Health Net

Health Net Health Plan of Oregon, Inc.
PPO Single
High Deductible Health Plan
Copayment and Coinsurance Schedule HD15008060 /17

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

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

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

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

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

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

	For Covered Services, pay:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual Deductible: Single coverage	$1,500 ■	$3,000 ■

Physician/Professional/Outpatient Care		
Preventive care, women's and men's health care - Pap test, breast exam, pelvic exam, PSA test and digital rectal exam	No charge ◆	40% MAA◆
Routine mammography	No charge ◆	40% MAA ◆
Physician services, office visits	20% contract rate	40% MAA
Physician services, urgent care center	20% contract rate	40% MAA
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/EKG/Ultrasound	20% contract rate	40% MAA
Diagnostic laboratory tests	20% contract rate	40% MAA
CT/MRI/PET/SPECT/EEG/Holter monitor/Stress test	20% contract rate	40% MAA
Allergy and therapeutic injections	20% contract rate	40% MAA
Maternity delivery care (professional services only)	20% contract rate	40% MAA
Outpatient rehabilitation therapy – 30 days/year max⅄	20% contract rate	40% MAA
Outpatient at Ambulatory Surgery Center	15% contract rate	40% MAA
Outpatient at Hospital based facility	20% contract rate	40% MAA
Hospital Care		
Inpatient services ✪	20% contract rate	40% MAA
Inpatient rehabilitation therapy - 30 days/year max⅄	20% contract rate	40% MAA
Emergency Services		
Outpatient emergency room services	20% contract rate	20%
Inpatient admission from emergency room	20% contract rate	20%
Emergency ground ambulance transport – 3 trips/year max	20%	20%
Emergency air ambulance transport - 1 trips/year max	20%	20%
Behavioral Health Services – Chemical Dependency and Mental or Nervous Conditions		
Physician services, office visits ▲	20% contract rate	40% MAA
Outpatient services ▲	20% contract rate	40% MAA
Inpatient services ▲	20% contract rate	40% MAA
Other Services		
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
Diabetes management - one initial program	20% contract rate	40% MAA
Durable Medical Equipment and Prosthetic Devices/Orthotic Devices ⅆ	20% contract rate	40% MAA
Health education	Not covered	Not covered

Home health visits	20% contract rate	40% MAA
Home infusion therapy	20% contract rate	40% MAA
Hospice services	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% MAA
Outpatient chemotherapy (non-oral anticancer medications and administration)	20% contract rate	40% MAA
Skilled Nursing Facility care - 60 days/year max	20% contract rate	40% MAA
Telemedical Services	20% contract rate	40% MAA
TMJ services - $500 lifetime max	50% contract rate	50% MAA
Benefit Maximums		
Annual Out-of-Pocket Maximum: Single coverage ✚ (Combined Medical and Prescription Drugs)	$3,000	$9,000
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

- ■ You must meet the specified Deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.
- ◆ Deductible is waived.
- ✪ The above Coinsurance for inpatient Hospital services is applicable for each admission for the hospitalization of an adult, pediatric or newborn patient. If a newborn patient requires admission to an intermediate or intensive care nursery, a separate Coinsurance for inpatient Hospital Services will apply.
- ▲ For mental health or Chemical Dependency services, call 800-977-8216.
- ✚ The annual Out-of-Pocket Maximum includes the annual Deductible. After you reach the Out-of-Pocket Maximum in a Calendar Year, we will pay your Covered Services during the rest of that Calendar Year at 100% of our contract rates for PPO services and at 100% of MAA for Out-of-Network (OON) services. You are still responsible for OON billed charges that exceed MAA.
- Corrective shoes and arch supports, including foot orthotics, are excluded unless prescribed in the course of treatment for, or complications from, diabetes.
- **Visit/ day limits do not apply to services to treat mental health conditions.**

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

Health Net Health Plan of Oregon, Inc. ● 888-802-7001 ● www.healthnet.com

Health Net

Health Net Health Plan of Oregon, Inc.
PPO Family
High Deductible Health Plan
Copayment and Coinsurance Schedule HD30008060/17

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

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

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

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

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

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

	For Covered Services, pay:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual Deductible: Family coverage	$3,000 ■	$6,000 ■

Physician/Professional/Outpatient Care		
Preventive care, women's and men's health care - Pap test, breast exam, pelvic exam, PSA test and digital rectal exam	No charge ◆	40% MAA ◆
Routine mammography	No charge ◆	40% MAA ◆
Physician services, office visits	20% contract rate	40% MAA
Physician services, urgent care center	20% contract rate	20% MAA
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/EKG/Ultrasound	20% contract rate	40% MAA
Diagnostic laboratory tests	20% contract rate	40% MAA
CT/MRI/PET/SPECT/EEG/Holter monitor/Stress test	20% contract rate	40% MAA
Allergy and therapeutic injections	20% contract rate	40% MAA
Maternity delivery care (professional services only)	20% contract rate	40% MAA
Outpatient rehabilitation therapy – 30 days/year max⅄	20% contract rate	40% MAA
Outpatient at Ambulatory Surgery Center	15% contract rate	40% MAA
Outpatient at Hospital based facility	20% contract rate	40% MAA
Hospital Care		
Inpatient services ✪	20% contract rate	40% MAA
Inpatient rehabilitation therapy - 30 days/year max⅄	20% contract rate	40% MAA
Emergency Services		
Outpatient emergency room services	20% contract rate	20%
Inpatient admission from emergency room	20% contract rate	20%
Emergency ground ambulance transport – 3 trips/year max	20%	20%
Emergency air ambulance transport - 1 trips/year max	20%	20%
Behavioral Health Services – Chemical Dependency and Mental or Nervous Conditions		
Physician services, office visits ▲	20% contract rate	40% MAA
Outpatient services ▲	20% contract rate	40% MAA
Inpatient services ▲	20% contract rate	40% MAA
Other Services		
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
Diabetes management - one initial program	20% contract rate	40% MAA
Durable Medical Equipment and Prosthetic Devices/Orthotic Devices ⅆ	20% contract rate	40% MAA
Health education	Not covered	Not covered

Home health visits	20% contract rate	40% MAA
Home infusion therapy	20% contract rate	40% MAA
Hospice services	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% MAA
Outpatient chemotherapy (non-oral anticancer medications and administration)	20% contract rate	40% MAA
Skilled Nursing Facility care - 60 days/year max	20% contract rate	40% MAA
Telemedical Services	20% contract rate	40% MAA
TMJ services - $500 lifetime max	50% contract rate	50% MAA
Benefit Maximums		
Annual Out-of-Pocket Maximum: Family coverage ✚ (Combined Medical and Prescription Drugs)	$6,000	$18,000
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

- ■ You must meet the specified Deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims. Family coverage means the Subscriber and spouse; the Subscriber and child(ren); or the Subscriber, spouse and child(ren). Under family coverage, each Member's covered expenses count toward the Deductible, but the specified family coverage Deductible must be met before Health Net pays any claims.
- ◆ Deductible is waived.
- ✪ The above Coinsurance for inpatient Hospital services is applicable for each admission for the hospitalization of an adult, pediatric or newborn patient. If a newborn patient requires admission to an intermediate or intensive care nursery, a separate Coinsurance for inpatient Hospital Services will apply.
- ▲ For mental health or Chemical Dependency services, call 800-977-8216.
- ✚ The annual Out-of-Pocket Maximum includes the annual Deductible. After you reach the Out-of-Pocket Maximum in a Calendar Year, we will pay your Covered Services during the rest of that Calendar Year at 100% of our contract rates for PPO services and at 100% of MAA for Out-of-Network (OON) services. You are still responsible for OON billed charges that exceed MAA.
- Corrective shoes and arch supports, including foot orthotics, are excluded unless prescribed in the course of treatment for, or complications from, diabetes.
- **Visit/ day limits do not apply to services to treat mental health conditions.**

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

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

Health Net Health Plan of Oregon, Inc.
Prescription Benefits
SUPPLEMENTAL BENEFIT SCHEDULE
NMSLHD80/17 (NO MAC S)

In this Supplemental Benefit Schedule, the terms "we," "our" and "us" refer to Health Net Health Plan of Oregon, Inc. (Health Net) and the terms "you" and "your" refer to the Subscriber and to each Enrolled Dependent unless otherwise specified.

Purpose and Function of this Schedule

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

Subject to all terms, conditions, exclusions and definitions in the Health Net Health Group Medical and Hospital Service Agreement and its attachments, except the exclusion of prescription drugs in the Exclusions and Limitations section of the Group Plan Benefits section, you are entitled to receive benefits set forth in this Schedule upon payment of the relevant premium and Copayments and/or Coinsurance.

Benefits

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

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

- The amount of drug to be dispensed per filled prescription shall be for such quantities as directed by the licensed prescriber (e.g. physician, pharmacist) as allowed by law, but in no event shall the quantity exceed a 90-day supply when filled in a pharmacy or a 90-day supply when filled through mail order. Benefits are based on FDA approved dosing guidelines. Some drugs, including but not limited to compounded medications, require Prior Authorization and/or may have a dosage or quantity restriction set by the Plan.

- All drugs, including insulin and diabetic supplies, must be prescribed by a Participating Provider or by a Physician under Referral and must be dispensed by a Participating Provider pharmacy, except for Emergency Medical Care rendered outside the Service Area. The requirement that drugs must be prescribed by a Participating Provider or by a Physician under Referral does not apply under a Triple Option, PPO, or Flex Net Plan.

- Copayments and/or Coinsurance shall be as follows for each prescription or refill. Prescription Deductibles (if any), Copayments and/or Coinsurance and other amounts you pay for prescription drugs apply toward

your plan's medical Deductibles, Copayment, Out-of-Pocket Maximums, or stop loss amounts, whichever is applicable under this Agreement.

	In Pharmacy (Per Fill Up to a 30-day Supply)	**Mail Order (Per Fill Up to a 90-day Supply)**
Tier 1	20%	20%
Tier 2	20%	20%
Tier 3	20%	20%
Specialty Pharmacy	20%	Mail order not available
Orally administered anticancer medications	20%	Mail order not available
Preventive Pharmacy and Tobacco cessation medications and Women's contraception methods	No Copayment and/ or Coinsurance. Deductible waived	No Copayment and/ or Coinsurance. Deductible waived.

- Specialty Pharmacy. Certain drugs identified on the formulary (drug list) are classified as Specialty Pharmacy drugs under your plan. Specialty Pharmacy drugs are high cost biologic, injectable and oral drugs typically dispensed through a limited network of pharmacies and having significantly higher cost than traditional pharmacy benefit drugs.

- Preventive Pharmacy. Preventive Pharmacy medications require a prescription and are limited to prescription drugs and over-the-counter medications that are determined to be preventive 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/. No Deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a generic class drug when dispensed by a Participating Provider pharmacy. If a generic class drug is not available, no Deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a brand name drug. Deductible, Copayment and/ or Coinsurance will apply to brand name drugs that have generic equivalents.

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

- Women's contraception methods. Generic class Food and Drug Administration (FDA) approved contraceptive methods, patient education and counseling for all women with reproductive capacity are covered when dispensed by a Participating Provider pharmacy. If the initial 3 month supply is prescribed, then a 12 month refill of the same contraceptive is covered, regardless if the initial prescription was covered under the plan.

  FDA approved, over-the-counter contraceptive methods for women require a prescription from your Participating Provider. This plan also covers hormonal contraceptive patches and self-administered oral hormonal contraceptives prescribed by a participating licensed prescriber (e.g. physician, pharmacist) as allowed by law.

  No Deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a generic class drug when dispensed by a Participating Provider pharmacy. If a generic class drug is not available,

no Deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a brand name drug. Deductible, Copayment and/ or Coinsurance will apply to brand name drugs that have generic equivalents unless the Provider indicates the brand name drug is Medically Necessary.

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

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

- Growth Hormone Drugs. Growth hormone drugs are covered if determined to be Medically Necessary and if our medical/pharmacy policy criteria are met for the following conditions: growth hormone deficiency in children and adolescents; chronic renal insufficiency in pre-transplantation children with growth failure; SHOX (short stature homeobox-containing gene) deficiency in children; Central nervous system tumor treated with radiation; Prader Willi Syndrome/Turner Syndrome; therapy of infantile Hypoglycemia; growth hormone deficiency in adults, for Short-Bowel Syndrome and AIDS Wasting Syndrome. Prior Authorization is required.

- The level of benefit you receive is based on the status of the drug at the time your prescription is filled. The drug list may be revised up to four times per Calendar Year based on the recommendations of the Pharmacy and Therapeutics Committee. Any such changes including additions and deletions from the drug list will be communicated to Participating Providers. Compounded medications are subject to the Tier 3 Copayment and/or Coinsurance. Brand name drugs with generic equivalents are subject to the Tier 3 Copayment and/or Coinsurance as soon as a generic becomes available.

- Reimbursement (minus the Copayment and/or Coinsurance) will be made for prescriptions filled by a pharmacy other than a Participating Provider pharmacy for Emergency Medical Care rendered outside the Service Area, upon presentation of receipts to Health Net and sufficient documentation to establish the need for Emergency Medical Care.

- Reimbursement (minus the Copayment and/or Coinsurance) will be made for coverable prescriptions filled by a licensed practitioner at a rural health clinic for an urgent medical condition if there is not a pharmacy within 15 miles of the clinic or if the prescription is dispensed for a patient outside of the normal business hours of any pharmacy within 15 miles of the clinic. For these purposes, “urgent medical condition” means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems.

- In accordance with state regulations, upon request, Health Net will synchronize refill dates of prescription drugs so that drugs that are refilled at the same frequency may be refilled concurrently. To request synchronization please call the Customer Contact Center at the number listed at the back of your Agreement.

Exclusions

The following items are excluded from coverage:

- Drugs and medicines prescribed or dispensed other than as described in this Schedule.
- Early refills other than for changes in directions (all medications), or for eye drops used in the treatment of glaucoma.
- Over-the-counter drugs other than insulin and preventive pharmacy medications, tobacco cessation medications or contraceptive methods and devices as noted above in this Schedule.
- Any prescription drug for which an over-the-counter therapeutic equivalent is available, except for preventive pharmacy medications, tobacco cessation medications or women's contraceptive methods prescribed by a Provider.
- Diabetic supplies other than blood glucose test strips, lancets, insulin syringes and needles.
- Therapeutic or prosthetic devices, orthotics and all supplies, even though they might require a prescription, including but not limited to: hypodermic needles and syringes other than for insulin, appliances, support garments, braces, splints, bandages, dressings and other non-medicinal substances regardless of intended use.
- Injectable medications other than those listed on the drug list.
- Dental only drugs.
- Dietary supplements, food, health and beauty aids, and vitamin preparations other than prescription prenatal vitamins, prescription vitamins with fluoride, and covered supplements or vitamins which are prescribed for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations as described in the "Preventive Pharmacy" section above.
- Medical foods except as covered under the "Inborn Errors of Metabolism" subsection in the Group Plan Benefits section**.**
- Drugs for the treatment of onychomycosis (nail fungus); infertility; drugs used for weight loss; growth hormone therapy except as noted above.
- In the absence of a DSM mental health disorder of sexual dysfunction being the primary diagnosis, drugs used for sexual enhancement, to improve sexual performance, to treat erectile dysfunction or to increase libido are not covered.
- Prescription refills due to loss or theft.
- Drugs and medicines used for diagnostic purposes.

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Prescription Benefits
SUPPLEMENTAL BENEFIT SCHEDULE
NMSLHD80/17 (NO MAC S)

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Benefits

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

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

- The amount of drug to be dispensed per filled prescription shall be for such quantities as directed by the licensed prescriber (e.g. physician, pharmacist) as allowed by law, but in no event shall the quantity exceed a 90-day supply when filled in a pharmacy or a 90-day supply when filled through mail order. Benefits are based on FDA approved dosing guidelines. Some drugs, including but not limited to compounded medications, require Prior Authorization and/or may have a dosage or quantity restriction set by the Plan.

- All drugs, including insulin and diabetic supplies, must be prescribed by a Participating Provider or by a Physician under Referral and must be dispensed by a Participating Provider pharmacy, except for Emergency Medical Care rendered outside the Service Area. The requirement that drugs must be prescribed by a Participating Provider or by a Physician under Referral does not apply under a Triple Option, PPO, or Flex Net Plan.

- Copayments and/or Coinsurance shall be as follows for each prescription or refill. Prescription Deductibles (if any), Copayments and/or Coinsurance and other amounts you pay for prescription drugs apply toward

your plan's medical Deductibles, Copayment, Out-of-Pocket Maximums, or stop loss amounts, whichever is applicable under this Agreement.

	In Pharmacy (Per Fill Up to a 30-day Supply)	**Mail Order (Per Fill Up to a 90-day Supply)**
Tier 1	20%	20%
Tier 2	20%	20%
Tier 3	20%	20%
Specialty Pharmacy	20%	Mail order not available
Orally administered anticancer medications	20%	Mail order not available
Preventive Pharmacy and Tobacco cessation medications and Women's contraception methods	No Copayment and/ or Coinsurance. Deductible waived	No Copayment and/ or Coinsurance. Deductible waived.

- Specialty Pharmacy. Certain drugs identified on the formulary (drug list) are classified as Specialty Pharmacy drugs under your plan. Specialty Pharmacy drugs are high cost biologic, injectable and oral drugs typically dispensed through a limited network of pharmacies and having significantly higher cost than traditional pharmacy benefit drugs.

- Preventive Pharmacy. Preventive Pharmacy medications require a prescription and are limited to prescription drugs and over-the-counter medications that are determined to be preventive 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/. No Deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a generic class drug when dispensed by a Participating Provider pharmacy. If a generic class drug is not available, no Deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a brand name drug. Deductible, Copayment and/ or Coinsurance will apply to brand name drugs that have generic equivalents.

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

- Women's contraception methods. Generic class Food and Drug Administration (FDA) approved contraceptive methods, patient education and counseling for all women with reproductive capacity are covered when dispensed by a Participating Provider pharmacy. If the initial 3 month supply is prescribed, then a 12 month refill of the same contraceptive is covered, regardless if the initial prescription was covered under the plan.

  FDA approved, over-the-counter contraceptive methods for women require a prescription from your Participating Provider. This plan also covers hormonal contraceptive patches and self-administered oral hormonal contraceptives prescribed by a participating licensed prescriber (e.g. physician, pharmacist) as allowed by law.

  No Deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a generic class drug when dispensed by a Participating Provider pharmacy. If a generic class drug is not available,

no Deductible, Copayment and/ or Coinsurance shall apply for each prescription or refill of a brand name drug. Deductible, Copayment and/ or Coinsurance will apply to brand name drugs that have generic equivalents unless the Provider indicates the brand name drug is Medically Necessary.

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

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

- Growth Hormone Drugs. Growth hormone drugs are covered if determined to be Medically Necessary and if our medical/pharmacy policy criteria are met for the following conditions: growth hormone deficiency in children and adolescents; chronic renal insufficiency in pre-transplantation children with growth failure; SHOX (short stature homeobox-containing gene) deficiency in children; Central nervous system tumor treated with radiation; Prader Willi Syndrome/Turner Syndrome; therapy of infantile Hypoglycemia; growth hormone deficiency in adults, for Short-Bowel Syndrome and AIDS Wasting Syndrome. Prior Authorization is required.

- The level of benefit you receive is based on the status of the drug at the time your prescription is filled. The drug list may be revised up to four times per Calendar Year based on the recommendations of the Pharmacy and Therapeutics Committee. Any such changes including additions and deletions from the drug list will be communicated to Participating Providers. Compounded medications are subject to the Tier 3 Copayment and/or Coinsurance. Brand name drugs with generic equivalents are subject to the Tier 3 Copayment and/or Coinsurance as soon as a generic becomes available.

- Reimbursement (minus the Copayment and/or Coinsurance) will be made for prescriptions filled by a pharmacy other than a Participating Provider pharmacy for Emergency Medical Care rendered outside the Service Area, upon presentation of receipts to Health Net and sufficient documentation to establish the need for Emergency Medical Care.

- Reimbursement (minus the Copayment and/or Coinsurance) will be made for coverable prescriptions filled by a licensed practitioner at a rural health clinic for an urgent medical condition if there is not a pharmacy within 15 miles of the clinic or if the prescription is dispensed for a patient outside of the normal business hours of any pharmacy within 15 miles of the clinic. For these purposes, “urgent medical condition” means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems.

- In accordance with state regulations, upon request, Health Net will synchronize refill dates of prescription drugs so that drugs that are refilled at the same frequency may be refilled concurrently. To request synchronization please call the Customer Contact Center at the number listed at the back of your Agreement.

Exclusions

The following items are excluded from coverage:

- Drugs and medicines prescribed or dispensed other than as described in this Schedule.
- Early refills other than for changes in directions (all medications), or for eye drops used in the treatment of glaucoma.
- Over-the-counter drugs other than insulin and preventive pharmacy medications, tobacco cessation medications or contraceptive methods and devices as noted above in this Schedule.
- Any prescription drug for which an over-the-counter therapeutic equivalent is available, except for preventive pharmacy medications, tobacco cessation medications or women's contraceptive methods prescribed by a Provider.
- Diabetic supplies other than blood glucose test strips, lancets, insulin syringes and needles.
- Therapeutic or prosthetic devices, orthotics and all supplies, even though they might require a prescription, including but not limited to: hypodermic needles and syringes other than for insulin, appliances, support garments, braces, splints, bandages, dressings and other non-medicinal substances regardless of intended use.
- Injectable medications other than those listed on the drug list.
- Dental only drugs.
- Dietary supplements, food, health and beauty aids, and vitamin preparations other than prescription prenatal vitamins, prescription vitamins with fluoride, and covered supplements or vitamins which are prescribed for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations as described in the "Preventive Pharmacy" section above.
- Medical foods except as covered under the "Inborn Errors of Metabolism" subsection in the Group Plan Benefits section**.**
- Drugs for the treatment of onychomycosis (nail fungus); infertility; drugs used for weight loss; growth hormone therapy except as noted above.
- In the absence of a DSM mental health disorder of sexual dysfunction being the primary diagnosis, drugs used for sexual enhancement, to improve sexual performance, to treat erectile dysfunction or to increase libido are not covered.
- Prescription refills due to loss or theft.
- Drugs and medicines used for diagnostic purposes.

Health Net Health Plan of Oregon, Inc.

Well Net Benefits

SUPPLEMENTAL BENEFIT SCHEDULE CAM80-1500HD

Purpose and Function of this Schedule

The purpose of this Schedule is to provide coverage for complementary and alternative care services by Providers of chiropractic, acupuncture, massage therapy, and naturopathic medicine. This Schedule is an amending attachment to the Group Plan Benefits.

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

Copayments and Maximums

Copayments and/or Coinsurance and other amounts you pay for alternative care benefits apply toward your plan's medical Out-of-Pocket Maximum as shown on your Copayment and Coinsurance Schedule under "Benefit Maximums."

Calendar Year Deductible for complementary benefits: Refer to your medical plan Deductible.

The maximum combined benefit per Calendar Year for each specialty type is: $1,500. Medically Necessary services provided by a naturopathic Physician are not subject to this Calendar Year maximum.

	For Covered Services you pay:	
Well Net Services	**ASH* Group**	**Out-of-Network**
Chiropractic Care	20% per visit	Not covered
Acupuncture Care	20% per visit	Not covered
Naturopathic Care	20% per visit	Not covered
Massage Therapy – maximum of 27 visits/Calendar Year	20% per visit	Not covered

* American Specialty Health Group, Inc. (ASH Group)

Chiropractic Services

- Chiropractic services are covered as follows:

    a. Patients have direct access to American Specialty Health (ASH) Group contracted chiropractors for their initial visit. A new patient examination is performed by the ASH Group contracted Provider to determine the nature of the Member's problem and, if Covered Services appear warranted, a treatment plan is prepared. A Copayment is required.

b. An established patient examination may be performed by the ASH Group contracted Provider to assess the need to continue, extend or change a treatment plan approved by ASH Group. A reevaluation may be performed during a subsequent office visit or separately. If performed separately, a Copayment is required.

c. Subsequent office visits, as set forth in a treatment plan approved by ASH Group, may involve an adjustment, a brief reexamination and other services, in various combinations. A Copayment is required for each visit to the office.

d. Adjunctive therapy, as set forth in a treatment plan approved by ASH Group, may involve modalities such as ultrasound, electrical muscle stimulation, therapeutic exercises, and other therapies.

e. X-rays and clinical laboratory tests are payable in full when performed by or referred by an ASH Group contracted chiropractor and approved by ASH Group. Radiological consultations are a covered benefit when approved by ASH Group as Medically Necessary services and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or Hospital which has contracted with ASH Group to provide those services.

f. Chiropractic appliances are covered up to a maximum of $50 per year when prescribed by an ASH Group contracted chiropractor and approved by ASH Group.

g. All chiropractic services, except for the initial visit, must be verified by ASH Group as Medically Necessary for treatment of Musculoskeletal and Related conditions.

- Chiropractic Exclusions and Limitations.

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

b. Services or treatments not delivered by ASH Group contracted chiropractors for the delivery of chiropractic care to Members, except for urgent services.

c. Services for examinations and/or treatments from ASH Group contracted chiropractors for conditions other than those related to Musculoskeletal and Related Disorders.

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

e. Thermography.

f. Services, lab tests, x-rays and other treatments not documented as Medically Necessary and appropriate or classified as Experimental or Investigational and/or as being in the research stage, except as provided in the “Clinical Trials” section of the Group Plan Benefits.

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

h. Transportation costs including local ambulance charges.

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

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

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

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

m. Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.

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

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

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

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

r. Vitamins, minerals or other similar products.

Acupuncture Services

- Acupuncture services are covered as follows:

a. Patients have direct access to ASH Group contracted acupuncturists for their initial visit. A new patient examination is performed by the ASH Group contracted Provider to determine the nature of the Member's problem and, if Covered Services appear warranted, a treatment plan is prepared. A Copayment is required.

b. An established patient examination may be performed by the ASH Group contracted Provider to assess the need to continue, extend or change a treatment plan approved by ASH Group. A reevaluation may be performed during a subsequent office visit or separately. If performed separately, a Copayment is required.

c. Subsequent office visits, as set forth in a treatment plan approved by ASH Group, may involve acupuncture treatment, a brief reexamination and other services in various combinations. A Copayment is required for each visit to the office.

d. Adjunctive therapy, as set forth in a treatment plan approved by ASH Group, may involve modalities such as acupressure, indirect moxibustion, and other therapies.

e. All acupuncture services, except for the initial visit, must be verified by ASH Group as Medically Necessary for treatment of nausea, pain syndromes or Musculoskeletal and Related conditions.

- Acupuncture exclusions and limitations:

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

b. Services or treatments not delivered by ASH Group contracted acupuncturists for the delivery of acupuncture care to Members, except for urgent services.

c. Services for examinations and/or treatments from ASH Group contracted acupuncturists for conditions other than those related to Musculoskeletal and Related Disorders, nausea or pain syndromes.

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

e. Thermography.

f. Services, lab tests, x-rays and other treatments not documented as Medically Necessary and appropriate or classified as Experimental or Investigational and/or as being in the research stage, except as provided in the "Clinical Trials" section of the Group Plan Benefits.

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

h. Transportation costs including local ambulance charges.

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

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

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

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

m. Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.

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

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

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

compatible with hearing aids.

q. Adjunctive therapy not associated with acupuncture.

r. Vitamins, minerals or other similar products.

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

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

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

Massage Therapy Services

- Massage therapy services are covered as follows:

  a. Patients have direct access to ASH Group contracted massage therapists for up to four visits. All visits beyond the first four visits annually must be verified by ASH Group as Medically Necessary to be eligible for coverage for myofascial, Musculoskeletal and Related conditions or pain syndromes. A Copayment is required for each massage therapy session/office visit.

  b. After the first four visits, the ASH Group contracted massage therapist will provide therapeutic massage in support of a covered medical condition. The ASH Group contracted massage therapist develops an applicable treatment plan and submits it to ASH Group for approval. A Copayment is required for each massage therapy session/office visit.

  c. Subsequent sessions include therapeutic massage and possibly a brief reassessment of patient status and progress toward therapy goals. A Copayment is required for each massage therapy session/office visit with the ASH Group contracted massage therapist. The subsequent session includes all services related to the massage therapy, a brief reassessment if necessary and any consultative support services.

  d. Any treatment for a minor under the age of 18 requires parental consent and participation.

- Massage therapy exclusions and limitations:

  a. Services or treatments not delivered by ASH Group contracted Providers for the delivery of massage therapy care to Members.

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

  c. Massage therapy services beyond the fourth annual visit that are not verified by ASH Group as Medically Necessary.

  d. Massage services rendered by a Provider of massage therapy services that are not delivered in accordance with the massage benefit plan, including but not limited to limited massage services rendered directly in conjunction with chiropractic, acupuncture or naturopathic services.

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

f. Services and/or treatments not documented as Medically Necessary and appropriate or classified as Experimental or Investigational and/or as being in the research stage, except as provided in the "Clinical Trials" section of the Group Plan Benefits.

g. Transportation costs including local ambulance charges.

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

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

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

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

l. Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.

m. Services provided outside the scope of a massage therapist's license.

n. Hospitalization.

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

p. Adjunctive therapy whether or not associated with massage therapy.

q. Vitamins, minerals, nutrition supplements or other similar products.

Naturopathic Care

Refer to Your Plan Benefits and Group Medical and Hospital Service Agreement for further details regarding coverage of Medically Necessary Physician services provided by naturopathic physicians, other than naturopathic care.

- Complementary and alternative naturopathic care and/ or treatments are covered as follows:

a. Patients have direct access to ASH Group contracted naturopaths for their initial visit. A new patient examination or consultation, including the history and physical examination, is performed by the ASH Group contracted Provider to determine the nature of the Member's problem and, if Covered Services appear warranted, a treatment plan of services is prepared and furnished to ASH Group. A Copayment is required.

b. An office visit represents an all-inclusive per diem rate for all services associated with the office visit, including evaluation or reevaluation, any consultative services and any adjunctive services.

c. Adjunctive therapy is limited to that which is allowed by the Provider's state scope of practice and, is also limited to non-invasive modalities such as diathermy, electrical stimulation, hot and cold packs,

hydrotherapy, manipulation, massage, range of motion exercises and therapeutic ultrasound. Acupuncture is also covered as allowed by the Provider's state scope of practice. If provided independent of an examination, a Copayment is required.

d. Diagnostic tests are limited to those required for further evaluation of the Member's condition.

e. Covered conditions and services are limited to those the Provider is qualified to treat or perform pursuant to state licensure and scope of practice, excluding obstetrics, surgery, invasive procedures, psychological services and services listed as Limitations and Exclusions.

- Naturopathic medicine exclusions and limitations:

a. Services or treatments not approved by ASH Group as Medically Necessary, except for a new patient examination, services allowed under an applicable treatment plan threshold and urgent services.

b. Services or treatments not delivered by ASH Group contracted Providers for the delivery of naturopathic care to Members, except for urgent services.

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

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

e. Preventive health services, such as those defined by the following: a) United States Preventive Services Task Force (USPSTF) recommended type “A” and “B” services; b) Immunizations and inoculations as recommended by the Advisory Committee on immunization Practices of the Center for Disease Control (CDC); c) Pediatric preventive care and screenings, as supported by the Health Resources and Services Administration (HRSA) guidelines; d) Women’s health care services not included in the “Preventive Care” section of the Group Plan Benefits, as supported by HRSA guidelines; e) Other USPSTF recommendations for breast cancer screening, mammography and prevention, are not available under the Naturopathy Benefit. Members seeking such services should consult their primary Physician.

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

g. Thermography

h. Services, lab tests, x-rays and other treatments not documented as Medically Necessary and appropriate; those classified as Experimental or Investigational; those that are in the research stage; and/or those not specifically referenced as covered diagnostic tests in the naturopathy Covered Services section above, except as provided in the “Clinical Trials” section of the Group Plan Benefits.

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

j. Transportation costs including local ambulance charges.

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

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

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

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

o. Prescription drugs or medicines.

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

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

r. Adjunctive therapy that is considered by ASH Group to be invasive or not listed on the payor summaries

This document presents general information only. Refer to the Plan Agreement for complete details, limitations and exclusions.

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Health Net Health Plan of Oregon, Inc.

Vision Benefits

SUPPLEMENTAL BENEFIT SCHEDULE ELITE E1010-1/17

Purpose and Function of this Schedule

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

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

Benefits

Benefits are based on the following Schedule:

	Participating Provider	Any Other Provider
Exam **Exam Options (fit and follow-up)**	After you pay a $10 Copayment, Covered Services are paid in full by the plan.	You are reimbursed up to $40 of the cost for Covered Services.
Standard contact lenses	After you pay up to $55, Covered Services	You receive no discount.
Premium contact lenses	are paid in full by the plan. You receive 10% off retail cost.	You receive no discount.
Eyewear (lenses and frame)		
Single vision lenses	Covered in full after a $10 Copayment.	You are reimbursed up to $40.
Lined bifocal lenses	Covered in full after a $10 Copayment.	You are reimbursed up to $60.
Lined trifocal lenses	Covered in full after a $10 Copayment.	You are reimbursed up to $80.
Lined lenticular lenses	Covered in full after a $10 Copayment.	You are reimbursed up to $80.
Standard progressive lenses	Covered in full after a $75 Copayment.	You are reimbursed up to $60.
Premium progressive lenses	$75 Copayment, then 80% of total charge less $120 allowance.	You are reimbursed up to $60.
Frame	Covered up to $150 allowance. You will receive a 20% discount on the balance over your allowance.	You are reimbursed up to $45.
Lens Options		
UV Coating	Covered in full after a $15 Copayment. **	You receive no discount.
Tint, solid and gradient	Covered in full after a $15 Copayment. **	You receive no discount.
Standard scratch-resistance	Covered in full after a $15 Copayment. **	You receive no discount.
Standard polycarbonate	Covered in full after a $40 Copayment. **	You receive no discount.

Standard anti-reflective	Covered in full after a $45 Copayment. **	You receive no discount.
Other add-ons and services	You receive 20% off retail cost. **	You receive no discount.

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

Contact lenses (instead of spectacle lenses) –Materials

Conventional	You receive a maximum allowance of $120, plus a discount of 15% over your allowance.	You are reimbursed up to $105 of the cost for Covered Services.
Disposables	You receive a maximum allowance of $120, you are responsible for remaining balance over your allowance.	You are reimbursed up to $105 of the cost for Covered Services.
Medically Necessary	Paid in full.	You are reimbursed up to $210 of the cost for Covered Services.

Frequency of Service

Examination	Once every 12 months from the last date of service.
Lenses	Once every 12 months from the last date of service.
Frame	Once every 12 months from the last date of service.
Contact lenses in lieu of lenses	Once every 12 months from the last date of service.

Limitations, Options and Exclusions

- To receive maximum benefits, you must utilize Participating Providers. A list of Participating Providers is available at www.healthnet.com or by calling our Customer Contact Center.

  When services are received from a Participating Provider, we make payment directly to the Provider. You are responsible for paying the Copayment to the Provider.

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

  a. Orthoptics or vision training, subnormal vision aids and any associated supplemental testing.

  b. Aniseikonic lenses.

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

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

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

  f. Plano non-prescription lenses and non-prescription sunglasses.

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

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

- Value Added Discounts

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

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

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

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

Health Net Health Plan of Oregon, Inc.
Non-Registered Domestic Partner Eligibility
AMENDING ATTACHMENT

In this Addendum, the terms "we," "our" and "us" refer to Health Net Health Plan of Oregon, Inc. and the terms "you" and "your" refer to the Subscriber and each Enrolled Dependent unless otherwise specified.

Purpose and Function of this Schedule

The purpose of this schedule is to provide benefits for Non-Registered Domestic Partners of Subscribers of Subscriber Groups selecting this supplemental benefit in addition to the basic benefits. This schedule is an amending attachment to the Group Medical and Hospital Service Agreement.

Subject to all terms, conditions, exclusions and definitions in the Group Medical and Hospital Service Agreement and its attachments, except as expressly amended by the Benefits provisions of this Schedule, eligible Members are entitled to receive benefits set forth in this schedule upon payment of the relevant premium, Deductible (if any), and Copayments and/or Coinsurance.

Provisions, Group Medical and Hospital Service Agreement

1. The definition of Dependent in the "Definitions" section of the Group Medical and Hospital Service Agreement is amended to read as follows:

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

   a. The spouse or Registered Domestic Partner of the Subscriber.

   b. A Non-Registered Domestic Partner of the Subscriber.

   c. A Child of the Subscriber, from birth and extending up to the last day of the month in which that Child becomes age 26, including a child, who is the subject of a qualified medical child support order requiring the Subscriber to provide health coverage for the Child. Proof of compliance with this requirement must be furnished annually.

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

Enrollment of a child because the child was: (a) born out of wedlock; (b) is not claimed on the parent's federal tax return; or (c) does not reside with the parent or within our Service Area.

2. The following definition of Non-Registered Domestic Partner is added to the "Definitions" section of the Group Medical and Hospital Service Agreement;

   "Non-Registered Domestic Partner" means a person who is in a "Domestic Partnership" with the Subscriber. A Non-Registered Domestic Partnership is defined as:

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

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

   c. A couple that has lived continuously in an exclusive and loving relationship that they intend to maintain for the rest of their lives.

   d. A partnership that includes joint financial accounts and joint financial responsibilities for basic living expenses, including but not limited to food, shelter, and living expenses with the intent to do so indefinitely.

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

3. The following provision is added to the "Termination" section of the Group Medical and Hospital Service Agreement:

   A Non-Registered Domestic Partner losing group coverage under this Agreement because of termination of the Domestic Partnership is not entitled to provisions of the "Federal Continuation of Coverage" section, or to the provisions of the "Oregon State Continuation of Coverage" section.

HEALTH NET HEALTH PLAN OF OREGON, INC.

LARGE GROUP (51+) PPO AND HDHP PLAN CONTRACT

Group Plan Benefits and
Group Medical and Hospital Service Agreement

2017

Welcome to Health Net Health Plan of Oregon, Inc. (Health Net),

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

Thank you for choosing Health Net.

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Health Net Health Plan of Oregon, Inc.
PPO Plan
GROUP PLAN BENEFITS

General Terms Under Which Benefits Are Provided

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

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

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

- All benefits are subject to the terms, conditions and definitions in the Group Medical and Hospital Service Agreement and the exclusions and limitations in the "Exclusions and Limitations" portion of this Group Plan Benefits section, including payment of any applicable Deductible, Copayments and/or Coinsurance identified in the attached Copayment and Coinsurance Schedule.

- All services other than the limited preventive care services outlined in the Agreement are covered only if Medically Necessary as defined in the "Definitions" section of the Group Medical and Hospital Service Agreement.

- The fact that a Provider may provide, prescribe, order, recommend, approve, refer or direct a service or supply does not, in and of itself, make the service or supply a covered benefit. To qualify as covered Medical Services and supplies, all services and supplies must be expressly set forth as benefits in this Group Plan Benefits section.

  Subject to the Specialty Care Provider requirements, you may choose to obtain covered Medical Services and supplies from a Nonparticipating Provider. You may incur higher out-of-pocket expenses if you receive services or supplies from a Nonparticipating Provider.

  When services are performed by or received from a Nonparticipating Provider, your expenses include a Calendar Year Deductible (if any), fixed dollar amounts for certain services and the amount by which billed charges exceed the Maximum Allowable Amount (MAA). The definition of MAA is set forth in the "Definitions" section of the Group Medical and Hospital Service Agreement. The MAA for covered Medical Services and supplies may not be the same as what the Nonparticipating Provider bills.

  Even though a Hospital or other Provider may be a Participating Provider, during your visit or stay you may receive Covered Services or Supplies, which are performed by or received from Nonparticipating Providers. We recommend that you contact your treating Provider or the Hospital or other facility where you are receiving services to discuss the other types of Providers that may be used for your services, as these Nonparticipating Provider charges may not be covered or will be reimbursed at the Out-Of-Network level

for Covered Services. Such other types of Providers may include, but are not limited to, those who provide anesthesia services, emergency room physician services, radiology (x-ray), pathology and laboratory services.

For Covered Services, Health Net uses available guidelines of Medicare, including billing and coding requirements, to assist in its determination as to which services and procedures are eligible for reimbursement, and in determining the Maximum Allowable Amount (MAA). The definition of MAA is set forth in the "Definitions" section of the Group Medical and Hospital Service Agreement.

- A Medical service or supply not expressly included in this Group Plan Benefits section is not a covered benefit, even if it is not specifically listed as an exclusion in the "Exclusions and Limitations" section of this Group Plan Benefits section.

- **Specialty Care Providers.** Medical Services for certain conditions or certain treatment procedures are covered only if such services are provided at Participating Providers that are designated as Specialty Care Providers. Services which require use of a Specialty Care Provider include but are not limited to: 1) Birthing Center services; 2) Home Health Care; 3) infusion services that can be safely administered in the home or in a home infusion suite; 4) organ and tissue transplant services; 5) Durable Medical Equipment; and 6) Prosthetic Devices/Orthotic Devices. We shall have the right to require a Member to use a designated Specialty Care Provider as a condition to receive coverage under this Agreement. Specialty Care Providers may be located anywhere in the United States. Members may be required to travel out of the Service Area to receive care. If a Member is required by us to use a Specialty Care Provider outside the Service Area, we will pay reasonable transportation, board and lodging expenses for the Member, to be determined by us based upon individual circumstances, including without limitation, the distance between the Member's home and the Specialty Care Provider, and the Member's medical condition.

- The benefits described under this Agreement do not discriminate on the basis of race, ethnicity, nationality, gender, age, disability, sexual orientation, genetic information, or religion, and are not subject to any pre-existing condition exclusion period. Please refer to the Notice of Nondiscrimination section in the Group Medical and Hospital Service Agreement.
- The benefits, premiums and availability of insurance as described under this Agreement do not discriminate between individuals of the same class and equal expectation of life or between risks of essentially the same degree of hazard.

Physician Services

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

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

Medically Necessary Physician services are covered as follows:

- **Allergy Injections.** Administration of treatment compounds, solutions and medications for allergy care is covered.

- **Diagnostic Services.** Diagnostic services, including radiology (X-ray), pathology, laboratory tests, and other imaging and diagnostic services are covered. Sleep studies and imaging services, including but not limited to, MRA, MRI, CT, PET, cardiac catheterization, echocardiography and nuclear cardiac imaging, require Prior Authorization. Hearing tests in support of a diagnosis are covered.

  Exclusions and Limitations: Screening audiometry and tympanograms not in support of a diagnosis, except as recommended by the United States Preventive Services Task Force (USPSTF), are not covered.

- **Radiation Therapy and Chemotherapy.** Radiation therapy and chemotherapy are covered. Prior Authorization is required.

  Chemotherapy is the use of anticancer drugs to treat cancer. The chemotherapy benefit covers anticancer drugs and drugs used to treat the side effects of chemotherapy. It also includes administration of the drugs, and medical supplies related to the mixing and administration of the drugs. Orally administered anticancer medications are covered as a prescription benefit.

- **Office Visits.** Your office visits, including Medical Services for illness or injury, are covered. Office procedures require Prior Authorization.

- **Physician Services While Hospitalized.** The services of Physicians during a covered hospitalization, including services of primary care providers, specialist surgeons, assistant surgeons, anesthesiologists, pediatrician visits to an Enrolled newborn Child, and other appropriate medical personnel, are covered.

- **Home Visits.** Visits to your home are covered.

- **Specialty Physician Services.** Services of specialty Physicians and other specialty providers are covered.

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

- **Family planning.** Counseling and assessment for birth control are covered. Outpatient consultations, examinations, procedures and Medical Services that are necessary to prescribe, dispense, deliver, distribute, administer or remove a prescription contraceptive are covered. The Deductible, if any, is waived for these services.

  Women's contraception methods and counseling, as supported by the Health Resources and Services Administration (HRSA) guidelines, are covered as preventive care in the "Preventive Care" subsection of this Group Plan Benefits section.

- **Primary Care Provider Designation**. Health Net allows the designation of a primary care Provider. You have the right to designate any primary care Provider who participates in our network and who is available to accept you or your family Members. For information on how to select a primary care Provider, and for a list of the participating primary care Providers, you may contact us at:

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

  Customer Contact Center
  Monday - Friday 7:30 a.m. to 5:00 p.m.
  888.802.7001
  www.healthnet.com

  Hearing and Speech Assistance
  Monday - Friday 7:30 a.m. to 5:00 p.m.
  TTY 888.802.7122 TTY:711

  For children, you may designate a pediatrician as the primary care Provider.

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

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

  Customer Contact Center
  Monday - Friday 7:30 a.m. to 5:00 p.m.
  888.802.7001
  www.healthnet.com

  Hearing and Speech Assistance
  Monday - Friday 7:30 a.m. to 5:00 p.m.
  TTY 888.802.7122 TTY:711

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

Hospital Inpatient Services

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

Medically Necessary Hospital inpatient services are covered as follows:

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

- **Hospital Room and Board.** While you are a patient in a Hospital, an average two-bed accommodation; general nursing care; meals; special diets; use of operating room and related facilities; intensive care unit and services; x-ray, laboratory, and other diagnostic tests; drugs; medications; biologicals; anesthesia and oxygen services; radiation therapy; chemotherapy other than high dose chemotherapy which requires the support of a non-covered bone marrow transplant or autologous stem cell rescue procedure; inhalation therapy; internal or implantable devices, such as pacemakers and hip joints, approved by the Food and Drug Administration and implanted during a surgery pursuant to a Prior Authorization.

- **Maternity Hospitalization.** Refer to the "Maternity Benefits" subsection of this Group Plan Benefits section.

- **Newborn Nursery Care.** Routine care in the Hospital nursery is covered for the Enrolled newborn Child.

Exclusions and Limitations:
A private room or services of private or special duty nurses other than as Medically Necessary when you are an inpatient in a Hospital. Personal comfort items, such as television, telephone, lotions, shampoos, meals in the home, guest meals in inpatient facilities, housekeeping services, etc. Prescriptions relating to an inpatient/outpatient confinement filled at a hospital pharmacy prior to discharge for use at home (take-home medications) except for prescriptions for a 24-hour supply or less, following an emergency room visit.

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

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

We use Medicare guidelines to determine the circumstances under which claims for assistant surgeons, co-surgeons and team surgeons will be eligible for reimbursement, in accordance with our normal claims filing requirements.

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

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

Outpatient Services

Benefits are subject to payment of any applicable Copayments or Coinsurance and will vary depending on whether the procedure is performed in a Physician's office or Hospital setting, outpatient, or Ambulatory

Surgery Center setting. Applicable Copayments and Coinsurance can be found in your Copayment and Coinsurance Schedule.

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

Medically Necessary outpatient services are covered as follows:

- **Diagnostic Services.** Diagnostic services, including radiology (X-ray), pathology, laboratory tests, and other imaging and diagnostic services are covered. Sleep studies and imaging services, including but not limited to, MRA, MRI, CT, PET, cardiac catheterization, echocardiography and nuclear cardiac imaging, require Prior Authorization. Outpatient services may be provided in a non-hospital based health care facility or at a Hospital.

- **Radiation Therapy and Chemotherapy.** Radiation therapy and chemotherapy are covered. Prior Authorization is required.

  Chemotherapy is the use of anticancer drugs to treat cancer. The chemotherapy benefit covers anticancer drugs and drugs used to treat the side effects of chemotherapy. It also includes administration of the drugs, and medical supplies related to the mixing and administration of the drugs. Orally administered anticancer medications are covered as a prescription benefit.

- **Outpatient Surgery.** Outpatient surgery is covered only when Prior Authorized or as Emergency Medical Care.

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

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

We use Medicare guidelines to determine the circumstances under which claims for assistant surgeons, co-surgeons and team surgeons will be eligible for reimbursement, in accordance with our normal claims filing requirements.

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

Emergency Medical Care

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

Emergency Medical Care is covered inside or outside the Service Area without Prior Authorization, including emergency eye care. See the "Definitions" section of the Group Medical and Hospital Service Agreement. Benefits payable to Nonparticipating Providers are paid at the Nonparticipating Provider Level specified in the Copayment and Coinsurance Schedule.

Emergency Inside the Service Area. If you have an Emergency Medical Condition inside the Service Area and you reasonably believe that the time required to contact your primary care Provider or to go to a Participating Provider Hospital or urgent care facility would seriously jeopardize your health (including an unborn child), medical care should be sought from the nearest Provider appropriate for the severity of your condition (Physician's office or Clinic, urgent care center, or Hospital emergency room) or call 911.

Emergency Outside the Service Area. If you have an Emergency Medical Condition outside the Service Area and reasonably believe that the time required to contact your primary care Provider would seriously jeopardize your health (including an unborn child), medical care should be sought from the nearest Provider appropriate for the severity of your condition (Physician's office or Clinic, urgent care center, or Hospital emergency room) or call 911.

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

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

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

Ambulance Transport. Licensed ground or air ambulance services are covered in the event of an Emergency Medical Condition. The maximum benefit is shown on the Copayment and Coinsurance Schedule.

Exclusions and Limitations:
Ambulance transport that is not Emergency Medical Care is not covered.

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

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

Autism Spectrum and Pervasive Developmental Disorder

Outpatient Behavioral Health Treatment for Pervasive Developmental Disorder or Autism. Professional services for behavioral health treatment, including Applied Behavior Analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member diagnosed with Pervasive Developmental Disorder or autism, are as shown in the Copayment and Coinsurance Schedule under Behavioral Health and Chemical Dependency Services, outpatient services.

- 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 Autism Service Provider providing treatment to the Member for whom the treatment plan was developed. The treatment must be administered by the Autism Service Provider.
- A licensed Physician or licensed psychologist must establish the diagnosis of Pervasive Developmental Disorder or autism. In addition, the Autism Service Provider must submit the initial treatment plan to the Behavioral Health Administrator.
- The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Autism Service Provider for the specific patient being treated and must be reviewed by the Autism Service Provider not more than every six months and modified whenever appropriate. The treatment plan must not be used for purposes of providing or for the reimbursement of respite, day care or educational services, or to reimburse a parent for participating in a treatment program.
- The Autism Service Provider must submit updated treatment plans to Health Net for continued behavioral health and at ongoing intervals of no 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.

Autism Service Provider means one of the following:

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

Exclusions and Limitations:

Applied behavioral analysis and other forms of behavioral health treatment for autism and Pervasive Developmental Disorder requires notification, certification of diagnosis and treatment plan for the first 6 months of treatment; after 6 months, Prior Authorization is required for determination of ongoing Medical Necessity.

Blood

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

Exclusions and Limitations:
Extraction and storage of self-donated (autologous) or family member or friend, blood and derivatives are not covered.

Chemical Dependency (Alcohol & Drugs) Benefits

Benefits are provided for Medically Necessary treatment of Chemical Dependency.

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

Services provided for Chemical Dependency services are covered following the provisions of the "Office Visits," the "Specialty Physician Services," the "Hospital Inpatient Services," and the "Outpatient Services" subsections of this Group Plan Benefits section.

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

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

For purposes of this section:

"Facility" means a corporate or governmental entity or other provider of services licensed for the treatment of Chemical Dependency.

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

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

- A health care Facility;

- A residential Program or Facility;

- A day or partial hospitalization Program;

- An outpatient service; or

- An individual behavioral health or medical professional authorized for reimbursement under Oregon law.

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

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

- The coverage of a treatment or service that is or may be excluded from coverage under state law;

- Educational or correctional services or sheltered living provided by a school or halfway house; however, a Member may receive covered outpatient services while in custody or living temporarily in a sheltered living situation or receive treatment or services related to a Member's education that are included in a Medically Necessary treatment plan provided by a Provider;

- Expenses related to a stay at a sober living facility;
- A court ordered sex offender treatment program or;

- Support groups.

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

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

Clinical Trials

We will provide coverage for the routine patient costs of the care of a Qualified Individual enrolled in and participating in an Approved Clinical Trial. We will not exclude, limit or impose special conditions on the coverage of the routine patient costs for items and services furnished in connection with participation in an Approved Clinical Trial; and we will not include provisions that discriminate against an individual on the basis of the individual's participation in an Approved Clinical Trial. Prior Authorization is required. The following provisions apply:

- A Qualified Individual is a Member who is eligible to participate in an Approved Clinical Trial according to the trial protocol, and either;

    a. the referring Provider has concluded that the Member's participation in such trial is appropriate; or

    b. Member provides medical and scientific information establishing that his or her participation in such trial is appropriate.

- Routine patient costs are defined as all Medically Necessary conventional care, items or services that would be covered if typically provided to a Member who is not enrolled in a clinical trial.

  Routine patient costs do not include:

  a. The drug, device or service being tested in the Approved Clinical Trial unless the drug, device or service would be covered for that medical condition by the Health Benefit Plan if provided outside of an Approved Clinical Trial;

  b. Items or services required solely for the provision of the study drug, device, or service being tested in the clinical trial;

  c. Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;

  d. Items or services customarily provided by a clinical trial sponsor free of charge to any participant in the clinical trial; or

  e. Items or services that are not covered by the Health Benefit Plan if provided outside of the clinical trial.

  f. Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

- Approved Clinical Trial is defined as a clinical trial that is:

  a. Funded or approved by the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs;

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

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

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

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

  f. Exempt by federal law from the requirement to submit an INDA to the United States Food and Drug Administration.

- Under this section, life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

- Qualified Individuals may be required to participate in an Approved Clinical Trial through a Participating Provider if such a Participating Provider is available and will accept the individual as a participant in the trial.

- You must pay any Deductibles, Copayments or Coinsurance that apply to the drug, device or service being tested in the absence of an Approved Clinical Trial.

Colorectal Cancer Screenings

Colorectal cancer screening examinations and laboratory tests are covered as preventive care as listed under the "Preventive Care" subsection of this Group Plan Benefits section. Colorectal cancer screening examinations and laboratory tests assigned either a grade of A or a grade of B by the United States Preventive Services Task Force (USPSTF) are covered.

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

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

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

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

Craniofacial Anomalies

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

Exclusions and Limitations:

Craniofacial Anomalies does not include developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth or temporomandibular joint disorder (TMJ).

Dental Anesthesia

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

- Is under the age of six, or physically or developmentally Disabled with a dental condition that cannot be safely and effectively treated in a dental office; or

- Has a medical condition that the Member's Physician determines would place the Member at an undue risk if performed in a dental office. The dental procedure must be approved by the Member's Physician.

The services must be Prior-Authorized and must be performed in a Hospital or in an "Ambulatory Surgery Center." The dental procedures performed are only covered as specifically outlined in this Agreement.

Dental Injury

Dental services required because of an injury by external force or trauma are covered up to a maximum of $1,000 provided that the services are furnished within 12 months after an injury or accident.

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

Diabetes Management

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

- Diabetes self-management programs are covered including: (a) one program of assessment and training and (b) up to three hours annually, of assessment and training following a material change in the condition, medication or treatment in an existing treatment of diabetes.

- Appropriate and Medically Necessary supplies and equipment related to Diabetes Management including blood glucose test strips, lancets, insulin syringes and needles as described in the "Medical Supplies" subsection of this Group Plan Benefits section.

- Routine foot care in connection with the treatment of diabetes.

- Screening for gestational diabetes, as supported by HRSA guidelines, is covered as preventive care in the "Preventive Care" subsection of this Group Plan Benefits section.

- Unless you are on a Single or Family High Deductible Health Plan (HDHP), you are eligible for no cost benefits for diabetes management from the beginning of your pregnancy for up to six weeks postpartum. For

more information please contact our Customer Contact Center at the phone number found at the back of this Agreement.

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

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

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

Durable Medical Equipment

Durable Medical Equipment, including your initial rental or purchase, is covered provided it is the least costly alternative that achieves a medically acceptable result. Coverage includes, but is not limited to, braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatus used to support, align, or correct deformities or to improve the function of moving parts. Medically Necessary lenses for the treatment of aphakia and keratoconus are covered as Durable Medical Equipment. Prior Authorization is required.

We apply 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.

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

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

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

Fertility Preservation

Medically Necessary services and supplies for 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 Copayment and Coinsurance Schedule) as would be required for Covered Services to treat any illness or condition under this plan.

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

Gender Reassignment Services/Gender-affirming treatment

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

Health Education Services

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

- We will cover up to the maximum reimbursement amount shown on the Copayment and Coinsurance Schedule for each health education class.

- The total benefit under this section is not to exceed the Calendar Year maximum shown on the Copayment and Coinsurance Schedule.

Hearing Aids

We will provide coverage for one hearing aid per impaired ear. The following provisions apply:

- The hearing aid(s) must be prescribed, fitted and dispensed by a licensed audiologist with the approval of a licensed Physician;

- The hearing aid(s) must be necessary for the treatment of hearing loss for a Member Enrolled under the plan who is either:

    a. 19 years of age or younger (through the end of the month that the enrollee turns 19 years of age); or

    b. 19 to 25 years of age, eligible as a Dependent under the plan, and enrolled in a secondary school or an accredited educational institution.

***Exclusions and Limitations*:**
This benefit is for the hearing aid devices only. Cochlear implants, masking devices, or other hearing devices are not covered.

The maximum benefit is one hearing aid per ear per every three years.

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

Home Health Care

Home Health Care for Skilled Nursing Services is covered in your home or place of residence which is not a Skilled Nursing Facility. Daily coverage is limited to what we would pay a participating Skilled Nursing Facility for 24-hour Skilled Nursing Services. Prior Authorization is not required.

***Exclusions and Limitations*:**
We may utilize a Specialty Care Provider of home health services if you live in the Service Area. Prior Authorization is required for physical, occupational and speech therapy performed in the home. We do not cover Custodial Care.

Home Infusion Services

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

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

Hospice Care

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

Inborn Errors of Metabolism

Clinical visits, biochemical analysis, treatment and medical foods are covered for inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage includes diagnosis, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders. "Medical foods" are defined as those formulated to be consumed or administered enterally under the supervision of a Physician, that are specifically processed or formulated to be deficient in one or more of the nutrients present in typical nutritional counterparts, that are for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained therein or have other specific nutrient requirements as established by medical evaluation and that are essential to optimize growth, health and metabolic homeostasis.

Maternity Benefits

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

Medically Necessary maternity care is covered as follows:

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

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

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

Unless you are on a Single or Family HDHP plan, you are eligible for no cost benefits for diabetes management from the beginning of your pregnancy for up to six weeks postpartum. For more information please contact our Customer Contact Center at the phone number found at the back of this Agreement.

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

Delivery and Nursing Care. Delivery services and facilities and nursing care are covered. Birthing Center services will be directed to a designated Specialty Care Provider in accordance with the "General Terms Under Which Benefits Are Provided" portion of this Group Plan Benefits section. Services provided by other than the designated Specialty Care Provider will not be covered.

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

Exclusions and Limitations:
Services of a lay midwife are not covered.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT:

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

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

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

Medical Supplies

Medical supplies are covered as follows.

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

- Ostomy supplies are covered, including flanges, pouches, irrigators, irrigator sleeves and drains, closed-end pouches, stoma caps, ostomy deodorant, belts, convex inserts, drain tube adapters, drainable pouch clamps, medical adhesive, replacement filters, security tape, and skin barriers.

- Unless you are on a Single or Family HDHP plan, you are eligible for no cost benefits for diabetes management from the beginning of your pregnancy for up to six weeks postpartum. For more information please contact our Customer Contact Center at the phone number found at the back of this Agreement.

- Non-durable supplies required for the function of Durable Medical Equipment are covered.

- The first pair of Medically Necessary eyeglasses or contact lenses following covered cataract surgery are covered. Contact our Customer Contact Center at the phone number listed at the back of this Agreement for benefit limitations.

- Allergy serums, treatment compounds, solutions, and medications are covered. Substances administered by therapeutic injection in a Provider's office are covered.

- Non-durable medical supplies provided in the Provider's office are covered.

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

Mental or Nervous Conditions

Benefits are provided for Medically Necessary treatment of Mental or Nervous Conditions.

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

Medically Necessary services provided for Mental or Nervous Conditions are covered following the provisions of the "Office Visits," the "Specialty Physician Services," the "Hospital Inpatient Services," and the "Outpatient Services" subsections of this Group Plan Benefits section.

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

- An Enrollee's interruption of or failure to complete a prior course or treatment;
- Health Net's categorical exclusion of such treatment or service when applied to a class of Mental or Nervous Conditions; or

- The fact that a court ordered the Enrollee to receive or obtain the treatment or service for a Mental or Nervous Condition, unless otherwise allowed by law.

For purposes of this section:

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

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

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

- A health care Facility;

- A residential Program or Facility;

- A day or partial hospitalization Program;

- An outpatient service; or

- An individual behavioral health or medical professional authorized for reimbursement under Oregon law.

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

- The coverage of a treatment or service that is or may be excluded from coverage under state law;

- Educational or correctional services or sheltered living provided by a school or halfway house; however, a Member may receive covered outpatient services while in custody or living temporarily in a sheltered living situation or receive treatment or services related to a Member's education that are included in a Medically Necessary treatment plan provided by a Provider;

- Psychoanalysis or psychotherapy received as part of an educational or training program and not otherwise covered, regardless of diagnosis or symptoms that may be present;
- Expenses related to a stay at a sober living facility;
- A court-ordered sex offender treatment program; or
- Support groups.

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

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

Nonprescription Elemental Enteral Formula

Nonprescription elemental enteral formula for home use is covered if the formula is Medically Necessary for the treatment of severe intestinal malabsorption, and a Participating Provider has issued a written order for the formula, and the formula comprises the sole source, or an essential source, of nutrition.

Oral and Maxillofacial Services

The following oral and maxillofacial services are covered:

- Oral and surgical care for tumors and cysts (benign or malignant);
- Treatment of cleft lip, cleft palate, or other maxillofacial congenital anomalies; and
- Maxillofacial prosthetic services for restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma, or birth and developmental deformities when the services are performed for the purpose of (1) controlling or eliminating infection or pain, or (2) restoring facial configuration or functions such as speech, swallowing, or chewing.

Organ and Tissue Transplants

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

- kidney transplants;
- pancreas after kidney transplants;
- cornea transplants;
- heart transplants;
- liver transplants;
- lung transplants;
- heart-lung transplants;

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

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

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

Exclusions and Limitations:

- No other organ or tissue transplants are covered.
- Organ or bone marrow search, selection, storage, and eye bank costs are not covered.
- All organ and tissue transplants or autologous stem cell rescue not explicitly listed as covered in this section.
- Services for an organ donor or prospective organ donor when the transplant recipient is not a Member.
- Non-human or artificial organs and the related implantation services.
- Permanent or temporary implantation of artificial or mechanical devices to replace or assist human organ function until the time of organ transplant, except for dialysis to maintain a kidney and artificial pump bridge to approved cardiac transplants.
- High dose chemotherapy which requires the support of a non-covered bone marrow transplant or autologous stem cell rescue.
- Bone marrow transplantation, stem cell rescue or hematopoietic support for human gene therapy (enzyme deficiencies), autologous stem cell transplantation for acute myocardial infarction (ASTAMI) or heart failure stem cells for spinal fusion.
- Transplant services not Prior Authorized and/or not provided at the Specialty Care Provider designated by us are not covered.

Outpatient Pharmaceuticals

Certain outpatient pharmaceuticals, whether administered in a Physician's office, free-standing infusion center, Ambulatory Surgery Center, outpatient dialysis center or outpatient Hospital, are covered under your medical

plan with Prior Authorization. Refer to the Health Net website, www.healthnet.com or call our Customer Contact Center at the phone number listed in the back of this Agreement for a list of drugs that require Prior Authorization. Prior Authorization is not required for prescription drugs and over-the-counter medications that are determined to be preventive as recommended by the United States Preventive Services Task Force (USPSTF) A and B recommendations.

Preventive Care

When preventive care services, as described in this section, are received from a Participating Provider they are covered at no cost share to you. If the primary purpose of the office visit is unrelated to a preventive care service or if other non-preventive care services are received during the same office visit, the non-preventive care, services are payable at benefit levels indicated on your Copayment and Coinsurance Schedule. If you receive services from a Nonparticipating Provider, benefits are subject to your Nonparticipating and/or Out-of-Network cost share amounts including Deductible (if any), as indicated on your Copayment and Coinsurance Schedule.

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

Covered recommended preventive care services include the following:

- United States Preventive Services Task Force (USPSTF) recommended type “A” and “B” services;
- Immunizations and inoculations as recommended by the Advisory Committee on immunization Practices of the Center for Disease Control (CDC);
- Pediatric preventive care and screenings, as supported by the Health Resources and Services Administration (HRSA) guidelines;
- Women’s health care services as supported by HRSA guidelines such as, screening for gestational diabetes; human papillomavirus (HPV) DNA testing for women 30 years and older; sexually-transmitted infection counseling; human immunodeficiency virus (HIV) screening and counseling; FDA-approved contraception methods and contraceptive counseling; breastfeeding support, supplies and counseling; and domestic violence screening and counseling;
- Other USPSTF recommendations for breast cancer screening, mammography and prevention.

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

- Additionally, coverage is provided for the human papillomavirus (HPV) vaccine for female members between the ages of 11 and 26.

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

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

Prosthetic Devices and Orthotic Devices

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

Exclusions and Limitations:

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

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

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

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

Reconstructive Breast Surgery

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

Exclusions and Limitations:

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

Rehabilitation Therapy

For the purposes of this section:

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

Rehabilitation Therapy is covered as follows:

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

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

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

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

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

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

Rehabilitative services to treat mental health conditions are not subject to the day/visit limit maximums.

Skilled Nursing Care

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

Specialty Pharmacy

Certain drugs identified on the formulary are classified as Specialty Pharmacy Drugs under your plan. Specialty Pharmacy drugs are covered only under a Supplemental Prescription Benefit Schedule. Specialty Pharmacy drugs are high cost biologic, injectable and oral drugs typically dispensed through a limited network of pharmacies and having significantly higher cost than traditional pharmacy benefit drugs.

Sterilization

Male and female sterilization procedures are covered.

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

Male sterilization benefits are subject to payment of any applicable Copayments or Coinsurance and will depend on whether the procedure is performed in a Physician's office or Hospital setting, outpatient, or Ambulatory Surgery Center setting. Applicable Copayments and Coinsurance can be found in your benefit schedule.

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

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

Telemedical Services

Telemedical refers to services delivered through a two-way electronic communication that allows a health professional to interact with a patient, a parent or guardian of a patient or another health professional on a patient's behalf. Coverage is subject to any applicable Deductible, Copayment or Coinsurance that would apply to a comparable health service provided in person.

We will provide coverage for telemedical services under the following conditions:

- We would otherwise provide coverage for the service when provided in person by the health professional;
- The service is Medically Necessary;
- The service is determined to be safely and effectively provided using synchronous two-way interactive video conferencing according to generally accepted health care practices and standards; and
- The application and technology used to provide the health service is attested to meet all standards required by state and federal laws governing the privacy and security of protected health information.

Additionally, we will provide coverage for telemedical services in connection with the treatment of diabetes under the following conditions:

- We would otherwise provide coverage for the service when provided in person by the health professional; and
- The service is Medically Necessary.
- The telemedical health service relates to a specific patient; and

- One of the participants in the telemedical health service is a representative of an academic health center.

Exclusions and Limitations:
Services that are not otherwise covered are not covered when provided in the Telemedical format.
Unless all conditions listed in this section for such services are met, you may be responsible for billed charges from a Provider for telemedical services. For more information, please contact our Customer Contact Center at the phone number listed at the back of this Agreement.

Temporomandibular Joint Syndrome (TMJ)

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

Tobacco Use Cessation Programs

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

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

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

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

Case Management

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

Prior Authorization

- The services requiring Prior Authorization, as defined in the "Definitions" section of the Group Medical and Hospital Service Agreement, are specified in this Group Plan Benefits section. You are responsible for obtaining Prior Authorization from us before obtaining such services. Prior Authorization may be obtained by you or your Provider by calling 888.802.7001 or faxing a request to 800.495.1148. For Prior

Authorization of mental health or Chemical Dependency services, please call 800-977-8216. Coverage for those services will be provided only if Prior Authorization has been obtained from us.

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

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

Exclusions and Limitations (What's not covered)

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

- **Not Medically Necessary.** Any care not Medically Necessary as defined in the "Definitions" section of the Group Medical and Hospital Service Agreement; and any hospital or medical care services not specifically provided for in the Group Medical and Hospital Service Agreement or this Group Plan Benefits section.

- **In Excess of Benefit Maximums or Limitations**. All services or supplies that exceed any maximum cost or time (days or visits) limitation imposed in this Group Plan Benefits section, the Copayment and Coinsurance Schedule, or any Supplemental Benefit Schedule.

- **Other Insurance.** All services or supplies rendered for any illness, injury, or condition to the extent that benefits are available to you as an insured under the terms of any other insurance (except group or individual health insurance) including without limitation automobile medical, personal injury protection, automobile no-fault, automobile uninsured or underinsured motorist, homeowners or renters, commercial premises or comprehensive general liability insurance coverage. If we pay benefits before any such insurance payments are made, reimbursement must be made out of any other subsequent insurance payments made to you and, when applicable, we may recover benefits already paid directly from the insurer, in accordance with the "Subrogation" section in the Group Medical and Hospital Service Agreement.

- **Experimental or Investigational Procedures.** Except as provided in the "Clinical Trials" subsection of the Group Plan Benefits section, medical, surgical or other health care procedures, treatments, devices, products or services (collectively, "health care services") which are determined by us to be Experimental or Investigational, and complications directly caused thereby. However, Emergency Medical Care for such complications is covered.

- **Unauthorized Services.** Non-emergency services without Prior Authorization, if Prior Authorization is required pursuant to the "Prior Authorization" subsection of this Group Plan Benefits section.

- **Expenses Related to Non-Covered Services or Supplies.** Expenses, other than for Emergency Medical Care, for any condition or complication caused by any procedure, treatment, service, drug, device, product or supply excluded from coverage.

- **Hospital Room.** A private room or services of private or special duty nurses other than as Medically Necessary when you are an inpatient in a Hospital.

- **Alternative Care.** Chiropractic care, acupuncture, naturopathic medicine, massage therapy, and hypnotherapy. Medically Necessary services, other than the services listed in this exclusion, that are provided by a naturopathic physician (ND) and are within the scope of his or her licensure are not subject to this exclusion.

- **Dental Services.** Services performed in connection with treatment to teeth or gums, upper or lower jaw augmentation or reduction, or orthognathic surgery, including treatment or devices for disorders of the temporomandibular joint; all dental services and dentures except as specified under the "TMJ," "Oral and

Maxillofacial Services," "Dental Anesthesia," and "Dental Injury" subsections of this Group Plan Benefits section or as otherwise covered under the "Preventive Care" section. Prior Authorization may be required.

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

- **Custodial Care; Respite Care.**

- **Optometrics, Eyewear, Vision and Hearing Examinations**. Eye refractions, regardless of diagnosis; routine eye examinations; eye exercises; visual analysis; therapy or training; radial keratoplasty; photo refractive keratotomy and clear lensectomy. Also excluded are eyeglasses and all other types of vision hardware or vision corrective appliances and contact lenses, except as provided in the "Durable Medical Equipment" and "Medical Supplies" subsections of this Group Plan Benefits section. Hearing screening and tests except as provided in the "Diagnostic Services" provision of the "Physician Services" section and the "Preventive Care" subsections of this Group Plan Benefits section. Hearing aids except as provided in the "Hearing Aids" subsection, masking devices, or other hearing devices or the fitting thereof.

- **Non-covered Equipment and Supplies.** Corrective appliances and artificial aids; braces; disposable or non-prescription or over-the-counter supplies, such as ace bandages, splints, and syringes unless dispensed by a Participating Provider and except as specifically provided elsewhere in this Group Plan Benefits section; exercise and hygiene equipment; support garments; electronic monitors; devices other than blood glucose monitors to perform medical tests on blood or other body substances or excretions; devices or equipment not exclusively medical in nature including but not limited to sauna baths, spas, elevators, light boxes, air conditioners or filters, humidifiers or dehumidifiers; orthopedic chairs and motorized scooters; devices or equipment which can be used in the absence of a medical need; or modifications to the home or motorized vehicles. Corrective shoes and arch supports including foot orthotics are excluded unless prescribed in the course of treatment for, or complications from diabetes.

- **Cosmetic Services.** Except for treatment covered under the "Oral and Maxillofacial Services" and "Dental Injury" subsections of this Group Plan Benefits section, all cosmetic or other services rendered to improve a condition which falls within the normal range of function are not covered unless they are Medically Necessary. Services performed to reshape normal structures of the body in order to improve or alter your appearance and/or self-esteem and are not primarily to restore an impaired function of the body are not covered. In addition, hair transplantation, hair analysis, hairpieces and wigs, and cranial/hair prostheses are not covered.

- **Breast Reduction or Augmentation.** Reduction or augmentation mammoplasty, except if Medically Necessary or as provided in the "Reconstructive Breast Surgery" subsection of this Group Plan Benefits section.

- **Preparation and Presentation of Medical or Psychological Reports or Physical Examinations Required Primarily for Your Protection and Convenience or for Third Parties.** Including but not limited to examinations or reports for school events, camp, employment, marriage, registered domestic partnership, trials or hearings, licensing and insurance.

- **Immunizations and Inoculations.** Except as provided under the "Preventive Care" subsection of this Group Plan Benefits section.

- **Diagnosis and Treatment of Infertility,** except as covered as outlined in the "Fertility Preservation" subsection of this Group Plan Benefits section. Except for Emergency Medical Care, complications caused by treatment for infertility are not covered. Infertility is the failure of a couple during normal childbearing years to achieve conception after one or more years of regular sexual intercourse without practicing contraceptive measures. Sexual dysfunction that prevents successful intercourse may also be considered infertility. Infertility-related diagnosis and treatment includes but is not limited to:

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

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

  c. Assisted reproductive technologies and artificial insemination.

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

- **Reversal of Voluntary Infertility (Sterilization).**

- **Weight Loss Surgery or Complications Caused by Weight Loss Surgery**. Except for Emergency Medical Care. Diagnosis, treatment, rehabilitation services and diet supplements for any classification of obesity, including but not limited to morbid obesity, (regardless of co-morbidities), except as provided in the "Preventive Care" subsection of this Group Plan Benefits section.

- **Personal Comfort Items.** Such as television, telephone, lotions, shampoos, meals in the home, guest meals in inpatient facilities, housekeeping services, etc.

- **Diagnosis and treatment for learning disorders** in the absence of a DSM diagnosis.

- **Speech Generating Devices; Augmentive and Alternative Communication Devices or Communicators.** This exclusion does not include an artificial larynx for Members who have had a complete laryngectomy.

- **Rehabilitation Therapy.** Except for Covered Services provided in the "Rehabilitation Therapy" subsection of the Group Plan Benefits, speech language pathology therapy for emotional or behavioral disorders, which fall under special education, is not covered.

- **Hearing therapy.**

- **Chiropractic manipulations** except if Medically Necessary.

- **Treatment of Sexual Dysfunction.** In the absence of a DSM mental health disorder of sexual dysfunction being the primary diagnosis, medications, surgical treatment or hospitalization for treatment of impotency; penile implants; services, devices, or aids related to treatment for any types of sexual dysfunction, congenital or acquired; sperm storage or banking are not covered.

- **Genetic Engineering.**

- **Recreational or Educational Therapy; Non-medical Self-help Training.** Except as specifically stated below, services related to or consisting of education or training, including for employment or professional purposes, are not covered, even if provided by an individual licensed as a health care provider by the state of Oregon.

  Excluded services include education and training for non-medical purposes such as:

  - Gaining academic knowledge for educational advancement to help students achieve passing marks and advance from grade to grade. This Agreement does not cover tutoring, special education/instruction required to assist a child to make academic progress; academic coaching; teaching members how to read; educational testing or academic education during residential treatment.

  - Developing employment skills for employment counseling or training, investigations required for employment, education for obtaining or maintaining employment or for professional certification or vocational rehabilitation, or education for personal or professional growth.

  - Teaching manners or etiquette appropriate to social activities except for services related to behavioral health treatment for Pervasive Developmental Disorder or autism as shown in the "Autism Spectrum and Pervasive Developmental Disorder" section.

  - Behavioral skills for individuals on how to interact appropriately when engaged in the usual activities of daily living, such as eating or working, except for services related to behavioral health treatment for Pervasive Developmental Disorder or autism as shown in the "Autism Spectrum and Pervasive Developmental Disorder" section.

- **Bone Bank and Eye Bank Charges.**

- **Counseling or training in connection with family, sexual, marital, or occupational issues** in the absence of a DSM diagnosis/mental health disorder are not covered.

- **Orthoptics, Pleoptics.**

- **No-charge Items.** Services and supplies for which the Member is not required to pay or that the Member would receive at no cost in the absence of health coverage; services and supplies for which the Member is not billed by a Provider or for which we are billed a zero dollar charge.

- **Services for any illness, condition or injury occurring in or arising out of the course of employment for which a claim has been approved under workers' compensation insurance coverage.** In an event you have not submitted a claim with the workers' compensation insurer or self-insured employer and we deny payment for services on the basis of the claim being work-related, state law allows you to file a claim with your workers' compensation insurer or self-insured employer within 90 days from the date we reject the claim. If your workers' compensation claim is denied, the workers' compensation insurer or self-insured employer shall inform us of the denial and we will process the claim for payment in accordance with the terms, conditions and benefits of this Agreement.

- **Treatment Related to Judicial or Administrative Proceedings.** Court-ordered care, unless determined to be Medically Necessary and Prior Authorized by us. Psychiatric therapy as a condition of parole or probation unless by court order.

- **Education Related to Judicial or Administrative Proceedings.** No coverage shall be provided for educational programs to which drivers are referred by the judicial system or for volunteer mutual support groups.

- **Outpatient Prescription or Other Drugs and Medications.** Prescriptions relating to an inpatient/outpatient confinement filled at a hospital pharmacy prior to discharge for use at home (take-home medications) except for prescriptions for a 24-hour supply or less, following an emergency room visit.

- **Professional Athletic Training and Competition** Diagnosis, treatment and rehabilitation services for injuries sustained while practicing for or competing in a professional or semi-professional athletic contest unless the injuries were sustained before Enrollment in this plan.

- **Programs for the specific intent of pain management.**

- **Biofeedback.** Biofeedback for the treatment of vulvodynia, ordinary muscle tension, or for the management of chronic pain in pain rehabilitation programs.

- **Routine Foot Care.** Including treatment for corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes.

- **Growth hormone therapy.**

- **Preventive and Routine Examinations, Services, Testing, and Supplies.** Except as outlined in the "Preventive Care" subsection of this Group Plan Benefits section.

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

- **Nutritionist.** Services of a nutritionist, except as outlined in the "Diabetes Management" and "Inborn Errors of Metabolism" subsections of this Group Plan Benefits section, or as listed in the "Preventive Care" subsection (as described in the USPSTF Guidelines).

- **Wilderness Residential Treatment Programs.** All services provided in wilderness residential treatment programs.

- **Treatment by an Immediate Family Member or Self Treatment.** Services and supplies rendered by an immediate family member (spouse, Registered Domestic Partner and/or non-registered domestic partner, parent, child, grandparent or sibling related by blood, registered domestic partnership, marriage or adoption) or services and supplies, or medications prescribed or ordered by an immediate family member of the Member; Member self-treatment, including but not limited to self-prescribed medications and medical self-ordered services and laboratory tests.

- **Outside the United States.** Services provided outside the United States which are not Emergency Medical Care.

- **Conditions caused by your commission (or attempted commission) of a felony.** However, the following are not excluded:
  - Treatment for injuries as a result of an act of domestic violence or an injury resulting from a medical condition, or
  - treatment for injuries sustained solely as a consequence of the Enrolled Member being intoxicated or under the influence of a narcotic.
  - Court-ordered screening interviews or treatment programs when a person is convicted of driving under the influence of intoxicants (DUII).

- **Missed Appointments.** Charges to a Member for failure to keep a scheduled appointment are not covered.

- **Hair Analysis and Replacement.** Hair transplantation, hair analysis, hairpieces and wigs, and cranial/hair prostheses are not covered.

- **Services While in Custody**. A Member cannot be denied coverage of services or supplies while in custody of a local supervisory authority while disposition of charges are pending if the services or supplies would otherwise be covered by this plan. Coverage will be denied for the treatment of injuries resulting from a violation of law.

- **Non-Licensed Providers.** Treatment or services rendered by non-licensed health care Providers, treatment or services outside the scope of a license of a licensed health care Provider and treatment or services for which the Provider of services is not required to be licensed. This includes treatment or services from a non-licensed Provider under the supervision of a licensed Physician, except for services related to behavioral health treatment for Pervasive Developmental Disorder or autism as shown in the "Autism Spectrum and Pervasive Developmental Disorder" subsection of this Group Plan Benefits section.

- **Non-Standard Therapy.** Yoga, hiking, rock climbing and any other type of sports activity are not covered.

Health Net®

Health Net Health Plan of Oregon, Inc.
PPO Plan
GROUP MEDICAL AND HOSPITAL SERVICE AGREEMENT

Introduction

- This Agreement is entered into between us and the Subscriber Group named on the attached Signature Sheet.

- We are an authorized health care service contractor in the State of Oregon.

- Subscriber Group desires to make available prepaid comprehensive health care services to eligible persons who participate in its Health Benefit Plan.

- In consideration of the mutual promises of the parties and the periodic payment to us of the required premiums and subject to the terms and conditions contained in this Agreement, we agree to provide Subscribers and their Enrolled Dependents with Medical and Hospital Services and other benefits specified in this Agreement.

- It is agreed by the parties that this is not an indemnity health insurance contract but is an agreement to provide Subscribers and their Enrolled Dependents with health care benefits as specified by this Agreement. All interpretations of this Agreement shall be guided by such nature of this Agreement.

Definitions

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

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

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

- Denial of eligibility for or termination of enrollment in a Health Benefit Plan; or

- Rescission or cancellation of a policy or certificate; or

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

- Determination that a health care item or service is Experimental, Investigational, or not Medically Necessary, effective, or appropriate; or

- Determination that a course or plan of treatment that an Enrollee is undergoing is an active course of treatment for purposes of continuity of care.

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

"Agreement" means this Medical and Hospital Service Agreement, all attached Benefit Schedules and Copayment and Coinsurance Schedules, the Signature Sheet, any exhibits, supplements, addenda, attachments, amendments, endorsements, applications or riders, conditions of enrollment, underwriting assumptions, and any information submitted as part of an application for this Agreement or for membership under this Agreement. A copy of the Agreement serves as both the description of coverage portion of the contract between us and the Subscriber Group, and when distributed to a Member, as the Member's Evidence of Coverage (EOC) document.

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

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

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

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

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

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

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

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

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

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

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

"Copayment" means the fixed dollar amount stated in a Copayment and Coinsurance Schedule or any applicable Supplemental Benefit Schedule to be paid by Members directly to Providers for Covered Services.

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

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

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

"DSM" Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) or the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). The reference book, published by the American Psychiatric Association, is the diagnostic standard for most mental health professionals in the United States.

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

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

- The spouse or Registered Domestic Partner of the Subscriber.

- A Child of the Subscriber, from birth and extending up to the last day of the month in which that Child becomes age 26, including a child who is the subject of a qualified medical child support order requiring the Subscriber to provide health coverage for the Child. Proof of compliance with this requirement must be furnished annually.

  "Child" means a natural child of the Subscriber, an adopted child of the Subscriber, or a stepchild of the Subscriber during the marriage or Registered Domestic Partnership of the Subscriber and the natural parent,

or a child of the Subscriber's Registered Domestic Partner during the Registered Domestic Partnership, but does not include foster children, wards, or children who are the subject of an Assignment of Parental Rights, even if decreed by a court. "Child" also does not include children of Dependents unless the Subscriber is a court-appointed guardian. Provided, however, that a child who is placed with a Subscriber for the purposes of adoption shall be considered a Dependent of the Subscriber as required by the laws of the State of Oregon. As defined in ORS 743A.090(5), child means an individual who has not reached 26 years of age at the time of the adoption or placement for adoption. Placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligations. Coverage for any Dependent child of a Subscriber shall not be terminated by the child's attaining the limiting age if the child is and continues to be Disabled and is not eligible to be covered under any government program except Medicaid. Proof of disability must be furnished annually. We will not deny Enrollment of a child because the child was: (a) born out of wedlock; (b) is not claimed on the parent's federal tax return; or (c) does not reside with the parent or within our Service Area.

"Disabled" means, in the case of an adult person an individual who by reason of developmental disability, injury or illness is totally unable to perform the usual tasks in the work he/she was performing at the time of the developmental disability, injury or illness and is wholly unable to perform in any physical or mental capacity in his/her current occupation or is wholly unable to engage in the normal activities of a person of the same age and sex. A Dependent prior to his/her 26th birthday will be considered Disabled when, by reason of injury or illness, he/she is wholly unable to engage in the normal activities of a person of the same age and sex. The determination of the Medical Director regarding the existence of a disability will control, subject only to the "Rights of Members" section of this Group Medical and Hospital Service Agreement.

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

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

"Eligible Employee" means an employee who is eligible for coverage under a group Health Benefit Plan.

"Emergency Medical Care" means the services and supplies to diagnose and treat an Emergency Medical Condition to the extent they are required for the Stabilization of the condition.

"Emergency Medical Condition" means a medical condition:

- That manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:

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

  b. Result in serious impairment to bodily functions; or

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

- With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child.

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

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

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

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

"Grievance" means:

- A communication from an Enrollee, or an authorized representative (defined as an individual who by law or by the consent of a person may act on behalf of the person) of an Enrollee, expressing dissatisfaction with an Adverse Benefit Determination, without specifically declining any right to appeal or review, that is:

  a. in writing, for an Internal Appeal or an external review; or

  b. in writing or orally, for an expedited response or an expedited external review; or

- A written complaint submitted by an Enrollee or an authorized representative of an Enrollee regarding the following:

  a. availability, delivery or quality of a health care service;

b. claims payment, handling or reimbursement for health care services, in which the Enrollee has not submitted a request for an Internal Appeal, and the complaint is not disputing an Adverse Benefit Determination; or

c. matters pertaining to the contractual relationship between an Enrollee and an insurer.

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

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

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

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

"Hospital" means an institution which is either:

- An institution which is primarily engaged in providing, on an inpatient basis, medical care and treatment for sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be located on its premises, under the supervision of a staff of Physicians and with 24 hour-a-day nursing services; or

- An institution not meeting all the requirements of (a) above, but which is accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations or pursuant to Title XVIII of the Social Security Act as amended.

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

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

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

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

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

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

- The individual applies for coverage during an open enrollment period;

- A court has ordered that coverage be provided for a spouse, Registered Domestic Partner or minor child under a covered Participant's Health Benefit Plan and request for enrollment is made within 31 days after issuance of the court order;

- The individual is employed by a Group Subscriber who offers multiple Health Benefit Plans and the individual elects a different Health Benefit Plan during an open enrollment period agreed upon by Group Subscriber and us;

- The individual qualifies for Special Enrollment under the "Enrollment and Effective Date" section of this Group Medical and Hospital Service Agreement.

"Maximum Allowable Amount (MAA)" is the amount that we use to calculate what we pay for Covered Medical Services and Supplies provided by a Nonparticipating Provider or Out-of-Network Provider. MAA may be less than the amount billed for those Medical Services and supplies. MAA is calculated as the lesser of the amount billed by the Nonparticipating Provider or the amount determined in the order set forth below. MAA is not the amount that we pay for a Covered Service or Supply; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles and other applicable amounts set forth in your Copayment and Coinsurance Schedule.

- The MAA for Out-of-Network Emergency Care will be the greatest of: (1) the amount negotiated with Participating Providers for the emergency service provided, excluding any in-network Copayment or Coinsurance; (2) the amount calculated using the same method we generally use to determine payments for Nonparticipating Providers, excluding any in-network Copayment or Coinsurance; or (3) the amount paid under Medicare Part A or B, excluding any in-network Copayment or Coinsurance.

- The MAA for covered outpatient pharmaceuticals (including but not limited to injectable medications) dispensed and administered to the patient by a Nonparticipating Provider, in an outpatient setting, including, but not limited to, Physician office, outpatient Hospital facilities, and services in the patient's home will be the lesser of billed charges or the "Average Wholesale Price" for the drug or medication. "Average Wholesale Price" is the amount listed in a national pharmaceutical pricing publication, and accepted as the standard price for that drug by Health Net.

- The MAA for Covered Services and Supplies, excluding Emergency Medical Care and outpatient pharmaceuticals, received from a Nonparticipating Provider is a percentage of what Medicare would pay (known as the Medicare allowable amount). Medicare pays 100% of the Medicare allowable amount.

- The MAA for facility services, including but not limited to Hospital, Skilled Nursing Facility, and Outpatient Surgery, is determined by applying 160% of the Medicare allowable amount.

- The MAA for Physician and all other types of services and supplies is the lesser of the billed charge or 160% of the Medicare allowable amount.

- In the event there is no Medicare allowable amount for a billed service or supply code, MAA shall be determined as the lesser of: (1) the average amount negotiated with Participating Providers for similar Covered Services or Supplies provided; (2) the amount calculated using databases of provider charges and allowable payments maintained by entities including, but not limited to, FAIR Health and Data iSight; (3) an amount based on the Medicare allowable amount for a similar Covered Services or Supplies; or (4) 50% of Out-of-Network Provider's billed charges for Covered Services.

- MAA is subject to other limitations on covered Medical Services. See your Copayment and Coinsurance Schedule, Group Plan Benefits section, and any Supplemental Benefit Schedules and Amending Attachments for specific Deductibles, benefit limitations, maximums, requirements and multiple surgery payment policies that limit the amount that we pay for covered Medical Services and Supplies. We use available guidelines of Medicare and/or Medicaid to assist in our determination as to which services and procedures are eligible for reimbursement. We will, to the extent applicable, apply Medicare claim processing rules to claims submitted. We will use these rules to evaluate the claim information and determine accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying Medicare rules may affect the MAA if it is determined the procedure or diagnosis codes used were inconsistent with Medicare procedure coding rules or reimbursement policies.

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

The following example shows how MAA applies to claims payment:

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

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

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

In addition to the above, from time to time, we also contract with networks that have contracted fee arrangements with Providers ("third party networks"). In the event we contract with a third party network that

has a contract with the Nonparticipating Provider, we may, at our option, use the rate agreed to by the third party network as the MAA.

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

In the event that the billed charges for covered Medical Services and supplies received from a Nonparticipating Provider are more than the MAA, you are responsible for any amounts charged in excess of the MAA, in addition to applicable Deductibles, Copayments or Coinsurance.

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

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

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

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

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

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease, and;
- not primarily for convenience of the patient, Physician, or other health care Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.
- An Oregon-licensed doctor of medicine or osteopathy shall be responsible for all final recommendations regarding the necessity or appropriateness of services or the facility where they will be provided and shall consult as appropriate with medical and mental health specialists in making such recommendations.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant

medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas, and any other relevant factors.

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

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

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

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

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

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

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

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

"Participating Provider" means a licensed or certified Physician, health professional, Hospital, home health agency, pharmacy, laboratory, or other licensed or certified entity or person who has entered into a contract or other arrangement to provide health care services to Members of this PPO Plan with an expectation of receiving payment, other than Deductibles, Coinsurance, and Copayments, directly or indirectly from us, and such contract or other arrangement is in effect at the time such services are rendered.

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

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

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

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

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

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

- A Prior Authorization issued by us shall be binding in accordance with its terms for 30 days, except that a Prior Authorization shall not be binding if:

  a. The services authorized by the Prior Authorization are performed on a date more than five days after the Prior Authorization is issued and the Member is ineligible on that date;

  b. The Prior Authorization specifies a date on which coverage terminates and services were obtained after that date; or

  c. The Prior Authorization was obtained through misrepresentation.

- We will answer a request for Prior Authorization of non-emergency services within two working days.

- A Physician will retain responsibility for recommendations related to whether a service or procedure, and where it is to be performed, is appropriate for treating a specific medical condition.

"Prosthetic Device" means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg.

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

"Registered Domestic Partner" means a person who has entered into a civil contract with the Subscriber, both of whom are the same sex and both of whom are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon. A Registered Domestic Partner relationship must be supported by a Certificate of Registered Domestic Partnership issued by the Oregon Department of Human Services.

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

"Service Area" means the state of Oregon and the state of Washington.

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

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

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

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

- Ensure that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur during or to result from the transfer of the patient from a facility; and

- With respect to a pregnant women who is in active labor, to perform the delivery, including the delivery of the placenta.

"Subscriber" means a Participant who meets all applicable requirements of this Agreement, who has Enrolled hereunder by submitting an enrollment application which has been approved by us, and for whom the monthly premium has been received by us in accordance with the terms hereof. One person from each family unit Enrolled as a Member hereunder who signs and executes the necessary enrollment application form shall be considered the Subscriber under this Agreement and shall exercise all rights, privileges, and responsibilities of a Subscriber with respect to us.

"Subscriber Group" means the entity, such as an employer, trust or association, sponsoring the health and welfare plan pursuant to which the benefits of this Agreement are made available to Participants. A Subscriber Group is limited to an entity that would, under Oregon law, be eligible for a group medical policy or contract. In order to qualify as a Subscriber Group, an entity must meet our current underwriting standards for the product sought.

"Utilization Review" means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings.

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

Monthly Payments (Premiums)

- The monthly premium rate is set forth on the Signature Sheet. If the State of Oregon or any other taxing authority imposes upon us any new or additional tax or license fee which is levied upon or measured by premium, by our gross receipts, or by any portion of either, then we may amend this Agreement to increase the premium by an amount sufficient to cover all such taxes or license fees rounded to the nearest cent, effective as of the date stated in a notice sent to Subscriber Group. The effective date of such a premium increase shall not be earlier than the date of the imposition of such tax or license fee increase. We shall also have the right to change the premium as of any date as permitted or mandated by law or regulation.

- Premiums are due on the first day of each month. Each monthly premium shall be calculated on the basis of our records reflecting the number of Subscribers and Dependents in each coverage classification, as set forth on the Signature Sheet, at the time of calculation and at the premium rate then in effect. Subscriber Group shall submit to us, on behalf of each Subscriber and Enrolled Dependents, the entire amount due, on or before the first day of the month for which coverage is provided. If a payment is rejected by the financial institution on which it is drawn, premium is not considered paid until the payment, or an alternate payment, is honored by the issuing financial institution. We may charge a fee for any payment that is returned as unfunded. Subscriber Group assumes responsibility for collection of the contributory portion of the premium, if any, from each Subscriber.

- Only Members for whom the premium is actually received shall be entitled to benefits, and then only for the period to which such premium is applicable. If the required premium for a Member is not received within 25 days of the due date, all rights of the Member shall terminate automatically. Thereafter, the Member will be reinstated only by renewed application and re-enrollment in accordance with all requirements of this Agreement.

- The total amount paid monthly under this Agreement may change from time to time to reflect any change in the status of a Member or any change in the type of membership applicable to the Member (single, two party or family) or any change in state or federal benefit mandates.

- Subscriber Group shall provide us with notice of changes in eligibility and enrollment within 30 days of the effective date of such changes. At our option, retroactive adjustments for premium may be made for any additions or terminations of Members and changes in coverage classification not reflected in our records at the time the monthly premium is calculated by us. However, in no event shall we refund to a Subscriber Group any premiums paid for a Member by Subscriber Group if the request for such refund is made later than 60 days after our receipt of payment for said retroactively terminated Member.

- We reserve the right to change the premium rates under this Agreement at any time. Written notice of premium rate change will be given to Subscriber Group at least 60 days prior to the effective date of the change.

Eligibility

- **Subscriber:** To be eligible to Enroll as a Subscriber, a person must, at the time of Enrollment and throughout the term of this Agreement, be a Participant of the Subscriber Group and must meet the Subscriber Group's eligibility criteria. Eligibility is not based on any health status related factors.

- **Dependent:** To be eligible to Enroll as a Dependent, a person must be a Dependent of a Subscriber and must meet the Subscriber Group's eligibility criteria. A Dependent who is Enrolled as a Member will continue as an eligible Dependent through the last day of the month in which such Dependent ceases to meet the requirements of a Dependent. Dependent coverage will terminate when a Member ceases to be an eligible Dependent. Eligibility is not based on any health status related factors.

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

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

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

Enrollment and Effective Date

- **Initial Eligibility.** Participants and/or their Dependents may Enroll within 31 days of becoming eligible for coverage, subject to any waiting period as required by the group. Waiting periods for enrollment are defined as beginning on the date the employee becomes a qualifying employee and must not exceed 90 days. Coverage shall become effective as specified on the Signature Sheet, provided that a completed application form and the required premium payment are received within 31 days of the person's first day of eligibility.

- **Open Enrollment.** Participants and/or Dependents who do not Enroll when initially eligible may Enroll by submitting a completed application form during the open Enrollment period specified on the Signature Sheet.

- **Newborn or Newly Adopted Child.** A newborn child or a child placed with a Member for the purpose of adoption will be covered from the moment of birth, the date of adoption or placement for adoption if the Child is Enrolled as a Member within the first 31 days. If additional premium is required, coverage shall not take effect unless application and premium required are received within 31 days after birth or placement. Additional premium is required if Enrollment of the additional Dependent places the family in a higher premium bracket.

  After the first 31 days, a newborn child must meet the definition of Dependent in the "Definitions" section of this Group Medical and Hospital Service Agreement in order to continue coverage under the plan.

- **Other Newly Eligible Dependents.** A Subscriber may Enroll a newly eligible Dependent by submitting a completed application form within 31 days of attaining eligibility. Enrollment is effective the first day of the following month or as specified on the Group Application.

- **Special Enrollment.**

  a. Loss of Other Coverage. A Participant and/or Dependents who previously declined coverage under this Agreement because of coverage under another Health Benefit Plan can Enroll in this Agreement by submitting a completed application form within 31 days of loss of such other coverage because of marriage, registered domestic partnership, birth of a child, legal separation, dissolution of a registered domestic partnership, divorce, death, termination of employment, reduction in hours of employment, discontinuation of employer contributions, attainment of a policy lifetime maximum, or exhaustion of COBRA continuation under such other group coverage. A Participant and/or Dependents who previously declined coverage under this Agreement because of coverage under a Medicaid plan or

Oregon State Children's Health Insurance Plan (SCHIP) can Enroll in this Agreement by submitting a completed application form within 60 days of loss of such coverage. Enrollment is effective the first day of the following month.

b. Newly Acquired Dependents. A Participant and/or newly acquired Dependents can Enroll in this Agreement by submitting a completed application form within 31 days of marriage, registered domestic partnership, birth, or placement for adoption. Enrollment is effective the first day of the following month.

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

- **Late Enrollee.**

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

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

c. Employee eligibility wait periods established by the Subscriber Group may apply but must not exceed 90 days.

If a Member is confined as an inpatient in a Hospital on the Effective Date of this Agreement, and prior coverage terminating immediately before the Effective Date of this Agreement furnishes benefits for the hospitalization after the termination of prior coverage, then services and benefits will not be covered under this Agreement for that Member until the Member is discharged from the Hospital or benefits under the prior coverage are exhausted, whichever is earlier.

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

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

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

Termination

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

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

  b. For fraud or intentional misrepresentation of material fact by the Subscriber Group, or with respect to the coverage of a Member by the Member or the Member's representative.

  c. Failure of the Subscriber Group to maintain minimum participation requirements as follows: Where coverage is offered on a contributory basis, health plan enrollment represents the greater of 75% of the eligible active employee population or 38 Enrolled active employees; if more than one health plan is offered, Health Net's Enrollment represents the greater of 38% of the eligible active employee population or 19 Enrolled active employees; if coverage is offered on a non-contributory basis, health plan Enrollment will be 100% of the eligible employee population.

  d. Failure of the Subscriber Group to meet the participation requirement(s) as set forth in the group proposal offer.

  e. For noncompliance with the contribution requirements as outlined in this Agreement.

  f. When we discontinue offering or renewing, or offering and renewing, all of our group Health Benefit Plans in this state or in a specified service area within this state. In order to discontinue plans under this Agreement, we:

     1. Must give notice of the decision to the Director of the Department of Consumer and Business Services and to all Subscriber Groups covered by the plans;

     2. May not cancel coverage under the plans for 180 days after the date of the notice required under section f.1 above if coverage is discontinued in the entire state or, except as provided in section f.3 below, in a specified service area;

     3. May not cancel coverage under the plans for 90 days after the date of the notice required under section f.1 above if coverage is discontinued in a specified service area because of an inability to reach an agreement with Providers to provide services under the plans within the Service Area; and

     4. Must discontinue offering or renewing, or offering and renewing, all Health Benefit Plans issued by us in this state or in the specified service area.

  g. When we discontinue offering and renewing a group Health Benefit Plan in a specified service area within this state because of an inability to reach an agreement with Providers to provide services under the plan within the Service Area. In order to discontinue a plan under this paragraph, we:

     1. Must give notice of the decision to the director and to all Subscriber Groups covered by the plan;

     2. May not cancel coverage under the plan for 90 days after the date of the notice required under section f.1 above; and

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

h. When we discontinue offering or renewing, or offering and renewing, a Health Benefit Plan for all groups in this state or in a specified service area within this state, other than a plan discontinued under section f. above with respect to plans that are being discontinued, we must:

1. Offer in writing to each Subscriber Group covered by the plan, all Health Benefit Plans that we offer in the specified Service Area.

2. Offer the plans at least 90 days prior to discontinuation.

3. Act uniformly without regard to the claims experience of the affected Subscriber Groups or the health status of any current or prospective enrollee.

i. When the director orders us to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would not be in the best interest of the Members or would impair our ability to meet contractual obligations.

j. When, in the case of a group Health Benefit Plan that delivers Covered Services through a specified network of health care Providers, there is no longer any Member who lives or works in the service area of the provider network.

k. When, in the case of a Health Benefit Plan that is offered only through one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any Enrollee.

- We may modify this Agreement at the time of renewal. The modification is not a discontinuation of this Agreement under section f. or g. above, of this Group Medical and Hospital Service Agreement. Written notice of modifications, including modifications to preventive benefits, will be given to Subscriber Group at least 60 days prior to the Effective Date of the renewal. The 60 day notice requirement does not apply to normal and customary administrative changes that do not have an actuarial impact, such as formulary changes, or to a decrease or increase required by state or federal law.

- Notwithstanding any provision of the "Termination" section of this Group Medical and Hospital Service Agreement to the contrary, we may rescind an Agreement for fraud or intentional misrepresentation of material fact by a Subscriber Group and the coverage of a Member may be rescinded for fraud or intentional misrepresentation of material fact by the Member.

- In the event of termination of this Agreement on one of the grounds specified in this Agreement, termination will be effective as to the Subscriber Group and all Subscribers and Enrolled Dependents irrespective of whether monthly premiums have been received for periods beyond the termination date. However, in no event will this Agreement continue beyond the last day of the month for which monthly premiums have been received. Premium will be charged and collected for any period between the date through which premiums are paid and the termination date. If the Agreement is to terminate due to the required premium not paid when due, we will provide a written notice to the Policyholder, specifying the last date the

premiums may be paid (no less than 10 days from the date of the notice) in order to reinstate the Agreement. We may charge a fee to reinstate the Agreement after termination.

- **Continued payment of monthly premiums.** Subject to continued payment of monthly premiums, if a Subscriber or a covered Dependent is in the Hospital on the day this Agreement is terminated and immediately replaced by a group contract with another company, we will continue to accept and pay toward covered expenses incurred during the balance of that hospitalization. The covered expenses must be incurred for the same sickness, injury or pregnancy that was under treatment before this Agreement terminated. Eligibility for benefits will end upon discharge from the Hospital or when benefits of this Agreement are exhausted, whichever happens first. In no other situation will we pay for the benefits of this Agreement toward expenses incurred by a person who is not then covered.

- Coverage under this Agreement for a Member also will terminate on 30 days' written notice if the Member knowingly permits another to use his or her plan identification card or has otherwise misused our plan.

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

- After the effective date of a termination pursuant to this section, neither we nor the Participating Providers shall have any further obligation to provide care for the condition under treatment and no claim shall be paid by us for treatment arising after such termination date, except as provided in the "Continued payment of monthly premiums" section above of this Group Medical and Hospital Service Agreement.

- The membership of a Subscriber and all Dependents shall terminate in the event that the Subscriber leaves employment with the Subscriber Group or otherwise becomes ineligible, unless the Subscriber or any Dependent continues or converts his or her membership in accordance with the "Federal Continuation of Coverage," and "Oregon State Continuation of Coverage" sections of this Group Medical and Hospital Service Agreement. If a Subscriber does not work for 120 consecutive working days, the Subscriber will be deemed to have left employment with the Subscriber Group.

- Except as expressly provided in this section, all rights to benefits hereunder shall cease as of the effective date of termination.

- We shall notify Subscriber Group by mail on a form that complies with applicable law within 10 days after this Agreement is terminated and not replaced by the Subscriber Group. This provision shall apply when an employer terminates participation in a multiple employer trust as well as in the event of termination of this Agreement when held by a multiple employer trust. If notice is not given as required under this section, coverage shall continue from the date notice should have been provided until the date notice is received and premiums for that period shall be waived.

- The Subscriber Group may voluntarily terminate this Agreement for any reason upon 30 days written notice to us. When the group coverage is terminated by the Subscriber Group and replaced by other group coverage, no notice of termination will be given to the Member by us.

Federal Continuation of Coverage

- **Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")**

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

  b. Subscriber Group is solely responsible for (a) ensuring compliance with COBRA; (b) giving Members timely notice, in accordance with COBRA, of their continuation coverage option; (c) notifying us within 15 days of a Member's election to continue coverage and the applicable maximum coverage period; and (d) notifying us of any event which terminates Subscriber Group's obligation to provide the Member with COBRA continuation coverage before the end of the maximum coverage period.

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

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

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

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

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

Oregon State Continuation of Coverage

- Continuation of our group coverage under this section is available to Subscribers and Enrolled Dependents when the Subscriber Group is not required to offer continuation of coverage under COBRA.

- A Member who would otherwise lose coverage under this Agreement, or similar predecessor Agreement, may continue uninterrupted coverage hereunder upon payment of applicable monthly premiums if:

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

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

- Continuation of coverage is not available if a Subscriber is eligible for: (a) Federal Medicare coverage; or (b) a medical-hospital benefit plan that did not cover him or her when his or her eligibility under this Agreement ended.

- Continuation coverage is available for all Dependents who were Enrolled at the time coverage terminated. All Dependents who were Enrolled under this Agreement must continue to be covered with the Subscriber or with the surviving or divorced spouse or Registered Domestic Partner who is continuing coverage.

- Members who wish to have continued coverage under this Agreement must sign a special application form for themselves and their Enrolled Dependents within 31 days after the Subscriber's termination of employment, dissolution of a registered domestic partnership, divorce or death. The Subscriber Group must send the application to us along with its next regular monthly billing. The billing should note the individuals who are continuing group coverage.

- If a Member wishes to continue group coverage, the correct premium must be paid to the Subscriber Group each month in advance. The Subscriber Group must then send the premium payments to us along with its regular monthly premium. We will accept continuation of premiums only if they are included in the Subscriber Group's regular monthly premium payments. Please Note: The first premium must be sent to the Subscriber Group with the signed application within 31 days of the date the Member's group coverage was terminated.

- A Member's continuation of coverage will end on the last day of the month during which any one of the following occurs:

  a. Nine months expire from the time eligibility for group coverage normally would have ended;

  b. We fail to receive full premiums for the Member with the Subscriber Group's regular monthly payment;

  c. The Member becomes insured under any other group health plan or becomes eligible for Medicare;

  d. We received 30-day written notice through the Subscriber Group that the Member wishes to terminate group coverage; or

  e. This Agreement is terminated by either the Subscriber Group or us.

- A Subscriber who has terminated employment by reason of layoff shall not be subject upon any rehire that occurs within nine months of the time of the layoff to any waiting period prerequisite to coverage under this Agreement if the Subscriber was eligible for coverage at the time of the termination and regardless of whether the Subscriber continues coverage during the layoff.

- A Member age 55 or older who would otherwise lose coverage due to the death of a Subscriber, dissolution of a registered domestic partnership, divorce or legal separation from a Subscriber may continue coverage for himself or herself and his or her Dependent children who would otherwise lose coverage due to the death, dissolution of a registered domestic partnership, divorce or legal separation. This section applies only if the Subscriber Group has twenty or more Subscribers. Termination of coverage under this section shall be on the earlier of:

  a. The failure to pay premiums when due;

  b. The termination of this Agreement;

  c. The date on which the Member becomes covered under another group health plan;

  d. The date on which the Member becomes eligible for Medicare coverage; or

  e. For Dependent children only, the date on which a Dependent ceases to meet the requirements according to the definition of Dependents in the "Definitions" section of this Group Medical and Hospital Service Agreement.

Reinstatement Of Medical Coverage After Military Leave

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

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

- You make a written request for reinstatement to us with:

  a. 90 days of your discharge from active services; or

  b. one year following hospitalization which continues after your discharge from active service.

The coverage provided will be the same coverage provided by your Subscriber Group to other employees and Dependents at the time of application. Your coverage will start on the date we receive your request for reinstatement. If you had completed all or part of an exclusionary or waiting period under this Agreement before your entry into active military service, you will not be required to complete that period a second time.

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

Participating Providers

- If a Member receives care from a nonparticipating Physician or other nonparticipating health care Provider without a required Prior Authorization, the Member shall be responsible for the cost of those services. Failure of the nonparticipating Provider to obtain the Prior Authorization shall in no way relieve the Member of the financial responsibility for services received from that Provider. If you receive care for covered Medical Services and supplies from a participating Physician or other participating health care Provider without a required Prior Authorization, that Provider is not permitted to bill you for those services.

- Upon Enrollment, each Member will be issued a plan identification card. It is the Member's responsibility to notify us if the card is not received within a reasonable time after the Member's Effective Date of coverage. In addition, it is the Member's responsibility to present the card to each health care Provider at the time of service.

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

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

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

- The relationship between us and Participating Providers is that of independent contractors. Participating Providers are independent professionals who operate their own offices and business, make their own medical decisions, and provide services to entities and patients other than us and our Members. Participating Providers agree to methods and rates of payment from us, concurrent and retrospective review by us of Medical Services provided to Members, and our medical management procedures.

- The fact that Members and Participating Providers each have contractual relationships with us does not prevent a Member from obtaining nor a Participating Provider from providing services that are not covered by us. We have no direct control over the examination, diagnosis or treatment of a Member. We do perform medical management, including but not limited to case review for purposes of determining coverage, consultation with Providers regarding Prior Authorization, and concurrent and retrospective review of Medical Services provided to Members. The purpose of our medical management procedures is to encourage the lowest cost method of treating a Member which, based upon the Medical Director's sole judgment of the prevailing standards of medical treatment, meets the needs of the Member. These procedures are not intended to ration care or limit care to methods not appropriate to treat a Member's condition. These procedures are not intended to create a Physician/patient relationship or to replace the relationship between a Member and his or her Physician. A Member is always entitled to obtain, at his or her own expense, services not covered under the terms of this Agreement.

- We shall use ordinary care in the exercise of our power and in the performance of our obligations under this Agreement.

- A Nonparticipating Provider must cooperate with our requirements for review of treatment and to the same extent as a Participating Provider in order to be eligible for reimbursement.

General Limitations

- **Discontinued or modified benefits.** Benefits provided by this Agreement may be discontinued or modified on at least 60 days prior written notice to the Subscriber, subject to prior approval by the Department of Consumer and Business Services. You do not acquire a vested right to continue to receive a benefit as set forth in this Agreement on or after the effective date of any revocation or change to such benefit. Your right is to receive only such benefits as are expressly provided for and in effect on the date of each treatment. The 60 day notice requirement does not apply to normal and customary administrative changes that do not have an actuarial impact, such as formulary changes, or to a decrease or increase required by state or federal law. Upon termination of this Agreement or a Member's coverage under this Agreement, a Member's right to continued benefits consists solely of those benefits expressly set forth in the "Federal Continuation of Coverage," "Oregon State Continuation of Coverage" sections of this Group Medical and Hospital Service Agreement.

- **Members are entitled to receive benefits subject to the exclusions and limitations as stated in any provision of this Agreement.**

- **Benefits are available only for services that are Medically Necessary.**

- **Nonparticipating Provider Services.** Coverage for the services of a Nonparticipating Provider is limited to and based on a Maximum Allowable Amount fee.

- **Unauthorized Benefits.** Members who are treated by a Provider without a Prior Authorization, if required pursuant to the "Prior Authorization" subsection of the Group Plan Benefits section, will have any and all such claims denied by us.

- **All benefits, exclusions and limitations set forth in the attached Copayment and Coinsurance Schedules, or any Supplemental Benefit Schedules are incorporated herein by this reference.**

- **To the extent that a natural disaster, war, riot, civil insurrection, epidemic, or any other emergency** or similar event not within our control results in our facilities, personnel, or financial resources being unavailable to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of this Agreement, we are required only to make a good faith effort to provide or arrange for the provision of the service, taking into account the impact of the event. For purposes of this section, an event is not within our control if we cannot exercise influence or dominion over its occurrence.

- **Nonparticipating Provider Claims.** Written notice of claim for Nonparticipating Provider benefits must be given to us within 90 days after the date of treatment or as soon as reasonably possible, but in no event later than one year from the date of treatment unless the Member is legally incapacitated throughout that year. If a Member is hospitalized at a Hospital that is a Nonparticipating Provider, the Member shall or shall cause the Hospital or the Subscriber to notify us by telephone of the hospitalization on the first business day after the admission or as soon as reasonably possible. In the event that a Member is unable to personally contact us or is unable to instruct some other person to do so, the notification period will not begin until such time as the Member is again able to notify us. If a Member is conscious and able to communicate with others, he or she shall be deemed capable of notifying us.

- **Filing a Grievance or Appeal.** Any Grievance or Appeal brought to recover on this Agreement shall be limited to the Grievance and Appeal procedure under the "Rights of Members" section of this Group Medical and Hospital Service Agreement. No Grievance or Appeal, including, but not limited, to inquiries regarding denial of claims for payments or for services, may be brought more than one year after the event which precipitates the action, unless the complainant is legally incapacitated throughout that year in which case the Grievance or Appeal must be brought as soon as reasonably possible.

- **Calendar Year.** Any benefit limitation or other dollar amount that is calculated on an annual basis hereunder shall be calculated on the basis of a Calendar Year.

Rights of Members

- **Confidentiality of Medical Records.** We shall have access to information from medical records of Members and information received by Physicians in the course of the Physician/patient relationship and the right to use such information as is reasonably necessary in connection with our administration of this Agreement, for records review incident to any peer review, quality assurance program or Utilization Review program. All provisions of law or professional ethics forbidding, restricting or treating as privileged or confidential such information are waived by or on behalf of each Member hereunder by acceptance of the benefits of this Agreement, and Members shall sign any specific releases necessary to effect this provision. Except as provided above, all such information shall be confidential and shall not be disclosed except as allowed by federal and state law.

- **Your right to information about Health Net.** The following information about Health Net is available upon request: An annual summary of grievances and appeals, an annual summary of utilization review policies, an annual summary of quality assessment activities, the results of all publicly available accreditation surveys, an annual summary of health promotion and disease prevention activities, an annual summary of scope of network and accessibility of services.

  This information is available from the Department of Consumer and Business Services by calling (503) 947-7984 or the toll free message line at (888) 877-4894, or by writing to the Oregon Division of Financial Regulation (DFR), Consumer Advocacy Unit, PO Box 14480; Salem, OR 97309-0405 or through the Internet at http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx, or by e-mail at cp.ins@state.or.us. You may also call the Customer Contact Center at the phone number listed at the back of this Agreement.

- **Nondiscrimination.** A Member may not be canceled or non-renewed on the basis of the status of his or her health or health care needs, provided however, that this paragraph shall not negate, waive, alter or otherwise change any other provisions of this Agreement. Subscriber Group must conform to underwriting requirements on the Group Effective Date hereof and throughout the term of this Agreement and all succeeding terms.

- **Filing an Appeal.** A Member has the right to file an Appeal under the "Grievances and Appeals" section of this Group Medical and Hospital Service Agreement if dissatisfied with an Adverse Benefit Determination and may then submit an unresolved claim to arbitration under the "Grievances and Appeals" section of this Group Medical and Hospital Service Agreement. An enrollee may receive, free of charge, reasonable access to documents used in the Adverse Benefit Determination.

- Upon the request, we will provide the following:

  - Reasonable access to and copies of all documents, records and other information relevant to a claim or request for coverage to a Member or the Member's authorized representative.

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

  - Compliance with these disclosure requirements is not determinative of compliance with any other provisions of applicable federal or state law.

Grievances and Appeals

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

a. **Internal Appeal.** A Member aggrieved by denial of a claim or an Adverse Benefit Determination has 180 days from the date of receipt of our denial letter to request an Appeal and submit to our Appeals and Grievances department all information in support of the claim, including additional supporting information, if any. An Appeal must be submitted in writing. A written request can be made by sending it to us at: Health Net Health Plan of Oregon, Inc. Grievances and Appeals Department, P.O. Box 10342, Van Nuys, CA 91410-0342. When the Appeal requires an expedited response, it is not required to be submitted in writing, but can be submitted orally by contacting our Customer Contact Center. We will acknowledge the Appeal within 7 days and report our decision and rationale within 30 days (72 hours for Expedited Claims). A person who was involved in the consideration of the initial denial will not be involved in determining our decision during this Internal Appeal process. The Member will be informed of the determination in writing and notified of further Appeal rights as well as the possible right of Members participating in ERISA-qualified plans to seek legal redress under Section 502(a) of ERISA, Civil Enforcement. You will have the opportunity to receive continued coverage of an ongoing course of treatment previously approved by the insurer, pending the conclusion of the Internal Appeal process. If the insurer's denial is not reversed, you will be responsible to pay for the disputed item or service.

b. **External Review**. **You have the right to request that your claim be submitted for external review by an Independent Review Organization (IRO)**. This right applies to an Adverse Benefit Determination that is based on whether a course or plan of treatment is: (i) Medically Necessary; (ii) Experimental or Investigational; (iii) subject to the provisions described in the "Continuity of Care" section of this Group Medical and Hospital Service Agreement; or (iv) delivered in an appropriate health care setting and with the appropriate level of care. The Member can apply in writing for external review of an Adverse Benefit Determination by us no later than the 180th day after receipt of our final written decision following our internal review through our Grievances and Appeals process. We will notify the Oregon DFR of your request for an external review no later than the second business day after receipt of the request. A Member is eligible for External Review (i) once we receive a signed waiver granting the IRO access to the Member's medical records; and (ii) the Member has exhausted the Internal Appeals process shown above. Health Net will pay the cost for external review. We may waive the requirement of compliance with the Internal Appeals process and have a dispute referred directly to external review upon the Member's consent,

including when a Member simultaneously requests expedited internal and expedited external reviews. The Member who applies for External Review of an Adverse Benefit Determination shall provide complete and accurate information to the IRO in a timely manner. A Member may submit additional information to the IRO no later than 5 business days after the receipt of notice of the appointment of the IRO or 24 hours in the case of an expedited review. The IRO will make its review and report its decision within 30 days (72 hours for expedited reviews). **We hereby state that we will abide by the decisions rendered by the IRO, including decisions which may conflict with our definition of Medically Necessary. If we fail to comply with the decision of the IRO, the Member has a right to bring a lawsuit against us.** If the Member is a participant in an ERISA-qualified plan, the Member also has the alternate right to seek legal redress under Section 502(a) of ERISA, Civil Enforcement.

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

- Appeal of Utilization Review Determination.

  a. When a Member or a Provider first Appeals a decision to deny Prior Authorization or benefits for services as not Medically Necessary or Experimental:

     1. We shall acknowledge receipt of the notice of Appeal within 7 days of receiving the notice; and

     2. A medical consultant shall review the Appeal and decide the issue within 30 days of receipt of the notice.

  b. We shall treat an Appeal from a decision by a medical consultant under this section as an Appeal under section b. above in this Group Medical and Hospital Service Agreement.

  c. Nothing in this section shall prevent a Member from filing a Grievance under the “Grievances and Appeals” section of this Group Medical and Hospital Service Agreement.

- An otherwise applicable standard for timeliness outlined in this section of this Group Medical and Hospital Service Agreement does not apply when:

  a. The period of time is too long to accommodate the clinical urgency of the situation;

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

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

  d. The claim qualifies as an Expedited Claim as defined, in which case we will review and report our decision and rationale within 72 hours for Expedited Claims unless the claimant fails to provide

sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or health insurance policy.

- In addition, a Member has the right to file a complaint with or seek other assistance from the Oregon DFR. If a Member chooses to do so, assistance is available. Contact the Oregon Division of Financial Regulation, Consumer Advocacy Unit at PO Box 14480, Salem, OR 97309-0405. Contact them by phone at 503-947-7984 or toll free at 888-877-4894, by email at cp.ins@state.or.us or online at http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx.

- A Subscriber Group or Member aggrieved by any action by us, including an Adverse Benefit Determination, must first exhaust the Grievance procedure as set forth in the "Grievances and Appeals" section of this Group Medical and Hospital Service Agreement. Arbitration is not required in Oregon, but when the Grievance procedure is exhausted, an aggrieved Subscriber Group or Member may submit his or her claim to binding arbitration. The arbitration shall be conducted in accordance with the Commercial Rules of the American Arbitration Association in effect at the time the arbitration is commenced before an arbitrator(s) selected by mutual agreement of the Subscriber Group or Member and us or, failing agreement, the American Arbitration Association. Information regarding the arbitration rules is available from our Customer Contact Center. Arbitration proceedings shall be governed by Oregon law unless Oregon law conflicts with Federal Code and shall be held in the Member's county of residence in Oregon or another county in Oregon if agreed upon between the Member and us. Unless there is a mutual agreement between the Subscriber or Member and us to use the arbitration process, the decision resulting from the arbitration will only be binding on the party that demanded arbitration.

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

- We will furnish to the Subscriber Group for delivery to each Eligible Employee or Member of the Subscriber Group a copy of this Agreement outlining the essential features of the coverage of the Eligible Employee or Member, to whom the benefits are payable, and the rights and conditions applicable in obtaining such benefits. If Dependents are included in the coverage, only one statement will be issued for each family unit.

- Upon the request of a Member, applicant, or prospective applicant, we will provide our annual report on Grievances and Internal Appeals and requests for external review, which is submitted to the Oregon DFR annually.

Coordination of Benefits

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

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

- **"Plan"** means any of the following which provide benefits or services for, hospital-medical-surgical-dental care or treatment or other care described in separate policy endorsements to this benefit policy. If separate

contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered part of the same plan and there is no coordination among those separate contracts.

a. Plan includes: group and individual insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law and group and individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

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

- Each contract or other arrangement for coverage described above is a separate plan. Also, if an arrangement has two or more parts and the Coordination of Benefits provision applies to only one of the two, each of the parts is a separate plan.

- **"This plan"** means, in a Coordination of Benefits provision, the part of this Agreement that provides benefits for health care expenses to which the Coordination of Benefits provision applies and which may be reduced because of the benefits of other plans. Any other part of this Agreement providing health care benefits is separate from this plan. This Agreement may apply one Coordination of Benefits provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another Coordination of Benefits provision to coordinate other benefits.

- The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.

When this plan is primary, it determines payment for its benefit first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total allowable expense.

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

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

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

  b. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar

reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

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

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

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

- **"Closed panel plan"** is a plan that provides health care benefits to covered person primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

- **"Custodial parent"** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

- **Order of Benefit Determination Rules.** If this Coordination of Benefits provision applies, the order of benefit determination rules should be looked at first. These rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan. The benefits of this plan may be reduced when under the order of benefit determination rules; another plan determines its benefits first.

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

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

  a. In general, when there is a basis for a claim under this plan and another plan, this plan is a secondary plan which has its benefits determined after those of the other plan unless: (1) the other plan has rules

coordinating its benefits with those of this plan; and (2) both those rules and this plan's rules as set forth in section b. below require that this plan's benefits be determined before those of the other plan.

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

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

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

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

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

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

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

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

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

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

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

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

2. then, the plan of the Registered Domestic Partner or spouse of the parent with the custody of the child;

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

4. finally, the plan of the Registered Domestic Partner or spouse of the parent not having custody of the child.

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

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

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

3. **Active/Inactive Employee.** The benefits of a plan which covers a person as an active employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a plan which covers that person as an inactive employee who is laid off or retired (or as that employee's Dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Non-Dependent/Dependent" section above can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, Member, Subscriber or retiree or covering the person as a Dependent of an employee, Member, Subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if section b.1 above can determine the order of benefits.

5. **Longer/Shorter Length of Coverage**. If none of the previous rules determines the order of benefits, the benefits of the plan which covered the employee, Member, or Subscriber longer are determined before those of the plan which covered that person for the shorter time.

6. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of "Plan" above in this section. In addition, this plan will not pay more than it would have paid had it been the primary plan.

- **Effect on the Benefits of This Plan.** This section applies when in accordance with the order of benefit determination rules stated in the "Order of Benefit Determination Rules" section above, this plan is a secondary plan to one or more other plans. In that event, the benefits of this plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in section a. below.

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

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

- **Right to Receive and Release Necessary Information.** Certain facts about health care coverage are needed to apply these coordination of benefits provisions and to determine benefit payable under this plan and other plans. We have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell or get the consent of any person to do this. Each person claiming benefits under this plan must give us any facts we need apply these provisions and to pay the claim.

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

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

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

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

Medicare

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

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

Subrogation

- In the event any Medical or Hospital Service or benefit is provided for, or any payment is made, or credit extended to a Member under this Agreement, we shall be subrogated and shall succeed to the Member's rights of recovery against any person or any organization including the right at our discretion to bring suit against any and all liable third parties. A Member shall pay over to us all sums recovered by suit, settlement or otherwise in an amount equal to such Medical or Hospital Service or benefit. The Member shall take such action, furnish such information and assistance and execute such assignments or other instruments as we may require to facilitate enforcement of its subrogation rights and shall take no action prejudicing our rights and interests under this Agreement.

- In some cases, the Subscriber or covered Dependents may have a legal right to recover costs for health care from a third party that may be responsible for the illness or injury. The following rules apply:

    a. If we have provided any benefits, we shall be entitled to recover the amount paid from the proceeds of any settlement or recovery the Subscriber or a covered Dependent receives from the third party. If the Subscriber or a covered Dependent continues to receive medical treatment for the illness or injury after obtaining the settlement or recovery, we will not provide benefits for that continuing treatment unless the Subscriber or covered Dependent can prove that the total cost of treatment including the cost of obtaining the settlement or recovery is more than the amount the Subscriber or covered Dependent has recovered or expects to recover.

    b. The Subscriber or enrolled dependent must hold the rights of recovery in trust for us, up to the amount of benefits already provided.

    c. We may require Subscriber or enrolled dependent to sign and deliver all legal papers necessary to secure our rights and the rights of the Subscriber or Enrolled Dependent. If requested, the Subscriber or covered Dependent must sign an agreement to hold the proceeds of any recovery in trust for us before any payment for benefits is provided.

    d. We will pay our share of the expenses of obtaining a recovery, such as attorney fees and court costs, out of any part of that recovery which is reimbursed to us.

    e. In the event our interests are not protected by judgment or settlement entered into by the insured and a liable third party, we retain the right to deduct the amount of the overpayment/wrongful payment from future benefits that would have been otherwise payable, until said overpayment/wrongful payment is recovered.

- Most motor vehicle liability policies are required by law to provide liability insurance, primary medical payments insurance, and uninsured motorist insurance, and many motor vehicle policies also provide underinsurance coverage.

    a. We will not pay benefits for health care costs to the extent that the Member is able to, or is entitled to, recover from motor vehicle insurance.

b. If we pay benefits before motor vehicle insurance payments are made, reimbursement must be made out of any subsequent motor vehicle insurance payments made to the Member and, when applicable, we may recover benefits already paid directly from the motor vehicle insurer or out of any settlement or judgment which the Member obtains by exercising his/her rights against a third party.

c. Before we will pay benefits: (1) the Member must give us information about any motor vehicle insurance payments which may be available to the Member; and (2) if we ask, the Member must sign an agreement to hold the proceeds of any recovery in trust for us.

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

  a. We make a payment to which a Member is not entitled under this Agreement; or

  b. We pay a person who is not eligible for benefits at all.

Independent Agents

- The relationship between Subscriber Group and a Subscriber is that of plan sponsor and participant and is defined by the Group's health and welfare plan. We have no involvement in that relationship. The relationship between Subscriber Group and us is that of purchaser and seller and is entirely governed by the provisions of this Agreement. In addition, Subscriber Group acts as the agent of those Participants who are Subscribers with respect to all terms and provisions of this Agreement. Because the Subscriber pays the premium to us indirectly through his or her agent, the Subscriber Group, the relationship between a Subscriber and us is also that of purchaser and seller and is entirely governed by the provisions of this Agreement.

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

- We shall use ordinary care in the exercise of our power and in the performance of our obligations under this Agreement.

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

Continuity of Care

- If the Member is undergoing treatment with a Participating Provider on the date our contract with that Participating Provider will terminate, the Member may be able to continue to receive care from that Provider, subject to the following conditions:

  a. The Member must be undergoing an active course of treatment that is Medically Necessary on the date the contract would otherwise terminate; and

  b. The benefits available to the Member under this Agreement, in relation to that course of treatment, would otherwise be eliminated or reduced to a benefit level below the benefit level specified in the plan for out-of-network Providers if the Member continued to receive care from that Provider; and

  c. Our contract with the Participating Provider terminates for reasons allowed under Oregon statute; and

  d. Both the Member and the Provider agree that it is desirable to continue the course of treatment with that Provider; and

  e. If the course of treatment is related to the Member's pregnancy, the Member has already entered the second trimester of that pregnancy; and

  f. The Provider agrees to continue the relationship with us as a Participating Provider, in relation to the course of treatment for that Member, as if the contract between that Provider and us had not terminated. This relationship shall continue for the duration of the course of treatment, as specified in the "Continued Course of Treatment" section below of this Group Medical and Hospital Service Agreement.

- When a contract with a Participating Provider will terminate, we will notify all Members who we know, or reasonably should know, are under the care of that Participating Provider. If we first learn that a Member is affected at a later date, we will notify that Member within 10 days of identifying that Member. The notice will be in writing and notify affected Members of the termination and the right to Continuity of Care as provided under this section of this Group Medical and Hospital Service Agreement. The notice will be provided as soon as we are aware of the termination, but in no event later than 10 days following the effective date of the termination. For the purpose of the "Continued Course of Treatment" section below of this Group Medical and Hospital Service Agreement, the date of the notice will be the earlier of the date the notice was received by the Member, and the date we receive or approve the request for Continuity of Care. If the Participating Provider is part of an Independent Practice Association (IPA), we may allow the IPA to deliver the notice to the Member for us, if the notice otherwise meets all other requirements of this section of this Group Medical and Hospital Service Agreement.

- **Continued Course of Treatment**. A course of treatment continued under this provision will be treated as if the Provider was still a Participating Provider, until the following dates:

  a. For pregnancy; the later of (i) 45 days following the birth of the child; and (ii) when the care for that pregnancy ends.

  b. For all other conditions; when the care for that condition ends.

c. However; in no instance shall the provisions of this section extend beyond the 120th day following the date the Member was notified of the termination of the contract with the Participating Provider and the Member's right to Continuity of Care.

Miscellaneous

- By this Agreement, Subscriber Group makes our coverage available to all eligible persons. By electing medical and hospital coverage pursuant to this Agreement, or accepting benefits hereunder, all Members legally capable of contracting agree to all terms, conditions, and provisions hereof. This Agreement may be amended, modified, or terminated by mutual agreement between us and Subscriber Group without the consent or concurrence of any Member. Any modification or amendment must be in writing and signed by us. We may submit any proposed amendment or modification in writing to Subscriber Group. If Subscriber Group does not reject the proposed amendment or modification in writing within 30 days, it shall be deemed to be agreed to by the Subscriber Group and shall be effective as an amendment or modification, as the case may be, on the 31st day following such submission.

- Members or applicants for membership shall complete and submit to us such applications and other forms or statements as we may reasonably request.

- Cards issued by us to Members are for identification only. Possession of our identification card confers no right to service or other benefits. The holder of our identification card must be a Member on whose behalf all amounts under this Agreement have actually been paid. Any person receiving services or other benefits to which he or she is not entitled shall be charged at the usual rates of the Provider. If any Member permits the use of his or her plan identification card by any other person, such card may be reclaimed by us, and all rights of such Member and his or her Dependents may be terminated without notice at our election. Such Member shall be liable to us for all associated costs.

- We may adopt reasonable policies, procedures, rules and interpretations not inconsistent with this Agreement to promote orderly and efficient administration of this Agreement.

- Any notice under this Agreement shall be given by the U.S. mail, postage paid, addressed as follows:

  a. To us at 13221 SW 68th Parkway, Tigard, Oregon 97223;

  b. To Member at the address of record;

  c. To Subscriber Group at the address indicated on the Signature Sheet.

- ENTIRE CONTRACT; CHANGES: This Agreement, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Agreement shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No insurance producer has authority to change this Agreement or to waive any of its provisions.

- A Member's Copayments and/or Coinsurance is limited as stated on the Copayment and Coinsurance Schedule attached hereto. It is the Member's responsibility to maintain accurate records of the Copayments and/or Coinsurance paid during the Calendar Year for application of the maximum. Any claims for personal reimbursement for exceeding the maximum must be submitted and accompanied by the required documentation within 90 days from the date the services were rendered or as soon as medically possible, but in no event later than one year from the date the services were rendered unless you were legally

incapacitated, or the claims will be ineligible for reimbursement. No form or documentation need be submitted until the maximum has been met.

- The benefits of this Agreement are personal to the Member. The Member may not assign such benefits nor may the Member assign or otherwise transfer any claim, right of recovery or right to payment arising under this Agreement.

- The rights of Members and our obligations shall be determined solely by this Agreement without regard to any other agreement or relationship between us and any Provider, Physician, Group Subscriber or other person. No Provider (except for services actually rendered by such Provider) or any director, officer, employee, agent or representative of ours is liable for the conduct of any Provider in furnishing health care services.

- When the premium for this Agreement or any part thereof is paid by an employer under the terms of a collective bargaining agreement, if there is a cessation of work by employees covered under this Agreement due to a strike or lockout, this Agreement, upon timely payment of the premium to us, will continue in effect with respect to employees covered under this Agreement on the date of the cessation of work who continue to pay their individual contribution and who assume and pay the contribution due from the employer.

  a. When a covered employee pays the monthly premium pursuant to this section, if the Subscriber Group is not a trustee of a fund established or maintained in whole or in part by an employer, the employee's individual contribution shall be: (1) the rate in this Agreement on the date the cessation of work occurs, applicable to an individual in the class to which the employee belongs as set forth in this Agreement; or (2) if this Agreement does not provide for a rate applicable to individuals, an amount equal to the amount determined by dividing the total monthly premium in effect under this Agreement at the date of cessation of work by the total number of persons insured under the policy on such date.

  b. When an employee covered under this Agreement pays a premium pursuant to this section, if the Subscriber Group is a trustee of a fund established or maintained in whole or in part by an employer, the employee's individual contribution shall be the amount which the employee and employer would have been required to contribute if the cessation of work had not occurred.

  c. When an employee elects to continue coverage under this section, each individual premium rate under this Agreement may be increased by 20% during the period of cessation of work in order to provide sufficient compensation to us for increased administrative costs and increased mortality and morbidity.

  d. Coverage under this section shall not continue beyond the earlier of: (1) the time that 75% of covered employees continue coverage; (2) the time at which an employee takes full-time employment with another employer; or (3) six months after cessation of work by the covered employees.

- Subscriber Group and each Subscriber acknowledge that we, as most managed health care organizations, operate on a system which may involve one, more or all of the following: financial incentives, medical management and Utilization Review. Subscriber Group and all Subscribers acknowledge that, absent a declaration that any of the foregoing is contrary to public policy in the State of Oregon, such system does not violate medical ethics nor constitute negligence, fraud, breach of trust or a tortious breach of the Physician/patient relationship.

- We rely substantially upon licensing and regulatory authorities, continuing education requirements, Peer Review Committees, medical and Hospital staff decisions, Provider representations and insurability in the selection of Participating Providers. We are not responsible for the decisions of Providers.

- It is understood that nothing in this Agreement shall entitle either party to this Agreement to recover attorneys' fees from the other party in the event of litigation between the parties, except as provided for by statute.

- Each party shall advise the other as to matters that come to their attention with respect to potential substantial legal actions involving matters related to this Agreement, and shall promptly advise each other of legal actions commenced against each party that come to their attention. Each party shall fully cooperate with the other in the defense of any action arising out of matters related to this Agreement by providing without additional fee all information relating to disputed claims and providing necessary testimony.

- Waiver of any default shall not be deemed to be a waiver of any subsequent default. Waiver or breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach and shall not be construed to be a modification of the terms of this Agreement unless stated to be such in writing, signed by the parties and attached to this Agreement.

- Members must submit claims to us for all services provided by Nonparticipating Providers within 90 days from the date the services were rendered or as soon as medically possible, but in no event later than one year from the date services were rendered unless the Member is legally incapacitated. Claims filed by Medicaid must be received no later than three years from the date the services were rendered. The claim will be paid or denied within 30 days following receipt of the claim, or if additional information is needed to make the determination, we will notify the Member and the Provider in writing within 30 days following receipt of the claim and provide an explanation of the additional information needed to process the claim. Claims must include a statement describing the services rendered, date of services and charges therefore.

  We will respond to submitted claims as follows:

  a. Expedited Claims will be decided upon no later than 72 hours following receipt of the claim. If additional information is needed to make a determination, we will notify the Member within 24 hours following receipt of the claim.

  b. Pre-Service Claims will be decided upon no later than 15 days following receipt of the claim. If additional information is needed to make a determination, we will notify the Member within 15 days following receipt of the claim. The Member will have up to 45 days to provide the additional information. We will make a final determination within 15 days following receipt of the additional information, or within 15 days of the end of the 45-day period if the Member has not responded.

  c. Post-Service Claims will be decided upon no later than 30 days following receipt of the claim. If additional information is needed to make a determination, we will notify the Member within 30 days following receipt of the claim. The Member will have up to 45 days to provide the additional information. We will make a final determination within 15 days following receipt of the additional information or within 15 days of the end of the 45-day period if the Member has not responded.

- Notwithstanding any other provision of this Agreement, the provisions of this Agreement which, on or after the Group Effective Date, are in conflict with applicable state or federal laws or state or federal regulations, are hereby amended to conform to the minimum requirements of such laws or regulations.

- This Agreement is issued and delivered in the state of Oregon and is governed by the laws of the state of Oregon.

- When services are provided to a Member by a Participating Provider in accordance with the terms of this Agreement, the Member is responsible only for payment of the contractually stated Copayments, Deductibles, and Coinsurance and for non-Covered Services. A Member shall not be responsible for amounts owed by us to a Participating Provider even if we are unable to pay.

- No benefit, right or any interest of any beneficiary under this Agreement can be assigned or transferred and any such assignment or transfer shall be held invalid and void. Payment of any benefits hereunder shall, at our exclusive option, be made directly to the Physician, Hospital or institution providing their services, or to his or her representative, or directly to the beneficiary. Exception: We will make benefit payments for ambulance services directly to the ambulance company.

- We may assign this Agreement to its successor in interest or an affiliate. We reserve the right to contract with other corporations, associations, partnerships, or individuals to provide services and supplies described in this Agreement.

- Subscriber Group warrants that it presently has and will maintain throughout the term of this Agreement all coverage required of it by applicable workers' compensation or employer's liability laws or other laws of similar purpose.

- Continuation of benefits after injury or illness covered by workers' compensation claim. Health insurance will continue to be in effect if an employee incurs an injury or illness for which a workers' compensation claim is filed as long as timely payment by the employee of the premiums which includes the individual contribution and contributions due from the employer under the applicable benefit plan continue. The employee may continue such coverage until whichever of the following occurs first:

  a. The employee takes full-time employment with another employer; or

  b. Six months from the date that the employee first makes the premium payment under this continuation of benefits provision following their workers' compensation claim.

- If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions and the Agreement shall remain in force and effect, and in no way shall be affected, impaired, or invalidated.

- The headings in this Agreement are provided solely for convenience of reference and are not a part of this Agreement or guides to interpretation hereof.

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

- We do not consider the availability or eligibility for medical assistance under Medicaid in any state when considering eligibility for coverage or paying benefits for eligible Members under this plan.

- Benefits payable under this Agreement are subject to the Deductible shown in the Copayment and Coinsurance Schedule which must be satisfied each Calendar Year before benefits will be paid.

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

- If You Are Enrolled In An Employer Plan That Is Subject To ERISA, 29 U.S.C. 1001 et seq., a federal law regulating some employer plans:

  IN ADDITION TO THE RIGHTS SET FORTH IN THIS EVIDENCE OF COVERAGE (EOC), YOU MAY HAVE RIGHTS UNDER APPLICABLE STATE LAW OR REGULATIONS AND/OR UNDER THE FEDERAL ERISA STATUTE.

  If You Are Enrolled In A Plan That Is Not Subject To ERISA:

  IN ADDITION TO THE RIGHTS SET FORTH IN THIS EVIDENCE OF COVERAGE (EOC), YOU MAY HAVE RIGHTS UNDER APPLICABLE STATE OR FEDERAL LAWS OR REGULATIONS.

  Contact your Subscriber Group to determine if you are enrolled in a Plan that is subject to ERISA.

- This Agreement will not be denied or canceled solely because the mother of the Member used drugs containing diethylstilbestrol prior to the Member's birth.

Medical Loss Ratio (MLR) Rebates

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

Notice of Nondiscrimination

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 and written information in other formats (large print, accessible electronic formats, other formats).

- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at 1-888-802-7001, TTY number: TTY 888.802.7122 TTY:711.

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/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, (TDD: 1-800–537–7697).

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

Notice of Privacy Practices

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

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

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.

- 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.

III. 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.

IV. 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.

V. 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.

VI. 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.

VII. 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, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

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

Questions About this Notice
If you have any questions about this notice, please call the toll-free phone number on the back of your ID card or contact the Health Net at 1-800-522-0088.

**This Notice of Privacy Practices also applies to enrollees in any of the following Health Net entities: Health Net of Arizona, Inc., Health Net of California, Health Net Life Insurance Company, Health Net Health Plan of Oregon, Inc., Managed Health Network, Health Net Community Solutions, Inc.
Rev. 06/11/2015

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

Customer Contact Center
Monday - Friday 7:30 a.m. to 5:00 p.m.
888.802.7001
www.healthnet.com

Hearing and Speech Assistance
Monday - Friday 7:30 a.m. to 5:00 p.m.
TTY 888.802.7122 TTY:711

www.healthnet.com

Effective 1/2017 (HNOR Rev. 9/2016)

Notice of Language Assistance

English

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

Arabic

علىبـ ناا تـ صلالمساعدة، علىلـ لحصول.لكمقروءةوثـائق علىالحصول ويمكنك فـ وريم ترجم علىالحصول يمكنك.مجاذ يةالـ لغةخدمات
الرقم على الموجود الرقم على بطاقة الهوية. يرجى من أعضاء مجموعة أصحاب العمل الاتصال على الرقم 1-888-802-7001 711). (TTY:

Chinese

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

Cushite (Oromo)

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

French

Services linguistiques sans frais. Vous pouvez obtenir un interprète. Les documents peuvent vous être lus. Pour obtenir de l'aide, appelez-nous au numéro indiqué sur votre carte d'identité. Membres du groupe employeur veuillez composer le 1-888-802-7001 (TTY: 711).

German

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

Japanese

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

Korean

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

Khmer

សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។

ដើម្បីទទួលបានជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈទូរស័ព្ទដែលមាននៅលើកាតសមាជិករបស់អ្នក។

សមាជិកក្រុមនិយោជក សូមទាក់ទងលេខ សម្ព័ន្ធ សូមទាក់ទងលេខ 1-888-802-7001 (TTY: 711)។

Romanian

Servicii lingvistice gratuite. Puteţi obţine un interpret. Puteţi avea documente citite pentru dvs. Pentru asistenţă telefonaţi-ne la numărul indicat pe cardul de membru. Membrii grupului angajatorilor să telefoneze la 1-888-802-7001 (TTY: 711).

Persian (Farsi)

اعضای .بۀ گیریدتماس شده ۀید ک سبب رای .شوند قرائت شمابرای اسناد که دیگن درخوا ست دیوان می .بۀ گیریید ش فاهی مترجم یک ئواندید می
شناسایی‌کارت در که ای شماره به‌ما با اطلا عات، .رایگان طور به زبان خدمات شماره با ◌ٔلط فا کارفرماگروه
شما

تماس بگیرید. (TTY: 711) 1-888-802-7001

Russian

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

Spanish

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

Thai

ไม่มคี ◌าบรการดานภาษา คุณสามารถใชล้ ◌ามได้ คุณสามารถใหอ้ งได้ สก? โทรหาเราตามหมายเลขทใี◌ ห
◌านเอกสารใหฟ หรบความช่วยเหลอ

ไวบนบตรประจา? ตวของคุณ สมาชกกลุ่มนายจาง กรุณาโทร 1-888-802-7001 (TTY:711)

Ukrainian

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

Vietnamese

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

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