concerning Prior Authorization can be directed to the Primary Care Physician or Health Net's Customer Contact Center at 1-800-289-2818.

The following are examples of Diabetic supplies that are covered when they meet the specific requirements for coverage:

- Glucose test strips;
- Visual reading testing strips;
- Urine testing strips;
- Insulin pumps;
- Insulin preparations;
- Injection aids and syringes;
- Insulin aids (when medically necessary);
- Glucagon (requires Prior Authorization);
- Drawing up devices (syringes) and monitors for the visually impaired;
- Insulin vials/pens;
- Insulin cartridges for the sighted and the legally blind (requires Prior Authorization);
- Lancets and Automatic lancing devices;
- Spacers and holding chambers for inhaled medications;
- Inhalers (nasal or oral);
- Prescribed oral agents for controlling blood sugar that are included on the plan formulary; and
- Other devices, medication, equipment or supplies that Medicare adds to its list of covered diabetic supplies will become eligible for coverage under this Health Plan within 6 months following Medicare's inclusion of such item for coverage.

The following diabetic *equipment* is covered under the Durable Equipment Benefit:

- Podiatric appliances necessitated by a diabetic condition in accordance with Medicare guidelines; and
- Foot orthotics are covered for the treatment of diabetes.

DIALYSIS SERVICES

Covered services include:

- Equipment, training, and medical supplies required for home peritoneal dialysis;
- Maintenance of dialysis equipment required for home peritoneal dialysis;
- Medical and Hospital Services for dialysis for renal disease. Hemodialysis for Chronic Health Conditions are covered only in Health Net contracted Facilities approved for participation in the Medicare program; and
- A maximum of 6 Out-of-Area dialysis treatments per Year are provided when Prior Authorization has been obtained by Us.

DURABLE MEDICAL EQUIPMENT (DME), BRACES AND ORTHOTICS

Health Net applies nationally recognized Durable Medical Equipment coverage guidelines as defined by the Medicare Durable Medical Equipment Regional Administrative Contracts (DME MAC), Healthcare Common Procedure Coding System (HCPCS) Level II and Medicare National Coverage Determinations (NCD) in assessing Medical Necessity for coverage.

Covered services when Medically Necessary include:

- Apnea monitors when Medically Necessary, as determined by Us;
- Therapeutic oxygen and equipment for the administration of oxygen;
- Crutches, canes, walkers, and manual hospital beds are covered when determined to be Medically Necessary;
- A manual adult size or pediatric size wheelchair is covered when determined to be Medically Necessary. If a Member requires an electric or specialized wheelchair, then the Member may receive reimbursement for the purchase price of a manual adult size or pediatric size wheelchair as determined by Health Net to use towards the cost of the electric or specialized wheelchair in accordance with Health Net's rules and regulations. This provision does not apply to leased wheelchairs. Electric or specialized wheelchairs are not a covered benefit under this Health Plan, unless Your Group has purchased a supplemental DME Benefit. Refer to the Schedule of Benefits to determine whether Your particular Health Plan contains enhanced DME benefits.
- Medical supplies that are determined by Health Net to be Medically Necessary to operate and/or maintain a covered prosthesis or item of Durable Medical Equipment are covered, subject to the limitations stated herein.
- Podiatric appliances are covered, in accordance with Medicare guidelines, when such appliances are directly related to a diabetic condition;
- Peak flow meters are covered when prescribed by a Participating Physician and plan Approved;
- DME items must be obtained from a Participating Provider of DME in order to be covered;
- Health Net retains the right to determine if DME items shall be leased or purchased;
- A Member may request specialized equipment but the extra cost associated with specialized equipment will be the responsibility of the Member; and
- Breastfeeding support, supplies and counseling as supported by Health Resource and Services Administration (HRSA) guidelines, are covered as preventive care listed under the “Preventive Care” section in the Schedule of Benefits.

Health Net applies nationally recognized Durable Medical Equipment coverage guidelines as defined by the Medicare Durable Medical Equipment Regional Administrative Contracts (DME MAC), Healthcare Common Procedure Coding System (HCPCS) Level II and Medicare National Coverage Determinations (NCD) in assessing Medical Necessity for coverage.

Braces and Orthotics:

- Coverage is limited to rigid or semi-rigid devices used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured body part;
- Coverage is limited to therapeutic braces that are dispensed, prescribed and Authorized through a Participating Physician, which cannot be reused by another person, and are necessary for a Member to engage in the activities of normal daily living; and

Selected services and treatments require Preauthorization in order to be covered. Questions concerning Prior Authorization can be directed to the Primary Care Physician or Health Net’s Customer Contact Center at 1-800-289-2818.

- Replacement of braces is covered only when Medically Necessary, as determined by US, and results from a change in a Member's medical condition such as physical growth.

Covered Services for Durable Medical Equipment, including Braces and Orthotics, **do not include**:

- Exercise equipment, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses, or waterbeds, escalators or elevators, ramps, automobile modifications, safety bars, saunas, swimming pools, Jacuzzi or whirlpools, and hygienic equipment;
- Equipment for a patient in an institution that is ordinarily provided by an institution, such as wheelchairs, hospital beds and oxygen tents, unless these items have been Preauthorized by Health Net;
- More than one device designed to provide essentially the same functional assistance;
- Deluxe, electric, specialized or customized, model upgrades, and portable equipment requested for travel, unless your Group has purchased a supplemental DME benefit;
- Transcutaneous Electrical Nerve Stimulation (TENS) units;
- Scooters and other power operated vehicles;
- Repair or replacement of deluxe, electric, specialized or customized equipment, model upgrades, and portable equipment for travel;
- Communication devices (speech generating devices) and/or training to use such devices;
- Repair or replacement of equipment or parts due to misuse and/or abuse;
- Repair or replacement of equipment or parts due to normal wear and tear, adjustment, model upgrades and duplicates, unless your Group has purchased a supplemental DME Benefit. Refer to the Schedule of Benefits to determine whether your particular Health Plan contains enhanced DME benefits;
- Over-the-counter braces and other DME devices, except as specifically listed as being covered herein;
- Prophylactic braces, except as specifically listed as being covered herein;
- Braces used primarily for sports activities;
- Warning devices, stethoscopes, blood pressure cuffs, or other types of apparatus used for diagnosis or monitoring, except as specifically listed as being covered herein;
- Foot Orthotics which are not an integral part of a leg brace. Examples include shoe lifts, arch supports, orthopedic and/or corrective shoes. (This exclusion does not apply to the coverage of special shoes and inserts for certain patients with diabetes. Please refer to your diabetic benefits for further specification.);
- Pulse oximeters; and
- ThAIRapy® vests, except when Health Net medical criteria are met, as determined by Us.

EMERGENCY SERVICES

If you are faced with a medical or psychiatric Emergency, call 911, or go to the Emergency room.

Emergency/Emergent is defined as a condition or illness which, if not immediately diagnosed and treated:

- Would result in extended or permanent physical impairment or loss of life, and

- Requires the Member to seek immediate medical or psychiatric attention necessary for the relief of Acute pain, repair of accidental injury, initial treatment of infection or the relief of illness.

Examples of Emergency include a severe burn, profuse bleeding, a suspected heart attack, sudden Acute pain in the chest, a severe allergic reaction or suspected poisoning.

Emergency Services means health care services that are provided to a Member in a licensed Hospital Emergency Facility by a Provider after the recent onset of a medical or psychiatric condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical or psychiatric attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the patient's health;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services do not include use of a Hospital Emergency room or other Emergency medical Facility for Routine Medical Services, or follow-up or continuing care. The Member will be financially responsible for any Emergency room charges for any non-Emergency Services as determined by Health Net.

Emergency Services are provided 24 hours a day, 7 days a week, worldwide. Emergency Services**:**

- Do not require Prior Authorization;
- Include an initial medical screening examination and any immediate treatments or services necessary to stabilize a condition. Additional treatments or services may be retrospectively reviewed for Medical Necessity;
- If admitted, require the Member to notify Health Net within 24 hours after Emergency Services are provided by a Non-Participating Provider, or as soon thereafter as is medically possible. If admitted to a non-contracted inpatient Facility, Health Net may transfer a Member to a Participating Hospital for continued care if it is medically appropriate, as determined by Us. Members must also notify the Primary Care Physician for follow up care; and
- Require the Member to provide full details, including medical records of Emergency Services rendered by a Non-Participating Provider, if requested by this Health Plan. Costs associated with Emergency Services will be reimbursed only after Health Net receives and reviews the Emergency medical records and determines that such services were Medically Necessary. Services that have been Preauthorized will not be retrospectively denied during the review of charges incurred.

Emergency Services Outside the Service Area
Members who sustain an injury or become ill while away from the Service Area may receive Emergency Services as provided herein. Benefits are limited to conditions that require immediate attention.

Emergency Services outside of the Service Area do not include:

- Elective or specialized care; and
- Non-emergent, continuing, routine or follow-up care.

Selected services and treatments require Preauthorization in order to be covered. Questions concerning Prior Authorization can be directed to the Primary Care Physician or Health Net's Customer Contact Center at 1-800-289-2818.

FAMILY PLANNING SERVICES

The following Family Planning Services Benefit is hereby added and shall become a part of the Evidence of Coverage. Exclusions and Limitations listed in the Evidence of Coverage will apply to this Family Planning Services Benefit.

Covered Services include:

Abortions

- *Lifetime Maximum* benefit for non-Medically Necessary (elective) abortions is limited as shown in the *Schedule of Benefits.* Elective abortions must be performed during the first trimester.
- *Copayment and/or Coinsurance* will correspond to the charge associated with the Facility in which services are received.

Contraceptives

- Contraceptive drugs and devices are covered and require a prescription from your Participating Provider;
  - Prescribed contraceptive drugs and devices (diaphragms and cervical caps) are covered under the *Outpatient Prescription Drug Benefit. Refer to the Prescription Drug Benefit Rider;* and
  - Women's contraceptives drugs and devices are covered only when provided by a Health Net Participating Pharmacy. Refer to the Schedule of Benefits for applicable Copayment and/or Coinsurance. However, this plan does not cover brand name contraceptives that have generic equivalents, mail order prescriptions, abortifacient drugs, compounded medications, over–the-counter methods, devices and supplies, refills for lost or stolen drugs, or prescriptions or refills dispensed by a Non-Participating Pharmacy.

Genetic Testing

- Diagnostic genetic testing is covered when determined to be Medically Necessary and authorized through the Primary Care Physician, or referring Specialist. Genetic testing, amniocentesis, ultrasound, or any other procedure required **solely** for the purposes of determining the gender of a fetus is not covered.

Sterilization Procedures

- Sterilization procedures, including tubal ligation and vasectomy are covered. *Copayment and/or Coinsurance* will correspond to the charge associated with the Facility in which services are received.
- Preventive sterilization of females are covered under the Preventive Care benefit, subject to the applicable *Copayment and/or Coinsurance* listed under the Preventive Care section.

Selected services and treatments require Preauthorization in order to be covered. Questions concerning Prior Authorization can be directed to the Primary Care Physician or Health Net's Customer Contact Center at 1-800-289-2818.

FERTILITY PRESERVATION

Medically Necessary services and supplies for standard fertility preservation treatments are covered when a cancer treatment 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 that may be provided for cancer treatment. This benefit is subject to the applicable deductibles, Copayments and/ or Coinsurance (identified in the attached Schedule of Benefits).

Exclusions and Limitations: Services and supplies for gamete or embryo storage, use of frozen gamete or embryos to achieve future conception, pre-implantation genetic diagnosis, donor egg, sperm or embryos and/ or gestational carriers.

GENDER REASSIGNMENT SURGERY

Medically Necessary gender reassignment services, including Surgical services, for the treatment of gender dysphoria and/or gender identity disorder are covered. Services deemed not Medically Necessary for the treatment of gender dysphoria and/or gender identity disorder is not covered. All gender reassignment services must be performed by a qualified Provider.

HEARING SERVICES

Covered Services include, but are not limited to:

- Treatment for disease or injury to the ear;
- Hearing screenings by the Primary Care Physician to determine the presence of hearing loss and/or to diagnose and treat a suspected disease or injury to the ear, when such services are performed by the Primary Care Physician;
- Referrals to a Specialist for members 18 years or younger when an initial consultation and/or audiogram is determined to be Medically Necessary. Referrals to a Specialist must be approved through the Primary Care Physician; and
- Cochlear implants when Medically Necessary, as determined by Us.

Covered Services **do not include**:

- Hearing aid batteries (except those for cochlear implants) and charges are not covered
- Referrals to a Specialist for the purpose of determining hearing loss and/or for the purpose of obtaining hearing aids for Members over the age of 18 years, unless otherwise stated in the Schedule of Benefits.

HOME HEALTH CARE SERVICES

Home Health Care is covered when a Member is physically unable to obtain necessary medical care on an Outpatient basis, would otherwise be confined as an Inpatient, and is under the care of a Participating Physician, subject to the following:

- Covered Services must be provided by a Health Net contracted Home Health Care Agency;
- Coverage is limited to Medically Necessary patient care for a short period of time pursuant to guidelines, frequency, duration and level Preauthorized by Health Net;
- Covered Services include nursing care under the supervision of a registered nurse and rehabilitative therapy and/or IV therapy, when prescribed, authorized or directed by the Primary Care Physician and Preauthorized by Health Net;
- Covered Services are limited to part-time and intermittent patient care that is determined to be Medically Necessary by Us. For purposes of this provision, part-time and intermittent is defined as up to 8 hours of Medically Necessary care per day for up to 21 consecutive days, or longer when Preauthorized by Health Net. Refer to the Schedule of Benefits to determine whether your particular Health Plan includes enhanced benefits for Home Health Care; and
- Services for infusion must be obtained in Your physician's office, home setting, or an infusion center. Health Net has contracts with preferred providers who specialize in home infusion services and may be able to offer these services in an alternate setting.

Covered Services do not include:

- Housekeeping services;
- Services of a person who resides in the Member's home;
- Custodial Care, rest cures, respite care and home care that is or can be performed by Family Members or non-medical personnel;
- Services of a person who qualifies as a Family Member; and
- Services of an unlicensed person.

HOSPICE CARE SERVICES

Members who are diagnosed as having an illness giving them a life expectancy of 6 months or less, may request Hospice Care. All Hospice Care must be provided by a licensed participating Hospice and include Inpatient and Outpatient care related to the terminal condition and family counseling. Hospice care will continue only while the Member is under the direct and active medical supervision of a Participating Physician for a condition that necessitates Hospice care and will require Prior Authorization by Health Net.

MAMMOGRAMS

Mammograms are Covered Services when requested by a Participating Physician. A suggested schedule for preventive care is listed below:

- One baseline mammogram for women between the ages of 35 and 39 years;
- One mammogram every 2 years for women who are between the ages of 40 and 49 years, or more frequently if recommended by a Participating Physician;
- One mammogram each year for women who are age 50 and over; and
- Such other mammography screenings are determined to be Medically Necessary for a woman considered "at risk," as determined by Us and requested by a Participating Physician.

MATERNITY CARE SERVICES

- Prenatal and post-partum care;
- Birth services, including delivery room and birthing centers;
- Anesthesia;
- Injectables;
- Pre-natal diagnostic procedures in cases of high risk pregnancy or as otherwise Medically Necessary;
- Breastfeeding support, supplies, and counseling as supported by the Health Resources and Services Administration (HRSA) guidelines, are covered under the Preventive Care benefit listed in the Schedule of Benefits;
- Ultrasound;
- Special procedures such as caesarian section;
- Surgical procedures;
- X-ray and laboratory services;
- Complications of Pregnancy, as defined in this Evidence of Coverage;
- Prenatal screenings as outlined in the USPSTF recommendations under the Preventive Care benefit listed in the Schedule of Benefits; and
- Diagnostic genetic testing is covered when determined to be Medically Necessary and authorized through the Physician, or referring Specialist.

NOTE: The Subscriber must notify Health Net within 31 days of the birth to designate a Primary Care Physician for the newborn and to obtain a Health Net Member identification card.

Self-Referral

Female Members may self-refer to an obstetrics Specialist, Physician or Provider within their Network, or a Health Net contracted obstetrics Specialist, Physician or Provider if none is available within the Member's Network, for the purpose of obtaining prenatal, delivery and post-partum care. This self-referral does not require Prior Authorization through your Primary Care Physician. The obstetric Specialist, Physician or Provider will consult with the Member's Primary Care Physician regarding the Member's condition, treatment and any need for follow-up care.

Minimum Hospital Stay Requirements
Hospital length of stay for the mother and newborn following delivery will be at the discretion of the treating Physician in consultation with the mother. Hospital benefits for the mother and newborn will not be restricted to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarian section, if ordered by the treating Physician. Providers will not be required to obtain Prior Authorization for such lengths of stay. These provisions do not prohibit lengths of stay of less than the minimum otherwise required when the attending Physician, in consultation with the mother, makes a decision for early discharge. Hospital confinements that exceed the minimum stay requirements as described herein will require Prior Authorization by Health Net.

Travel Outside of the Service Area
Expectant Members who have reached 32 weeks gestation are encouraged to discuss any travel arrangements outside of the Service Area with their Primary Care Physician. Prenatal visits or elective care received outside of Health Net's Service Area are not covered unless Preauthorized by Us. Emergency Services received outside the Service Area are limited to conditions that require immediate attention.

Enrollment of Newborn
A newborn child of the Subscriber (including a legally adopted newborn child and a newborn child who has been placed for adoption with the Subscriber) is automatically covered for the first 31 days following the date of birth, date of adoption or placement for adoption. Failure to enroll a newborn within 31 days following the date of birth, date of adoption or placement for adoption will terminate Coverage at the end of the initial 31 day period. If additional Premium is required for continued Coverage of the newborn, continued Coverage of the newborn after the initial 31 day period is subject to Health Net's receipt of Premium payment for such newborn retroactive to the date of birth, date of adoption or date of placement.

Newborn Charges
Medically Necessary services, including Hospital Services, are also provided for a newborn child of the Subscriber (including legally adopted newborn children and newborn children who have been placed for adoption with the Subscriber) immediately after birth. In addition, Medical Services for the newborn child shall be provided for the first 31 days following birth. Continued Coverage beyond the first 31 days following birth is subject to the enrollment requirements and receipt by Health Net of any required Premiums, if applicable.

The expenses of the natural mother of any Child legally adopted by the Subscriber, within 1 year of birth are covered provided that:

- The Subscriber must be legally obligated to pay the costs of such birth;
- The Subscriber must pay all required Copayment and/or Coinsurance amounts for such care;
- The Subscriber must otherwise be eligible for Coverage; and
- The Subscriber notifies Health Net of his or her acceptability to adopt within 60 days after a change in insurance policies, plans or companies.

In the event that the mother remains in the hospital beyond the minimum hospital stay requirements or is discharged from the hospital and the newborn child remains hospitalized or is readmitted, the

hospital stay for the newborn child is subject to the applicable Copayment and/or Coinsurance in addition to the mother's Copayment and/or Coinsurance.

The Subscriber must notify Health Net of the existence and extent of any coverage the natural mother may have. If the natural mother has maternity coverage under another Health Plan, those benefits will be primary. Health Net benefits will be secondary, if needed.

Dependent Benefits
Maternity benefits are also provided for a Dependent daughter of the Subscriber who is enrolled in this Health Plan, except that Coverage shall not extend to the newborn child of the Dependent, unless such newborn meets the eligibility requirements as defined in the Group Enrollment Agreement.

MEDICAL FOODS

Medical Foods prescribed or ordered under the supervision of a Participating Physician or registered nurse practitioner will be covered if Medically Necessary for the therapeutic treatment of an Inherited Metabolic Disorder or to prevent mental or physical impairment arising from an Eosinophilic Gastrointestinal Disorder.

Medical foods coverage must:

- Be part of the newborn screening program;
- Involve amino acid, carbohydrate or fat metabolism; and
- Have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues.

Medical foods coverage for an Eosinophilic Gastrointestinal Disorder (EGD) must:

- Be diagnosed with EGD by a disease specialist

Medical Foods for Members with an Inherited Metabolic Disorder that meet the above criteria will be covered with a 50% Coinsurance

Medical Foods for Members with an Eosinophilic Gastrointestinal Disorder that meet the above criteria will be covered with a 25% Coinsurance.

MEDICAL SUPPLIES

Medical Supplies are issued when Medically Necessary, as determined by Us. Covered Services include:

- Casting materials;
- Surgical dressings only when provided under the supervision of a Home Health Agency and prescribed by the Primary Care Physician;
- Ostomy supplies and urinary catheters (are limited as defined by Medicare guidelines);
- Medical supplies that are necessary to operate and/or maintain a covered prosthesis or item of Durable Medical Equipment, subject to the limitations stated herein; and

- Breastfeeding devices and supplies, as supported by Health Resources and Services Administration (HRSA) guidelines, are covered as preventive care listed under "Preventive Care" section in the Schedule of Benefits.

Covered Services are subject to the following exclusions and limitations:

- Most medical supplies are issued for a 31 day supply as defined by Medicare guidelines;
- Surgical dressings are limited to those provided under the supervision of a participating Home Health Agency and prescribed by the Primary Care Physician;
- Medical supplies necessary to operate a non-covered item of DME or prosthesis are not covered; and
- Over-the-counter dressings and soft goods, such as ace wraps, gauze, alcohol swabs and dressings, not provided in the Primary Care Physician's office or under the supervision of a Participating Home Health agency are not covered.

MENTAL HEALTH SERVICES

Mental Health Services are those services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to mental health will not be considered to be charges made for treatment of mental health.

All services are administered by MHN. MHN's Customer Services Department can be reached at 1-800-977-0281.

Appointments for professional Mental Health conditions must be canceled at least 24 hours in advance. Coverage is not provided for missed appointments or appointments not canceled 24 hours in advance. Members will be required to pay the applicable Copayment or late cancellation fee for missed appointments.

Crisis – For purposes of this provision is defined as: Significant decline in Global Assessment of Functioning (GAF) of greater than 10 points in the past 60 days, and currently below 60, that is treatable to restoration of premorbid levels by the application of brief (3 to 6 sessions), solution-focused treatment and/or medication management.

COVERED SERVICES

Inpatient Services

Covered services include:

Inpatient Mental Health Services must be received in any Participating Hospital or Facility. Hospitalization will be subject to review proceedings by the designated behavioral health representative.

- If hospitalization is due to an Emergency condition, the Member must contact Health Net within 24 hours of admission, or as soon as is reasonably possible to ensure Coverage. Emergency Services, which are Precertified, will not be retrospectively denied;
- Psychiatric assessment/stabilization/treatment in an ER setting;
- Crisis assessment/stabilization in the community;

- Electroshock and other convulsive therapy; and
- Psychological and neuropsychological testing.

If your Health Plan provides for Inpatient Mental Health Services, the following provisions will apply:

- Hospitalization will be subject to Precertification by the designated behavioral health representative.
- If hospitalization is due to an Emergency condition, the Member must contact Health Net within 48 hours of admission, or as soon as is reasonably possible to ensure Coverage at the higher In-Network benefit level. Emergency Services, which are Precertified, will not be retrospectively denied.

Outpatient Services

Health Net subscribes to the philosophy that Mental Health Services be provided in the least restrictive environment.

Covered services include, but are not limited to:

- Outpatient treatment of conditions such as: anxiety or depression which interferes with daily functioning;
- Emotional adjustment or concerns related to chronic conditions, such as psychosis or depression;
- Psychological and neuropsychological testing;
- Partial Hospitalization and Intensive Outpatient Treatment Programs;
- Emotional/behavioral reactions to life changes;
- Child/adolescent problems of conduct or poor impulse control;
- Affective disorders;
- Eating disorders;
- Electroshock and other convulsive therapy;
- Acute Exacerbation of chronic mental health conditions (crisis intervention relapse prevention);
- Outpatient assessment, and medication management when provided in conjunction with a consultation;
- Learning disabilities; and developmental and education counseling; and
- Autism testing

MISSED / CANCELED APPOINTMENTS

Appointments for professional Mental Health conditions must be canceled at least 24 hours in advance. Coverage is not provided for missed appointments or appointments not canceled 24 hours in advance. Members will be required to pay the applicable Copayment/Coinsurance or late cancellation fee for missed appointments.

LIMITATIONS AND EXCLUSIONS

In addition to the Exclusions and Limitations listed herein, the following services are not covered under this Mental Health Services Benefit:

Selected services and treatments require Preauthorization in order to be covered. Questions concerning Prior Authorization can be directed to the Primary Care Physician or Health Net's Customer Contact Center at 1-800-289-2818.

- Treatment for chronic or organic conditions, including Alzheimer's, dementia or delirium. Delirium will not be excluded when reported as a symptom of treatment for a Mental Disorder or Substance Use Disorder according to DSM-5/ICD-10. This exclusion does not apply to the initial assessment for diagnosis of the condition.
- Ongoing treatment for mental disorders that are long-term or chronic in nature for which there is little or no reasonable expectation for improvement, unless reported as symptoms of treatment for a Mental Disorder or Substance Use Disorder according to DSM-5/ICD-10. These disorders include mental retardation, personality disorders, and organic brain disease. This exclusion does not apply to the initial assessment for diagnosis of the condition.
- Psychosexual disorders or transsexualism, unless reported as symptoms of treatment for a Mental Disorder or Substance Use Disorder according to DSM-5/ICD-10. *This exclusion does not apply to the initial assessment for diagnosis of the condition*.
- Counseling, testing, evaluation, treatment or other services in connection with the following: learning disorders and/or disabilities, disruptive behavior disorders, conduct disorders, motor skill disorders, communication disorders, attention deficit disorders, unless reported as symptoms of treatment for a Mental Disorder or Substance Use Disorder according to DSM-5/ICD-10. *This exclusion does not apply to the initial assessment for diagnosis of the condition*.
- Psychological testing or evaluation specifically for ability, aptitude, intelligence, interest or competency;
- Psychiatric evaluation, therapy, counseling or other services in connection with the following: child custody, parole and/or probation, and other court ordered related issues.
- Therapy, counseling or other services related to relationship and/or communication issues unless reported as symptoms of treatment for a Mental Disorder or Substance Use Disorder according to DSM-5/ICD-10.
- Marriage counseling, unless otherwise specifically stated as a Covered Service in the Schedule of Benefits;
- Services that exceed a Member's maximum allowable benefit as described in the Schedule of Benefits; and
- Charges incurred for missed appointments or appointments not canceled within 24 hours of appointment.

NUTRITIONAL COUNSELING SERVICES

Nutritional evaluation and counseling from a Participating Provider is covered when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including but not limited to:

- Morbid obesity
- Diabetes;
- Cardiovascular disease;
- Hypertension;
- Kidney disease;
- Gastrointestinal disorders;
- Food allergies; and

Selected services and treatments require Preauthorization in order to be covered. Questions concerning Prior Authorization can be directed to the Primary Care Physician or Health Net's Customer Contact Center at 1-800-289-2818.

- Hyperlipidemia.

ORAL AND MAXILLOFACIAL SURGERY

Covered under this benefit:

- The reduction or manipulation of an Acute fracture of facial bones including the jawbone and supporting tissues due to an Accidental Injury;
- Oral surgery for the excisions of lesions, cysts or tumors;
- Reconstruction or repair of the palate or cleft lip.

Not Covered:

- Any treatment for orthognathic and/or arthroplastic surgery;
- Any services related to malocclusion or malposition of the teeth or jaw;
- TMJ except in connection with an Acute dislocation of the mandible; and
- Oral implants and transplants.

PROSTHETIC DEVICES

Covered Services include:

- Prosthetic Devices when they are determined to be Medically Necessary and result from an illness, injury, or surgery causing anatomical functional impairment, or from a Congenital Defect. Coverage includes the fitting and purchase of a standard model. Replacement of devices is covered only if determined Medically Necessary or results from a change in the Member's physical condition;
- Artificial limbs including the initial purchase, and subsequent purchases due to physical growth, for a Covered Member that meets all other screening criteria. Covered Services must be obtained from a Participating Provider in order to be covered. Coverage is limited to limbs that are necessary because of an illness, injury or surgery causing anatomical functional impairment, or from a Congenital Defect;
- The first pair of contacts or corrective lenses following cataract surgery, treatment of aphakia, treatment of keratoconus or corneal transplantation, including eyewear allowance up to $75 subject to the limitations stated herein; and
- Repair and/or replacement of equipment or parts due to normal wear and tear is covered only when Medically Necessary, as determined by Health Net.

Covered Services **do not include**:

- Repairs and/or replacement of parts or devices worn out due to misuse or abuse;
- Model upgrades;
- Penile implants; and
- Custom breast prosthesis, except following covered mastectomy as specifically provided herein.

RECONSTRUCTION SURGICAL SERVICES

Covered Services include:

- Surgeries for the correction of disease or injury which cause anatomical functional impairment. Coverage of surgical procedures will be based upon the reasonable expectation that the condition or disease will be corrected. The determination process will include Health Net's clinical and medical criteria;
- Reconstructive surgery incidental to Congenital Defects of a covered Dependent. Coverage is limited to the Medically Necessary care and treatment of medically diagnosed Congenital Defects and birth abnormalities of a newborn, adopted child or child placed for adoption. Surgery will be covered past the Newborn Period if Medically Necessary and medical criteria are met; and
- Surgical services for breast reconstruction and for post-operative Prostheses incidental to a Medically Necessary mastectomy. Coverage includes reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, Prostheses and physical complications for all stages of mastectomy, including lymphedemas. Health Net will cover mastectomy bras.

Covered Services **do not include**:

- Reconstructive surgery to correct an abnormal structure resulting from trauma or disease when there is no restorative function, except as specifically provided herein;
- Breast reduction which is not Medically Necessary, except following a covered mastectomy as specifically provided herein; and
- Rhinoplasty and associated surgery, rhytidectomy or rhytidoplasty, breast augmentation (except following a covered mastectomy as specifically stated herein), blepharoplasty without visual impairment, otoplasty, skin lesions when there is no functional impairment or suspicion of malignancy or located in an area of high friction, or keloids, procedures utilizing an implant which does not alter physiologic function, treatment or surgery for sagging or extra skin, or liposuction.

REHABILITATIVE SERVICES

Short term Rehabilitation Services and treatments for Acute conditions when significant improvements can be expected in a predictable period of time are covered. A "predictable period of time" means the length of time as submitted by the Primary Care Physician or referring Physician or as determined by the rehabilitation Specialist, and will require Prior Authorization by Health Net.

Rehabilitative Services include, but are not limited to, the following:

- Physical therapy;
- Occupational therapy;
- Cardiac rehabilitation; and
- Pulmonary rehabilitation.
- Speech and language services limited to:
  - Corrections of speech impairment, cognitive or perceptual deficits related to an Accident, injury, stroke, surgical procedure or Autism Spectrum Disorder; and

Selected services and treatments require Preauthorization in order to be covered. Questions concerning Prior Authorization can be directed to the Primary Care Physician or Health Net's Customer Contact Center at 1-800-289-2818.

- Therapies for organic swallowing disorders that are related to a medical condition, such as multiple sclerosis and muscular dystrophy.

Please refer to the Schedule of Benefits for applicable Copayment and/or Coinsurance and maximum allowable day limit per Year.

The following limitations apply to Rehabilitative Services:

- Routine and/or non-Acute speech therapy is not covered;
- Services and treatment must be for Acute impairment of capacity due to accidental injury, Autism Spectrum Disorder or other medical conditions;
- Services are provided on an Outpatient, Inpatient or home basis as determined by the Primary Care Physician, referring Physician or rehabilitation Specialist and by Us;
- Rehabilitative services are limited to the maximum allowable number of days per Year, as specified in the Schedule of Benefits, for all services and conditions combined regardless of the number of injuries or illnesses in one Year;
- Services provided on the same day, regardless of place of service (Inpatient Rehabilitation, or Outpatient Facility, or any combination thereof), will count as one day towards the maximum allowable number of days per Year, as specified in the Schedule of Benefits;
- Rehabilitative services provided during an Inpatient Hospital stay for which Rehabilitation is not the primary reason for the Hospital stay, will not apply to the maximum allowable number of days per Year, as specified in the Schedule of Benefits;
- Rehabilitative services related to 1) Developmental delay; 2) Maintaining physical condition; 3) Maintenance therapy for a Chronic Condition are not Covered Services;
- Continued and repetitive Rehabilitative treatment without a clearly defined endpoint is considered Maintenance and is not covered; and
- Functional capacity or work capacity evaluations are not covered.

SECOND OPINION

This plan covers second opinion by a Physician. A second opinion is an additional evaluation of a member's condition by a Physician to provide his or her view about the condition and how it should be treated. To request a referral to a Specialist for a second opinion, contact your Primary Care Physician. All second opinions must be provided by a Physician who has training and expertise in the illness, disease or condition associated with the request.

SKILLED NURSING FACILITY SERVICES

Skilled Nursing Facility Services are covered when determined to be Medically Necessary. Covered Services include:

- Admission to a Skilled Nursing Facility, when appropriate and Medically Necessary, as determined by Us;
- Medical care and treatment, including room and board in semi-private accommodations at a Skilled Nursing Facility which is a Participating Provider for non-Custodial Care;
- Covered Services shall be of a temporary nature and must be supported by a treatment plan; and

Selected services and treatments require Preauthorization in order to be covered. Questions concerning Prior Authorization can be directed to the Primary Care Physician or Health Net's Customer Contact Center at 1-800-289-2818.

- Covered Services must be Approved in advance through the Primary Care Physician and Health Net with expectations of rehabilitation and increased ability to function within a reasonable and generally predictable period of time.

Covered Services **do not include**:

- Custodial or domiciliary care; and
- Long-term care admissions.

SUBSTANCE ABUSE SERVICES

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any conditions of physiological instability requiring medical hospitalization will not be considered to be charges made for treatment of substance abuse.

Substance Abuse services are managed by MHN and Preauthorization is required for all services, except Outpatient Office Visits and Emergency services. MHN's Customer Service Department can be reached at 1-888-926-5122.

Inpatient Services
The following provisions apply to Inpatient Substance Abuse Services:

- Hospitalization will be subject to Precertification by Health Net's Utilization Management Department;
- Preadmission authorization and continued stay authorization is required for both Substance Abuse rehabilitation and non-emergent detoxification services. All admissions for rehabilitation are non-emergent and must be Prior Authorized as Medically Necessary prior to admission. Detoxification services are covered only when Prior Authorized or as Emergency 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.
- If hospitalization is due to an Emergency condition, the Member must contact Health Net within 24 hours of admission, or as soon as is reasonably possible to ensure Coverage at the higher In-Network benefit level;
- Inpatient services must be received in a Participating Hospital, specialty Hospital or Facility. Hospitalization will be subject to review proceedings by MHN's Utilization Management Department and/or MHN; and
- Residential Substance Abuse treatment will be covered for chemical and alcohol dependency.

Outpatient Services/Intensive Outpatient/Partial Hospitalization

Health Net subscribes to the philosophy that Substance Abuse Services be provided in the least restrictive environment. Outpatient services are covered subject to the limitations stated herein.

Outpatient Substance Abuse Services include services for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs including outpatient rehabilitation in an individual, group, structured group or intensive outpatient structured therapy program.

Intensive outpatient structured therapy programs consist of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Partial Hospitalization Service is an ambulatory treatment approach that includes coordinated, intensive, comprehensive, and multidisciplinary treatment usually found in a comprehensive inpatient hospital program.

In addition to the Exclusions and Limitations listed in this Evidence of Coverage, the following services are not covered under this Substance Abuse Services Benefit:

- Long term services;
- Continuing in a course of counseling for patients who are disruptive or physically abusive;
- Referral for non-Medically Necessary ancillary services such as vocational programs and employment counseling;
- Court ordered testing;
- Services which exceed the Member's maximum allowable benefit;
- Expenses related to a stay at a sober living facility.

TELEMEDICINE

Telemedicine refers to services delivered through a two-way communication that allows a Health Professional to interact with a Member, through the use of audio, video, or other electronic media for the purpose of diagnosis, consultation or treatment.

We will provide health care services through telemedicine under, the following conditions:

- Health Net would otherwise provide coverage for the service when provided in person by the Health Professional; and
- The Member is accessing care within the geographic Service Area defined by their Health Plan

The following definition applies to the terms mentioned in this provision only.
Health Care Services include, but are not limited to, services provided for the following conditions or in the following settings:

- Trauma;
- Burn;
- Cardiology;
- Infectious Diseases;
- Mental Health Disorders;
- Neurologic Diseases including Strokes;
- Dermatology; and
- Coverage is subject to same applicable Deductible, Copayment or Coinsurance that would apply to a comparable health care service provided in person.

Services not covered include but are not limited to:

Services through telemedicine if such services are not otherwise covered when provided in-person. Additionally, the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail without an interaction between the Member and health care provider for the purpose of diagnosis, consultation or treatment is also not covered.

Selected services and treatments require Preauthorization in order to be covered. Questions concerning Prior Authorization can be directed to the Primary Care Physician or Health Net's Customer Contact Center at 1-800-289-2818.

TRANSPLANT SERVICES - ORGAN AND TISSUE

Medically Necessary required organ and tissue transplants are Covered Services as listed below when ordered or arranged by a Participating Physician and Our Medical Director. All transplants are Preauthorized based on specific medical and eligibility criteria in order to be covered. In every case, Our Medical Director must determine the Medical Necessity of the transplant. Any transplant which is specifically excluded under the Evidence of Coverage will not be covered. Covered Charges are payable under the Evidence of Coverage when medical eligibility criteria adopted by Us are met and when services are provided in an accredited facility, where applicable, and licensed to deliver the appropriate level of care as dictated by Medical Necessity

Health Net uses established medical criteria when determining benefits and Coverage for internal organ and tissue transplants. Health Net will provide Coverage for all Medical and Hospital Services in connection with Medically Necessary transplant surgery based on current criteria. The following organ and tissue transplants are covered:

- Heart;
- Simultaneous Heart / Lung;
- Kidney;
- Simultaneous Kidney / Pancreas;
- Pancreas;
- Lung;
- Liver/Living Liver;
- Cornea;
- Autologous and Allogeneic Bone Marrow Stem Cell;
- Small bowel/liver; and
- Kidney/Liver

FDA approved ventricular assist devices (VADs) are covered as a bridge to transplant when used according to FDA labeling instructions. VADs are not covered when used as artificial hearts.

Donor Searches and Coverage
Donor searches are not covered unless otherwise specifically stated in the *Schedule of Benefits*. Coverage includes Medically Necessary services, supplies and medications provided to a donor of organs and/or tissues, whether or not the donor is a Member of Health Net. Such Coverage is only available for the purpose of obtaining organs or other tissue for transplants where the recipient is a Health Net Member.

Covered Services for transplants **do not include**:

- Services, supplies and medications provided to a donor of organs and/or tissue, for transplants where the recipient is not a Health Net Member;
- Transplants that are considered Experimental, Unproved or Investigational;
- Non-human or artificial organs, and the related implantation services;
- Bone marrow transplants for human gene therapy (enzyme deficiencies, severe hemoglobinopathies, and primary lysosomal storage disorders);

- Donor searches;
- Collection and/or storage of blood products to include stem cells for any unscheduled medical procedure, or non-covered medical procedures; and
- VADs when used as an artificial heart.

URGENT CARE SERVICES

We encourage Members to contact their Primary Care Physician before seeking Urgent Care Services.

Urgent Care is defined as those services, which are provided for the relief of Acute pain, initial treatment of Acute infection, or a medical condition that requires medical attention, but a brief time lapse before care is obtained does not endanger life or permanent health. Examples of Urgent Care services would include minor sprains, fractures, pain, and heat exhaustion. An individual patient's urgent condition may become emergent upon evaluation by a Participating Provider.

Covered Services for Urgent Care:

- Include treatment for unforeseen medical situations (initial visit only); and
- Require the Member to provide full details, including medical records of Urgent Care services rendered by a Non-Participating Provider, if requested by this Health Plan. Costs associated with Urgent Care services will be reimbursed only after Health Net receives and reviews the Urgent Care medical records and determines that such services were Medically Necessary. Services that have been Preauthorized will not be retrospectively denied;

Covered Services **do not include**:

- Continuing, routine or follow-up care in an Urgent Care Facility.

Routine care provided by an Urgent Care provider is not covered. The Member will be financially responsible for any Urgent Care provider charges for non-Urgent Care. Routine care includes, but is not limited to, conditions such as colds, flu, sore throats, superficial injuries, minor infections, follow-up care and preventive care.

VISION SERVICES

Covered Services include:

- Vision screenings to diagnose and treat a suspected disease or injury of the eye, when such services are performed by the Primary Care Physician or referring Specialist;
- Vision screenings to determine the need for correction of refractive error, when such services are performed by the Primary Care Physician;
- For Members 18 years or younger, an initial consultation from the appropriate Specialist, including refraction, if Medically Necessary or indicated by the screening. Follow-up services by an appropriate Specialist are covered for Members l8 years or younger, as determined Medically Necessary by the Primary Care Physician; and
- Members who have been diagnosed with diabetes may self-refer once each Year to an eye care Specialist within their Network, or a Health Net contracted eye care Specialist if none is available within the Member's Network, for the purpose of receiving an eye exam for the

detection of eye disease. Continued, or follow-up care from the eye care Specialist will require a Referral through your Primary Care Physician.

Covered Services **do not include**:

- Referrals to a Specialist for evaluation and diagnosis of eye disorders, including presbyopia, for Members over the age of 18 years, unless your Group has purchased supplemental vision benefits. Please refer to the Schedule of Benefits to determine whether your particular Health Plan includes enhanced Vision Services Benefits;
- Eye examinations required by an employer or as a condition of employment;
- Radial keratotomy, LASIK and other refractive eye surgery;
- Eyeglasses, contact lenses and/or servicing of eyeglasses and contact lenses, unless your Group has purchased supplemental vision benefits. Please refer to the Schedule of Benefits to determine whether your particular Health Plan includes benefits for vision materials;
- Services or materials provided as a result of any workers' compensation law, or required by any governmental agency; and
- Orthoptics, vision training or subnormal vision services.

OUTPATIENT IMAGING AND TESTING SERVICES

Covered Services include:

- CT;
- MRI/MRA;
- PET/SPECT;
- Related Facility charges;
- BEAM (Brain Electrical Activity Mapping); and
- ECT (Emission Computerized Tomographam)

Copayments and Coinsurance may be different depending on whether the services are provided at a Physician's office, an independent, freestanding facility, or a hospital, outpatient surgery facility or ambulatory surgical facility.

X-RAY AND LABORATORY SERVICES

Covered Services include:

- Diagnostic x-rays;
- Electrocardiograms;
- Laboratory tests;
- Portable x-rays;
- X-ray therapy;
- Fluoroscopy;
- Therapeutic radiology services (radiation therapy); and
- Mammography

Copayments and Coinsurance may be different depending on whether the services are provided at a Physician's office, an independent, freestanding facility, or a hospital, outpatient surgery facility or ambulatory surgical facility. Please see the *Schedule of Benefits* for details.

EXCLUSIONS AND LIMITATIONS

In addition to those Exclusions and Limitations described in the *Description of Benefits* section of this Evidence of Coverage, the following services are not covered or are limited in benefit application. Unless expressly stated as limited in Coverage, the services are not covered:

Abortions
Elective abortions are not covered under this Health Plan, unless otherwise specifically stated in the *Schedule of Benefits*. Abortions which are determined to be necessary to save the life of the woman having the abortion; when the pregnancy is the result of rape or incest; or is necessary to avert substantial and irreversible impairment of a major bodily function of the woman having the abortion are covered.

Alternative Therapies
Acupuncture, acupressure, hypnotherapy, biofeedback, behavior training, educational, recreational, art, dance, sex, sleep or music therapies, and other forms of holistic treatment or alternative therapies, unless otherwise specifically stated as a covered benefit herein or in the *Schedule of Benefits*.

Benefits or Services (Non-Covered)
Services, supplies, treatments or accommodations which:

- Are not Medically Necessary except as specifically described herein;
- Are not specifically listed as a Covered Service herein, whether or not such services are Medically Necessary;
- Are incident or related to a non-Covered Service;
- Are not considered generally accepted health care practices;
- Are considered cosmetic as determined by Us, unless specifically listed as a Covered Service herein;
- Are provided prior to the Effective Date of Coverage hereunder, or after the termination date of Coverage hereunder;
- Are provided under Medicare or any other government program except Medicaid;
- The person is not required to pay, or for which no charge is made; and
- Exceed a Member's annual or Lifetime Maximum benefit as described herein or as otherwise specifically stated in the *Schedule of Benefits*.

Blood Products
Collection and/or storage of blood products to include stem cells for any unscheduled medical procedure, or non-covered medical procedures. Salvage and storage of umbilical cord and/or after birth are not covered.

Braces

- Over-the-counter braces;
- Prophylactic braces; and
- Braces used primarily for sports activities.

Breast Implants, Prostheses
Breast implants, including replacement, except when Medically Necessary, as determined by Us, and related to a Medically Necessary mastectomy. Removal of breast implants, except when Medically Necessary as determined by Us.

Chiropractic Care

- Any services provided by a non-Participating Chiropractor regardless of whether the services were obtained within or outside of the Health Plan's Service Area;
- Any services after the initial 12 visit limit, including consultations (except for the initial evaluation visit), that are not Preauthorized by the designated Chiropractic Provider as shown in the *Schedule of Benefits*;
- Any treatments or services, including x-rays, determined to not be related to neuromusculoskeletal disorders as defined by the designated Chiropractic Provider as shown in the *Schedule of Benefits*;
- Services which are not provided in a participating Chiropractor's office;
- Services or charges which exceed the Member's maximum allowable benefit. Services which exceed the Member's maximum allowable benefit will be the Member's financial responsibility;
- Expenses incurred for any services provided before Coverage begins or after Coverage ends according to the terms of this Evidence of Coverage;
- Preventive care, educational programs, non-medical self-care, self-help training, or any related diagnostic testing, except that which occurs during the normal course of covered chiropractic treatment;
- Prescription medications;
- Vitamins, nutritional supplements or related products, even if they are prescribed or recommended by a Participating Chiropractor;
- Services provided on an Inpatient basis;
- Transportation costs, including Medically Necessary ambulance charges which have not been requested and Preauthorized by Health Net;
- Rental or purchase of Durable Medical Equipment, air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices, appliances or equipment as ordered by the Participating Chiropractor even if their use or installation is for the purpose of providing therapy or easy access;
- Charges resulting from a missed appointment which the Member failed to cancel;
- Treatment primarily for purposes of obesity or weight control;
- Vocational rehabilitation and long-term rehabilitation;
- Hypnotherapy, acupuncture, behavior training, sleep therapy, massage or biofeedback;
- Radiological procedures performed on equipment not certified, registered or licensed by the State of Arizona, and/or radiological procedures that, when reviewed by the designated Chiropractic Provider as shown in the *Schedule of Benefits* or Health Net, are determined to be of such poor quality that they cannot safely be utilized in diagnosis or treatment;
- Services, lab tests, x-rays and other treatments not documented as clinically necessary as appropriate or classified as experimental or investigational and/or as being in the research stage;
- Services and/or treatments that are not documented as medically necessary services, as determined by Us;
- All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids;
- Adjunctive therapy not associated with spinal, muscle or joint manipulation; and

- Manipulation under anesthesia.

Circumcision
Non-Medically Necessary circumcisions after the Newborn Period, including cases of premature birth.

Communications and Accessibility Services
Provider charges for interpretation, translation, accessibility or special accommodations.

Complications of Non-Covered Charges
Complications of an ineligible or excluded condition, procedure or service (non-Covered Charges), including services received without Preauthorization.

Cosmetic Surgery or Reconstructive Surgery
Cosmetic or Reconstructive surgery, which in the opinion of Health Net is, performed to alter an abnormal or normal structure solely to render it more aesthetically pleasing where no significant anatomical functional impairment exists. The following are examples of non-Covered Services:

- Rhinoplasty and associated surgery;
- Rhytidectomy or rhytidoplasty;
- Breast augmentation/implantation;
- Blepharoplasty without visual impairment;
- Breast reduction which is not Medically Necessary, as determined by Us;
- Otoplasty;
- Skin lesions without functional impairment, suspicion of malignancy or located in area of high friction;
- Keloids;
- Procedures utilizing an implant which does not alter physiologic function;
- Treatment or surgery for sagging or extra skin;
- Liposuction; and
- Non-Medically Necessary removal or replacement of breast implants, as determined by Us

This exclusion does not apply to breast reconstruction incidental to a covered mastectomy for either the breast on which the mastectomy has been performed or for surgery and reconstruction of the other breast to produce a symmetrical appearance. Reconstructive surgery incidental to birth abnormalities of a Covered Dependent is limited to the Medically Necessary care and treatment of medically diagnosed Congenital Defects and birth abnormalities of a newborn, adopted child or child placed for adoption. Surgery will be covered past the Newborn Period if Medically Necessary and medical criteria are met.

Counseling Services
Unless otherwise specifically stated as a covered benefit herein or in the *Schedule of Benefits*.

- Counseling for social, occupational, religious or other maladjustments;
- Marriage and/or family counseling unless otherwise specifically stated as a Covered Service in the *Schedule of Benefits*;
- Counseling for behavior modification, biofeedback (for reasons other than pain management, and for pain management related to Mental Health and Substance Abuse), or rest cures as treatment for Mental Disorder and Substance Use Disorder according to DSM-5/ICD-10;
- Sensitivity or stress-management training, and/or self-help training; and
- Counseling services including weight control clinics

Court or Police Ordered Services
Examinations, reports or appearances in connection with legal proceedings, including child custody, competency issues, parole and/or probation and other court ordered related issues. Services, supplies or accommodations pursuant to a court or police order, whether or not injury or sickness is involved.

Custodial Care
Any service, supply, care or treatment that Health Net determines to be incurred for rest, domiciliary, convalescent or Custodial Care. Examples of Non-Covered Services include:

- Any assistance with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medications;
- Any care that can be performed safely and effectively by a person who does not require a license or certification or the presence of a supervisory nurse;
- Non-covered Custodial Care Services no matter who provides, prescribes, recommends or performs those services;
- Services of a person who resides in the Member's home, or a person who qualifies as a Family Member; and
- The fact that certain Covered Services are provided while the Member is receiving Custodial Care does not require Health Net to cover Custodial Care.

Dental Services
The *medical* portion of your Health Plan covers only those dental services specifically stated in the section titled *Description of Benefits*. All other dental services are excluded. Non-Covered Services under your *medical* benefit include dental services in connection with the care, treatment, filling, removal or replacement of teeth, or structures directly supporting the teeth, except as specifically described herein.

Examples of Non-Covered Services include:

- Routine dental care and dental x-rays;
- Dental appliances and orthodontia;
- Medical treatments relating to orthognathic and/or arthroplastic surgery;
- Dental splits, implants and prostheses;
- Dentures;
- Medications prescribed by a Dentist;
- Medications needed prior to non-covered dental surgery; and
- General anesthesia for routine dental services

If you have elected additional Dental Benefits, please refer to the Dental Benefit Rider and corresponding Dental Policy, which will be mailed to you under separate cover, for a description of services and the limitations that apply.

Devices
Bionic and hydraulic devices, except when otherwise specifically described herein.

Diabetic Supplies, Equipment and Devices
Diabetic supplies are covered when Medically Necessary, as determined by Health Net and in accordance with guidelines established by the Centers for Medicare and Medicaid Services (CMS). The following are specific requirements for Coverage:

- Diabetic supplies must have a written prescription from a Provider, when Medically Necessary, as determined by Health Net.

- Refills are covered only when Authorized by a Provider, when Medically Necessary, as determined by Health Net.
- Covered Services must be obtained from a Provider unless otherwise Prior Authorized by Health Net.
- Plan approved standard blood glucose monitors are covered for both insulin-dependent and non-insulin-dependent Members when necessary for medical management as determined by Health Net in consultation with your Physician. Blood glucose monitors require a prescription from a Physician and must be obtained at a Pharmacy.
- Plan approved blood glucose monitors for the legally blind are covered when medically necessary and the Member has been diagnosed with diabetes. Blood glucose monitors require a written prescription from a Physician and must be obtained at a Pharmacy.

Dietary Food or Nutritional Supplements
Non-Covered Services include the following:

- Nutritional supplementation ordered primarily to boost protein-caloric intake or the mainstay of a daily nutritional plan in the absence of other pathology, except as otherwise stated herein or in the *Schedule of Benefits*. This includes those nutritional supplements given between meals to increase daily protein and caloric intake; and
- Services of nutritionists and dietitians, except as incidentally provided in connection with other Covered Services.

Disability Certifications
Disability Certifications if not required by Us.

Durable Medical Equipment
Durable Medical Equipment that fails to meet the criteria as established by Health Net. Examples of Non-Covered Services include, but are not limited to, the following:

- Exercise equipment, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses, or waterbeds, escalators or elevators, ramps, automobile modifications, safety bars, saunas, swimming pools, Jacuzzi or whirlpools, and hygienic equipment;
- Equipment for a patient in an institution that is ordinarily provided by an institution, such as wheelchairs, hospital beds and oxygen tents, unless these items have been Preauthorized by Health Net;
- More than one DME device designed to provide essentially the same function;
- Foot Orthotics, except when attached to a permanent brace (refer to exclusion entitled Orthotics) (This exclusion does not apply to coverage of special shoes and inserts for certain patients with diabetes. Please refer to your diabetic benefits for further specification.);
- Deluxe, electric, model upgrades, specialized, customized or other non-standard equipment;
- Repair or replacement of deluxe, electric, specialized or customized equipment, model upgrades, and portable equipment for travel;
- Transcutaneous Electrical Nerve Stimulation (TENS) units;
- Scooters and other power operated vehicles;
- Warning devices, stethoscopes, blood pressure cuffs, or other types of apparatus used for diagnosis or monitoring, except as specifically listed as being covered herein;
- Repair or replacement of equipment or parts due to normal wear and tear, adjustment, model upgrades and duplicates, except as specifically listed as being covered herein;
- Repair, replacement or routine maintenance of equipment or parts due to misuse or abuse;

- Over-the counter braces and other DME devices, except as specifically listed as being covered herein;
- Prophylactic braces, except as specifically listed as being covered herein;
- Braces used primarily for sports activities;
- Pulse oximeters;
- ThAIRapy® vests, except when Health Net medical criteria are met, as determined by Health Net; and
- Communication devices (speech generating devices) and/or training to use such devices

Emergency Services
Use of Emergency Facilities for non-Emergency purposes. Routine Care, follow-up care or continuing care provided in an Emergency Facility, unless such services were Preauthorized by the Primary Care Physician or Health Net.

Exercise Programs
Exercise programs, yoga, hiking, rock climbing, and any other types of sports activity, equipment, clothing or devices

Ex-Member (Services for)
Benefits and services provided to an ex-Member after termination of the ex-Member pursuant to the Group Enrollment Agreement.

Experimental, Investigational Procedures, Devices, Equipment and Medications (except for cancer drugs described in "off label" use below)
Experimental, Unproved and/or Investigational medical, surgical or other Experimental health care procedures, services, supplies, medications, devices, equipment or substances. Experimental, Unproved and/or Investigational procedures, services or supplies are those which, in the judgment of Health Net:

- Are in a testing stage or in field trials on animals or humans;
- Do not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed;
- Are not in accordance with generally accepted standards of medical practice;
- Have not yet been shown to be consistently effective for the diagnosis or treatment of the Member's condition;
- Are medications or substances being used for other than FDA approved indications; or
- Are medications labeled "Caution, Limited by Federal Law to Investigational Use."

This exclusion does not apply to coverage for Routine Patient Costs provided to Members participating in cancer treatment and Clinical Trials as required by state and federal law and defined in this Evidence of Coverage.

Family Member (Services Provided by) and Member Self-Treatment
Professional services, supplies or provider referrals received from or rendered by an immediate family member (spouse, domestic partner, child, parent, grandparent or sibling related by blood, marriage or adoption) or prescribed or ordered by an immediate family member of the member unless the immediate family member is an In-Network contracted Provider with Health Net on the date of services; Member self-treatment including, but not limited to self-prescribed medications and medical self-ordered services.

Foot Orthotics
See exclusion titled Orthotics.

Fraudulent Services
Services or supplies that are obtained by a Member or non-Member by, through or otherwise due to fraud.

Gastric Stapling/Gastroplasty
Gastric stapling and other similar restrictive gastrointestinal surgery, and/or elective reversals of such surgeries.

Genetic Testing, Amniocentesis
Services or supplies in connection with genetic testing, except those which are determined to be Medically Necessary, as determined by Us. Genetic testing, amniocentesis, ultrasound, or any other procedure required solely for the purpose of determining the gender of a fetus.

Government Hospital Services
Services provided by any governmental unit except as required by federal law for treatment of veterans in Veterans Administration or armed forces Facilities for non-service related medical conditions. Care for conditions received in a public Facility as required by federal, state, or local law.

Growth Hormone
- Human Growth Hormone except for children or adolescents who have one of the following conditions:
- Documented growth hormone deficiency causing slow growth;
- Documented growth hormone deficiency causing infantile hypoglycemia;
- SHOX;
- Short stature and slow growth due to:

1. Turner syndrome;
2. Prader-Willi syndrome;
3. Chronic renal insufficiency prior to transplantation;
4. Central nervous system tumor treated with radiation;

- Documented growth hormone deficiency due to a hypothalamic or pituitary condition.

Hair Analysis, Treatment and Replacement
Testing using a patient's hair except to detect lead or arsenic poisoning. Hair growth creams and medications. Wigs, hairpieces and implants. Scalp reductions.

Hearing Aids and Services
Hearing aids or other devices used to aid hearing, including the fitting of such devices unless otherwise specifically stated as a Covered Service in the *Schedule of Benefits*. Hearing examinations except as specifically provided herein.

Heavy Metal Screening and Mineral Studies
Heavy metal screenings and mineral studies. Screening for lead poisoning is covered when directed through the Primary Care Physician.

Home Maternity Services
Services or supplies for maternity deliveries at home.

Household and Automobile Equipment and Fixtures
Purchase or rental of household equipment or fixtures having customary purposes that are not medical. Examples of non-Covered Services include: exercise equipment, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses or waterbeds, escalators or elevators, ramps, automobile modifications, safety bars, saunas, swimming pools, Jacuzzi or whirlpools, hygienic equipment or other household fixtures.

Impotence (Treatment of)
All services, procedures, devices and medications associated with impotence or erectile dysfunction regardless of associated medical, or emotional or psychological conditions, causes or origins unless otherwise specifically stated herein.

Ineligible Status
Services or supplies provided before the Effective Date of coverage not cover. Services or supplies provided after midnight on the effective date of cancellation of coverage are not covered, except as specified in the "Extension of Benefits".

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

Infertility and Fertility
Unless otherwise specifically stated as a Covered Service in the *Schedule of Benefits*, the following services and treatments are not covered:

- Infertility and fertility services;
- Reversal of voluntary sterilization procedures;
- In vitro fertilization;
- Embryo or ovum transfer;
- Zygote transfers;
- Gamete transfers;
- GIFT procedure;
- ZIFT procedure
- Cost of donor sperm or sperm banking;
- Foams and condoms;
- Artificial insemination services;
- Medications used to treat infertility or impotence; and
- Services, procedures, devices and medications associated with impotence and/or erectile dysfunction unless otherwise specifically stated herein or in the *Schedule of Benefits*.

Institutional Requirements
Charges for services provided solely to satisfy institutional requirements.

Intoxicated or Impaired
Services or supplies for any illness, injury or condition caused in whole or in part by or related to the Member's use of a motor vehicle when tests show the Member had a blood alcohol level in excess of that permitted to legally operate a motor vehicle under the laws of the state in which the accident occurred, unless such illness, injury, or condition is caused by a mental health illness.

Late Fees, Collection Charges, Court Costs, Attorney Fees
Any late fees or collection charges that a Member incurs incidental to the payment of services received from Providers, except as may be required by state or federal law. Court costs and attorney fees. Costs due to failure of the Member to disclose insurance information at the time of treatment.

License (Not Within the Scope of)
Services beyond the scope of a Provider's license.

Lost Wages and Compensation for Time
Lost wages for any reason. Compensation for time spent seeking services or Coverage for services.

Maternity Benefits
Medical and Hospital charges incurred for the delivery, care and/or treatment of a newborn child born to a Dependent child of the Subscriber, unless such newborn meets the eligibility requirements defined in the Group Enrollment Agreement.

Medical Supplies
Consumable or disposable medical supplies, except as specifically provided herein. Examples of non-Covered Services include bandages, gauze, alcohol swabs and dressings, elastic stockings, compression hose, support hose, foot coverings, leotards, elastic knee and elbow supports, and pressure garments for the arms and hands, not provided in the Primary Care Physician's office, except as required by state or federal law. Medical supplies necessary to operate a non-covered Prosthetic Device or item of DME.

Missed Appointments, Telephone and Other Charges
The following are not covered:

- Charges made to Member by a Provider for not keeping or the late cancellation of appointments.
- Charges by Members or Providers for telephone consultations and clerical services for completion of special reports or forms of any type, including but not limited to disability certifications, unless otherwise specifically stated in the Schedule of Benefits.
- Charges by Members or Providers for copies of medical records supplied by a health care provider to the Member. Telemedicine services are covered as shown under the "Description of Benefits" section of the EOC.

Non-Licensed Providers
Treatment or services rendered by non-licensed health care Providers and treatment or services outside the scope of a license of a licensed health care provider or services for which the Provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed Physician, except for services related to behavioral health treatment for Pervasive Developmental Disorder or autism.

Non-Medically Necessary Services
Services, supplies, treatments or accommodations which are not Medically Necessary except as specifically described herein.

Non-Participating Provider (Services Rendered By)
Benefits and services from Non-Participating Providers, except in the case of a medical Emergency.

Nutritionists
Services of nutritionists and dietitians, except as incidentally provided in connection with other Covered Services.

Obesity (Treatment of)
Treatment of obesity, including morbid obesity, regardless of associated medical, surgical, emotional or psychological conditions, unless reported as symptoms of treatment for a Mental Disorder or Substance Use Disorder according to DSM-5/ICD-10. Examples of non-Covered Services include, drugs, weight reduction programs and related supplies, liposuction and laboratory tests included in such programs, excision of excessive skin and/or subcutaneous fat, treatment of chronic or underlying conditions associated with eating disorders, balloon insertion and removal, gastric stapling and other similar restrictive gastrointestinal surgery and procedures and complications arising therefrom.

Treatment or surgery for obesity, weight reduction or weight control, except when provided for morbid obesity or as a Preventive Care Services.

Orthotics
- Foot Orthotics which are not an integral part of a leg brace. Examples of non-Covered Services include shoe lifts, arch supports and corrective shoes, except as specifically listed as being covered herein;
- Repair, maintenance and repairs due to misuse and/or abuse;
- Over-the-counter items, except as specifically listed as being covered herein;
- Prophylactic braces; and
- Braces used primarily for sports activities.

Out-of-Service Area Services
Services received outside of the Service Area, except for Emergency Services as defined in this Evidence of Coverage, unless Preauthorized in advance by Health Net. Examples of non-Covered Services include the following:
- Services or treatments which could have been provided by Health Net within the Service Area;
- Services which were furnished after the Member's condition would permit the Member to return to the Service Area for continued care;
- Services which were connected with conditions resulting during travel which had been advised against because of health reasons such as impending surgery and/or delivery. This does not apply to Emergency Services as defined in this Evidence of Coverage; and
- Treatment in progress by a Participating Provider;

Over-the-Counter Items and Medications
Over-the-Counter items and medications, except as specifically listed as a covered benefit herein or in the *Schedule of Benefits*. For purposes of this Evidence of Coverage Over-the-Counter is defined as any item, supply or medication which can be purchased or obtained from a vendor or without a prescription.

Oxygen
Oxygen when services are outside of the Service Area and non-emergent or urgent, or when used for convenience when traveling within or outside of the Service Area.

Paternity Testing
Diagnostic testing to establish paternity of a child.

Penile Implants
Any costs or charges for or related to penile implants.

Personal Comfort Items
Personal comfort or convenience items, including services such as guest meals and accommodations, telephone charges, travel expenses, take-home supplies, barber or beauty services, radio, television and private rooms unless the private room is Medically Necessary.

Physical and Psychiatric Exams
Physical health examinations in connection with the following:

- Obtaining or maintaining employment;
- Obtaining or maintaining school or camp attendance;
- Obtaining or maintaining insurance qualification;
- At the request of a third party; and
- Sports participating whether or not school related.

Psychiatric or psychological examinations, testing and/or other services in connection with:

- Obtaining or maintaining employment;
- Obtaining or maintaining insurance relating to employment or insurance;
- Obtaining or maintaining any type of license;
- Medical research; or
- Competency issues.

Physical Conditioning
Health conditioning programs and other types of physical fitness training. Exercise equipment, clothing, performance enhancing drugs, nutritional supplements and other regimes.

Prescription Drugs
Outpatient prescription Drugs except as specifically described in the benefit description titled *Diabetic Supplies, Equipment and Devices*, or as otherwise listed as a Covered Service herein or in the *Schedule of Benefits*. Non-Covered Services include:

- Take home prescription drugs and medications from a Hospital or other Inpatient or Outpatient Facility;
- Supplies, medications and equipment dispensed by Non-Participating Providers; unless Preauthorized by Us;
- Supplies, medications and equipment labeled "Caution - Limited by Federal Law to Investigational Use";
- Supplies, medications and equipment deemed Experimental, Unproved or Investigational by Us, except for covered Preventive Medications (as determined to be preventive as recommended by the United States Preventive Services Task Force (USPSTF) A and B recommendations (medications listed at www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm) any non-prescription or over-the-counter drug that can be purchased without a prescription or physician order is not covered, even if the physician writes a prescription or order for such drug. Additionally, any prescription drug for which there is a therapeutic interchangeable non-prescription or over-the-

counter drug or combination of non-prescription or over-the-counter drugs is not covered, unless prescribed for the treatment of diabetes and for smoking cessation;

- Supplies, medications and equipment for other than FDA approved indications;
- "Off label" use of medications, except for certain FDA approved drugs used:
  1. for the treatment of cancer in accordance with state law provided that the drug is not contraindicated by the FDA for the off-label use prescribed
- Any Drug consumed at the place where it is dispensed or that is dispensed or administered by the Practitioner;
- Supplies, medications and equipment that are not Medically Necessary; as determined by Us;
- Replacement prescriptions for any reason;
- Mail order Drugs;
- Medications prescribed by a Dentist;
- Medications for sexual dysfunction;
- Medications for infertility;
- Medications purchased before a Member's Effective Date of Coverage or after the Member's termination date of Coverage;
- Medications used for cosmetic purposes a determined by Us;
- Vitamins, except those included on Health Net's Preferred Drug List;
- Drugs, weight reduction programs and related supplies to treat obesity, unless is covered under Preventive Care;
- Weight reduction programs and related supplies to treat obesity, except as covered under Preventive Care;
- Human Growth Hormone except for children or adolescents who have one of the following conditions:
  - Documented growth hormone deficiency causing slow growth
  - Documented growth hormone deficiency causing infantile hypoglycemia
  - SHOX
  - Short stature and slow growth due to:
    1. Turner syndrome;
    2. Prader-Willi syndrome;
    3. Chronic renal insufficiency prior to transplantation; or
    4. Central nervous system tumor treated with radiation
  - Documented growth hormone deficiency due to a hypothalamic or pituitary condition;
- Enteral Nutrition in situations involving temporary impairments;
- Enteral Nutrition for Members with a functioning gastrointestinal tract whose need for Enteral Nutrition is due to end-stage renal disease, or other impairments unrelated to the gastrointestinal tract; and
- Enteral Nutrition when adequate nutrition is possible by dietary adjustment, counseling and/or oral supplements.

Private Duty Nursing

Private duty nursing and private rooms except when Medically Necessary as determined by Health Net or unless specifically stated in the *Schedule of Benefits* as being covered. Private duty nursing does not include non-skilled care, Custodial Care, or respite care.

Public or Private School
Charges by any public or private school or halfway house, or by their employees.

Radial Keratotomy, LASIK
Radial keratotomy, LASIK surgery and other refractive eye surgery.

Reconstructive Surgery
Reconstructive surgery to correct an abnormal structure resulting from trauma or disease when there is no restorative function expected. *This exclusion does not apply to breast reconstruction following a covered mastectomy for either the breast on which the mastectomy has been performed or for surgery and reconstruction of the other breast to produce a symmetrical appearance*. Reconstructive surgery incidental to birth abnormalities of a Covered Dependent is limited to the Medically Necessary care and treatment of medically diagnosed Congenital Defects and birth abnormalities of a newborn, adopted child or child placed for adoption. Surgery will be covered past the Newborn Period if Medically Necessary and medical criteria are met.

Rehabilitation Services
Rehabilitation services, Maintenance and/or non-Acute therapies, or therapies where a significant and measurable improvement of condition cannot be expected in a reasonable and generally predictable period of time. Any combination of therapies (including rehabilitation and speech and language therapies) that exceed the maximum allowable number of days per Year, as specified in the *Schedule of Benefits.* Rehabilitative services related to 1) Developmental delay; 2) Maintaining physical condition; 3) Maintenance therapy for a Chronic Condition are not Covered Services. Rehabilitation services for conditions relating to mental health or substance abuse are not covered. Rehabilitation therapy for physical impairments in Members with autism spectrum disorders 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.

Residential Treatment Facility
Residential treatment that is not Medically Necessary is excluded. Admissions that are not considered medically appropriate and are not covered include admissions for wilderness center training; for Custodial Care; for a situational or environmental change; or as an alternative to placement in a foster home or halfway house.

Reversal of Voluntary Sterilization Procedures
Expenses for services to reverse voluntary sterilization.

Riots, War, Misdemeanor, Felony
Illness or injury sustained by a Member caused by or arising out of riots, war (whether declared or undeclared), insurrection, rebellion, armed invasion or aggression. Illness or injury sustained by a Member while in the act of committing a misdemeanor, felony, any illegal act regardless of whether Member is arrested or convicted or while engaging in an illegal occupation, unless the condition was an injury resulting from an act of domestic violence or an injury resulting from a medical condition, mental disorder, or substance abuse disorder.

Routine Foot Care
Routine foot care. Examples of non-Covered Services include trimming of corns, calluses and nails, and treatment of flat feet.

Sexual Dysfunction
Behavioral treatment for sexual dysfunction and sexual function disorders regardless if cause of dysfunction is due to physical or psychological reasons.

Shipping, Handling, Interest Charges
All shipping, handling or postage charges, except as incidentally provided without a separate charge, in connection with Covered Services or supplies. Interest or finance charges except as specifically required by law.

Skin Titration Testing
Skin titration (wrinkle method), cytotoxicity testing (Bryans Test), RAST testing, MAST testing, urine auto-injection, provocative and neutralization testing for allergies.

Speech and Language Services
Speech therapy services, Maintenance and/or non-Acute therapies, or therapies where a significant and measurable improvement of condition cannot be expected in a reasonable and generally predictable period of time as determined by Health Net in consultation with the treating provider. Any combination of therapies (including rehabilitation and speech and language therapies) that exceed the maximum allowable benefits as described in the *Schedule of Benefits.* Rehabilitative services relating to developmental delay, provided for the purpose of maintaining physical condition, or Maintenance therapy for a Chronic Condition are not covered. Rehabilitation and speech therapy services for conditions relating to mental health or substance abuse are not covered. Communication devices (speech generating devices).

Substance Abuse Services
Covered Services do not include:

- Court ordered testing and/or evaluation.
- House calls
- Continuation in a course of counseling for patients who are disruptive or physically abusive.
- Referral for non-Medically Necessary services such as vocational programs or employment counseling.
- Expenses related to a stay at a sober living facility.

Temporomandibular Joint Disorder (Treatment of)
Covered Services under the *medical* portion of your Health Plan do not include the following:

- Services for temporomandibular joint syndrome, except for Medically Necessary services in connection with Acute dislocation of the mandible (but not dislocation of the cartilage without dislocation of the mandible) from direct and immediate extrinsic trauma, fractures, neoplasm's, rheumatoid arthritis, ankylosing spondylitis and disseminated lupus erythematosus;
- Dental splints, dental prosthesis or any treatment on or to the teeth, gums, or jaws and other services customarily provided by a dentist or dental Specialist;
- Treatment of pain or infection due to a dental cause, surgical correction of malocclusion, maxilla facial orthognathic and prognathic surgery, orthodontia treatment, including Hospital and related costs resulting from these services when determined to relate to malocclusion; and
- Services related to injuries caused by or arising out of the act of chewing.

Refer to the *Schedule of Benefits* to determine whether your particular Health Plan includes additional dental services and the restrictions and limitations that apply.

Thermography
Thermography or thermograms and related expenses.

Transplant Services
Services for organ and tissue transplants except as specifically listed as a Covered Service herein or as otherwise specifically stated in the *Schedule of Benefits*. **Donor searches are not covered.**

- Services, supplies and medications provided to a donor of organs and/or tissue, for transplants where the recipient is not a Health Net Member;
- Transplants which are considered Experimental, Unproved or Investigational;
- Non-human or artificial organs and the related implantation services; and
- Bone marrow transplants for human gene therapy (enzyme deficiencies, severe hemoglobinopathies, primary lysosomal storage disorders).

Transportation Services
Transportation of a Member to or from any location for treatment or consultation, except for ambulance services associated with an Emergency condition or for Qualified Travel Expenditures authorized by Health Net as part of Preauthorized Covered Services outside the Service Area

Travel Expenses
Travel and room and board, even if prescribed by a Physician for the purpose of obtaining Covered Services unless specifically stated in the Schedule of Benefits. This exclusion does not apply to Qualified Travel Expenditures.

Unauthorized Services
Services or medical supplies that have not been performed, prescribed or arranged through the Primary Care Physician, and Preauthorized by Health Net, as required by the Group Agreement. Services necessary to treat a medical Emergency shall be covered without Prior Authorization.

Urgent Care Services
Use of Urgent Care Facilities for non-urgent purposes. Routine Care, follow-up or continuing care provided in an Urgent Care Facility.

Vision Services
If you have elected additional Vision Benefits, please refer to the EyeMed Vision Benefit Rider and corresponding Vision Policy, for a description of services and the limitations that apply.

- Vision services are not covered. Eyeglasses and contact lenses, and the vision examination for prescribing and fitting of same, except as specifically listed as a covered benefit herein or as otherwise specifically stated in the Schedule of Benefits;
- Eye examinations required by an employer as a condition of employment;
- Services or materials provided as a result of any workers' compensation law, or required by any government agency;
- Radial keratotomy and other refractive eye surgery; and
- Orthoptics and any other vision training.

Vitamin B-12 injections
Vitamin B-12 injections are not covered except for the treatment of pernicious anemia when oral vitamin B cannot be absorbed.

Vocational Programs/Employment Counseling
Vocational programs and counseling for employment, including counseling during mental or substance abuse rehabilitation.

Work-Related Injuries
Charges in connection with a work-related injury or sickness for which coverage is provided under any state or federal worker's Compensation, employer's liability or occupational disease law.

LIVING WILLS AND OTHER HEALTH CARE DIRECTIVES

You are getting this information about your rights to make or control your own health care decisions because of a 1991 federal law. Participating Providers contracted with Health Net will honor any Member's health care directives in accordance with federal and state laws. Health Net will not condition the provision of Coverage or discriminate against an individual based on whether or not the individual has executed an advance directive. If you have completed a living will or health care power of attorney, please send it directly to your Primary Care Physician to put in your medical record. You are also encouraged to talk with your family, your doctor, and anyone else who could help you in these matters. We hope the following information gives you the information you need to make informed health care decisions in advance.

WHO MAKES YOUR HEALTH CARE DECISIONS?
You do, if you can make and communicate them. Your doctors should tell you about the treatment they recommend, other reasonable alternatives, and important medical risks and benefits of that treatment and the alternatives. You have the right to decide what health care, if any, you will accept.

WHAT HAPPENS IF YOU BECOME UNABLE TO MAKE OR COMMUNICATE YOUR HEALTH CARE DECISIONS?
You still have some control over your health care decision, if you have planned ahead. One way to plan ahead is by making a health care directive which names someone to make those decisions for you, or which guides and controls those decisions. If you have not named someone in a health care directive, your doctors must seek a person authorized by law to make these decisions. A person who makes health care decisions for you is called a surrogate.

WHAT IS A HEALTH CARE DIRECTIVE?
It is a written statement about how you want your health care decisions made. Under Arizona law, there are three common types of health directives. They are:

- A health care power of attorney, which is a written statement in which you name an adult to make health care decisions for you. That person will make health care decisions for you only when you cannot make or communicate such decisions;
- A living will, which is a written statement about health care you want or do not want that is to be followed if you cannot make your own health care decisions. For example, a living will can say whether you would want to be fed through a tube if you were unconscious and unlikely to recover; and
- A pre-Hospital medical care directive, which is a directive refusing certain lifesaving Emergency care given outside a Hospital or in a Hospital Emergency room. To make one, you must complete a special orange form. You can request the pre-Hospital orange form from the Dorothy Garske Center.

These directives, used separately or together, can help you say "yes" to treatment you want and "no" to treatment you don't want.

MUST YOUR HEALTH CARE DIRECTIVES BE FOLLOWED?
Yes. Both health care providers and surrogates must follow valid health care directives.

CAN YOU BE REQUIRED TO MAKE A HEALTH CARE DIRECTIVE?
No. Whether you make a health care directive is entirely up to you. A health care provider cannot refuse care based on whether or not you have a health care directive.

CAN YOU CHANGE OR REVOKE HEALTH CARE DIRECTIVES?
Yes. If you change or revoke a health care directive, you should notify everyone who has a copy.

WHO CAN LEGALLY MAKE HEALTH CARE DECISIONS FOR YOU IF YOU ARE UNABLE TO MAKE YOUR OWN DECISIONS AND IF YOU HAVE NOT MADE A HEALTH CARE POWER OF ATTORNEY?
A court may appoint a guardian to make health care decisions for you. Otherwise, your health care provider must go down the following list to find a surrogate to make health care decisions for you.

1. Your husband or wife, unless you are legally separated;
2. Your adult child. If you have more than one adult child, a majority of those available;
3. Your mother or father;
4. Your domestic partner, unless someone else has financial responsibility for you;
5. Your brother or sister;
6. A close friend of yours. (Someone who shows special concern for you and is familiar with your health care views.)

If your health care provider cannot find an available and willing surrogate to make health care decisions for you, then your doctor can decide with the advice of an ethics committee or, if this is not possible, with approval of another doctor. You can keep anyone from becoming your surrogate by saying, preferably in writing, that you do not want that person to make health care decisions for you.

A surrogate will not have the right to refuse the use of tubes to give you food or fluids unless:

- You have appointed that surrogate to make health care decisions for you in a health care power of attorney;
- A court has appointed that surrogate as your guardian to make health care decisions for you;
- You have stated in a health care directive that you do not want this specific treatment.

WHAT IF YOU ALREADY HAVE A LIVING WILL OR ANOTHER HEALTH CARE DIRECTIVE?
A health care directive which was valid when made anywhere in the U.S. is valid under Arizona law. However, Arizona law changed on September 30, 1992, making new choices available to you. You should review your health care directives periodically and update them as needed.

DO YOU NEED A LAWYER TO MAKE A HEALTH CARE DIRECTIVE?
No. Just be sure that your directive is valid under Arizona law.

WHAT DOES THE LAW REQUIRE FOR A HEALTH CARE DIRECTIVE AFTER SEPTEMBER 30, 1992?
A health care power of attorney must:

- Name a person to make health care decisions for you if you become unable to make your own decisions. You may also name an additional person or persons to make decisions for you if your first choice cannot serve. The person or persons must be at least 18 years old;
- Be signed or marked by you and dated;
- Be signed by a notary or by an adult witness or witnesses, who saw you sign or mark the document and who say that you appear to be of sound mind and free from duress. A notary or witness cannot be the person you name to make your decisions and cannot be providing health care to you. If you have only one witness, that witness cannot be related to you or someone who will get any of your property from your estate if you die.

A LIVING WILL MUST:

- State how you want your health care decisions to be made in the future;
- Be signed or marked by you and dated; and
- Be notarized or witnessed in the same way as described above for a health care power of attorney.

A PRE-HOSPITAL MEDICAL DIRECTIVE MUST:

Be in exactly the form required by law. The form must be orange and must say:

> In the event of cardiac or respiratory arrest, I refuse any resuscitation measures including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related Emergency medical procedures.

You should talk to your doctor about pre-Hospital directives if you are thinking about signing one.

A pre-Hospital directive must also:

- Be signed or marked by you and dated; and
- Be signed by a licensed health care provider and a witness.

If you have signed an orange pre-Hospital medical care directive, you may also wear a special orange bracelet. It must state your name, your doctor's name, and the words "do not resuscitate." The bracelet will call to the attention of Emergency medical personnel that you have completed the form and that you do not want the Emergency medical care described on the form.

WHO SHOULD HAVE COPIES OF YOUR HEALTH CARE DIRECTIVES?

It is very important that you give copies to your doctors at once and to any health care Facility upon admission. You should also give copies to anyone you have named to make health care decisions for you in a health care power of attorney. You may also want to give copies to close family members. Be sure to keep extra copies for yourself.

SOURCES OF INFORMATION AND FORMS
The following organizations provide health care directive forms and information:

Aging and Adult Administration
State of Arizona
1789 W. Jefferson Street, Site Code 950A
Phoenix, Arizona 85007
602-542-4446

American Association of Retired Persons (AARP)
601 E Street, NW
Washington, D.C. 20049
888-687-2277

Arizona Medical Association
810 W. Bethany Home Road
Phoenix, Arizona 85013
602-246-8901
800-482-3480

Dorothy Garske Center
2140 E. 5th Street
Tempe, AZ 85281-3034
480-966-2674

Arizona Senior Citizens Law Project
1818 S. 16th Street
Phoenix, Arizona 85034
602-495-5193

Bureau of Emergency Medical Services and Trauma System
150 N. 18th Avenue, Suite 540
Phoenix, AZ 85007
602-364-3150
800-200-8523

CONTRACT PROVISIONS FOR COVERAGE

ELIGIBILITY REQUIREMENTS

The Group (Employer) determines who is eligible to enroll in this Health Plan. Specific questions regarding eligibility should be directed to the employer's benefits administrator. As a general rule, all employees of the Group, and their eligible Dependents, who have met the Group's probationary Waiting Period and eligibility requirements, will be eligible to enroll as a Member.

Subscriber Eligibility

To be eligible as a Subscriber at the time of enrollment and throughout the term of the Group Agreement, all employees must:

1. Live, work or reside in the Health Net Service Area when originally enrolled; and
2. Be an employee of the Group employed to work the number of hours required per week or mutually agreed upon by Health Net and the Group; and
3. Satisfy all eligibility requirements, including any Waiting Periods required by the Group, as stated in the Group Agreement and mutually agreed upon by Health Net; and
4. Be entitled and willing on his/her own behalf to participate in the Health Plan; and
5. Be entitled to Coverage under a trust agreement, employment contract, or rules of professional trade or occupational association; and
6. Elect to be a Member by submitting a completed and signed Enrollment Form.

Dependent Eligibility

A Subscriber's spouse, Child, and other Dependents as defined by the employer may enroll in this Health Plan provided such individual satisfies the Dependent eligibility requirements established by the Group. **Dependent Coverage must be allowed under the Group Enrollment Agreement in order for eligible Dependents to enroll**. At the time of enrollment and throughout the term of the Group Enrollment Agreement, the term *eligible Dependent* shall include:

1. A Subscriber's lawful spouse, living within the Service Area serviced by Health Net; or
2. A Subscriber's Child under the age of 26. For purposes of this provision, the term Child shall include a natural child, stepchild, legally adopted child, a child who has been placed for adoption with the Subscriber, a child under a Subscriber's permanent guardianship or permanent custody by court order, or a child eligible for Coverage pursuant to a Qualified Medical Child Support Order; or
3. A Subscriber’s Child over the age of 26 who is both incapable of self-sustaining employment by reason of intellectual disability or physical handicap and chiefly dependent on the employee or Member for support and maintenance. Proof of such incapacity and dependency shall be furnished to the insurer by the employee or member within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by the insurer, but not more frequently than annually after the two-year period following the child's attainment of the limiting age; or
4. Such other Dependents agreed upon by Health Net and the Group and specifically defined in the Group Enrollment Agreement.

For purposes of this provision, a Child must be younger than 26 years of age as of the date of adoption or placement for adoption. The term *Dependent* does not include a Member's natural child for whom legal rights have been given up through adoption. Additionally, unless otherwise specifically stated in the Group Enrollment Agreement, the term *Dependent* does not include a grandchild of the Subscriber for whom the Subscriber does not have court ordered permanent guardianship or custody.

ENROLLMENT REQUIREMENTS
Individuals meeting the Subscriber or Dependent eligibility and enrollment requirements will not be refused enrollment by Health Net because of a person's preexisting physical or mental condition, including pregnancy.

Open Enrollment
Employees, and their eligible Dependents, may apply for membership in this Health Plan during the Group's Open Enrollment Period provided such individual satisfies the Group's eligibility requirements, including any required probationary Waiting Period. All eligible enrollees submitted by the Group for membership in this Health Plan must be listed on the Enrollment Form. The Enrollment Form must include all requested information on all persons and must be signed and dated by the employee and the Group.

Enrollment Of Newly Eligible Employee
Newly Eligible Employees of the Group must satisfy the Group's eligibility requirements, including any required Waiting Periods, before applying for membership in this Health Plan. Employees who have met the eligibility requirements shall be permitted to enroll himself/herself, and any eligible Dependents, within 31 days after attaining eligibility. Coverage will be effective on the first day of the month following Health Net's receipt of the notification.

If a newly Eligible Employee chooses not to enroll during the first 31 days of attaining eligibility, or chooses not to enroll his/her eligible Dependents during their first 31 days of attaining eligibility, then the provisions titled *Late Enrollees* contained in this section will be applied.

Enrollment Of Newly Eligible Family Member When Subscriber Already Has Dependent Coverage
If a Subscriber has family or Dependent Coverage when a family member attains eligibility (including newborn children, newly adopted children or children placed for adoption), the Subscriber should enroll the newly eligible family member by completing and submitting to the Group a signed Enrollment Form. Health Net should receive the Enrollment Form signed and dated by the Subscriber and the Group, within 31 days after the family member attains eligibility. Coverage will be effective on the first day of the month following Health Net's receipt of the notification, or in the case of a newborn child, newly adopted child, child placed for adoption, or child for whom the Subscriber has become legally responsible, Coverage will be effective on his or her date of birth or the date of adoption or placement for adoption.

Health Net will not, however, deny Coverage for a newly eligible family member whose Enrollment Form has not been received so long as additional Premium amounts for such new Dependent, if any, have been received by Health Net within the required 31 day period.

Enrollment Of Newly Eligible Family Member When Subscriber Does Not Have Existing Dependent Coverage
If a Subscriber does not have family or Dependent Coverage when a family member attains eligibility, (including a spouse, newborn child, newly adopted child, child placed for adoption, or child for whom the Subscriber has become legally responsible), then Subscriber must enroll the newly eligible family member by completing an Enrollment Form and submitting the form along with the required Premium payment to the Group. Enrollment Forms must be submitted within 31 days of the date such family member attains eligibility. Coverage will be effective on the date the Dependent attains eligibility, so long as the Enrollment Form is received timely. The Group will forward the Premium and Enrollment

Form to Health Net. **The Enrollment Form and Premium payment must be received by Health Net within 31 days of the date such Dependent attains eligibility, otherwise there is no Coverage.**

Late Enrollees

A *late enrollee* is defined as:

1. An employee or Dependent who was eligible to enroll in this Health Plan during the Group's Open Enrollment Period, but did not do so; or
2. An employee or Dependent who was eligible to enroll in this Health Plan during the first 31 days of attaining eligibility, but did not do so; or
3. An employee or Dependent who was eligible to enroll after any Waiting Period required by the Group, but did not do so within 31 days of become eligible.

Any person who is denied Coverage as a late enrollee may enroll for Coverage during the Group's next Open Enrollment Period for coverage to begin at the following Anniversary Date, or upon a Qualifying Event during the Special Enrollment Period.

Employees of Groups who have less than 50 Eligible Employees, as defined by Us, are not eligible to participate in the Late Enrollee provision. Any person who is denied Coverage as a late enrollee may enroll for Coverage during the Group's next Open Enrollment Period for Coverage to begin at the following Anniversary Date or during the Special Enrollment period

Special Enrollment Periods

An enrollee is eligible to enroll within 30 days of the Qualifying Event, unless otherwise specified below:

"Qualifying Events" are when the following triggering events occur:

1. Employees or Dependents who at the time of initial enrollment were covered under a public or private health insurance policy and who later lost their coverage due to termination of employment, loss of eligibility, reduction in the number or hours of employment, termination of coverage of another health plan, the death of a spouse, divorce or legal separation of a spouse, the covered employee becoming entitled to benefits under Medicare, a dependent child ceasing to be a dependent child, or termination of Employer contributions towards the coverage, or a proceeding in a case under Title 11 bankruptcy, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time, when the loss of coverage includes a substantial elimination of coverage within one year before or after the date of commencement of the proceeding. Employees or Dependents who become ineligible for or lose their Medicaid or Children's Health Insurance Program (CHIP) coverage, or if they become eligible for a State's premium assistance program.
2. Employees or Dependents who request enrollment into this Health Plan within 31 days after the termination of Creditable Coverage as described in numbered 1 above;
3. Employees or Dependents who are employed by an Employer which offers multiple health benefit plans and elect a different plan during an Open Enrollment Period;
4. Employees who are ordered, by a court or administrative order, to provide Coverage for a spouse or minor Child and request such Coverage within 31 days of the order;
5. Employees who request enrollment within 31 days after the date of marriage;
6. A person who becomes a Dependent of a covered person through marriage, birth, adoption or placement for adoption, and requests enrollment no later than 31 days after becoming a Dependent.

For purposes of this provision, the term *creditable coverage* is defined as coverage solely for an individual, other than limited benefits coverage, under any of the following:

(a) An employee welfare benefit Plan that provides medical care to employees or the employees' Dependents directly or through insurance, reimbursement or otherwise, pursuant to the Employment Retirement Income Security Act of 1974 (ERISA);
(b) A church Plan as defined in ERISA;
(c) A health benefits Plan issued by an accountable health Plan as defined in Arizona Revised Statutes §20-2301;
(d) Part A or Part B of Title XVIII of the Social Security Act;
(e) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
(f) Title 10, Chapter 55, of the United States Code;
(g) A medical care program of the Indian Health service or of a tribal organization;
(h) A health benefits risk pool operated by any state of the United States;
(i) A health Plan offered pursuant to Title 5, Chapter 89, of the United States Code;
(j) A public health Plan as defined by federal law;
(k) A health benefit Plan pursuant to section 5(e) of the Peace Corps Act;
(l) A policy or contract, including short-term limited duration insurance, issued on an individual basis by an insurer, a health care services organization, a hospital service corporation, a medical services corporation or a hospital, medical, dental and optometric service corporation or made available to persons defined as eligible under Arizona Revised Statutes §36-2901, paragraph 4, subdivisions (d) (e) (f) and (g);
(m) A policy or contract issued by a health care insurer or an accountable health Plan to a member of a bona fide association.

EFFECTIVE DATES OF COVERAGE

Subject to the eligibility and enrollment requirements, and subject to Health Net's receipt of a properly completed Enrollment Form and the payment of applicable Premium(s), membership in Health Net and therefore Coverage under this Evidence of Coverage, shall become effective on the following dates:

1. For the Subscriber and any eligible Dependents who enroll during the Group's Open Enrollment Period, Coverage shall be effective on the first day of the plan year, as described in the Group Agreement;
2. For newly Eligible Employees not enrolling during the Group's Open Enrollment Period, Coverage shall be effective on the first day of the month following Health Net’s receipt of the notification of eligibility, unless otherwise specified in the Group Agreement;
3. For newly eligible Dependents who become eligible after the Subscriber's original Effective Date hereunder, and whose Enrollment Form is received and Approved by Health Net, Coverage shall be effective as follows:
   (a) Newborns are automatically covered for the first 31 days from the date of birth. Continued Coverage beyond the first 31 days is subject to Health Net's receipt of a signed Enrollment Form and payment of additional Premium, if such premium required;
   (b) Adopted children are automatically covered for the first 31 days following the date of adoption. Continued Coverage beyond the first 31 days is subject to Health Net's receipt of a signed Enrollment Form and payment of additional Premium, if such premium is required;
   (c) Children placed for adoption with the Subscriber are automatically covered for the first 31 days following the date of placement. Continued Coverage beyond the first 31 days is subject to Health Net's receipt of a signed Enrollment Form and payment of additional Premium, if such premium is required;

(d) A newly eligible spouse (and children of a newly eligible spouse if they are eligible) shall be covered from the date of the qualifying event, provided that an Enrollment Form and any required Premium are submitted to Health Net within 31 days of the qualifying event;
(e) Other eligible Dependents and Subscribers, including those who attain eligibility by experiencing a qualifying event as described above in the late enrollee section, will be covered from the date they attain eligibility or on the dates specified in the Group Agreement. Enrollment Forms and any required Premium must be submitted to Health Net within 31 days of the date such family member attains eligibility, unless otherwise agreed to between Us and the Group.

If a Subscriber's contract includes membership in Health Net for Dependents, and no additional Premium is required, Covered Services shall automatically extend to a newly eligible Dependent of the Subscriber. To ensure continuity in the medical care and to prevent any billing inaccuracies, Health Net recommends that the Subscriber complete an Enrollment Form specifically naming the Dependent to be added as a new Dependent of the Subscriber within 31 days of the date that such Dependent attains eligibility.

If additional Premium is required to add a newly eligible Dependent, Health Net must receive the Premium amount (that the Subscriber must submit through the Group) and an Enrollment Form within 31 days of the date such family member attains eligibility. Otherwise, such newly eligible Dependent will be subject to the Late Enrollment Requirements and may not be eligible for Coverage until the Group's next Open Enrollment Period.

Qualified Medical Child Support Orders
When a Subscriber, or Subscriber's covered spouse, is ordered either by a court or administrative order, to provide health care coverage for their child or ward, Health Net will recognize the order and Coverage hereunder will become effective on the date so ordered. In the event that an employee who is not covered and who would otherwise be a late enrollee is ordered, pursuant to a Qualified Medical Child Support Order to provide coverage for their child or ward, the employee and the child or ward must both enroll in the plan. Applicable Premium payment and an Enrollment Form must be submitted to ensure the continuance of Coverage.

Persons Hospitalized
Any eligible Member who is a registered bed patient in a Hospital on the Effective Date of Coverage hereunder will not be denied any of the provisions of Coverage under this Health Plan beginning with the Effective Date.

CHANGE IN STATUS - NOTICE REQUIRED
Subscriber and the Group agree that Subscriber shall notify the Group, and the Group shall notify Health Net, of any changes that will affect the Subscriber's, or any of his enrolled Dependents, eligibility for services or benefits within 31 days of the event. This includes changes of address, addition or deletion of Dependents resulting from marriage, divorce or death, and changes in Dependent disability or Dependent status. Coverage for ineligible Members will terminate in accordance with the termination provisions described in this Evidence of Coverage.

PREMIUMS
Monthly Premiums for Coverage of Subscribers and their enrolled Dependents are paid through the Group. Premiums are due to Health Net on the last business day of the month preceding the Coverage period. A portion of Premium payments (employee contribution) may be due from the Subscriber and paid through payroll deductions.

Grace Period
Unless otherwise stated in the Group Agreement, required Premium payments to Health Net are subject to a 10 day period (called the Grace Period) following the Premium due date during which Premium payments may be made to Health Net without a lapse of Coverage. If Premium payments are not received by Health Net by the end of the Grace Period, Coverage may be canceled to the last date for which Premium has been received and accepted by Health Net's accounts receivable department. In this event, the Group shall be terminated and Members shall not be eligible to continue Coverage. The Group shall not be permitted to unilaterally reinstate Coverage through the submission of Premium after the date on which termination occurs.

Return of Premium for Ineligible Enrollees
If Health Net receives a Premium for an individual or a Subscriber's family member whom Health Net determines does not satisfy the eligibility and enrollment requirements of the Group Agreement, Health Net will credit or refund that Premium to the Group within 30 days of determination. The individual or family member shall not be a Member of this Health Plan, and shall have no rights to services or benefits under the Group Agreement as of the date they were determined to be ineligible.

COPAYMENTS / COINSURANCE

Members are required to pay the Copayment and/or Coinsurance amounts described in the attached *Schedule of Benefits*. Copayment and/or Coinsurance amounts are determined by the benefit Plan purchased by the Group for its employees.

Copayment and/or Coinsurance amounts are due to the Participating Provider at the time Covered Services are received.

RELIGIOUS EMPLOYER

Only a “Religious Employer” that meets the definition below will be issued, upon request by the Subscriber Group, an Agreement that does not provide coverage for contraceptives.

A Religious Employer is exempt from the requirements of mandated contraceptive coverage with respect to medical and/or Prescription Drug coverage it provides to its employees if it meets the following conditions:

- It opposes providing coverage for any contraceptive services otherwise required to be covered under the Affordable Care Act (45 CFR § 147.130(a)(1)(iv)) on account of religious objections.
- It is organized and operates as a nonprofit entity.
- It holds itself out as a religious organization.

If the Group provides outpatient Prescription Drug coverage, outpatient Prescription Drugs for contraception are not covered.

MEMBERSHIP IDENTIFICATION CARDS

Identification card(s) will be issued by Health Net to Subscribers for identification purposes only. Members must present the identification card when receiving Covered Services. However, possession of an identification card in and of itself does not confer any rights to Covered Services under the Group Agreement. To be entitled to Covered Services, the holder of the identification card must be a Subscriber, or a Subscriber's enrolled Dependent, on whose behalf all applicable Premiums have been paid. Any person receiving Covered Services who is not entitled to such services, including but not limited to, anyone who has obtained Coverage or services by submitting fraudulent information to Health Net or a Participating Provider, is fully responsible for payment of the Medical Services received.

How to File a Claim for Covered Services - Medicare
When you are enrolled in Medicare and Medicare is the primary insurer, you or your provider must first file a claim with Medicare. After Medicare has processed your claim, you or your provider must send a copy of the itemized bill and a copy of the explanation of Medicare benefit (EOMB) statement to Us.

When you are enrolled in Medicare and Medicare is the secondary insurer, you or your provider must first file a claim with Us. After We have processed your claim, you or your provider must send a copy of the itemized bill and a copy of the explanation of benefit (EOB) statement to Medicare so that claim payment may be coordinated.

How to File a Claim for Covered Services – Participating Providers including Participating Providers Outside of the United States
Providers will file claims on your behalf with Us for Covered Charges. All claims, including the bill for services, must be submitted in English and in U.S. currency. Present your identification card at the time of service. Payment for Covered Charges will be made directly to the Provider. You will be responsible for Copayments, Deductibles, Coinsurance amounts, any non-Covered or Excluded Charges, and amounts over specifically limited benefits. Please refer to the Provider Directory for a list of In-Network Providers.

How to File a Claim for Covered Services - Non-Participating Providers (Including Non-Participating Providers Outside of the United States)
In the case of a medical Emergency or as Preauthorized by Health Net, You may need to get care from Non- Participating Providers. Providers who do not have an agreement with Us may, or may not file your claim with Us. If a Provider does not file a claim with Us, send a copy of your paid, itemized bill to Us, along with a completed claim form which can be obtained from the Group or by calling Our Customer Contact Center. All claims, including the bill for services, must be submitted in English and in U.S. currency. Payment for Covered Services will be paid to you, except as directed by applicable state or federal law. You will be responsible for Copayments, Deductibles, Coinsurance amounts, any non-Covered or Excluded Charges, and amounts over specifically limited benefits.

We may contract with a third party to negotiate discounts with Non Participating Providers. If we do, the discounted rate fees will be used to calculate your financial responsibility (if applicable).

Medical claims should be addressed to:
Health Net of Arizona
ATTN: Claims Department
P.O. Box 14225
Lexington, KY 40512-4225

Pharmacy claims should be addressed to:
Health Net of Arizona
ATTN: Pharmacy Department
5255 E Williams Circle, Suite 4000
Tucson, Arizona 85711

Travel reimbursement requests should be addressed to:
Health Net of Arizona
ATTN: Travel Reimbursement Department
1230 W. Washington St., Suite 401
Tempe, AZ 85281-1245

Members who receive Emergency Services from Non-Participating Providers are required to submit to Us in writing an itemized statement of the charges incurred by the Member, along with a completed claim form, to request reimbursement. Claim forms can be obtained from the Group by calling Our Customer Contact Center. Pharmacy claims and travel reimbursement requests do not require a completed claim form. Pharmacy claims must have an original receipt for the prescription with the patient's name and must be in English and in U.S. currency.

Proof of payment must accompany the request for reimbursement. Member requests for medical or pharmacy reimbursement must be forwarded to Us within 90 days of the date Covered Services were received. If it is not reasonably possible for a Member to submit proof of payment at the time the request for reimbursement is made, proof of payment must be submitted to Us as soon thereafter as is reasonably possible. Failure to provide proof of loss within the required time does not invalidate the claim if it was filed as soon as reasonably possible.

We may require the Member to provide additional medical and other documentation to verify that the services rendered were, in fact, Covered Services before paying Providers, or reimbursing the Member. Any costs associated with copying medical records to verify the services are the Member's responsibility.

In no event shall We be responsible for a reimbursement request submitted by a Member more than 1 year from the date proof of loss is required to be submitted to Us, except in the absence of legal capacity. This includes the resubmission of any Claims previously filed but denied or returned to Member due to incomplete, incorrect or insufficient information or improper billing.

We reserve the right to issue payment based on current medical billing guidelines. Any services not paid by the Plan could be determined as Member responsibility.

APPEAL OF A CLAIM DENIED BY THE HEALTH PLAN
If a Claim for reimbursement, or payment for health care services, is denied by Health Net, the Subscriber may obtain a review of the denial through Health Net's appeal procedures. A summary of the appeal procedures appears in this section. Your Evidence of Coverage also contains a brochure titled *How to File Complaints and Appeals*. Please keep the brochure with this Evidence of Coverage

for future reference. Additional brochures can be obtained or questions concerning an appeal can be answered by contacting Health Net's Customer Contact Center.

COORDINATION OF BENEFITS

Coordination of benefits is the division of responsibility to pay for care between two or more group Plans covering the same individual, including pharmacy benefits (if available). Coordination of benefits does not apply to individual policies, school accident type coverages, and hospital indemnity policies as described in Arizona Administrative Code R20-6-214. In this provision, the word *Payor* means an insurance carrier, benefit Plan or any other policy or Plan which provides medical coverage, except as provided in Arizona Administrative Code R20-6-214.

Each Member shall disclose to Health Net the existence of any other Payor coverage, including the identity of the carrier, and the group through which it is provided. Member agrees to provide such disclosure:

- At the time of enrollment;
- At the time Covered Services are received;
- Annually; and
- Such other times as may be requested by Health Net.

When Health Net of Arizona is the secondary insurance carrier, reimbursement for covered pharmacy benefit (prescription) claims is equal to the amount the member paid under their primary insurance less the applicable Health Net prescription Copayment. When determining a reimbursement due, all plan provisions and benefit requirements and exclusions under the Member's Health Net Pharmacy Benefit will be applied.

How Coordination Works

Any Member who is eligible for services or benefits under two or more group Payors will have payment of Allowable Expenses for Covered Services coordinated so that up to, but no more than, 100% of Allowable Expenses for Covered Services will be paid for or provided by all Payors combined. Therefore, in the case of duplicate coverage, Health Net may recover from the Member or other Payor, payment from or on behalf of the Member, up to the amount of Health Net's payment obligation. Member can only recover up to 100% of Allowable Expenses.

Any Member eligible for services or benefits under two or more group Payors will be subject to the Order of Benefit Determination Rules, as described below, to determine whether Health Net is considered to be the *primary plan* or the *secondary plan*.

1. If Health Net is determined to be the primary plan, coordination will not apply. Payments are determined before those of the other Payor(s) without considering the other Payor(s) payments.
2. If Health Net is determined to be the secondary plan, you are required to:
   - File your claim with the primary plan
   - Obtain a copy of the Explanation of Benefits (EOB) form from the primary plan after they have paid
   - Submit a request for reimbursement to Health Net with a copy of the EOB from the primary plan. Reimbursement for covered pharmacy benefit (Prescription Drug) Claims is equal to the amount the Member paid under their primary insurance less the applicable Health Net Prescription Drug Copayment, Coinsurance, and/or Deductible. All Health Plan provisions of this Evidence of Coverage will apply in the consideration process for payment under this Health Plan.

3. If two or more plans cover the same individual, Health Net may be determined a primary plan as to one or more Payors, and a secondary plan as to a different Payor(s).
4. To be eligible for coordination under secondary plan rules, all Plan provisions of the secondary plan must be followed, not limited to, but including Prior Authorization requirements.

Order of Benefit Determination Rules

1. In the event there are two or more plans covering the same individual, Health Net shall be considered the secondary Plan and its benefits shall be determined after those of the other Plan(s) unless:
   (a) The other Plan(s) have rules coordinating its benefits with those of Health Net; and
   (b) All plans (Health Net and other Payors) agree that Health Net's benefits shall be determined before those of any other Payors; or
   (c) Any Payor is a governmental Plan and federal law requires Health Net to be the primary Plan.
2. In the event there are two or more plans covering the same individual, the order of benefit determination shall be the first of the following rules, which apply:
   (a) The benefits of the Plan which covers the individual as a Subscriber;
   (b) The benefits of the Plan which covers the individual as a Dependent;
   (c) Dependent Child / Parents not Separated or Divorced. If a Dependent child is covered under two or more plans, primary responsibility and the order of determination shall be:
      (i) The benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year will be determined to be the primary Plan;
      (ii) If both parents have the same birthday, the benefits of the Plan which covered the parent longer will be determined to be the primary Plan;
      (iii) The term *birthday* as used in this provision refers only to the month and day in a Calendar Year, not the year in which the person was born.
   (d) Dependent Child / Parents Separated, Divorced or Never Married. If a Dependent child is covered under two or more plans, primary responsibility and the order of benefit determination shall be:
      (i) The Plan of the parent having custody of the child;
      (ii) The Plan of the spouse of the parent having custody of the child;
      (iii) The Plan of the parent not having custody of the child;
      (iv) If the specific terms of a court order state that one parent shall be responsible for the health care benefits of such child, and the Plan entity who is obligated to pay or provide expenses of the Plan of that parent has actual knowledge of the court order, then the benefits of that Plan shall be determined first. This paragraph does not apply with respect to any claim determination period or Year during which any benefits are actually paid or provided before the entity has that actual knowledge.
   (e) Dependent Child / Parents Separated, Divorced, or Never Married Having Joint Custody. If the specific terms of a court order state that the parents shall have joint custody of the child, without specifying which parent has responsibility for the child's health care expenses, benefits will be determined on the same basis as for a child whose parents are not separated or divorced.
   (f) If one of the other Plan(s) is issued out of the state of Arizona and has a rule based upon the *gender* of the parent, and not the *birthday* rule as described above, and as a result, the plans do not agree on the order of benefits, then the *gender rule* as described above shall prevail. Otherwise, the *birthday rule* shall control.
3. Active / Inactive Employee. The benefits of a Plan which covers a person as an employee (or as that employee's Dependent) are determined before those of a Plan which covers that person as a

laid off or retired employee (or as that employee's Covered Service). 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.

4. Continuation Coverage. If an individual is covered under a group continuation Plan as a result of the purchase of group coverage as provided under federal or state law, and also under another group Plan, the following shall be the order of benefit determination:
   (a) First, the benefits of a Plan covering the person as an employee (or as that employee's Dependent);
   (b) Second, the benefits of coverage purchased under the group continuation Plan. 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.
5. **Totally Disabled** on your Effective Date. Generally, under the federal Health Insurance Portability and Accountability Act, Health Net cannot deny you benefits due to the fact that you are **totally disabled** on your Effective Date. However, if upon your Effective Date you are **totally disabled** and pursuant to state law you are entitled to an extension of benefits from your prior group health plan, benefits of this Plan will be coordinated with benefits payable by your prior group health plan, so that not more than 100% of covered expenses are provided for services rendered to treat the disabling condition under both plans.
   For the purposes of coordinating benefits under this Evidence of Coverage, if you are entitled to an extension of benefits from your prior group health plan, and state law permits such arrangements, your prior group health plan shall be considered the primary plan (paying benefits first) and benefits payable under this Evidence of Coverage shall be considered the secondary plan (paying any excess covered expenses), up to 100% of total covered expenses.
6. Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the benefits of the Plan that covered the claimant longer are determined before those of the Plan which covered that person for the shorter term.
   Health Net shall be entitled to:
   (a) Determine whether and to what extent a Member is entitled to services or benefits under a Payor other than Health Net for Covered Services under this Evidence of Coverage; and
   (b) Establish in accordance with the priorities for determining primary responsibility among the Payors obligated to provide services or indemnity; and
   (c) Release to or obtain from any other Payor information needed to implement coordination of benefits; and
   (d) Recover the value of Covered Services rendered to the Member to the extent that they are actually provided or indemnified by another Payor.

Med Pay Insurance

If a Member is injured as a result of a motor vehicle Accident, Health Net will arrange for Medically Necessary services. In such event, the Member is responsible to Health Net for the reasonable expenses actually incurred by Health Net for necessary medical treatment actually provided to the Member to the extent that the Member receives payment and/or reimbursement for such treatment under a medical payment provision of an automobile insurance policy. Health Net reserves the right to pursue legal remedies available for recovery of funds which are duplicated under the provisions of a Member's Med Pay automobile insurance policy.

Member must take any actions necessary which include, but are not limited to, providing information, completing and submitting consents, releases, assignments, and other documents to assist Health Net in enforcing its rights under this provision.

Right to Receive and Release Information
Health Net may release or receive any information considered to be necessary for Health Net to coordinate benefits with respect to any person claiming benefits under this Evidence of Coverage and without any additional consent, or notice to, the Member or any other person or organization. Health Net shall not, however, be required to determine the existence of any other group Payor or insurer or the benefits payable under such Payor or insurer when computing Covered Services due a Member under this Evidence of Coverage.

Recovery of Overpayment
If the Covered Services provided by Health Net exceed the total amount of benefits that should have been paid under this section, Health Net has the right to recover from one or more of the following:
1. Any person to or from whom such payments were made; or
2. Insurance companies.

Facility of Payment
Payment(s) made under another Plan, which included amounts that should have been paid by Health Net, shall be reimbursed by Health Net to that entity and treated as though it was a benefit paid under this Plan. Health Net will not be required to pay that amount again. The term *payment(s) made* shall include providing benefits in the form of services, in which case *payment(s) made* will be interpreted as the reasonable cash value of the benefits provided in the form of services.

MEDICARE
This provision describes how Health Net coordinates and pays benefits when a Member is also enrolled in Medicare and duplication of Coverage occurs. If a Member is not enrolled in Medicare or receiving benefits, there is no duplication of Coverage and Health Net does not have to coordinate with Medicare.

The benefits under this Evidence of Coverage are not intended to duplicate any benefits to which Members are entitled under Medicare. All sums payable under such programs for services provided shall be payable to and retained by Health Net. Each Member shall complete and submit to Health Net such consents, releases, assignments and other documents as may be requested by Health Net in order to obtain or assure reimbursement under Medicare or any other government program for which Members are eligible. In cases where Medicare or another government program (excluding Arizona AHCCCS) has primary responsibility, Medicare benefits will be taken into account for any Member who is enrolled for Medicare. This will be done before the benefits under this Health Plan are calculated.

Charges for services used to satisfy a Member's Medicare Part B deductible will be applied in the order received by Health Net. Two or more charges for services received at the same time will be applied starting with the largest first.

Any rules for coordination of benefits will be applied after Health Net's benefits have been calculated under the rules in this provision. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

This provision will apply to the maximum extent permitted by federal or state law. Health Net will not reduce the benefits due any Member because of a Member's eligibility for Medicare where federal law requires that Health Net determine its benefits for that Member without regard to the benefits available under Medicare.

HEALTH CARE LIENS

When there is a source of payment for a Covered Service in addition to the coverage provided by Health Net, such as, for example, a liability insurer, government payer or uninsured and/or underinsured motorist coverage, Participating Providers may collect from that other source any difference between the negotiated amount of payment agreed upon between Health Net and the Participating Provider for a Covered Service and the Participating Provider's customary charge, by following the procedures set forth in Arizona law (A.R.S. Sec. 33-931).

WORKERS' COMPENSATION

The benefits which a Member is entitled to receive under this Evidence of Coverage are not designed to duplicate any benefits to which the Member is entitled under workers' compensation law. All sums payable for services provided to a Member pursuant to workers' compensation are deemed to be assigned to Health Net.

1. Member is required to file for workers' compensation when an employment related Accident, illness or injury occurs.
2. If Member's workers' compensation carrier denies a claim, Member may submit the claim to Health Net with a copy of the denial for consideration under this Evidence of Coverage. All Plan provisions of this Evidence of Coverage will apply in the consideration process for payment under this Plan.
3. Workers' compensation claims that are not a benefit under this Evidence of Coverage are not payable by Health Net.
4. Any benefits payable are subject to all provisions of this Evidence of Coverage, including but not limited to the Prior Authorization requirements.

TERMINATION OF COVERAGE

The Group employer or Health Net may terminate Coverage under this Evidence of Coverage. The Group Agreement describes the conditions under which the Group employer may terminate Coverage. The following provisions describe the conditions under which Health Net may terminate Coverage. Health Net is not responsible for the cost of health care services received by a Member after the date of termination. Premiums received by Health Net for terminated Members shall be refunded or credited to the Group.

Termination of Group Coverage by Health Net

This Evidence of Coverage may be terminated by Health Net upon occurrence of any of the following events. The date of termination will be the last day of the month for which Premium payments have been received and accepted by Health Net's accounts receivable department.

1. Failure to Pay Premium. In the event that the Group fails to pay the required Premium fees as outlined herein, this Agreement shall automatically terminate as of the last day of the month for which full Premiums have been received and accepted by Health Net. The Group shall not be permitted to unilaterally reinstate Coverage through the submission of Premium after the date on which termination under this provision occurs;
2. Fraud or Misrepresentation. Upon written notice, if the Group performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of the Health Plan;
3. Violation of Participation Requirements. If the Group violates the participation or contribution rules set forth in the Group Agreement;
4. Failure of the Group to maintain minimum participation requirements as follows: where coverage is offered on a contributory basis, health plan enrollment represents the greater of 75% of the

eligible active employee population or 38 enrolled active employees; if more than one health plan is offered, Health Net's enrollment represents the greater of 38% of the eligible active employee population or 19 enrolled active employees; if coverage is offered on a non-contributory basis, health plan enrollment will be 100% of the eligible employee population;

5. No Enrollees in Service Area. If the Group no longer has any enrollee who lives, works or resides in Health Net's Service Area;
6. Health Net Ceases to Offer Coverage in the Group Market:
   (a) If Health Net ceases to offer Coverage in the Group market, Coverage for the Group may be terminated. Health Net will notify the Group 180 days in advance of its intent to discontinue Coverage upon expiration of the Group's current Year. The Group will be responsible for notifying each Subscriber of the loss of Coverage and informing the Subscriber of other insurance options offered by the Group;
   (b) If Health Net ceases to offer this particular Health Plan in the Group market, Coverage for the Group may be terminated. Health Net will notify the Group 90 days in advance of its intent to discontinue Coverage upon expiration of the Group's current Year. The Group will be responsible for notifying each Subscriber of the loss of Coverage and informing the Subscriber of other options offered by Health Net or the Group

Termination of Member's Coverage

A Member's Coverage under this Health Plan may be terminated upon occurrence of any of the following events.

A notice of termination shall be provided to the member at least 60 days before the effective date of such termination, except that notice of termination may be less than 60 days before the effective date of such termination when reason for termination is based on failure to pay Premiums in a timely manner, or fraud or intentional misrepresentation in the application or other enrollment documents, or loss of eligibility as defined in this document.

Unless otherwise stated, the date of termination shall be the last day of the month for which Premium has been received and accepted by Health Net's accounts receivable department. Termination of Subscriber's Coverage shall also terminate Coverage for Subscriber's enrolled Dependents.

1. Termination of Agreement. Upon written notice, termination of the Group Agreement by Health Net or the Group Employer;
2. Failure to Pay Premium. If the required Premium for a Subscriber, and Subscriber's enrolled Dependents, is not received by Health Net in the manner, amount and at the times specified in the Group Agreement, Coverage for that Subscriber will terminate. Neither the Subscriber nor the Group may be permitted to unilaterally reinstate Coverage through the submission of Premium after the date on which termination under this provision occurs;
3. Loss of Eligibility. If a Member fails to meet the eligibility requirements established by the Group, Coverage for that Member shall terminate. The date of termination will be the date specified in the Group Agreement, subject to the following:
   (a) Dependent Reaches Limiting Age. Dependents who reach the limiting age will be automatically terminated on the last day of the month in which the Dependent reaches the limiting age, except for those Dependents who qualify for Total Disability as otherwise stated in the Group Enrollment Agreement. Dependents that become ineligible due to age may request conversion coverage within 31 days of termination under this Evidence of Coverage, or may be eligible for continuation of group coverage (COBRA);

4. Loss of Eligibility due to Election of Other Coverage. If a Member elects coverage under any other Plan that is offered by, through or in connection with the Group as an option instead of Coverage under the Group Agreement, then Coverage for such Subscriber and the Subscriber's enrolled Dependents shall automatically terminate on the date the alternate coverage becomes effective. The Group agrees to immediately notify Health Net, in writing, that the Subscriber has elected other coverage;
5. Loss of Eligibility At End of Leave of Absence. The leave of absence period will be as defined by the Group and stated in the Group Enrollment Agreement. If the Group permits a leave of absence, Coverage for that Subscriber may terminate on the last day of the month in which the leave of absence ends. The Group shall notify the Subscriber of his options. Enrollment may be reinstated if the Subscriber meets the eligibility requirements. Health Net must receive a completed and signed Enrollment Form from the Group within 31 days of the new eligibility; or
6. Loss of Eligibility Due to behavior that threatens the safety of Health Net personnel or property, or of a participating provider, or disrupts the operation of either; or Subscriber commits theft from Health Net or a participating Provider.

Termination of Membership
Health Net is not responsible for the cost of health care services received by a Member after the date of termination. If a Member is confined in a Hospital or other Inpatient Facility on the date of termination, Coverage will cease on that date.

If a Member elects to terminate Coverage hereunder, and accepts coverage under another health plan, Health Net will pay charges for that Member until midnight on the date Member's Coverage is scheduled to terminate.

Requirements of the Federal Family and Medical Leave Act of 1993
Any provisions of the Group Agreement that provide reinstatement of Coverage following a Member's return to being Actively Employed are modified by the following provisions of the Federal Family and Medical Leave Act of 1993 where applicable.

1. Coverage will be continued during a leave of absence if that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993. Premiums must continue to be paid during the leave of absence in order to qualify; and
2. Upon a Subscriber's return to work following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled insurance under the Group Agreement will be reinstated as of the date the Subscriber returns to work.

For more information about the Family and Medical Leave Act of 1993, contact your employer.

Certificate of Creditable Coverage
Within 30 days of Health Net's receipt of notification that a Member's Coverage under this Health Plan has terminated, Health Net will issue a certification of creditable coverage to the Member. This certification will contain important information regarding the Member's Coverage under this Health Plan. Member may be required to produce such certification when applying for succeeding health coverage. Please call Health Net’s Customer Contact Center to request a copy of your certification of Creditable Coverage.

CONTINUATION OF GROUP COVERAGE UNDER COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, allows certain individuals the right to continue Group Coverage when a qualifying event for termination occurs.

Continuation Coverage under COBRA applies only to Groups that are subject to the provisions of COBRA. If Group is exempt from the requirements of COBRA, Group is prohibited from offering Continuation Coverage. Members should contact the Group's benefits administrator to determine if he/she is eligible for Continuation Coverage.

COBRA Plan Administrator
For purposes of COBRA administration, the Group employer shall be designated as the Plan administrator. It is the Group's responsibility to administer Continuation of Group Coverage under COBRA, including determining whether the Group is required to offer Continuation of Group Coverage under COBRA. It is the Group's responsibility to inform Members of the availability, terms and conditions of Continuation of Group Coverage under COBRA and to provide all notifications required by COBRA. Health Net may not be responsible for providing COBRA if the Group does not meet its administrative responsibilities under COBRA or those required in the Group Agreement.

The following is general information regarding COBRA relating to Groups that are required to provide COBRA continuation coverage and is provided for informational purposes only and is not legal advice or a guarantee of coverage.

Eligibility
A Subscriber, or Subscriber's eligible Dependent, who is enrolled by Health Net at the time of a qualifying event may apply for continuation coverage. A *qualifying event* is defined as the loss of Group Coverage resulting from the following:
1. Subscriber's termination of employment, except for gross misconduct as defined by the Group;
2. A reduction in the number of hours worked by the Subscriber;
3. The death of the Subscriber;
4. The divorce or legal separation of the Subscriber;
5. Subscriber becomes eligible for benefits under Medicare;
6. An enrolled Dependent child has reached the limiting age of eligibility under the Group Agreement or becomes married;
7. The Group filed for bankruptcy under Title XI of the United States Code. *This provision applies only to retired Subscribers and his/her enrolled Dependents.*

Enrolling for Continuation of Group Coverage
Individuals desiring continuation Coverage must complete the COBRA election form and return it to the Group within 60 days of the later of:
1. The date such individual lost Coverage under the Group Agreement; or
2. The date such individual received the COBRA election form.

Terminated individuals who fail to elect COBRA within the 60 day period will lose their rights to continuation Coverage under COBRA.

Premium Payment
It is the Member's responsibility to submit to the Group the required Premium payment for continuation Coverage. The Group will remit the Premium payment and COBRA election form to Health Net. Premium payments are due as follows:
1. The first Premium payment must be received by Health Net within 45 days of the date Member elects continuation Coverage;
2. Subsequent Premiums are due and payable on a regular monthly basis as required by the Group.

If Premium payments are not received by Health Net on or before the due date, Coverage will be terminated retroactive to the last day of the month for which Premium was received and accepted by Health Net's accounts receivable department. Health Net will notify the Group and the enrollee of Coverage termination. Neither the Subscriber, nor the Group, shall be permitted to unilaterally reinstate Coverage through the submission of Premium after the date on which termination under this provision occurs.

Benefits Coverage

Individuals electing continuation Coverage under COBRA may continue their Coverage under the Group policy for the time periods stated below. Coverage shall, however, be subject to the conditions, limitations and exclusions stated in the Group Agreement, including any amendments.

If a Member is entitled to continuation Coverage under COBRA and receives Covered Services before electing COBRA continuation, the Member will be required to pay for such services. Health Net will reimburse the Member for Covered Services, less applicable Copayments and/or Coinsurance, for such services if the Member elects continuation Coverage within the 60 day allowable period, pays the required Premium, and submits a claim for reimbursement of Medical Services to Health Net.

Health Net will not issue a new Evidence of Coverage to Members continuing Coverage under COBRA. Health Net and the Group may agree to Modify the terms of the Group Agreement, including this Evidence of Coverage, after the Member enrolls for continuation Coverage. In such event, Member's Coverage under the Group policy will be identical to the Coverage offered to other active employees.

Termination of Group Coverage under COBRA

COBRA establishes the period of time that an enrollee may continue Coverage under the Group policy. Continuation Coverage will terminate on the earliest of the following dates:

1. 18 months from the date continuation Coverage began for an individual whose qualifying event was termination of employment or a reduction in hours worked subject to the following:
   (a) If during the initial 18 month period, a second qualifying event occurs, such individual may extend Coverage up to a maximum of 36 months;
   (b) If the individual is disabled on the date of the qualifying event, or is determined to have been disabled during the first 60 days of continuation Coverage, then Coverage may be extended for an additional 11 months subject to the following:
      (i) The individual must provide notice of such disability within 60 days of the date the determination of the disability is made, and in no event, later than the initial 18 month period;
      (ii) The individual must pay any increase in the required Premium to extend Coverage to a maximum of 29 months.
      (iii) If a disabled individual elects to extend Coverage by an additional 11 months, and during that extended period of time, no longer qualifies for disability, then Coverage under the Group policy will terminate on the last day of the month in which such individual no longer qualifies for disability.
2. 36 months from the date continuation Coverage began for all other qualifying events;
3. The date that the individual fails to make the timely payment of Premium. Termination will be retroactive to the last day of the month in which Premium payment has been received and accepted by Health Net's accounts receivable department;
4. The date that the individual becomes entitled to benefits under Medicare;

5. The date Coverage is obtained under any other group health Plan. *This provision does not apply if the other group Plan contains a pre-existing condition exclusion for which the Member would be denied Coverage*;
6. The date that the Group policy is terminated.

Extension of Benefits

When Benefits May Be Extended

Benefits may be extended beyond the date coverage would ordinarily end if you lose your Health Net coverage because the Group Enrollment Agreement is discontinued and you are ***totally disabled*** at that time. When benefits are extended, you will not be required to pay subscription charges. However, the Copayments shown in "Schedule of Benefits," will continue to apply.

Benefits will only be extended for the condition that caused you to become **totally disabled**. Benefits will not be extended for other medical conditions.

"Totally disabled" has a different meaning for different Family Members.

- For the Subscriber it means that because of an illness or injury, the Subscriber is unable to engage in employment or occupation for which he or she is or becomes qualified by reason of education, training or experience; furthermore, the Subscriber must not be employed for wage or profit.
- For a Family Member it means that because of an illness or injury, that person is prevented from performing substantially all regular and customary activities usual for a person of his or her age and family status.

How to Obtain an Extension

If your coverage ended because the Group Enrollment Agreement between Health Net and the Group was terminated, and you are **totally disabled** and want to continue to have extended benefits, you must send a written request to Health Net within 90 days of the date the Agreement terminates. The request must include written certification by the **Participating Physician** that the Member is **totally disabled**.

If benefits are extended because of **total disability**, provide Health Net with proof of total disability at least once every 90 days during the extension. The Member must ensure that Health Net receives this proof before the end of each 90-day period.

When the Extension Ends

The Extension of Benefits will end on the earliest of the following dates:

1. On the date the Member is no longer **totally disabled**;
2. On the date the Member becomes covered by a replacement health policy or plan obtained by the Group, and this coverage has no limitation for the disabling condition;
3. On the date that available benefits are exhausted; or
4. On the last day of the 12-month period following the date the extension began.

How Conversion Coverage Affects Extension of Benefits

Conversion Coverage

Conversion coverage affects extension of benefits when:

1. You receive an extension of the benefits of this Plan; and
2. You have also elected conversion coverage and it is in force.

Whichever coverage provides the higher benefits will be applied toward the disabling condition. Refer to "Conversion Coverage" section immediately below.

CONVERSION COVERAGE

A Subscriber, or Subscriber's enrolled Dependent, whose Coverage under the Group Agreement has been terminated may be eligible to convert to Health Net's individual conversion Plan. The terms of Health Net's conversion policy, including benefits and the amount of Premium payment, may be different from this Evidence of Coverage and the Group Agreement. Health Net's conversion policy provides the basic health care services required by state law.

Conversion coverage is available to Health Net Members whose Coverage under the Group Agreement has been terminated for the following:

1. Subscriber is leaving the Group (employer) employment;
2. Subscriber, or Subscriber's enrolled Dependent, ceases to qualify for Group Coverage due to the age of the Subscriber, or Subscriber's Dependent;
3. Subscriber's enrolled Dependent does not qualify as an eligible Dependent due to the Subscriber's death;
4. Subscriber's enrolled Dependent does not qualify as an eligible Dependent due to the Subscriber's dissolution of marriage;
5. Such individual elected continuation of Group Coverage under COBRA and the applicable maximum period of continuation have been exhausted.

Conversion coverage is not available to individuals:

1. Whose Coverage under the Group Agreement was terminated for failure to pay the required individual Premium;
2. Whose Coverage under the Group Agreement was terminated due to cancellation by the Group or termination by Health Net of the Group Agreement between the Group and Health Net;
3. Who are eligible for Medicare;
4. Who are eligible for or covered by other health insurance which would constitute over-insurance when combined with the conversion coverage.

Individuals desiring conversion coverage must live, work or reside within Health Net's Service Area when enrolling for conversion coverage. An Enrollment Application, and the first month's Premium, must be received by Health Net within 31 days of the date Coverage under the Group Agreement was terminated. All subsequent Premiums must be received on a timely basis to avoid cancellation. Conversion coverage will become effective on the day following termination under the Group Agreement.

No evidence of insurability shall be required for any individual satisfying the eligibility and enrollment requirements. Coverage shall, however, be the form of conversion policy then being issued by Health Net.

GRIEVANCE AND APPEALS PROCEDURES

A Member may, on occasion, be dissatisfied with quality of care, service issues, or the denial of a claim or request for service. Dissatisfaction with quality of care or service may be filed as a grievance**.** Dissatisfaction with the denial of a claim or request for service may be filed as an appeal. Below is a brief description of each process Please see your separate information package titled *How to File Grievance and Appeals* for a full description of the filing process and the different levels of appeal available to you.

YOUR SATISFACTION IS OUR CONCERN

At Health Net, we want you to be pleased with the quality of care and service you receive. Surveys show that most of our members are satisfied and many stay with Health Net year after year. We hope you are one of those members. If not, we want to hear from you so we can improve.

Anytime you have a concern about the quality of care you receive, the level of our service or any other aspect of your health plan – we want to know. Call us toll free at 1-800-289-2818 (1-800-977-6757 TTY: 711 for the hearing impaired). Many times, a single phone call to our Customer Contact Center staff can make things right.

In addition to calling our Customer Contact Center, there are other avenues for you to use if you do not agree with a decision made by Health Net or by one of the health care professionals who work with us. Like you, we want to be sure the appropriate decisions are made regarding your medical care and that you receive the benefits your health plan covers.

SHOULD YOU FILE A GRIEVANCE OR AN APPEAL?

Grievance

You initiate a grievance when you are not satisfied with the quality of care or service you are receiving. A grievance is the first step you take to tell Health Net that we are not meeting your expectations. A grievance tells us that you are not pleased with the quality of medical care or the service that you received. A grievance brings your concern to our attention.

We want you to let us know how we can improve any aspect of your medical care, preventive health benefits, customer service or your understanding of your health plan. Call, write or fax your grievance to us. Health Net will acknowledge receiving your grievance within five days. You will receive a decision within 30 days. Occasionally, Health Net may take an extra 15 days to receive and review information before we send you our decision. Every grievance about the quality of medical care is taken seriously. That's why we have a Quality Improvement Department for investigation and follow-up with the doctor or facility that provided the care.

Appeal

You file an appeal in response to a denial received from Health Net. This could be a denial of coverage for requested medical care or for a claim you filed for care already received. An appeal asks Health Net to review your request for coverage of medical care or claim for reimbursement. Your appeal goes to people who have not reviewed your case before. You can call, write or fax your request to start the appeal process.

You will want to know that medical information is reviewed by physicians at every level – from your primary care physician, to a referral specialist, other doctors in the medical group and Health Net's medical directors. The type of care requested must be medically necessary – and it must be a service or treatment that is covered by your health plan.

In many cases, you can present the specifics of your initial appeal by phone.

How to File Grievance and Appeals packet was delivered with Your policy. In addition, you may request additional copy by contacting Health Net by phone, mail or fax with the contact information below.

TO GET STARTED

Phone
You can initiate either the appeal or grievance process by phone. Just call our Customer Contact Center, Monday through Friday from 7 a.m. to 6 p.m. at 1-800-289-2818 (1-800-977-6757 TTY: 711 for the hearing impaired).

Mail
You can mail a written appeal or grievance to:
Commercial Appeals and Grievances Department
Attention: Appeals & Grievance Manager
Health Net of Arizona
P.O. Box 277610
Sacramento, CA 95827-7610

Fax
You may also fax a written appeal to the Health Net Commercial Appeals and Grievances Department at 1-800-977-6762.

OTHER APPEAL & GRIEVANCE INFORMATION

Getting Your Medical Records
Under Arizona law, you and your health care decision-maker are entitled to a copy of your medical records from any health care professional that has treated you. Make your request in writing and be sure to include the address where you want your records sent. You may be asked to pay for the photocopying and postage costs. In some cases, your records will be sent only to the medical professional that you have designated.

Confidential Medical Information
Your medical records are confidential. They are used only as needed to make decisions about your care or any appeals you may file. During an appeal, Health Net may release some portions of your medical records to the people who are reviewing your case.

Mailing Documents
We want to be sure our response reaches you. Please confirm that Health Net has your current mailing address in our records because that is where documents will be sent. We consider information mailed to you to be received on the fifth business day.

Questions
If you have questions or need assistance, please call Health Net's Customer Contact Center at 1-800-289-2818
(1-800-977-6757 TTY: 711 for the hearing impaired).

Medical Malpractice Disputes
Any disputes alleging the medical malpractice, negligence and/or wrongful act of a health care provider, or injury or property damage caused as a result of an Accident at the premises of a health care provider, shall not include Health Net and shall include only the provider subject to the allegation. Health Net, and Plan Providers are independent contractors in relation to one another.

ACCESS TO MEDICAL RECORDS
Health Net is entitled to receive from any provider who renders Covered Services to a Member all information reasonably related to such services. Subject to applicable confidentiality requirements,

Members authorize any provider rendering Covered Services to disclose all facts pertaining to the Member's care and treatment by the provider and to permit copying of reports and records by Health Net. Member agrees to execute a release and/or authorization for Health Net to obtain medical records if requested by Health Net during the term of the Member's Coverage. Health Net reserves the right to reject or suspend a claim based on lack of medical information or records.

Confidentiality
Health Net shall preserve the confidentiality of the Members' health and medical records consistent with the requirements of applicable Arizona and federal law.

Records
Health Net keeps records of all Members, but is not liable for any obligation dependent upon information from the Subscriber or Member prior to its receipt in a form satisfactory to Health Net. If Health Net has not acted to its prejudice by relying thereon, incorrect information furnished by the Subscriber or Member may be corrected.

ENTIRE AGREEMENT
The Group Agreement, this Evidence of Coverage, the Schedule of Benefits, the Group Enrollment Form, individual Enrollment Forms, conditions of enrollment, underwriting criteria and Amendments if any, constitute the entire Agreement between Health Net and the Group and supersede all prior and existing arrangements, understandings, negotiations, and discussions, whether written or oral, of the parties. There are no warranties, representations, or other agreements between the parties in connection with the subject matter of the Agreement, except as specifically set forth in the Group Agreement. No supplement, modification or waiver of the Agreement, other than as specifically provided for herein, shall be valid unless executed in writing by the President of Health Net, or an authorized executive officer of Health Net, and an authorized representative of the Group.

INDEPENDENT CONTRACTOR SERVICES
Health Net does not itself undertake to directly furnish any health care services under the Agreement. Health Net reserves the right to add or delete Participating Providers from its Provider panel.

The relationship between Health Net and Participating Providers, Physicians, Skilled Nursing Facilities, Networks, other Health Professionals, and other community agencies, is that of independently contracting entities. Such independently contracting entities are neither agents nor employees of Health Net nor is Health Net or any employee of Health Net an employee or agent of such entities. Health Net shall not be liable for any claim, demand or cause of action regarding damages arising out of, or in any manner connected with, any injuries, alleged or otherwise, suffered by the Member while receiving care in, from, or through any such entities.

ACCEPTANCE OF THE AGREEMENT
The Group enters into this Agreement on behalf of its employees who become Members of Health Net. Acceptance of the Agreement by the Group constitutes acceptance by the Members and is binding on all Members. By electing medical and Hospital Coverage pursuant to the Agreement, or accepting benefits hereunder, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions and provisions of the Agreement.

CONSENT OF MEMBERS NOT REQUIRED
The Group Agreement shall be subject to amendment, modification or termination in accordance with the provisions of the Group Agreement. Consent or concurrence of the Group's enrollees is not required.

STATEMENTS AND REPRESENTATIONS
The Group and each Subscriber shall complete and submit to Health Net the Enrollment Forms and such other statements that Health Net may reasonably request. The Group, and each Subscriber, represent that all information contained in the Enrollment Forms, and other statements or information submitted to Health Net pursuant to the Agreement, or regarding the administration of the Agreement, shall be true, correct, and complete. Any and all rights to Covered Services under the Agreement are subject to the condition that all such information shall be true, correct and complete.

POLICIES AND PROCEDURES
Health Net has adopted policies, procedures, rules and interpretations to promote orderly and efficient administration of the Agreement, and, in its discretion, may Amend, Modify, terminate, or adopt other policies, procedures, rules and interpretations. Consent or concurrence of the Group, or the Group's enrollees, is not required. Health Net, at its sole discretion and without obligation under this Health Plan, may offer to provide a Member alternative coverage for services and supplies which may be otherwise excluded or limited by the terms of this Evidence of Coverage. Such alternative coverage is available only where Health Net and the Member, or the Member's legal representative, agree in writing to the alternative treatment. All alternative treatment is subject to the determination by the Member's treating Provider that the alternative treatment Plan is appropriate for the Member. In no event shall the cost of alternative coverage exceed the cost of Covered Services to which the Member would otherwise be entitled.

COMMENCEMENT OR TERMINATION
Whenever an Effective Date of commencement or termination is provided, such commencement shall be effective as of 12:01 a.m. of that date in Arizona. Termination shall be effective as of 11:59 p.m. of that date in Arizona.

CONSTRUCTION
The Group Agreement has been entered into and delivered, and shall be construed according to the laws of the State of Arizona. For simplicity of expression, pronouns and other terms are sometimes expressed in one number and gender, but where appropriate to the context, these terms shall be deemed to include each of the other numbers and genders. The headings are solely for convenience and shall not affect interpretation.

EVIDENCE OF COVERAGE
Health Net will deliver to each Subscriber a copy of this Evidence of Coverage, including the *Schedule of Benefits,* which sets forth the terms and conditions governing the rights of such Subscriber and the Subscriber’s enrolled Dependents.

CLERICAL INACCURACIES
Clerical inaccuracies by Health Net in keeping any record pertaining to Coverage hereunder, will not invalidate Coverage otherwise validly in force or continue Coverage otherwise validly terminated.

NOTICES
Any notice to Health Net under the Group Enrollment Agreement may be addressed and mailed as follows:

Health Net of Arizona, Inc.
1230 West Washington Street, Suite 401
Tempe, Arizona 85281

Any notice to the Group or to a Subscriber, or a Subscriber's enrolled Dependent, shall be sufficient if the notice is addressed to the Group or the Subscriber at the address last appearing on the records of Health Net.

ASSIGNMENT

All rights of Members hereunder are personal to each Member and are not assignable or otherwise transferable. Neither the Agreement nor any right hereunder shall be assigned, transferred or otherwise conveyed by Health Net or the Group without the approval of Health Net. If a Member desires to assign any rights hereunder, such request shall be evidenced in writing signed by the Member and will be granted or denied at Health Net's sole discretion. Nothing herein shall be construed to prohibit Health Net from engaging in a corporate reorganization or merger without the consent of the Group or its enrollees.

SEVERABILITY

If any term, provision, covenant or condition of the Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions shall remain in full force and shall in no way be affected, impaired or invalidated.

IMPLIED WAIVER

Failure by Health Net on one or more occasion to avail itself of a right conferred by the Agreement shall in no event be construed as a waiver of its right to enforce said right in the future.

EVENTS NOT IN HEALTH NET'S CONTROL

To the extent that a disaster, war, riot, civil insurrection, epidemic or other Emergency or event not within the control of Health Net result in the offices, personnel, or financial resources of Health Net being unable to provide or arrange for the provision of Covered Services and benefits, Health Net shall have no liability or obligation for any delay in the provision of or failure to provide such services and benefits, except that Health Net shall make a good faith effort to provide such services, taking into account the impact of the event.

GLOSSARY OF TERMS

This section tells you meanings of some of the more important words you will see used in this Evidence of Coverage. Please read it carefully. It will help you understand this Evidence of Coverage.

Accident or Accidental means an unexpected, undesirable event that was unforeseen.

Actively Employed means working full-time as determined by the employer, in the performance of regular duties of the employer's business. A person is also considered to be Actively Employed on each day of a regular paid vacation, medical leave or other approved company leave.

Acute means the sudden onset of an illness or injury, or a sudden change in a person's health status, requiring prompt medical attention, but which is of limited duration.

Aggravation means a new incident or injury in the same area where a previous injury had occurred.

Alcoholism means the disease which is classified as Alcoholism in the International Classification of Diseases of the U.S. Department of Health and Human Services.

Allowable Expense means the negotiated schedules of payment developed by Health Net which are accepted by Participating Providers within a geographic area specified by Health Net as payment in full when the item of expense is a Covered Service.

Ambulatory Surgical Facility means a Facility that meets the states' professionally recognized standards and provides the following:

1. It mainly provides a setting for Outpatient surgeries; and,
2. It does not provide more than 2 days of Inpatient service; and,
3. It has all of the medical equipment needed to support the surgery performed, x-ray and laboratory diagnostic Facilities, and Emergency equipment and supplies for use in life threatening events; and,
4. It has a medical staff that is supervised full-time by a Physician and includes a registered nurse at all times when patients are in the Facility; and,
5. It maintains a medical record for each patient; and,
6. It has a written agreement with a local Hospital for the immediate transfer of patients who require greater care than can be furnished at the Facility; and,
7. It complies with all state and/or federal licensing and other requirements; and,
8. It is not the office or clinic of one or more Physicians.

Amend or Modify means adding, deleting, changing, correcting or rephrasing any of the terms or provisions of the Group Agreement, this Evidence of Coverage, the *Schedule of Benefits*, or Enrollment Forms, including amendments thereto. Such amendment or modification may include, but is not limited to, a change in the Copayments and/or Coinsurance, Coverages, and the policies or practices of Health Net.

Anniversary Date means the Effective Date of the Group Agreement and each subsequent annual renewal date thereafter.

Average Wholesale Price means an amount determined by the national pharmaceutical database company used by Health Net.

Behavioral Therapy means interactive therapies derived from evidence based research, including applied behavior analysis, which includes discrete trial training, pivotal response training, intensive intervention programs and early intensive behavioral intervention.

Birth Center means a facility that is primarily a place for the delivery of a Child at the end of a normal pregnancy, and meets all of the following tests:

1. It complies with all licensing and other legal requirements;
2. It is equipped to perform all of the needed routine diagnostic and laboratory tests;
3. It has a medical staff that is supervised full-time by a Physician, or, at his or her direction, by a Nurse Midwife, and that includes a registered nurse at all times when patients are in the facility;
4. It has all the medical equipment necessary to properly treat potential emergencies of the mother and Child;
5. It has a written agreement with a local Hospital for the immediate transfer of a patient in the event of a complication;
6. It maintains a medical record for each patient; and
7. It expects to discharge or transfer to a Hospital, each patient within 48 hours of the delivery.

Bridge To Transplant qualification means the Member must be accepted and approved as a recipient for a transplanted organ by the Medicare approved facility in accordance with the transplant program guidelines. Exclusion or removal from the transplant acceptance roster will discontinue coverage.

Brand Name Drug or Brand Name means a prescription Drug that has been given a Brand Name or trade name by its manufacturer and is advertised and sold under that name or is classified as such by a national pharmaceutical database company.

Calendar Year means January 1 at 12:01 a.m. to December 31 at 11:59 p.m. of the same year.

Child means a person:

- Born to you;
- Legally adopted by you (including being placed with you for the purpose of legal adoption);
- Who is your stepchild;
- For whom you have been appointed permanent legal guardian;
- For whom you are under court or administrative order to provide coverage; or
- For whom a Qualified Medical Child Support Order (QMCSO) has been issued

For the purpose of this definition, a Child must be younger than 26 years of age as of the date of adoption or placement for adoption.

Chronic Health Conditions means those conditions in which the patient's condition is either stabilized at a functional level or progressively deteriorating to the point where the Health Professional has determined that active Short-Term health treatment will not result in any reasonable expectation for improvement.

Claims means invoices or other standard billing documents containing details of health care services provided to a Member that a Provider of health care services submits for payment, or that a Subscriber submits to Health Net for reimbursement.

Claim Forms means any document supplied by an insurer to an insured, claimant or other person that the insured, claimant or other person is required to complete and submit in support of a claim for benefits.

Coinsurance means the percent of a Covered Charge that the Member must pay for Covered Services and Supplies. Coinsurance amounts are shown in the Schedule of Benefits. For example, Coinsurance may be shown as 20%. This means that 20% of Covered Charges are paid by the Member and 80% are paid by Us.

Complications of Pregnancy means:

1. When pregnancy is not terminated: conditions whose diagnoses are distinct from pregnancy but are adversely affected by or caused by pregnancy, such as Acute nephritis, nephrosis, cardiac decompensation, missed abortion; disease of the following body systems - vascular, hemopoietic, nervous, endocrine, toxemia (pre-eclampsia);
2. When pregnancy is terminated: non-elective caesarian section, ectopic pregnancy that is terminated, or spontaneous termination of pregnancy that occurs during a period of gestation when a viable birth is not possible. Viable birth means that the fetus has reached a stage that will permit it to live outside the uterus and is capable of living outside the uterus; or
3. Complications of Pregnancy do not include multiple births, preterm labor, false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy that do not constitute a nosologically distinct complication of pregnancy.

Concurrent Review means the examination of ongoing medical care by Us to determine the Medically Necessity, appropriateness, and level of care.

Congenital Anomaly or Congenital Defect means a defective development or formation of a part of the body which is determined to have been present at the time of birth.

Copayment means the fixed amount of Out-of-Pocket expenses that a Member is required to pay a Participating Provider when receiving Covered Services. Copayments are due to the Provider at the time Covered Services are received. Copayments may be in addition to Coinsurance or deductible amounts the Member must pay under this Evidence of Coverage, dependent upon the plan selected by your employer.

Cosmetic/Cosmetic Surgery means surgical procedures, including plastic surgery or other treatment, that We determine to be directed toward preserving, altering or enhancing appearance, whether or not for emotional or psychological reasons.

Coverage means health care services and treatments which are covered under this Evidence of Coverage.

Covered Service (s) and Supplies means those Medically Necessary services, supplies or benefits that are payable or eligible for reimbursement under this Evidence of Coverage, including any amendments hereto subject to any benefit limitations, or maximums under the Evidence of Coverage and are prescribed and/or performed by Providers within the scope of their practice. The fact that a Participating Provider may prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it a Covered Service.

Creditable Coverage means any of the following: (a) another group plan (including COBRA continuation coverage); (b) individual health insurance coverage; (c) Medicare Part A or B; (d) Medicaid; (e) CHAMPUS; (f) Federal Employees Health Benefit Plan (FEHBP); (g) medical care program of the Indian Health service or of a tribal organization; (h) a state health benefits risk pool; (i) a public health plan; or (j) a Peace Corps health plan.

Crisis means a change or alteration in a patient's condition which is responsible for dysfunction, anxiety, pain, depression or a danger to self or others.

Custodial Care means provision of room and board, nursing care (excluding skilled nursing care), and personal care designated to assist an individual who in the opinion of Health Net’s medical director has

reached the maximum level of recovery. Custodial Care also includes rest cures, respite care, and home care that is or can be performed by Family Members or non-medical personnel.

Deductible (Individual and Family) means the amount each Subscriber, or Subscriber and Members in a Family Unit must satisfy each Year before benefits are payable by Us unless otherwise stated herein. These Deductibles are shown on the Schedule of Benefits.

Dependent means a lawful spouse, Child (including an adopted Child, Child placed for adoption with Subscriber, and a Child eligible for Coverage pursuant to a Qualified Medical Child Support Order) or other Dependent who meets the full definition and requirement of a Dependent as determined by the Group employer and stated in the Group Agreement. For purposes of this definition, a Child must be younger than 26 years of age as of the date of adoption or placement for adoption. The term *Dependent* does not include a person who is a Member's natural Child for whom legal rights have been given up through adoption. The term *Dependent* also does not include a grandchild of the Subscriber for whom the Subscriber does not have court ordered permanent guardianship or custody, unless otherwise specifically stated in the Group Agreement.

Drugs or Prescription Drugs means any of the following:
1. A federal legend Drug (a medication that is required by the U.S. Food, Drug and Cosmetic Act to include a label that reads: "Caution: Federal law prohibits dispensing without a prescription");
2. A Drug that requires a prescription under state law but not under federal law;
3. A compound Drug that has more than one ingredient, one of which must be a federal legend Drug or a Drug that requires a prescription under state law; or
4. A substance (other than food) recognized by an official pharmacopoeia or formulary and intended for use in the diagnosis, cure, mitigation, or prevention of disease and otherwise defined by the Food and Drug Administration (FDA).

Drug Usage Guidelines means criteria and clinical treatment recommendations that are developed and approved by the Health Net Pharmacy and Therapeutics Committees for use in evaluating requests for medications that require approval for coverage.

Durable Medical Equipment or DME means durable items or appliances, as determined by Health Net, are:
1. Able to withstand repeated use; and
2. Are designed to serve a medical purpose; and,
3. Generally are not useful to a person in the absence of a medical condition, illness or injury; and,
4. Are not disposable; and,
5. Are not customarily dispensed from a Physician's office; and,
6. Are appropriate for use in the home; and
7. Are needed for functional rather than cosmetic reasons.

Effective Date means with respect to the Group Agreement, the date stated as the Effective Date in the Group Agreement between Health Net and the Group. With respect to a Member, the date Coverage under this Health Plan became effective.

Eligible Employee means an individual who satisfies the Group's requirements for Coverage as provided to Health Net in the Group Agreement.

Emergency/Emergent means a condition or illness which, if not immediately diagnosed and treated would result in extended or permanent physical impairment or loss of life, and requires the Member to seek immediate medical attention necessary for the relief of Acute pain, repair of accidental injury, initial treatment of infection, or the relief of illness.

Emergency Services means health care services that are provided to a Member in a licensed medical Facility by a Provider after the recent onset of a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to the patient's health;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services do not include use of a Hospital Emergency room or other Emergency medical Facility for routine services, follow-up or continuing care, unless Preauthorized by the Primary Care Physician or Health Net.

Employer means the legal entity who has contracted with Us to provide coverage to its employees and which is named in and has entered into the Group Agreement with Us to allow the Employer's employees, or other individuals as defined in the Group Agreement, the opportunity of selecting this Group Health Plan.

Enrollment Form means the form required by Health Net to be completed, signed and submitted by the Group for the purpose of enrollment or altering the enrollment of the Subscriber or Subscriber's enrolled Dependents, and/or for notifying Health Net of any applicable changes.

Exacerbation means a flare-up of an existing illness or injury.

Experimental, Unproved or Investigational means medical, surgical or psychiatric procedures, treatments, supplies or pharmacological regimes not generally accepted by the medical community. This includes, but is not limited to procedures, treatments, regimes of care, services, equipment, devices or supplies which are in a testing state or in field trials on animals or humans, or do not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed, or are not in accordance with generally accepted standards of medical practice, or have not yet been shown to be consistently effective for the diagnosis or treatment of a Member's condition.

Facility or Facilities means institutions operating pursuant to state and/or federal statutes and regulations which are primarily engaged in providing Short-Term medical care and treatment of sick and injured persons. Facility also includes licensed institutions that provide diagnosis on an Outpatient basis.

Family Member means a spouse, Child, brother, sister, parent or grandparent of the Member, or a spouse's Family Member if applicable.

Generic Drug or Generic means a drug product, containing identical active ingredients to the brand name product, that the FDA has determined to be therapeutically equivalent to the original brand name product and classified as such by a national pharmaceutical database company.

Grace Period means a period of 10 days following the Premium due date during which Premium payments may be paid without a lapse in Coverage, unless otherwise stated in the Group Agreement.

Group means the legal entity who has contracted with Us to provide coverage to its employees and which is named in and has entered into the Group Agreement with Us to allow the Employer's employees, or other individuals as defined in the Group Agreement, the opportunity of selecting this Group Health Plan.

Group Agreement or Group Enrollment Agreement means the written agreement entered into between Health Net and the Group.

Health Net of Arizona, Inc. or Health Net is a Health Maintenance Organization, licensed by the State of Arizona, and organized and operating as a health care services organization pursuant to the laws of the State of Arizona.

Health Plan means the benefits described in this Evidence of Coverage and provided by Health Net.

Health Professional means a health care Provider who is appropriately licensed, certified or otherwise qualified to deliver health services pursuant to state law and who has contracted with Health Net to render Medical Services to Members of Health Net.

Home Health (Care) Agency means an agency or organization that is duly licensed by the appropriate licensing authority to provide skilled nursing services and other therapeutic services in the state or locality in which it is located and certified under Medicare and/or accredited by the Joint Commission.

Home Health Care means medical care provided by a Participating Provider from an Approved Home Health Care Agency which is provided on an interim basis, or in lieu of hospitalization.

Hospice Care or Hospice Services means a program of care that is Approved by Health Net and which focuses on a palliative rather than a curative treatment for Members who have a life expectancy of 6 months or less.

Hospital means an institution operated pursuant to state or federal statutes and regulations and primarily engaged in providing medical care and treatment of sick and injured persons through medical and diagnostic procedures. It must be certified under Medicare and/or accredited by the Joint Commission.

Hospital Services means those Medically Necessary services for registered Inpatients which are customarily rendered in an Acute care general Hospital, or psychiatric specialty Hospital, and prescribed or directed by a Participating Physician.

Hospitalist means a physician who specializes in treating inpatients and who may coordinate a patient's care when he or she is admitted at a Participating Hospital.

Illness means a bodily sickness or disease, including Complication of Pregnancy, but not mental illness. All Illnesses that are due to the same or a related cause or causes will be one Illness.

Injury means an Accidental bodily Injury that is caused directly and independently of all other causes by an accident. Injury does not include non-accidental self-inflicted Injury or attempted self-destruction, whether sane or insane.

Inpatient means a person has been assigned to a bed in a Hospital, Hospice or Skilled Nursing Facility, and a charge for room and board is made.

Intensive Care Unit means a separate part of a Hospital which meets all of the following tests:
1. It provides treatment to patients in critical condition;
2. It continuously provides special nursing care or observation by trained and qualified personnel; and
3. It provides life-saving equipment.

Lifetime Maximum means the maximum amount of Covered Services that a Member can receive from Health Net during his or her lifetime. Lifetime Maximums may be applied to either dollar amounts or benefit amounts or both. When Covered Services reach the Lifetime Maximum, Member's benefits shall be exhausted and no additional benefits will be payable by Health Net. The term *Lifetime*

Maximum shall include benefits payable on behalf of a Member who was enrolled either as a Subscriber or a Dependent, or a combination of both. The term Lifetime Maximum shall also include benefits payable on behalf of a Member enrolled under any benefit plan or policy offered by Us.

Maintenance or Maintenance Care means services and supplies that are provided solely to maintain a condition at the level to which it has been restored or stabilized and from which level no significant practical improvement can be expected.

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 Food means modified low protein foods and metabolic formulas which are not Over-the-Counter and are FDA approved. Low protein foods and metabolic formulas must be: formulated to be consumed or administered eternally under the supervision of a Physician or registered nurse practitioner; administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; essential to a member's optimal growth, health and metabolic homeostasis. Metabolic formulas must also be processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs. Low protein food must also be processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein.

Medical Services means those professional services of a Physician and allied Health Professionals, including medical, surgical, diagnostic, and therapeutic services which are described in the section titled *Description of Benefits*, and which are performed, prescribed or directed by a Participating Physician with the scope of their license.

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:

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

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

The fact that a Provider may prescribe, order, recommend or approve a treatment, service, supply or medicine does not in itself make the treatment, service, supply or medicine Medically Necessary as defined in this Evidence of Coverage. The terms *Medically Necessary*, *medically indicated*, and *Medical Necessity* may be used interchangeably throughout this document.

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

Member means any person enrolled under this Evidence of Coverage, either as a Subscriber or Dependent, for whom Premium payment has been received and accepted by Health Net's accounts receivable department.

Mental Health Services means all services (including Hospital stays) provided by psychiatrists, psychologists, or other mental health Providers, including but not limited to, social workers and psychiatric nurses, that meet medical criteria and are specifically stated as being covered in the *Schedule of Benefits*.

Morbid Obesity means any of the following:

- A weight of at least two (2) times the ideal weight for frame, age, height, and gender pursuant to the National Institutes of Health (NIH) BMI
- BMI of greater than or equal to 35kg/m2 with one or more high risk co-morbidities.

Network means any Physician group practice or organization that has entered into a written agreement with Health Net for the provision of Medical Services to Members under this Evidence of Coverage. Health Net's agreement with a Network may terminate, and the Member may be required to select another Network, Primary Care Physician or other Participating Provider to be primarily responsible for providing and coordinating a Member's Medical Services.

Newborn Period means the first 31 days following birth.

Non-Participating Chiropractor means a chiropractor who is not under contract with the designated Chiropractic Provider as shown in the *Schedule of Benefits*, to treat Members through an arrangement with the Health Plan.

Non-Participating Pharmacy means any Pharmacy that has not contracted with Health Net to provide prescription medications to Members covered under this Evidence of Coverage. This can include specific stores within a chain of stores.

Non-Participating Provider means any Provider that has not contracted with Health Net to provide health care services to Members covered under this Evidence of Coverage.

Nurse Midwife means a person who:

1. Is licensed as, or certified to practice as a Nurse Midwife and is practicing within the scope of that license; or
2. Is licensed by a board of nurses as a registered nurse (R.N.) and
3. Has completed a program for the preparation of Nurse Midwife that is approved by the state in which the person is practicing.

Open Enrollment Period means those periods of time established by the Group and Health Net, periodically but at least every 12 consecutive months, during which Eligible Employees and their Dependents may enroll or change status as Members.

Orthotics means rigid or semi-rigid devices used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured body part.

Out-of-Area or Out-of-Service-Area means those services and supplies provided outside of Health Net's Service Area.

Out-of-Pocket Maximum means the total dollar amount of Copayment, Coinsurance and Deductibles that a Member or family unit is required to pay for Covered Services during any given Calendar Year. Out-of-Pocket Maximums are determined for Covered Services only and do not apply to any Medical Services or treatments that are not Covered Services. Copayment amounts for Outpatient Prescription

Drugs, and non-Covered Services identified in this Evidence of Coverage do not accumulate towards the Out-of-Pocket Maximum.

Outpatient means Covered Services provided on other than an Inpatient basis. An Outpatient visit is generally defined as 3 hours or less. 4 hours would be counted as one-fourth of an Inpatient day, and 5 through 8 hours would be counted as one-half of an Inpatient day. Anything over 8 hours would count as a full Inpatient day.

Over-the-Counter means any item, supply or medication which can be purchased or obtained from a vendor without a prescription.

Participating Chiropractor means an individual who is a licensed Doctor of Chiropractic and who is under contract with the designated Chiropractic Provider as shown in the *Schedule of Benefits* to provide chiropractic services to Members of this Health Plan.

Participating Hospital means a Hospital which has an agreement with Health Net to provide Hospital Services to Members covered under this Evidence of Coverage.

Participating Pharmacy means a pharmacy that has contracted with Health Net to dispense covered pharmaceutical services or supplies to Members of this Health Plan.

Participating Physician means a Physician who has entered into an agreement, or on whose behalf an agreement has been entered into, with Health Net to provide Medical Services to Members covered under this Evidence of Coverage.

Participating Provider (s) means any person or entity that has entered into a contract with Health Net to provide Covered Services to Members enrolled under this Evidence of Coverage. Participating Providers include, but not limited to, Hospitals, Urgent Care Facilities, Physicians, Pharmacies, laboratories, and other Health Professionals within Health Net's Service Area.

Participating Vision Provider means an optometrist, ophthalmologist or optician licensed to provide Covered Services and who or which, at the time care is rendered to a Member has a contract in effect with Health Net to furnish care to Members. The names of Participating Vision Providers are set forth in Health Net's Participating Vision Provider Directory. The names of Participating Vision Providers and their locations and hours of practice may also be obtained by contacting Health Net's Customer Contact Center.

Patient Costs mean services that would be considered a Covered Service if the Member were undergoing usual and customary care. Patient Costs do not include the cost of Investigational drugs or devices, the cost of any non-health services, the cost of managing research, services provided out of the state of Arizona, or services that would not otherwise be covered.

Payor (s) means an insurer, health maintenance organization, no-fault liability insurer, self-insurer, governmental program, or other entity or program that provides or pays for health care benefits.

Physician means a person who:

1. Is recognized and licensed under the laws of the state where treatment is received as qualified to treat the type of injury or illness for which a claim is made; and
2. Is practicing within the scope of his or her license; and
3. Is a duly licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.), or other Health Professional not specifically named in this Evidence of Coverage for whom reimbursement is

mandated under applicable Arizona or federal law, when licensed in the state where services are received.

Plan means any health care entity which provides coverage for health care service and treatment coverage.

Plan Year means each 12 consecutive month period commencing on the Effective Date and each Anniversary Date thereafter during which the Group Agreement is in effect.

Preferred Drug List means a listing of drugs eligible for certain levels of coverage under this benefit. The listing was created and is updated from time to time by Health Net and is posted on www.healthnet.com or provided in printed format upon request. The listing is updated periodically and is available to Participating Providers (Pharmacies and Physicians). Depending on your plan, drug coverage may be limited to those drugs on the Preferred Drug List and can change at any time without notice. Your doctor must request a patient specific authorization for select drugs on the Preferred Drug List. Requests for these drugs are evaluated by Health Net to determine if the established approval criteria are met. If approved, you will be responsible for your Copayments, Deductibles, Coinsurance amounts, any non-Covered or Excluded Charges, and amounts over specifically limited benefits. If the drug is not approved you will be responsible for the entire cost of the drug. The Health Net P&T committee, comprised of actively practicing physicians and pharmacists, reviews medications based on clinical efficacy, safety, side effects, quality outcomes, and comparisons to existing products, and develops protocols for medications requiring Precertification through consideration of benefit plans, step-care protocols, quantity or duration limits, benefit exclusions, potential for misuse, potential usage indications that do not meet Food and Drug Administration (FDA) criteria, experimental or off-label use, and required level of laboratory or safety monitoring. The HNPS Strategic Development Committee may recommend cost-based tier placement in the Preferred Drug List PDL for medications determined to be clinically equivalent by the P&T committees.

Premium means the payment, including any contributions made by Subscribers, which the Group must pay to Health Net for Coverage provided by the Group Agreement.

Primary Care Physician (PCP) means the Participating Physician who provides, arranges and coordinates a Member's health care. PCP's are Physicians in the areas of family practice, general medicine, internal medicine, and pediatrics. Upon enrollment, a Member selects a Physician from the list of Participating Physicians. Obstetricians may also act as a Member's PCP during pregnancy and postpartum periods. Members do not need to contact Health Net to change their PCP to an obstetrician during pregnancy and postpartum periods.

A PCP's relationship with Health Net may terminate, and the Member may be required to select another PCP who will be responsible for providing and coordinating a Member's total health care. A list of PCP's, their locations and hours of operation, is available to each Member upon enrollment. Such lists shall be revised periodically as deemed necessary by Health Net.

Prior Auth/Preauthorization/Authorization/Preauthorized means a review process that determines:

- Medical Necessity of requested services or supplies, and
- Whether the requested service or supply is a benefit under the Health Plan.
- Meets criteria established by Us.

Preauthorization does not guarantee coverage if other plan provisions are not satisfied (for example, member is not eligible on date of service).

The term "Precertification/Certification/Precertified" is interchangeable with the term "Prior Authorization/Preauthorization/Authorization/Preauthorized."

Private Duty Nursing means therapeutic services or observations that are prescribed by a Physician which require continuous 24 hour attendance by a licensed nurse (R.N. or L.P.N.).

Prosthetic, Prosthetic Devices, Prostheses means the mechanical devices that replace the function of an internal or external body part by an artificial substitute which may or may not be surgically implanted.

Provider means a licensed Physician, dentist, podiatrist, psychologist, Hospital or Facility, Pharmacy, nurse practitioner, social worker holding a master's degree in social work or other licensed medical practitioner practicing within the lawful scope of his or her license.

Providers also include other health care professionals not specifically named in this Evidence of Coverage for whom reimbursement is mandated under applicable Arizona or federal law, when licensed by the state in which services are delivered, and performing services within the scope of their license.

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

Qualified Autism Service Providers employ and supervise qualified autism service professionals and paraprofessionals who provide behavioral health treatment and implement services for pervasive developmental disorder or autism spectrum disorders pursuant to the treatment plan developed and approved by the Qualified Autism Service Provider.

- A qualified autism service professional is a behavioral service provider that has training and experience in providing services for pervasive developmental disorder or autism spectrum disorders and is approved; and
- A qualified autism service paraprofessional is an unlicensed and uncertified individual who has adequate education, training, and experience as certified by the Qualified Autism Service Provider.

Qualified Medical Child Support Order means any order that creates or recognizes an alternate payment right to receive benefits for which a person is eligible under a Group Plan. This order can be issued by a court or administrative agency that has jurisdiction for such matters. This term shall be applicable to Subscriber's unmarried child, including any stepchild, legally adopted child, child who has been placed for adoption with Subscriber, or a child eligible for Coverage pursuant to a Qualified Medical Child Support Order under the limiting age as stated in the Group Agreement.

Qualified Travel Expenditures means transportation, room and board costs incurred while obtaining Preauthorized Covered Services outside the Service Area in cases where it has been determined by Us that the Preauthorized Covered Services are not available in the Service Area.

Qualifying Events include, but are not limited to, events where the qualified individual:

- Employees or Dependents who at the time of initial enrollment were covered under a public or private health insurance policy and who later lost their coverage due to termination of employment, loss of eligibility, reduction in the number or hours of employment, termination of coverage of another health plan, the death of a spouse, divorce or legal separation of a spouse, the covered employee becoming entitled to benefits under Medicare, a dependent child ceasing to be a dependent child, or termination of Employer contributions towards the coverage, or a proceeding in a case under Title 11 bankruptcy, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time, when the loss of coverage includes a substantial elimination of coverage within one year before or after the date of commencement of the proceeding;
- Employees or Dependents who request enrollment into this Health Plan within 31 days after the termination of Creditable Coverage as described in numbered 1 above;
- Employees or Dependents who are employed by an Employer which offers multiple health benefit plans and elect a different plan during an Open Enrollment Period;
- Employees who are ordered, by a court or administrative order, to provide Coverage for a spouse or minor Child and request such Coverage within 31 days of the order;
- Employees who request enrollment within 31 days after the date of marriage;
- A person who becomes a Dependent of a covered person through marriage, birth, adoption or placement for adoption, and requests enrollment no later than 31 days after becoming a Dependent.
- Employees or Dependents who become ineligible for or lose their Medicaid or Children's Health Insurance Program (CHIP) coverage, or if they become eligible for a State's premium assistance program. These employees/dependents have up to 60 days from the date they lose their Medicaid or CHIP coverage to request enrollment in this Health Plan.

Referral means the request made through the Primary Care Physician for authorization of specialty services or equipment on behalf of a Member. In order for services to be covered, Referrals must be Approved by Health Net, or its designee, prior to Member receiving specialty services.

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

Routine Care or Routine Medical Care includes, but is not limited to, conditions such as colds, flu, sore throats, superficial injuries, minor infections, follow-up care and preventive care. Treatment for these conditions should be sought from a Primary Care Physician and are not considered Emergency or Urgent Services.

Service Area means the geographic area serviced by Health Net as authorized by the State of Arizona, and designated by Health Net for the provision of Covered Services. These areas may change from time to time as designated by Health Net.

Short-Term means the reasonable period of time when significant, documented, continued improvement in a Member's condition can be expected in a predictable period of time. A "predictable period of time" means the length of time as submitted by the Participating Provider and Approved by Health Net or its designee.

Skilled Nursing Facility means an extended care Facility which is licensed as a Skilled Nursing Facility and operated in accordance with the laws of the state in which the Member resides in and is approved by Medicare.

Sound Natural Teeth means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

Specialist or Specialist Physician means a duly licensed Participating Physician, other than the Primary Care Physician, under contract with Health Net to provide professional services when Preauthorized.

Subscriber means an employee of the Group who meets all applicable eligibility requirements of the Group, whose Enrollment Form has been received and accepted by Health Net, and whose Premium payment has been received and accepted by Health Net's accounts receivable department, in accordance with the terms of this Evidence of Coverage.

Specialized or Custom Durable Medical Equipment, Prosthetics or Orthotics means equipment, prosthetics or orthotics not generally considered to be the standard of care for a specific condition, disease or injury or made for a specific purpose not considered Medically Necessary as determined by Us.

Support Devices are the rigid or semi-rigid devices, such as braces or splints, used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured body part.

Total Disability or Totally Disabled means a Subscriber who is prevented because of injury or disease from performing his/her regular or customary occupational duties and is not engaged in any work or other gainful activity for compensation or profit. For a Dependent, a person who is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and gender in good health, including any work or other gainful activity for compensation or profit.

Urgent Care means services provided for the relief of Acute pain, initial treatment of Acute infection, or a medical condition that requires medical attention, but a brief time lapse before care is obtained does not endanger life or permanent health. Urgent conditions include, but are not limited to, minor sprains, fractures, pain, heat exhaustion, and breathing difficulties, other than those of sudden onset and persistent severity

Urgent Care Facility means any licensed Facility that provides Physician services for the immediate treatment only of an injury or disease.

Utilization Management, Utilization Review is a prior, concurrent and retrospective process whereby requests for service under this Plan are reviewed:
1. For Medical Necessity and appropriateness;
2. For verification that the service is a covered benefit;

3. For verification where benefits have a predetermined limit that Medical Services have not been exceeded, or are being appropriately applied, or applied in a timely manner consistent with the diagnosis and treatment; and
4. For verification that the Member is eligible for services under this Evidence of Coverage.

Utilization Review performed prior to receipt of services does not guarantee coverage if other plan provisions are not satisfied (for example, member is not eligible on date of service).

Waiting Period means the period of time established by the Group that must pass before an employee is eligible to apply for membership in this Health Plan.

We/Us/Our means Health Net of Arizona, Inc. or its designee and its affiliates.

Year means the type of Year your benefits are calculated on, as shown in the *Schedule of Benefits*. This can be either a Calendar Year or a Plan Year as defined earlier in this section.

You or Your means a Subscriber or Member who is covered under this Evidence of Coverage.

IMPORTANT NOTICES

Notice of Privacy Practices:

Health Net knows that personal information in your medical records is private. Health Net provides members with a Notice of Privacy Practices that describes how it uses and discloses protected health information; the individual's rights to access and to request amendments, restrictions and an accounting of disclosures of protected health information; and the procedures for filing complaints. Members receive the Notice of Privacy Practices in the new member Welcome Packet. However, you may also obtain a copy of Health Net's Notice of Privacy Practices on the website at www.healthnet.com or through Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card.

Women's Health and Cancer Rights Act of 1998:

Surgical services for breast reconstruction and for post-operative prostheses incidental to a Medically Necessary mastectomy are covered. Coverage includes:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- standard model prostheses and physical complications for all stages of mastectomy, including lymphedemas.

Newborns' and Mothers' Health Protection Act of 1996

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

Medical Loss Ratio (MLR) Rebates

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

Notice of Language Assistance

No Cost Language Service. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card. Employer group member please call 800-289-2818. For more help call the Arizona Department of Insurance Consumer Affairs Division at 1-800-325-2548.

Notice of Non-Discrimination

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

Health Net:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters & 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 & Information written in other languages

If you need these services, contact Health Net's Customer Contact Center at 1-800-289-2818, TTY number 711.

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

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

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

English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card. Individual & Family Plan members please call 1-888-926-5057 (TTY: 711); Small Business members please call 1-888-926-5122 (TTY: 711). Employer group members please call 1-800-289-2818 (TTY: 711).

Arabic
خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية. يرجى من أعضاء خطة الأفراد والعائلة الاتصال على الرقم 1-888-926-5057 (TTY: 711)؛ ويرجى من أعضاء الأعمال الصغيرة الاتصال على الرقم 1-888-926-5122 (TTY: 711). يرجى من أعضاء مجموعة أصحاب العمل الاتصال على الرقم 1-800-289-2818 (TTY: 711).

Chinese
免費語言服務。您可使用口譯員。您可請人將文件內容唸給您聽。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡。個人與家庭計畫的會員請致電 1-888-926-5057 (TTY: 711) 小型企業的會員請致電 1-888-926-5122 (TTY: 711) 。雇主團體的會員請致電 1-800-289-2818 (TTY: 711) 。

French
Aucun service linguistique avec coût. Vous pouvez obtenir un interprète. Les documents peuvent être lus pour vous. Pour obtenir de l'aide, appelez-nous au numéro figurant sur votre carte d'identité. Membres des programmes pour particuliers et familles, veuillez composer le 1-888-926-5057 (TTY: 711). Membres des programmes pour petites entreprises, veuillez composer le 1-888-926-5122 (TTY: 711). Membres du groupe d'employeurs, veuillez composer le 1-800-289-2818 (TTY: 711).

German
Kostenloser Sprachendienst. Dolmetscher sind verfügbar. Dokumente können Ihnen vorgelesen werden. Wenn Sie Hilfe benötigen, rufen Sie uns unter der Nummer auf Ihrer ID-Karte an. Mitglieder von Einzel- und Familienpolicen rufen bitte unter 1-888-926-5057 (TTY: 711) an; Kleinunternehmen-Mitglieder rufen bitte unter 1-888-926-5122 (TTY: 711) an. Arbeitgeber-Gruppenmitglieder rufen bitte unter 1-800-289-2818 (TTY: 711) an.

Japanese
無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話ください。個人および家族向けプランのメンバーの方は1-888-926-5057（TTY：711）まで、小規模企業メンバーの方は1-888-926-5122（TTY：711）までお電話ください。雇用主を通じた団体保険のメンバーの方は、1-800-289-2818（TTY：711）までお電話ください。

Korean
무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 문서 낭독 서비스를 받으실 수 있습니다. 도움을 원하시면, 보험 ID에 수록된 번호로 전화해 주십시오. 개인 및 가족 계획가입자분은 1-888-926-5057 (TTY: 711)번으로 전화해 주시고, 소기업가입자분은 1-888-926-5122 (TTY: 711)번으로 전화해 주십시오. 고용주 그룹 가입자분은 1-800-289-2818 (TTY: 711)번으로 전화해 주십시오.

Navajo

Saad Bee Áká E'eyeed T'áá Jíík'e. Ata' halne'ígíí hóló. T'áá hó hazaad k'ehjí naaltsoos hach'į' wóltah dóó ła' da hach'į' él'įįh.Shíká a'doowoł nínízingo naaltsoos bee néího'dólzinígíí bikáa'gi béésh bee hane'í bikáá' áajį' hodíílnih. T'áá hó dóó ha'áłchíní bił hak'é'ésti'ígíí kojį' hojilnih 1-888-926-5057 (TTY: 711); Small business deiłnínígí atah nílįįgo éí kojį' hólne' 1-888-926-5122 (TTY: 711). Employer groupọjí atah nílįįgo éí kojį' hodíílnih 1-800-289-2818 (TTY: 711).

Persian (Farsi)

کسب اطلاعات، با ما به شماره ای که در کارت شناسایی شما قید شده تماس بگیرید. اعضای برنامه انفرادی و خانواده لطفاً با شماره 1-888-926-5057 (TTY: 711) تماس بگیرید؛ اعضای واحد بازرگانی کوچک با شماره 1-888-926-5122 (TTY: 711) تماس بگیرید. اعضای گروه کارفرما لطفاً با شماره 1-800-289-2818 (TTY: 711) تماس بگیرید.

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Участники планов для семей и частных лиц: звоните по телефону 1-888-926-5057 (TTY: 711). Участники планов для малых предприятий: звоните по телефону 1-888-926-5122 (TTY: 711). Участники групповых планов, предоставляемых работодателем: звоните по телефону 1-800-289-2818 (TTY: 711).

Serbo-Croatian

Besplatne jezičke usluge. Možemo vam obezbediti tumača. Možemo vam pročitati vaše dokumente. Ukoliko vam je potrebna pomoć, nazovite broj napisan na vašoj zdravstvenoj kartici. Molimo članove individualnog i porodičnog plana da nazovu 1-888-926-5057 (TTY: 711); molimo članove malog preduzeća da nazovu 1-888-926-5122 (TTY: 711). Molimo članove grupe osigurane preko poslodavca da nazovu 1-800-289-2818 (TTY: 711).

Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación. Los afiliados de planes individuales y familiares deben llamar al 1-888-926-5057 (TTY: 711); los afiliados de pequeñas empresas deben llamar al 1-888-926-5122 (TTY: 711). Los afiliados del grupo del empleador deben llamar al 1-800-289-2818 (TTY: 711).

Syriac (Assyrian)

ܝܠܦܬܐ ܠܫܢܢܝܐ ܡܓܢ (ܕܠܐ ܦܘܪܥܢܐ). ܡܨܝ ܠܗ ܕܗܘܝܐ ܠܘܟܘܢ ܚܕ ܬܪܓܡܢܐ. ܡܨܝ ܠܗ ܕܩܪܝܢܝܗ ܕܡܥܒܪܢܐ ܩܕܡ ܡܢܟܘܢ ܟܬܒܐ. ܩܐ ܡܥܘܕܪܢܘܬܐ
ܩܪܘ ܠܢ ܥܠ ܡܢܝܢܐ ܕܟܬܝܒ ܥܠ ܦܬܩܐ ܕܗܘܝܬܘܟܘܢ. ܗܕܡܐ ܕܦܠܢ ܕܝܚܝܕܝܐ ܕܒܝܬܝܐ ܡܢ ܡܢܝܢܐ ܥܠ ܡܢܝܢܐ
1-888-926-5057 (TTY: 711); ܗܕܡܐ ܕܥܒܕܐ ܙܥܘܪܐ ܡܢ ܡܢܝܢܐ ܥܠ 1-888-926-5122 (TTY: 711).
ܗܕܡܐ ܕܦܠܢ ܕܫܘܬܦܘܬܐ ܡܢ ܡܢܝܢܐ ܥܠ ܡܢܝܢܐ 1-800-289-2818 (TTY: 711).

Tagalog

Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card. Para sa mga miyembro ng Plano para sa Indibiduwal at Pamilya mangyaring tawagan ang 1-888-926-5057 (TTY: 711); Para sa mga miyembro na Maliit na Negosyo, mangyaring tawagan ang 1-888-926-5122 (TTY: 711). Para sa mga miyembro ng grupo ng empleyado, mangyaring tawagan ang 1-800-289-2818 (TTY: 711).

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ สมาชิกแผนบุคคลและครอบครัว กรุณาโทร 1-888-926-5057 (TTY: 711); สมาชิกธุรกิจขนาดเล็ก กรุณาโทร 1-888-926-5122 (TTY: 711) สมาชิกกลุ่มนายจ้าง กรุณาโทร 1-800-289-2818 (TTY: 711)

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu c`ầu được đọc cho nghe tài liệu. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị. Các thành viên của Chương Trình Cá Nhân & Gia Đình vui lòng gọi số 1-888-926-5057 (TTY: 711); Các thành viên thuộc Doanh Nghiệp Nhỏ vui lòng gọi số 1-888-926-5122 (TTY: 711). Các thành viên thuộc chương trình theo nhóm của chủ sử dụng lao động vui lòng gọi số 1-800-289-2818 (TTY: 711).

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

FLY007786EH00 (06/16)

Group Number:	AJ889A
Service Representative:	SHERRIE SERVENTI
Region:	MLD