Health Net Health Plan of Oregon, Inc.
Washington PPO Plan
Agreement Signature Sheet

Anniversary Date: August 1 **Group Number: 86700, subsequent group numbers to be assigned**

This Agreement, consisting of the attached Basic Benefit Schedule, Group Medical and Hospital Service Agreement, Copayment and Coinsurance Schedule(s) and any Supplemental Benefit Schedules or Amending Attachments, as supplemented by this Signature Sheet and any other attachments, has been entered into between Health Net Health Plan of Oregon, Inc. and the Policyholder named below, in order to provide eligible Subscribers and eligible Dependents of Participating Employers electing to Enroll hereunder with health care benefits as specified in the Basic Benefit Schedule and any Supplemental Benefit Schedule(s) attached. In this Agreement, the terms "we," "our" and "us" refer to Health Net Health Plan of Oregon, Inc.

Policyholder Information

Policyholder Name	Pacific Health Trust
Policyholder Address	12121 Harbour Reach Drive, Suite 105 Mukilteo, WA 98275
Employer Identification Number	20-6201813
Administrator	Michele Dimmett
Administrator Title	Trustee

Monthly Premium Rates - subject to change as outlined in the Agreement

Initial monthly premium rates in effect for coverage from:	August 1, 2012 through July 31, 2013
Subscriber only	See attached
Subscriber and Spouse or State Registered Domestic Partner	See attached
Subscriber, Spouse or State Registered Domestic Partner, and Child(ren)	See attached
Subscriber and Child(ren)	See attached

Participating Employer Group Contribution

Not less than 50% of employee premium.

Participating Employer Group Eligibility

Employee: A regular full-time employee scheduled to work at least 20 - 40 hours per week (as determined by the Participating Employer).

Employees are eligible to begin coverage on the first day of the calendar month following the date of hire OR 30/60/90/180 days of employment. Hour Bank Employees are eligible to begin coverage on the first day of the calendar month following the accumulation of 130/260/390 hours credited to the employee's hour bank.

Participating Employer Minimum Participation

75% of eligible employees must enroll.

Open Enrollment Period

Applications for membership are accepted during a 30-day period designated by the Subscriber Group to provide coverage beginning on the next plan Anniversary Date.

Attachments

Group Application (for new group)
PacTr WA Employer Application 8/12

Plan Contract
HNOR WPPO Grp Contract 8/2012 PacTr

Schedule of Coverage (Participating Employer's Plan choice)
WPT152V2LX/12 HNOR WPPO SumA Grp 8/2012 PacTr,
WPT155V2DX/12 HNOR WPPO SumA Grp 8/2012 PacTr,
WPT207V2DX/12 HNOR WPPO SumA Grp 8/2012 PacTr,
WPT2515V2DX/12 HNOR WPPO SumA Grp 8/2012 PacTr,
WPT3025V2DX/12 HNOR WPPO SumA Grp 8/2012 PacTr,
WA20-250-2-2500D/11 HNOR WPPO SumA Grp 8/2012 PacTr
WA20-500-2-2500V/12 HNOR WPPO SumA Grp 8/2012 PacTr,
WA25-500-2-3500D/12 HNOR WPPO SumA Grp 8/2012 PacTr
WA25-1000-2-2500D/12 HNOR WPPO SumA Grp 8/2012 PacTr,
WA25-2000-2-2500D/12 HNOR WPPO SumA Grp 8/2012 PacTr
WA30-1000-3-3500V/12 HNOR WPPO SumA Grp 8/2012 PacTr ,
WA35-2000-3-3500V/12 HNOR PPO SumP Grp 8/2012 PacTr ,
WA35-3000-3-3500V/12 HNOR WPPO SumA Grp 8/2012 PacTr
WA35-5000-3-3500V/12 HNOR WPPO SumA Grp 8/2012 PacTr
(includes Participating Employer's choice of optional Prescription Supplemental Benefit Schedule:
WNM10-20-40/12 HNOR WA Rx (No MAC) Grp 8/2012 PacTr,
WNM15-30-50/12 HNOR WA Rx (No MAC) Grp 8/2012 PacTr,
WNM15-30%-50%5000M/12 HNOR WA Rx (No MAC) Grp 8/2012 PacTr, or
WNM15-35-60-5000M/12 HNOR WA Rx (No MAC) Grp 8/2012 PacTr,
which all include Pharmacy Disclosure Notice 8/2012 PacTr)

W1HD20008060/12 HNOR PPO SumP Grp 8/2012 PacTr
(plan includes Prescription Supplemental Benefit Schedule:
WNMHD80/12 HNOR WA HDRx (No MAC) Grp 8/2012 PacTr, which includes Pharmacy Disclosure Notice 8/2012 PacTr)

WFHD40008060/12 HNOR PPO SumP Grp 8/2012 PacTr
(plan includes Prescription Supplemental Benefit Schedule:
WNMHD80/12 HNOR WA HDRx (No MAC) Grp 8/2012 PacTr, which includes Pharmacy Disclosure Notice 8/2012 PacTr)

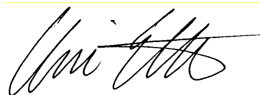
Optional Attachments

Other Attachments
HNOR WA 24hr Grp 8/2012 PacTr
HNOR WA DomPtr Grp 8/2012 PacTr
HNOR WA Limited Rx Grp 8/2012 PacTr

Executed at Tigard, Oregon

Effective Date: August 1, 2012

Health Net Health Plan of Oregon, Inc.



Chris Ellertson, President

Pacific Health Trust

Health Net of Oregon Underwriting Guidelines

As of August 1, 2012

Group Eligibility	Groups with 2 to 50 active eligible subscribers subject to OOA and Association Membership restrictions. Note: Groups of 51+ are subject to Underwriting approval
Association Membership Type	Active members only, Associate and Other members are not eligible.
Headquarters	Group must be headquartered in Washington.
Length of Time In Business	60 Days
Minimum Group Size	Minimum of 2 enrolled subscribers.
Out of Area Employees	A maximum of 49% of the total enrolling eligible population may be Out of State / Out of Area.
Eligible Employee	Eligible employees are defined as employees working a minimum of 20 hours per week. Retirees are not eligible.
1099 Employees	1099 employees are not eligible for coverage.
Probationary Period	Newly Eligible Employee: First of the month following DOH, 30, 60, 90 or 180 days. Hour Bank Employees: First of the Month following 130, 260, or 390 hours.
Minimum Contribution	A minimum group contribution of 50% of the employee premium is required.
Minimum Participation	A minimum participation of 75% of the eligible employees is required. Employees waiving coverage due to group coverage through another employer (i.e. spousal coverage), Medicare, Medicaid CHAMPUS, Indian Health Services or the Oregon Health Plan, will not be counted against minimum participation but will be counted in participation rating.
Current Health Net Groups	Association member groups currently enrolled directly with Health Net Oregon may only enroll under the Association at the August 1st annual group enrollment period. Note: The current Agent of Record for a Health Net group may request an Association quote at the group's renewal if the Agent is also appointed with the Association.
Other Carriers	Health Net must be sole carrier.
Carve Outs	Not eligible.
Workers Compensation	All employees except owners and those exempt by the definition of the Washington Labor & Industry, must be covered by Workers Compensation.
Plan Choices	Groups with 6 or more enrolling employees may offer as many plans offered through the association with no load impact for this offering.
Medical Riders	Groups may choose one RX rider to attach to the medical plan(s).

Pacific Health Trust

Health Net of Oregon Underwriting Guidelines

As of August 1, 2012

Funding Deductibles	Benefit plans may be combined with any form of self funding or insuring the deductible subject to Underwriting approval.
Effective Dates	1st of the month January through December
Case Submission	All new groups requesting coverage on the 1st must be submitted by the 20th of the month prior for which coverage is to be effective.
Final Rates	All rates are based on final enrollment and subject to Underwriting approval.
New Group Paperwork	Groups of 2 to 4 enrolled subscribers are required to submit a Form 5208 A/B and/or Ownership documents to establish the employer-employee relationship. Note: A Form 5208 A/B is required for those groups who have been in business long enough to have a Form 5208 A/B. Those groups who have not been in business long enough to have a Form 5208 A/B may submit 2 weeks of payroll. Ownership documents must be submitted for owners not appearing on the payroll/Form 5208 A/B.
Health Statement	Individual Health Statements are required.
Commission	Rates to the consumer has commission included.
Pre-Ex Waiting Period	Employer groups and newly eligible employees or dependents will be subject to Pre-Existing Condition Exclusion. Credit will be provided in accordance with State and Federal requirements.
Continuation of Benefits	COBRA or State Continuation provisions apply based on group size and location.
Dependent Coverage	Dependents are covered to age 26.
24 Hour Coverage	24 hour coverage is available to those not required to have Workers Compensation by law.
Domestic Partner Coverage	Coverage is available for same-sex or opposite-sex domestic partners.

Master Application 2012

OFFICE

Group Number: ________________
Med RL:________ RX RL:__________
Trust Fee: ❑ Paid ❑ Waived

Medical, RX, Dental and Vision plans offered under Pacific Health Trust are underwritten and administered by Health Net Health Plan of Oregon, Inc., Delta Dental and VSP®, respectively.

Company Information

Effective Date Requested: ____________________

Membership in Sub-Association (List Association)__________________ Member since: ____________________

Company: ____ Tax ID: ____________________________

DBA (if applicable): ____

Address: ____

City: ______________________ County: _________________________ ST: ___________ ZIP: ______

Phone: ________________________ Fax: ________________________ Email: ______________________

Benefits Administrator Name: ______________________________________ Title: _______________________

Address ***(if different)***: ____

Phone: ________________________ Fax: ________________________ E-mail: ______________________

Billing Contact ***(if different)***: _______________________________________ Title: _______________________

Address ***(if different)***: ____

Phone: ________________________ Fax: _________________________ E-mail: ______________________

Premiums will be paid by: ❑ EFT (complete enclosed form) ❑ Check (requires additional 2% admin fee)

Type of Organization: ❑ Corporation ❑ Partnership ❑ Sole Proprietorship ❑ Other SIC Code: _____________

Nature of Business: _______________ Date of Inception: __________ Previous Medical Carrier:________________

Participation Requirements

Total employees: _______ Total working 20+ hours a week: Full-time _______ Part-time ____________

Please check the appropriate box for total # of employees including: Full-time, Part-time and seasonal employees:

❑ 0-19 employees ❑ 20-99 employees ❑ 100+ employees

Please note: Federal regulations require you must promptly notify Health Net if the number of employees change from 0-19, 20-99, or 100+.

Since you are part of a multi-employer group health plan, have you obtained a small group employer exception from CMS so that Medicare become primary rather than your health plan, Health Net? ❑ Yes ❑ No

Number of employees eligible per employer guidelines to enroll in the plan: ___________

Number of employees enrolling: _________ Number of dependents enrolling: ________Number of employees waiving:__________

Employer Contribution and Eligibility Provisions

Employee Coverage: _______% of Monthly Rate OR $ __________ toward Monthly Rate

Dependent Coverage: _______% of Monthly Rate OR $ __________ toward Monthly Rate

Employees must enroll within 31 days of eligibility. Eligibility provisions may only be changed at annual contract renewal.

Eligible Employees: Regular active full-time employees scheduled to work at least _____ hours per week **(min 20 hrs, max 40 hrs)**

Newly Eligible Employees: First day of the month following ______ days from date of hire. (0, 30, 60, 90, 180)

Employees rehired within _____ (0 – 6) months are not required to complete a new probationary period.

COBRA

Are you subject to COBRA? ❑ Yes ❑ No

A group is subject to COBRA during the current calendar year if the group employed 20 or more employees on more than 50%of its typical business days in the preceding calendar year.

If Yes, Please Choose:

❑ Trust Administration – No Charge (BSI Agreement must be filled out. Form can be found on our website at: www.pacifichealthtrust.com)

❑ Self-Administration

Coverage Applied For (check plans that apply):

Enrollment Packets Needed:

Medical_____________ Dental: _____________

Health Net Medical Plans

- *Groups under 6 choose one plan*
- *Groups with 6+ enrolled may choose multiple plans (no minimum enrollment per plan)*

Premier Plans

❑ **Premier 250** (WPT152V2LX)
❑ **Premier 500** (WPT155V2DX)
❑ **Premier 750** (WPT207V2DX)
❑ **Premier 1500** (WPT2515V2DX)
❑ **Premier 2500** (WPT3025V2DX)

Preferred Plans

❑ **Preferred 250** (WA20-250-2-2500D/12)
❑ **Preferred 500** (WA25-500-2-3500D/12)
❑ **Preferred 1000** (WA25-1000-2-2500D/11)
❑ **Preferred 2000** (WA25-2000-2-2500D/12)
❑ **Preferred HDHP 2000** (HD2000 Single/ HD4000 Family – HSA Qualified)

Essential Plans

❑ **Essential 500** (WA20-500-2-2500V/11)
❑ **Essential 1000** (WA30-1000-3-3500V/11)
❑ **Essential 2000** (WA35-2000-3-3500V/11)
❑ **Essential 3000** (WA35-3000-3-3500V/12)
❑ **Essential 5000** (WA35-5000-3-3500V/12)

Health Net RX Plans *Choose one option*

❑ **Rx $10 / $20 / $40**
❑ **Rx $15 / $30 / $50**
❑ **Rx $15 / $35 / $60**
❑ **Rx $15 / 30% / 50% - $5,000 OOP Max**
❑ **No Rx**

Vision Plan *Choose one option*

❑ **$0 / $10** (Employer Paid)
❑ **$10 / $25** (Employer Paid)
❑ **$0 / $10** (Employee Paid)
❑ **$10 / $25** (Employee Paid)
❑ **No Vision**

Note: Pharmacy & Vision enrollment must match the medical enrollment.

Dental Plans

❑ **Plan 1000 ($1,000 Max)**
❑ **Plan 1500 ($1,500 Max)** ❑ **Plan 1500 ($1,500 Max) w/Ortho**
❑ **Plan 2000 ($2,000 Max)** ❑ **Plan 2000 ($2,000 Max) w/Ortho**
❑ **No Dental**

Optional Benefits:

❑ **Domestic Partner Coverage - No Charge–Select to add benefit only at renewal**

❑ **24 Hour Owner Coverage – No Charge - Attach a list including full names for all owners/officers excluded from Workers Comp.**

❑ **LifeBalance Card ($.86 per employee charge)**

Lifewise Assurance Life / AD&D Buy-up

(Base $10K Life/AD&D is included on all employees enrolling in the medical plan)

Life enrollment Election: (Must Choose one of the following options):

❑ **Medical Enrollees Only** ❑ **All Eligible**

☑ **Base $10K Life / AD&D (required)**
❑ **$20K Life / AD&D (Optional Buy-up)**
❑ **$30K Life / AD&D (Optional Buy-up)** **
❑ **$40K Life / AD&D (Optional Buy-up)****
❑ **$50K Life / AD&D (Optional Buy-up)****

**** Available to groups of 10 or more eligible employees**

Flexible Spending Account

Election: If yes to any of the below options, please complete and attach the BSI enrollment form. Additional charges apply.

FSA Yes ❑ No ❑ HRA Yes ❑ No ❑
DCAP Yes ❑ No ❑ HSA Yes ❑ No ❑

Participation/ Eligibility Requirements

Company must enroll at least 2 eligible employees and must meet the definition of a "business group" under Washington state law. All enrolled employees must have a bona fide employee relationship with the Employer. If the employer requires employees to contribute to the employee-only premium, a minimum of 75% of all eligible employees must enroll in the plan. A Refusal of Enrollment / Change / Waiver Form must be submitted for all employees and dependents declining coverage. Eligible employees must be full-time employees as defined on page 1 of the application.

Agent Designation

Agent Name: ______________________________ Agency: ______________________________

Address: ______________________________ City: ____________________ ST: ____ ZIP: ____________

Phone: ____________________ Fax: ______________________ Email: ______________________

Employer Statement

We, the Employer subscribed below, have read and approved the Pacific Health Trust Joinder Agreement effective May 1, 2004. In conjunction with our request for Trust participation, in consideration of granting this request, we hereby agree to be bound by the terms, conditions and provisions of said Joinder Agreement and to assume the obligations of an Employer specified therein. We accept the designated Trustee and agree to be bound by all decisions and actions of the Trustee. Specifically we agree to do the following:

- ☑ We wish to enroll our firm as a group account with the Pacific Health Trust. We understand that the Pacific Health Trust is the purchasing group that sponsors this plan, and that medical benefits are underwritten and administered by Health Net of Oregon, a Washington-licensed health care service contractor. Benefits and eligibility provisions are specified in the contract between the Pacific Health Trust and Health Net of Oregon, of which this application forms a part. We also understand that vision benefits are provided by VSP®, and VSP® is solely responsible for administration of those benefits.
- ☑ We understand the eligibility rules applicable to employee enrollment.
- ☑ We understand premiums are prepaid and are due no later than the first day of each month.
- ☑ We certify that we have received a fully completed and unaltered Enrollment / Change / Waiver Form from each eligible employee and that we will keep these forms on file in their original state indefinitely. They will be immediately available for use by the Plan Administrator or Carrier.
- ☑ We understand an individual's coverage terminates the last day of the month in which employee or dependent ceases to be eligible under eligibility provisions.
- ☑ There will be one open enrollment period per contract year 30 days prior to the renewal effective date.
- ☑ We understand that this plan contains a pre-existing conditions exclusion period for enrollees over age 19, which will be reduced by any applicable creditable coverage in accordance with Washington state and federal regulations.
- ☑ This Agreement consisting of the Plan Contract/Group Policy as supplemented by the Group Application has been entered into between Pacific Health Trust and the Employer Group in order to provide eligible subscribers and eligible dependents electing to enroll hereunder with the health care benefit as specified in the Plan Contract/Group Policy.

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

Executed at ______________________________ Date accepted ______________________
(City, ST)

______________________________	______________________	________________
Signature of Authorized Employer Group Representative	Print Name	Title

LifeWise Assurance Customer Service
2020 SW 4th Avenue, Suite 1000, Portland, OR 9201 1-800-258-0394

Delta Dental – Washington Dental Service Claims Line
PO Box 75983 Seattle, WA 98175-0983 1-800-554-1907

Vision Service Plan Claim Line
121 SW Morrison St, Suite 1050 Portland, OR 97204 1-800-877-7195

HEALTH NET HEALTH PLAN OF OREGON, INC.

WASHINGTON PPO PLAN CONTRACT

Basic Benefit Schedule and
Group Medical and Hospital Service Agreement

2012

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 DISCLOSURE

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

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

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

SECOND MEDICAL OPINION

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

SELF-REFERRAL FOR WOMEN'S HEALTH CARE SERVICES

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

THE RIGHT TO EXERCISE CONSCIENCE

Health care Providers or Employers have the right not to provide termination of pregnancy or other services to which they object because of religious belief or issues of conscience. If your Provider objects to providing a specific service that is normally provided, you will be told how to receive this particular service from another Provider, with no added cost to you.

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Health Net Health Plan of Oregon, Inc.
Washington PPO Plan
BASIC BENEFIT SCHEDULE

General Terms Under Which Benefits Are Provided

Throughout this Basic Benefit Schedule, 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 to each Enrolled Dependent unless otherwise specified.

You are entitled to receive the benefits set forth in this Benefit Schedule subject to the following conditions:

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

- All services, other than the preventive care services outlined in the Agreement, are covered only if Medically Necessary and required in accordance with accepted standards of medical practice.

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

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

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

  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.

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

- **Specialty Care Providers.** Medical Services for certain conditions or certain treatment procedures may be provided only at Participating Providers that we designate as Specialty Care Providers. Services which require use of a Specialty Care Provider include but are not limited to: 1) Home Health Care; 2) infusion services that can be safely administered in the home or in a home infusion suite; 3) organ and tissue transplant services; and 4) Durable Medical Equipment. We shall have the right to require a Member to use a designated Specialty Care Provider as a condition to receive coverage under this Agreement. 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.

Physician Services

Medically Necessary Physician services are covered as follows:

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

- **Diagnostic Services**. Diagnostic services, including radiology (X-ray), pathology, laboratory tests, and other imaging and diagnostic services are covered. Imaging services, such as MRIs and CT and nuclear scans, require Prior Authorization. Hearing tests in support of a diagnosis are covered.

  Exclusions and Limitations: Screening audiometry and tympanograms not in support of a diagnosis are not covered.

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

  Chemotherapy is the use of anti-cancer drugs to treat conditions including, but not limited to cancer. The chemotherapy benefit covers anti-cancer 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. Self-administered anticancer medications are covered as a prescription benefit.

- **Office Visits**. Your office visits, including diagnostic examination and treatment of 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.

- **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 children, you may designate a pediatrician as the primary care Provider. For information on how to select a primary care Provider, and for a list of the participating primary care Providers, you may contact us at:

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

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

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

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

Hospital Inpatient Services

Medically Necessary Hospital inpatient services are covered as follows:

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

- **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 Prosthetic Devices, such as pacemakers and hip joints, approved by the Food and Drug Administration and implanted during a surgery pursuant to a Prior Authorization. Single occupancy rooms are covered at those facilities which only offer single occupancy accommodations, but are not covered merely for patient convenience or preference.

- **Maternity Hospitalization**. Refer to the "Maternity Benefits" section of this Basic Benefit Schedule.

- **Newborn Nursery Care**. Routine care in the Hospital nursery is covered for a newborn Child. See the "Enrollment and Effective Date" section of the Group Medical and Hospital Service Agreement for newborn Child Enrollment guidelines.

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

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

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

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

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

Outpatient Services

Medically Necessary outpatient services are covered as follows:

- **Diagnostic Services**. Diagnostic services, including radiology (X-ray), pathology, laboratory tests, and other imaging and diagnostic services are covered. Imaging services, such as MRIs and CT and nuclear scans, 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 anti-cancer drugs to treat conditions including, but not limited to cancer. The chemotherapy benefit covers anti-cancer 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. Self-administered anticancer medications are covered as a prescription benefit.

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

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

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

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

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

Emergency Medical Care

Emergency Medical Care is covered inside or outside the Service Area without Prior Authorization. See the "Definitions" section of the Group Medical and Hospital Service Agreement. Benefits payable to Non-Participating Providers are paid at the Non-Participating Provider Level specified in the 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. Emergency Medical Condition means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

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 on the first 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 Non-Participating Provider Hospital and require continuous care, we will arrange to have you transferred to a Participating Provider as soon as Stabilization has occurred.

Ambulance Transport. Licensed ground or air ambulance services are covered in the event of an Emergency Medical Condition. 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 unless Prior Authorized or arranged by us.

We use a prudent layperson standard to determine whether the criteria for Emergency Care has 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 RCW 48.43.093, and the definitions of "Emergency Medical Care," "Emergency Medical Condition," and "Emergency Medical Screening Exam" in the "Definitions" section of the Group Medical and Hospital Service Agreement.

Other Services

The benefits and services listed below are subject to payment of any applicable Coinsurance and/or Copayments.

Other Medically Necessary services will be covered as follows:

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.

Chemical Dependency Treatment

Inpatient, outpatient, and professional services benefits are available for covered Chemical Dependency conditions. Prior Authorization is required for services other than detoxification.

Coverage for Chemical Dependency treatment includes:

- Medically Necessary services and supplies of a Provider, facility, or program approved under 70.96A.020 RCW for both Inpatient and outpatient care; and
- Detoxification, supportive services, and approved prescription drugs prescribed by the Provider or facility, licensed according to 70.41 RCW. Medically Necessary detoxification services are covered as an Emergency Medical Condition so long as the patient is not yet enrolled in other Chemical Dependency treatment. Charges incurred for detoxification services will be paid as any other medical benefit.

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

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

Circumcisions

Circumcisions for newborn male children are covered.

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

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. If you are also covered under a Health Net Health Plan of Oregon, Inc. dental plan, benefits for services covered under this provision will be paid before any available benefits for those same services are paid under your dental plan.

Diabetes Management

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

- Outpatient diabetes self-management training and education, including medical nutrition therapy, as ordered by the health care Provider is covered. Diabetes outpatient self-management training and education may be provided only by health care Providers with expertise in diabetes.

- Supplies and equipment related to Diabetes Management, as described in the "Medical Supplies" provision of this section.
- Screening for gestational diabetes, as supported by HRSA guidelines, is covered as preventive care in the "Preventive Care" section of this Basic Benefit Schedule.

Durable Medical Equipment and Prosthetic Devices

Durable Medical Equipment, including your initial rental or purchase, is covered provided it is the least costly alternative that achieves a medically acceptable result. Prosthetic Devices are covered as Durable Medical Equipment. Medically Necessary lenses for the treatment of aphakia and keratoconus are covered as Durable Medical Equipment. The maximum benefit is shown on the Copayment and Coinsurance Schedule. 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.

Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered as preventive care listed under the "Preventive Care" section in this Basic Benefit Schedule.

The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice Care, or when Home Health Care or Hospice Care are being provided under case management in lieu of Hospitalization.

Exclusions and Limitations: We may utilize a Specialty Care Provider of Durable Medical Equipment if you live in the Service Area.

Family planning

Covered services and supplies include, but are not limited to, the following: Counseling and assessment for birth control. Diaphragms and non-hormonal contraceptive devices, IUDs, contraceptive implants, contraceptive injectables are covered when provided in the doctor's office. These items, while covered under this Basic Benefit Schedule, are excluded under your Supplemental Prescription Benefits Schedule, if any. 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, is covered as preventive care in the "Preventive Care" section of this Basic Benefit Schedule.

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.

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 up to the limits set forth in this section. 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.

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. Prior Authorization is required.

Exclusions and Limitations: We may utilize a Specialty Care Provider of home health services if you live the Service Area. We do not cover Custodial Care.

Home Infusion Services

Medically Necessary home infusion services that are safely administered in the home or in a home infusion suite are covered when provided in lieu of inpatient/outpatient hospitalization, Physician's office or Skilled Nursing Facility care. Prior Authorization is required. Medically Necessary home injectables except insulin are covered when Prior Authorized. We may utilize a Specialty Care Provider of home infusion services if you live in the Service Area.

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

Hospice Care

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

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. Prior Authorization is required. "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

Medically Necessary maternity care is covered as follows:

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

- **Prenatal and Postnatal Care**. Prenatal and postnatal care is covered. Coverage includes prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures during pregnancy. Breastfeeding support, supplies and counseling, and screening for gestational diabetes as supported by HRSA guidelines, is covered as preventive care in the "Preventive Care" section of this Basic Benefit Schedule.

- **Hospital Room and Board**. Hospital room and board for the mother are covered the same as for any other covered illness or injury. In accordance with RCW 48.43.115, the attending Provider, in consultation with the mother, is permitted to make decisions on the length of inpatient stay. These decisions must be based on accepted medical practice.

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

- **Delivery and Nursing Care**. Delivery services and nursing care are covered in a Hospital, birthing center or at home. Charges from Providers offering delivery care under the scope of a professional license are covered.

- We will not restrict travel during pregnancy, including 3rd trimester.

Medical Supplies

Medical supplies are covered as follows.

- Appropriate and Medically Necessary diabetic equipment and supplies dispensed in accordance with any formulary adopted by us are covered, including but not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits.

- 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.

Exclusions and Limitations: wound care products; incontinence products; generic multi-use products; reusables.

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

- The first pair of Medically Necessary eyeglasses or contact lenses following covered cataract surgery is covered. Contact our Customer Contact Center for benefit limitations.

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

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

Exclusions and Limitations: All other non-durable medical supplies.

Mental Health Benefits

Benefits for treatment of Mental Disorders included in the Diagnostic and Statistical Manual of Disorders are provided. Prior Authorization is required, except in the case of a Member who is involuntarily committed to and subsequently treated in a state Hospital.

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

Neurodevelopmental Therapy (under age 7)

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

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 or for the treatment of phenylketonuria. Prior Authorization is required, except for the treatment of phenylketonuria.

Oral and Maxillofacial Services

The following oral and maxillofacial services are covered:

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

Organ and Tissue Transplants

Exclusion Period. A 12-month Exclusion Period applies for services related to any organ or tissue transplant. Creditable Coverage applies to this Exclusion Period.

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 Type1 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;
- 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.

No other organ or tissue transplants are covered. Organ or bone marrow search, selection, storage, and eye bank costs are not covered.

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" section of this Basic Benefit Schedule. Services provided by other than the designated Specialty Care Provider will not be covered.

Exclusions and Limitations: All organ and tissue transplants or autologous stem cell rescue not explicitly listed as covered in this Basic Benefit Schedule. Services for an organ donor or prospective organ donor when the transplant recipient is not a Member. Organ and bone marrow search, selection, storage, and eye bank costs. Non-human 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. Small bowel and pancreas transplants and islet cell transplantation. Transplant services not Prior Authorized and/or not provided at the Specialty Care Provider designated by us are not covered.

Preventive Care

When services are received by a Participating Provider, charges for preventive care are covered at no cost share to you. When the primary purpose of the office visit is unrelated to a preventive service, services are payable at benefit levels indicated on your Copayment and Coinsurance Schedule. If you receive services from a Non-participating Provider, benefits are subject to your Non-Participating and/or Out-of-Network cost share amount, as indicated on your Copayment and Coinsurance Schedule.

Covered recommended preventive care services, http://www.uspreventiveservicestaskforce.org/uspstf/ uspsabrecs.htm 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/.

The deductible, if any, is waived for services covered under this section which are billed as Preventive Care.

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

Reconstructive Surgery

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

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

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

Rehabilitation Therapy

The following are covered when expected to significantly improve an acute condition or acute exacerbation of a chronic condition: short-term Hospital-based or outpatient physical, occupational and speech therapy, cardiac rehabilitation, rehabilitation therapy following a covered mastectomy. The maximum benefits for inpatient and outpatient treatment are shown on the Copayment and Coinsurance Schedule. Prior Authorization is required. The Calendar Year maximum for outpatient rehabilitation therapy does not apply to services which are billed as Home Health visits.

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

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.

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" section in this Basic Benefit Schedule.

Male sterilization benefits are subject to payment of any applicable Copayments or Coinsurance.

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

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/or Coinsurance Schedule. Copayments and Coinsurance payments for TMJ services do not apply to your out-of-pocket maximum. Prior Authorization is required.

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

Services and supplies are covered only when obtained from licensed Providers. Benefits are provided for:

- Office visits to Providers of chiropractic, acupuncture, naturopathic medicine, and Medically Necessary massage therapy. Copayments or Coinsurance are required for each covered visit, as shown on the Copayment and Coinsurance Schedule.

- Diagnostic testing and radiology ordered or performed within a chiropractic or naturopathic scope of license.

Exclusions and Limitations:

- Benefits for manipulations, acupuncture and massage therapy are limited to the visit maximums shown on the Copayment and Coinsurance Schedule.

- Diagnostic testing and radiology except as outlined in this section.

- Prescription medications and over-the-counter drugs and remedies.

Case Management

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

Included under this case management provision is the substitution of Home Health Care, provided in lieu of hospitalization or other institutional care, furnished by home health, hospice and home care agencies licensed under chapter 70.127 RCW, at equal or lesser cost.

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

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

Prior Authorization

The services requiring Prior Authorization are specified in this Basic Benefit Schedule. Except in the case of Emergency Medical Care, coverage for those services will be provided only if Prior Authorization has been obtained from us. Refer to the "Participating Providers" section of the Group Medical and Hospital Service Agreement for further detail of the Prior Authorization process.

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.

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

In accordance with RCW 48.43.525, we will not retrospectively deny claims for services which were Prior Authorized at the time the care was rendered.

Exclusions and Limitations

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

- **Not Medically Necessary**. Any care deemed not Medically Necessary or not in accordance with accepted medical standards by the Medical Director; and any Hospital or medical care services not specifically provided for in the Medical and Hospital Service Agreement or this Basic Benefit Schedule.
- **In Excess of Benefit Maximums or Limitations.** All services or supplies that exceed any maximum cost or time (days or visits) limitation imposed in this Schedule, the Copayment and Coinsurance Schedule, or any Supplemental Benefit Schedule.
- **Third-Party Liability.** Covered services and supplies for injuries or illnesses for which another person or entity is legally responsible or agrees to a settlement for the injury or illness. If we pay benefits before any such payments are made, reimbursement must be made in accordance with the "Right of Recovery" section in the Group Medical and Hospital Service Agreement.
- **Experimental or Investigational Procedures.** Medical, surgical or other health care procedures, treatments, devices, products or services (collectively, "health care services") which are determined by us to be Experimental or Investigational, and complications directly caused thereby.
- **Unauthorized Services.** Non-emergency services without a Prior Authorization, if Prior Authorization is required pursuant to the "Prior Authorization" section of this Basic Benefit Schedule, and the "Participating Providers" section of the Group Medical and Hospital Service Agreement.
- **Expenses Related to Non-covered Services or Supplies.** Expenses for any condition or complication caused by any procedure, treatment, service, drug, device, product or supply excluded from coverage.
- **Dental Services.** Services performed in connection with treatment to teeth or gums, upper or lower jaw augmentation or reduction, or orthognathic surgery, including treatment or internal or external Prosthetic Devices for disorders of the temporomandibular joint; all dental services and dentures except as specified under the "TMJ", "Oral and Maxillofacial Services", "Dental Anesthesia", and "Dental Injury" sections of this Basic Benefit Schedule or for a child with a congenital anomaly.
- **Orthodontic Services and Dental Implants**. Except for treatment covered under the "Dental Injury" section of this Basic Benefit Schedule.
- **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 External Prosthetic Devices" and "Medical Supplies" sections of this Basic Benefit Schedule. Hearing screening exams and tests except as provided in the "Diagnostic Services" provision of the "Physician Services" section and the "Preventive Care" section of this Basic Benefit Schedule.
- **Non-covered Equipments 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 Basic Benefit Schedule; 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" sections of this Basic Benefit Schedule. All cosmetic or other services rendered to improve a condition which falls within the normal range of function.

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

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

- **Immunizations and Inoculations.** Except as provided under the "Preventive Care" section of this Basic Benefit Schedule.

- **Payment for Care for Conditions That State or Local Law Requires Be Treated in a Public Facility.** No payment will be made for any care or treatment given for an injury, illness, or physical or mental or nervous condition arising during and occurring as a direct result of your active service in the United States Armed Forces, as determined by the Secretary of Veteran's Affairs.

- **Diagnosis and Treatment of Infertility**, except as covered as outlined in the "Fertility Preservation" section of this Basic Benefit Schedule. Complications caused by treatment for infertility. Infertility is the failure of a couple during normal childbearing years to achieve conception after one or more years of regular sexual intercourse without practicing contraceptive measures. Sexual dysfunction that prevents successful intercourse may also be considered infertility. Infertility-related 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).** Procedures, services and supplies related to sex transformation, transsexualism or paraphilias (sexual deviations).

- **Weight Loss Surgery or Complications Caused by Weight Loss Surgery.** Diagnosis, treatment, rehabilitation services and diet supplements for any classification of obesity, including but not limited to morbid obesity, (regardless of co-morbidities), except as covered under the "Preventive Care" section of this Basic Benefit Schedule.

- **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, Psychosocial Problems, Speech Delay, Conceptual Handicap and Developmental Delay**, except as outlined in the "Neurodevelopmental Therapy (under age 7)" section of this Basic Benefit Schedule for Members under age 7. Also, dyslexia except as provided in the "Mental Health Benefits" section of this Basic Benefit Schedule.

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

- **Rehabilitation Therapy.** Except as provided in the "Rehabilitation Therapy" and "Neurodevelopmental Therapy (under age 7)" section of this Basic Benefit Schedule.

- **Treatment of Sexual Dysfunction.** Medications, surgical treatment or hospitalization for treatment of impotency; penile implants; services, devices, Prosthetic Devices, or aids related to treatment for any types of sexual dysfunction, congenital or acquired; sperm storage or banking, except as covered as outlined in the "Fertility Preservation" section of this Basic Benefit Schedule.

- **Genetic Engineering.**

- **Recreational or Educational Therapy; Non-medical Self-help Training.**

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

- **Counseling or training in connection with family, sexual, marital, or occupational issues.**

- **Orthoptics, pleoptics (visual therapy and/or training), visual analysis.**

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

- **Any illness, condition or injury occurring in or arising out of the course of employment.**

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

- **Outpatient Prescription and Over-the-Counter 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.

- **Programs for the Specific Intent of Pain Management.**

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

- **Hair Analysis.**

- **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" section of this Basic Benefit Schedule.

- **Nutritionist.** Services of a nutritionist, except for specific conditions such as diabetes, high blood pressure, and anemia.

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

- **Treatment by an Immediate Family Member or Self Treatment.** Services and supplies rendered by an immediate family member (spouse, State Registered Domestic Partner and/or non-registered domestic partner, parent, child, grandparent or sibling related by blood, marriage or adoption) or 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.

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

Introduction

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

Definitions

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

"Adverse Benefit Determination" means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of an enrollee's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

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

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

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

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

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

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

"Chemical Dependency" means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under chapter 69.50 RCW and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

"Coinsurance" means the percentage of a Provider's covered charge stated in the Copayment and Coinsurance Schedule or a 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 a Supplemental Benefit Schedule to be paid by Members directly to Providers for covered services. The deductible is waived for services where the Member's responsibility is a Copayment rather than Coinsurance. The office visit Copayment includes Physician services only.

"Creditable Coverage" means any of the following coverages: Group coverage (including FEHBP and Peace Corps); Individual Coverage (including student health plans); Medicaid; Medicare; state Children's Health Insurance Program (SCHIP); TRICARE; Indian Health Service or tribal organization coverage; state high risk pool coverage; employer-provided self-funded health plans; and public health plans. Creditable coverage does not include Coverage only for a specified disease or illness or Hospital indemnity (income) insurance. Coverage is Creditable only if there has not been a gap in coverage exceeding 90 days.

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

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

- The spouse or State Registered Domestic Partner of the Subscriber.
- A 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 (QMCSO) requiring the Subscriber to provide health coverage for the child. The QMCSO must be furnished to us to initiate Enrollment.

"Child" means a natural child of the Subscriber, an adopted child of the Subscriber, or a stepchild of the Subscriber during the marriage of the Subscriber and the natural parent, or a child of the Subscriber's State Registered Domestic Partner during the State Registered Domestic Partnership, but does not include foster children, wards, or children who are under temporary custody of the Subscriber or spouse. "Child" also does not include children of Dependents unless the Subscriber is a court-appointed guardian. Provided, however, that a child who is placed with a Subscriber for the purposes of adoption shall be considered a Dependent of the Subscriber as required by the laws of the State of Washington. Placement for adoption means the assumption and retention by a Subscriber or spouse of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. Coverage of any Dependent child of a Subscriber shall not be terminated by the child's attaining the relevant limiting age if the child is and continues to be Disabled. Proof of disability must be furnished within 31 days of reaching a limiting age and not

more frequently than annually after the first two years of continued coverage. We will not deny Enrollment of a Child because the Child was: (a) born out of wedlock; (b) is not claimed on the parent's federal tax return; or (c) does not reside with the parent or within our Service Area.

"Disabled" means, 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 who reaches the limiting age will be considered Disabled when the Dependent is both (1) incapable of self-sustaining employment by reason of developmental disability or physical handicap and (2) chiefly dependent upon the Subscriber for support and maintenance.

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

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

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

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

"Emergency Medical Condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

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

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

"Exclusion Period" means a period during which no benefits shall be provided for specified transplant services until you have been covered under this Agreement for a period of 12 consecutive months. The Exclusion Period does not apply to a newborn or newly adopted child. Upon receipt of a certificate of Creditable Coverage, the Exclusion Period will be reduced by the length of Creditable Coverage under other Health Benefit Plans.

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

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

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

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

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

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

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

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

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

"Grievance" means a written or an oral complaint submitted by or on behalf of a covered person regarding issues other than health care services or payment for health care services including dissatisfaction with health care services, delays in obtaining health care services, conflicts with carrier staff or Providers, and dissatisfaction with carrier practices or actions unrelated to health care services.

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

"Home Health Care" means a program of care provided by a public agency or private organization or a subdivision of such an agency or organization which (a) is primarily engaged in providing Skilled Nursing Services in homes or places of residence of its patients; (b) is licensed according to applicable laws of the State of Washington and of the

locality in which it is located or provides services; and (c) if the Member resides within the Service Area, has a written agreement with us as an agency or organization to provide Home Health Care to Members under this Agreement.

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

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

"Hospital" means an institution which is either:

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

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

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

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

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

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

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

- The individual applies for coverage during an Open Enrollment Period;

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

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

- The individual applies for coverage within 31 days after becoming eligible for a FHIAP (Family Health Insurance Assistance Program) subsidy; or

- The department of social and health services determines that it is cost-effective to Enroll a person eligible for medical assistance under chapter 74.09 in an employer-sponsored health plan for which he of she is otherwise eligible.

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

"Maximum Allowable Amount (MAA)" is the amount that we use to calculate what we pay for covered Medical Services and supplies provided by a Nonparticipating Provider. MAA is a percentage of what Medicare would pay (known as the Medicare Allowable Amount). Medicare pays 100% of the Medicare Allowable Amount. The percentage of Medicare at which we pay Out-of-Network claims is 160%, as determined by the Subscriber Group. If there is no Medicare Allowable Amount for a particular service or supply, MAA will equal seventy-five percent (75%) of the billed charges. If the billed charges for a claim are less than MAA, we will pay the billed charges.

MAA is subject to other limitations on covered Medical Services. See your Copayment and/or Coinsurance Schedule, Basic Benefit Schedule, and any Supplemental Benefit Schedules and Amending Attachments for specific deductibles, benefit limitations, maximums, requirements and surgery payment policies that limit the amount that we pay for covered Medical Services and supplies. 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.OO CHARGE THAT IS YOUR RESPONSIBILITY	**$56.32**

From time to time, we may 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, in which case you will not be responsible for the difference between the MAA and the billed charges. You will be responsible for any applicable deductible, Copayment and/or Coinsurance at the Out-of-Network level.

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

You may contact us and request assistance from our fee negotiation service on a pre-service or supply single case basis when the cost of your Out-of-Network services is projected to be $15,000 or more. We will provide information on our website about how to obtain this assistance, or you may also call the Customer Contact Center. Your use of our fee negotiation service does not obligate us to agree to any particular amount requested by an Out-of-Network Provider, or to negotiate with an Out-of-Network Provider who is contracted with a network with which we have an arrangement to pay the Provider in accordance with that network's fee schedule.

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

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

For more information on the determination of Maximum Allowable Amount, call the Customer Contact Center at the number on your Member identification card.

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

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

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

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

"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.

"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.

"Open Enrollment Period" is a period of time each Calendar Year, during which individuals who are eligible for coverage in this Plan may Enroll for the first time, or if they were Enrolled previously, may add their eligible dependents. The Group decides the exact dates for the Open Enrollment Period. Changes requested during the Open Enrollment Period become effective on the first day of the calendar month following the date the request is submitted, or on any date approved by Us.

"Participating Employer" means an employer group who qualifies for the coverage available through membership in the Subscriber Group, and who has applied for and been accepted for coverage under the Agreement. A Participating Employer is limited to an entity that would, under Washington law, be eligible for a group medical policy or contract. A Participating Employer must agree to follow the required administrative procedures outlined by Health Net in the underwriting guidelines.

"Participating Provider" means a licensed or certified Physician, health professional, Hospital, home health agency, pharmacy, 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.

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

"Pre-existing Condition" means a condition for which medical advice, diagnosis, care or treatment was recommended or received during the three-month period preceding the enrollment date, which means the earlier of the first day of the Participating Employer's probationary period or the Member's effective date of coverage. The enrollment date for a Late Enrollee is the effective date of coverage. Pregnancy is not a Pre-existing Condition. Genetic information does not constitute a Pre-existing Condition in the absence of a diagnosis of the condition related to such information. Treatment for phenylketonuria is not a Pre-Existing Condition. Pre-existing conditions do not apply to a Member under the age of 19.

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

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

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

    b. The Prior Authorization was obtained through misrepresentation.

    In accordance with RCW 48.43.525, we will not retrospectively deny claims for services which were Prior Authorized at the time the care was rendered.

- We will answer a request for Prior Authorization of non-emergency services within 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 Devices" means artificial substitutes that are required to replace all or any part of a body organ or extremity.

"Provider" means any licensed or certified Physician, health professional, Hospital, home health agency, pharmacy, or other entity or person who is licensed or certified and is acting within the scope of his or her license to furnish health care services.

"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 that, within reasonable medical probability, no material deterioration of an Emergency Medical Condition is likely to occur.

"State Registered Domestic Partner" means a person who has entered into a civil contract with the Subscriber, both of whom meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030 and who have been issued a certificate of state registered domestic partnership by the secretary of state's office.

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

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

"Women's Health Care Provider" means any generally recognized medical specialty of practitioners licensed under chapter 18.57 or 18.71 RCW who provides women's health care services; practitioners licensed under chapters 18.57A and 18.71A RCW when providing women's health care services; midwives licensed under chapter 18.50 RCW; and advanced registered nurse practitioner specialists in women's health and midwifery under chapter 18.79 RCW, 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 Washington or any other taxing authority imposes upon us any new or additional tax or license fee which is levied upon or measured by premium, by our gross receipts, or by any portion of either, then we may amend this Agreement to increase the premium by an amount sufficient to cover all such taxes or license fees rounded to the nearest cent, 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 that the extent or nature of the risk under this Agreement is changed by amendment to this Agreement or by reason of any change mandated by law or regulation.

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

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

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

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

- We reserve the right to change the premium rates and any other provisions of this Agreement effective at renewal on at least 30 days written notice before the renewal to the Subscriber Group. The 30 day notice requirement does not apply to normal and customary administrative changes that do not have an actuarial impact, such as formulary changes, or to a decrease or increase required by state or federal law.

Eligibility

- **Subscriber:** To be eligible to Enroll as a Subscriber, a person must, at the time of Enrollment and throughout the term of this Agreement, be an Eligible Employee of the Participating Employer and must meet the Participating Employer's eligibility criteria.

- **Dependent:** To be eligible to Enroll as a Dependent, a person must be a Dependent of a Subscriber and must meet the Participating Employer'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.

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

During the term of this Agreement, Subscriber Group and Participating Employers 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 Participating Employer 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 Participating Employer as a Subscriber, we shall also be entitled to repayment from the Participating Employer for the cost of benefits provided during the refund period in excess of the premium received by us for the ineligible person during that period.

Enrollment and Effective Date

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

- **Open Enrollment**. Eligible Employees and/or Dependents who do not Enroll when initially eligible may Enroll by submitting a completed application form during the Open Enrollment Period.

- **Newborn Child**. A newborn child of the Subscriber or the Subscriber's spouse will be covered as a Dependent for 21 days from the moment of birth. To continue coverage after 21 days, if an additional premium is required, you must submit a written request to us to add the Dependent within 60 days of the birth, and pay any required premiums. If you do not notify us within 60 days when an additional premium is required, the Child will be considered a Late Enrollee.

- **Newly Adopted Child**. Coverage for a newly-adopted Child, or a Child who has been placed for adoption with you and for whom the application procedures for adoption have been completed while your coverage is in effect, will be provided on the same basis as any other newly eligible Dependent. Placement for adoption means the assumption and retention by a Subscriber or spouse of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. An adopted child shall not be considered a Dependent child for coverage purposes upon termination of such legal obligations. This coverage applies to children under the age of 18 years at the time of adoption.

  You must submit a written request to us to add the Dependent within 60 days following the date of adoption or placement for adoption if an additional premium is required, and pay any required premium. If you do not notify us within 60 days when an additional premium is required, the Child will be considered a Late Enrollee.

- **Other Newly Eligible Dependents**. A Subscriber may Enroll a newly eligible Dependent by submitting a completed application form within 31 days of attaining eligibility. Enrollment is effective on the day the Dependent becomes eligible.

- **Special Enrollment**.

    a. Loss of Other Coverage. An Eligible Employee and/or Dependents who previously declined coverage under this Agreement because of coverage under another Health Benefit Plan can Enroll in this Agreement by submitting a completed application form within 31 days of loss of such other coverage because of marriage, birth of a child, legal separation, 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 under the Children's Health Insurance Plan (CHIP) 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. An Eligible Employee and/or newly acquired Dependents can Enroll in this Agreement by submitting a completed application form within 31 days of marriage. Enrollment is effective the first day of the following month.

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

- **Late Enrollee**. A person who does not Enroll during a period provided above is entitled to Enroll as a Late Enrollee upon submission of a completed application form at any time. Late Enrollees will be excluded from coverage for three months. Creditable Coverage will apply.

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

Participating Employer shall require each Member to disclose to us at the time of Enrollment, at the time of receipt of covered services and supplies, and from time to time as requested by us, the existence of any other group coverage the Member may have, the identity of the carrier, and the group through whom the coverage is provided.

We shall have the right, at reasonable times, to examine the records of Subscriber Group and Subscriber Group's subcontractors and Participating Employer's records, 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:

    a. With respect to the coverage of a Participating Employer group, for nonpayment of the required premiums by the Participating Employer.

    b. If the Subscriber Group is convicted of insurance fraud under state or local laws.

    c. For noncompliance with the minimum participation or contribution requirements shown on the Signature Sheet;

    d. For violation of our published policies that have been approved by the Insurance Commissioner;

    e. When the Agreement is materially breached;

    f. If upon written approval from the Insurance Commissioner, we cease to offer this particular Agreement form;

    g. If we cease to offer coverage in the group market under which the Agreement is issued;

h. If we are withdrawing from a Service Area or from a segment of a Service Area because we have demonstrated to the Insurance Commissioner that our clinical, financial or administration capacity to serve existing Members would be exceeded.

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

j When, in the case of a group Health Benefit Plan that delivers covered services through a specified network of health care Providers, there is no longer any Member who lives or works in the Service Area of the Provider network.

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

If we discontinue this particular Agreement form or cease to offer coverage in the group market, we will provide notice as required by the Insurance Commissioner.

- We may modify this Agreement at the time of renewal on at least 115 days notice before the renewal to the Subscriber Group. The modification is not a discontinuation of this Agreement under this section above. Written notice of negotiated modifications to the Agreement will be given to Subscriber Group at least 30 days prior to the Effective Date of the renewal. The notice requirement does not apply to normal and customary administrative changes that do not have an actuarial impact, such as formulary changes, or to a decrease or increase required by state or federal law.

- Notwithstanding any provision of this section to the contrary, we may rescind an Agreement for fraud or intentional misrepresentation of material fact by a Subscriber Group and the coverage of a Member may be rescinded for fraud or intentional material 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 Participating Employers, Subscribers and Enrolled Dependents irrespective of whether monthly premiums have been received for periods beyond the termination date. However, in no event will coverage of a Participating Employer under 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 coverage of a Participating Employer is to terminate due to the required premium not paid when due, we will provide a written notice to the Participating Employer, specifying the last date the premiums may be paid (no less than 10 days from the date of the notice) in order to reinstate coverage under the Agreement. <u>We shall have the right to change the premium amount</u> to reinstate the Agreement after termination.

- Coverage under this Agreement for a Member will also terminate on 30 days' written notice if the Member commits insurance fraud fraudulent acts against us, as defined by the state of Washington.

- After the effective date of a termination pursuant to this Agreement, neither we nor the Participating Providers shall have any further obligation to provide care for the condition under treatment and no claim shall be paid by us for treatment arising after such termination date.

- The membership of a Subscriber and all Dependents shall terminate in the event that the Subscriber leaves employment with the Participating Employer 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 "Washington State Conversion of Coverage" sections of this Group Medical and Hospital Service Agreement.

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

- We will issue certificates of Creditable Coverage to Members whose coverage under this Agreement or COBRA terminates. If a Member's coverage under this Agreement ceases before such Member's coverage under any health plan sponsored by Participating Employer ceases, we will provide sufficient information to the Participating Employer to enable a Certificate of Creditable Coverage as to this Agreement to be provided by Participating Employer after such Member's coverage under all health plans sponsored by Participating Employer ceases.

- The Subscriber Group may voluntarily terminate this Agreement for any reason upon 90 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. If the group coverage is not replaced by other group coverage, notice of the termination will be provided to the Members through the offer of conversion coverage as outlined in the "Washington State Conversion Coverage" section of this Group Medical and Hospital Service Agreement.

Federal Continuation of Coverage

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

  a. If the Participating Employer 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 Participating Employer 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. Participating Employer is solely responsible for (a) assuring compliance with COBRA; (b) giving Members timely notice, in accordance with COBRA, of their continuation coverage option; (c) notifying us within 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 Participating Employer'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 the Participating Employer fails to give the Member notice of any COBRA continuation rights or to give us notice of any COBRA election, each within the time stated in this section above, we shall be entitled to charge Participating Employer, and Participating Employer 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 Participating Employer 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 Participating Employer 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 Participating Employer), 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. Participating Employer's violation of its obligations under this section shall constitute grounds for termination of the Participating Employer's coverage under this Agreement.

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

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

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

Washington State Conversion Coverage

You may be eligible to apply for medical coverage under our conversion plan for you and your then covered Dependents, if any, if you lose coverage under this Agreement because:

- the Agreement terminates; or
- your coverage under this Agreement, or under any continuation option, ends.

Dependents are entitled to Conversion rights individually when:

- their benefits terminate on account of your death or divorce;
- a Dependent Child's benefits terminate because such Child attains the limiting age for eligibility as a covered Dependent;
- the Subscriber is not eligible for a conversion plan due to misconduct; or
- coverage under any continuation option ends.

Conversion coverage will be provided under the forms and at the premium rates being offered by us at that time for medical conversion plans, based on the age and the amount of coverage applied for. Each person entitled to a conversion policy may elect a lesser form of coverage. The effective date of the conversion coverage will be the day after the coverage under this Agreement ends.

Conversion coverage must be applied for, in writing, to us, and the first premium paid to us within 31 days after coverage under this Agreement ends.

There are no conversion options available to any Member when the Member is covered under any other group plan, policy, contract, or agreement providing benefits for Hospital or medical care. Such other coverage must not contain operable exclusions for Pre-existing Conditions or waiting periods greater than those remaining under the terminated plan.

If you accept conversion coverage at the end of coverage under this group health plan, you will not qualify as a HIPAA eligible individual.

Reinstatement of Medical Coverage After Military Leave

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

- You return to active full-time employment with your Subscriber Group; and
- You make a written request for reinstatement to us within:

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

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

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

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.

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

Participating Providers

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

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

To ensure the maximum available benefits under this Agreement, Members should obtain all Medical Services from Participating Providers and in accordance with any Prior Authorization requirements, even when a Member expects payment to be made by another plan or a third party. Care furnished by a Non-Participating 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 Non-Participating Provider Level specified in the Coinsurance Schedule.

Delegation of Authority

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

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

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

General Limitations

- Benefits provided by this Agreement may be revoked or modified. No Member acquires a vested right to continue to receive a benefit as set forth in this Agreement on or after the effective date of any revocation or change to such benefit. A Member's right is to receive only such benefits as are expressly provided for and in effect on the date of each treatment. Upon termination of this Agreement or a Member's coverage under this Agreement, a Member's right to continued benefits consists solely of those benefits expressly set forth in the "Federal Continuation of Coverage" and "Washington State Conversion 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 as Medically Necessary.

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

- Members who are treated by a Provider without a Prior Authorization, if required pursuant to the "Prior Authorization" section of the Basic Benefit Schedule, will have any and all such claims denied by us.

- All benefits, exclusions and limitations set forth in the attached Benefit Schedules are incorporated herein by this reference.

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

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

- Any Appeal or Grievance brought to recover on this Agreement shall be limited to the Grievances and Appeals under the "Grievances and Appeals," "Independent Review Process" and "Review of Investigational or Experimental Therapies" sections of this Group Medical and Hospital Service Agreement. No Appeal or Grievance, including but not limited to inquiries regarding denial of claims for payments or for services, may be submitted more than 180 days following the receipt of the denial notification.

- Pre-existing Conditions.

  a. "Pre-existing Condition" means a condition for which medical advice, diagnosis, care or treatment was recommended or received during the three-month period preceding the Enrollment date, which means the earlier of the first day of the Subscriber Group's probationary period or the Member's Effective Date of coverage. The Enrollment date for a Late Enrollee is the Effective Date of coverage. Pregnancy is not a Pre-existing Condition. Genetic information does not constitute a Pre-existing Condition in the absence of a diagnosis of the condition related to such information. Pre-existing Conditions do not apply to a Member under the age of 19.

  b. Services for a Pre-existing Condition will be covered after a three-month Pre-existing Conditions waiting period has been satisfied.

  c. The Pre-existing Conditions waiting period begins on the Member's Effective Date of coverage, which means the earlier of the first day of the Member's probationary period or the Member's Effective Date of coverage, and ends three months after the Effective Date of coverage.

  d. You can reduce the length of this Exclusion Period by the number of days of your prior "Creditable Coverage." Most prior health coverage is Creditable Coverage and can be used to reduce the Pre-existing Condition waiting period if you have not experienced a break in coverage of at least 90 days. To reduce the Exclusion Period by your Creditable Coverage, you should give us a copy of any certificates of Creditable

Coverage you have. If you do not have a certificate of Creditable Coverage, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have Creditable Coverage. Please contact us if you need help demonstrating Creditable Coverage. Upon receipt of a certificate of Creditable Coverage, the waiting period will be reduced by the length of Creditable Coverage under other Health Benefit Plans that are not preceded by a break in coverage of 90 days or more. We will give enrolling Members written notice of our determination of any Pre-Existing Conditions waiting period that applies to a Member.

e. If the Participating Employer offers Eligible Employees a choice of health coverage under either a federally-qualified HMO plan or this plan, an Employee transferring coverage from the HMO plan to this plan during an Open Enrollment Period will not be subject to the waiting period under this Agreement.

f. The Pre-Existing Conditions waiting period does not apply to a newborn child.

g. The Pre-Existing Conditions waiting period does not apply to a newly adopted child.

h. The Pre-existing Conditions waiting period does not apply to a Member under the age of 19.

i. The three-month Pre-existing Condition waiting period does not apply to a Late Enrollee who has been excluded from coverage for three months.

j. For further information or assistance regarding Pre-existing Conditions Exclusion Periods, 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

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

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

Rights of Members

- **Confidentiality of Medical Records:** We shall have access to information from medical records of Members and information received by Physicians in the course of the Physician/patient relationship and the right to use such information as is reasonably necessary in connection with our administration of this Agreement, for records review incident to any peer review, quality assurance program or utilization review program.

Right to Limit Disclosure of Health Information

a. We will limit disclosure of any information, including health information, about an individual who is the subject of the information if the individual clearly states in writing that disclosure to specified individuals of all or part of that information could jeopardize the safety of the individual. Disclosure of information under this provision will be limited consistent with the individual's request, such as a request for us to not release any information to a spouse to prevent domestic violence.

b. We will not disclose nonpublic personal health information concerning health services related to reproductive health, sexually transmitted diseases, Chemical Dependency and mental health, including mailing appointment notices, calling the home to confirm appointments, or mailing a bill or explanation of benefits to a Subscriber or certificate holder, if the individual who is the subject of the information makes a written request. In addition, we will not require an adult individual to obtain the Subscriber's or other covered person's authorization to receive health care services or to submit a claim.

c. We will recognize the right of any minor who may obtain health care without the consent of a parent or legal guardian pursuant to state or federal law, to exclusively exercise rights granted under this section regarding health information; and

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

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

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

- **Non-Discrimination:** 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.

Grievances and Appeals

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

Grievances. To process a Grievance, we will:

- Provide a notice to the Member within 2 business days of when the Grievance is received;
- Review the Grievance and make our determination within 45 business days from the receipt of the Grievance. We will notify the Member of our decision within 5 business days of making the determination on the Grievance.

  Grievance determinations are not Adverse Benefit Determinations and are not subject to the Appeals rights described below or the rights to the independent review process as described under the "Independent Review Process" section.

Appeals. We will provide written notice to a Member, or his or her designated representative of an Adverse Benefit Determination. The written notice will explain our decision and the supporting coverage or clinical reasons; and our Appeal process, including information, as appropriate, about how to exercise the Member's rights to obtain a second

opinion, and how to continue receiving services. We do not require that a Member file a complaint prior to seeking Appeal of an Adverse Benefit Determination.

To process an Appeal, we will:

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

In addition, a Member has the right to file a complaint with or seek other assistance from the Office of the Washington State Insurance Commissioner. If a Member chooses to do so, assistance is available. Contact the Office of the Washington State Insurance Commissioner, Consumer Protection Division, at PO Box 40256, Olympia, WA 98504-0256. Contact them by phone at (800)562-6900, or online at http://www.insurance.wa.gov/consumers/health/appeal/Table-of-Contents.shtml.

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

Independent Review Process

A Member may seek review by a certified independent review organization of our decision to deny, modify, reduce, or terminate coverage of or payment for a health care service, after exhausting our Grievance process and receiving a decision that is unfavorable to the Member, or after we have exceeded the timelines for Grievances provided above, without good cause and without reaching a decision. This right also applies to an Adverse Benefit Determination that is based on our requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

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

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

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

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

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

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

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

Review of Investigational or Experimental Therapies

We do not cover Experimental or Investigational drugs, devices, procedures or therapies.

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

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

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

A final determination will be made and provided to the Member in writing within 14 working days of receipt of the fully documented Appeal, unless we notify the applicant that an extension is necessary. We may extend the review period beyond 30 days only with the informed written consent of the Member. An Appeal will be expedited if the Member's Provider or our Medical Director determines that following the Appeal response, timelines could seriously jeopardize the applicant's life, health, or ability to regain maximum function. The decision regarding an expedited Appeal will be made within 72 hours.

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

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

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

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

A Member aggrieved by any action by us must first exhaust the Grievance procedure as set forth in this section.

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

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

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

Coordination of Benefits

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

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

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

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

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

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

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

- Each contract or other arrangement for coverage described above is a separate plan. Also, if an arrangement has two or more parts and the Coordination of Benefits provision applies to only one of the two, each of the parts is a separate plan.

- **"This plan"** means, in a Coordination of Benefits provision, the part of this Agreement that provides benefits for health care expenses to which the Coordination of Benefits provision applies and which may be reduced because of the benefits of other plans. Any other part of this Agreement providing health care benefits is separate from this plan. This Agreement may apply one Coordination of Benefits provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another Coordination of Benefits provision to coordinate other benefits.

- The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health coverage under more than one plan.

  When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim. This means that when this plan is secondary, it must pay the amount which, when combined with what the primary plan paid, totals 100% of the highest allowable expense. In addition, if this plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the primary plan) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that Calendar Year, whether or not they are an allowable expense under this plan. If this plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

- **"Allowable expense"** means a health care expense, including deductibles, Coinsurance and Copayments, but excluding pharmacy or vision care expenses, which are covered at least in part by one or more plans covering the person for whom the claim is made. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense and a benefit paid. An expense that is not covered by any of the plans covering the person is not an allowable expense.

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

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

  b. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method,

any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

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

- **"Closed panel plan"** is a plan that provides health care benefits to covered persons in the form of services through a panel of Providers who are primarily employed by the plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

- **"Custodial parent"** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.

- **Order of Benefit Determination Rules**. If this Coordination of Benefits provision applies, the order of benefit determination rules should be looked at first. These rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan shall not be reduced when, under the order of benefit determination rules, this plan determines its benefits before another plan. The benefits of this plan may be reduced when under the order of benefit determination rules; another plan determines its benefits first.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. first the plan of the parent with custody of the child;
2. then, the plan of the spouse of the parent with the custody of the child;
3. then, the plan of the parent not having custody of the child;
4. finally, the plan of the spouse of the parent not having custody of the child.

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

3. **Active/Inactive Employee**. The benefits of a plan which covers a person as an active employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a plan which covers that person as an inactive employee who is laid off or retired (or as that employee's Dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Non-Dependent/Dependent" section of this section can determine the order of benefits.

4. **COBRA or State Continuation Coverage**. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or federal law is covered under another plan, the plan covering the person as an employee, Member, Subscriber, or retiree or covering the person as a Dependent of an employee, Member, Subscriber, or retiree is the primary plan and the COBRA or state of other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Non-Dependent/Dependent" section of this section can determine order of benefits.

5. **Longer/Shorter Length of Coverage**. If none of the pervious rules determines the order of benefits, the benefits of the plan which covered the employee, Member, Subscriber or retiree longer are determined before those of the plan which covered that person for the shorter time.

6. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shall shared equally between the plans meeting the definition of plan in this section. In addition, this plan will not pay more than it would have paid had it been the primary plan.

- **Effect on the Benefits of This Plan**. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan must make the payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total allowable expense for that claim total allowable expense is the highest allowable expense of the primary plan or the secondary plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

- **Right to Receive and Release Necessary Information**. Certain facts are needed to apply these coordination of benefits provisions. We have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell or get the consent of any person to do this. Each person claiming benefits under this plan must give us any facts we need to pay the claim.

- **Facility of Payment**. If payments that should have been made under this plan are made by another plan, we have the right, at our discretion, to remit to the other plan the amount we determine appropriate to satisfy the intent of this provision. The amounts paid to the other plan are considered benefits paid under this plan. To the extent of such payments, we are fully discharged from liability under this plan.

- **Right of Recovery**. We have the right to recover excess payment whenever we have paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Coordination of Benefits provision. We may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

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

Medicare

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

Right of Recovery

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

- To cooperate with us or our agent and do whatever is reasonably necessary to assist to secure its rights;

- That we or our agent has a lien on any recovery, settlement or judgment which may be had from or against a Responsible Party to the extent that it has made payment for covered services and supplies but only after the Member has been fully compensated;

- To pay from any recovery, settlement or judgment (and the Member hereby authorizes his or her attorney to pay from any recovery, settlement or judgment), any and all amounts to which we or our agent is entitled under this section, unless otherwise agreed to by us or our agent in writing;

- To promptly give any and all written directions, authorizations and assignments as are requested by us or our agent to assist in accomplishing or confirming the above;

- That the benefits under this Agreement will be reduced if a Responsible Party has reimbursed a Member or paid for services which we would have covered as part of that benefit; and

- To do nothing to prejudice our rights.

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

  a. We make a payment to which a Member is not entitled under this Agreement; or

  b. We pay a person who is not eligible for benefits at all.

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

Independent Agents

- The relationship between Subscriber Group and a Subscriber is that of plan sponsor and participant and is defined by the Group's health and welfare plan. We have no involvement in that relationship. The relationship between Participating Employer and us is that of purchaser and seller and is entirely governed by the provisions of this Agreement. In addition, Subscriber Group and Participating Employer, as appropriate, act as the agent of those Eligible Employees who are Subscribers with respect to all terms and provisions of this Agreement. Because the Subscriber pays the premium to us indirectly through his or her agent, the relationship between a Subscriber and us is also that of purchaser and seller and is entirely governed by the provisions of this Agreement.

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

- The fact that Members and Participating Providers each have contractual relationships with us does not prevent a Member from obtaining services, from a Participating Provider, that are not covered by us. We have no direct control over the examination, diagnosis or treatment of a Member. We do perform medical management, including but not limited to case review for purposes of determining coverage, consultation with Providers regarding Prior Authorization, and concurrent and retrospective review of Medical Services provided to Members. The purpose of our medical management procedures is to encourage the lowest cost method of treating a Member which, based upon the prevailing standards of medical treatment, meets the needs of the Member. These procedures are not intended to ration care or limit care to methods not appropriate to treat a Member's condition. These procedures are not intended to create a Physician/patient relationship or to replace the relationship between a Member and his or her Physician. A Member is always entitled to obtain, at his or her own expense, services not covered under the terms of this Agreement.

- The Subscriber Group and Participating Employer agree 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 or Participating Employer, 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, Participating Employer, and their 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, Participating Employer, and their directors, officers or employees or any Members Enrolled under this Agreement.

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 Participating Employer or 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 shall complete and submit to us forms as we may reasonably request.

- Cards issued by us to Members are for identification only. Possession of our identification card confers no right to service or other benefits. The holder of our identification card must be a Member on whose behalf all amounts under this Agreement have actually been paid. Any person receiving services or other benefits to which he or she is not entitled shall be charged at the usual rates of the Provider. If any Member permits the use of his or her plan identification card by any other person, such card may be reclaimed by us, and all rights of such Member and his or her Dependents may be terminated without notice at our election. Such Member shall be liable to us for all associated costs.

- We may adopt reasonable policies, procedures, rules and interpretations not inconsistent with this Agreement to promote orderly and efficient administration of this Agreement.

- Any notice under this Agreement shall be given by the U.S. mail, postage paid, addressed as follows:

  a. To us at 13221 SW 68th Parkway, Tigard, Oregon 97223;

  b. To Member at the address of record;

  c. To Subscriber Group at the address indicated on the Signature Sheet.

- This Agreement, as defined in the "Definitions" section of this Medical and Hospital Service Agreement, constitutes the entire contract between the Subscriber Group, Participating Employer, Subscriber and us.

- A Member's Copayments and Coinsurance are limited as stated on the Copayment and Coinsurance Schedule attached hereto.

- The benefits of this Agreement are personal to the Member. The Member may not assign such benefits nor may the Member assign or otherwise transfer any claim, right of recovery or right to payment arising under this Agreement.

- The rights of Members and our obligations shall be determined solely by this Agreement without regard to any other agreement or relationship between us and any Provider, Physician, Group Subscriber or other person. No Provider (except for services actually rendered by such Provider) or any director, officer, employee, agent or representative of ours is liable for the conduct of any Provider in furnishing health care services.

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

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

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

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

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

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

- Subscriber Group and each Participating Employer and Subscriber acknowledge that we, as most health care organizations, operate on a system which may involve one, more or all of the following: financial incentives, medical management and utilization review. Subscriber Group and all Participating Employers and Subscribers acknowledge that, absent a declaration that any of the foregoing is contrary to public policy in the State of Washington, such system does not violate medical ethics nor constitute negligence, fraud, breach of trust or a tortious breach of the Physician/patient relationship.

- We rely substantially upon licensing and regulatory authorities, continuing education requirements, Peer Review Committees, medical and Hospital staff decisions, Provider representations and insurability in the selection of Participating Providers. We are not responsible for the decisions of Providers.

- It is understood that nothing in this Agreement shall entitle either party to this Agreement to recover attorneys' fees from the other party in the event of litigation between the parties, except as provided for by statute.

- Each party shall advise the other as to matters that come to their attention with respect to potential substantial legal actions involving matters related to this Agreement, and shall promptly advise each other of legal actions commenced against each party that come to their attention. Each party shall fully cooperate with the other in the defense of any action arising out of matters related to this Agreement by providing without additional fee all information relating to disputed claims and providing necessary testimony.

- Waiver of any default shall not be deemed to be a waiver of any subsequent default. Waiver or breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach and shall not be construed to be a modification of the terms of this Agreement unless stated to be such in writing, signed by the parties and attached to this Agreement.

- Members must submit claims to us for all services provided by Nonparticipating Providers within 90 days from the date the services were rendered or as soon as medically possible, but in no event later than one year from the date services were rendered unless the Member is legally incapacitated throughout that year. Claims filed by Medicaid must be received no later than three years from the date the services were rendered. Claims must include a statement describing the services rendered, date of services and charges therefore.

- Notwithstanding any other provision of this Agreement, the provisions of this Agreement which, on or after the Group Effective Date, are in conflict with applicable state or federal laws or state or federal regulations, are hereby amended to conform to the minimum requirements of such laws or regulations.

- This Agreement is issued and delivered in the State of Washington and is governed by the laws of the State of Washington.

- When services are provided to a Member by a Participating Provider in accordance with the terms of this Agreement, the Member is responsible only for payment of the contractually stated Copayments, deductibles, and Coinsurance and for non-covered services. A Member shall not be responsible for amounts owed by us to a Participating Provider even if we are unable to pay.

- 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 and Participating Employer warrant that it presently has and will maintain throughout the term of this Agreement all coverage required of it by applicable workers' compensation or employer's liability laws or other laws of similar purpose.

- If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions and the Agreement shall remain in force and effect, and in no way shall be affected, impaired, or invalidated.

- The headings in this Agreement are provided solely for convenience of reference and are not a part of this Agreement or guides to interpretation hereof.

- In the absence of fraud, all statements made by applicants, Subscriber Group, Participating Employers or a Member shall be deemed representations and not warranties, and no statement made for the purpose of effecting coverage shall void the coverage or reduce benefits unless contained in a written instrument signed by Subscriber Group, Participating Employer or a Member, a copy of which has been furnished to Subscriber Group, Participating Employer or to the Member or the Member's beneficiary.

- We do not consider the availability or eligibility for medical assistance under Medicaid in any state when considering eligibility for coverage or paying benefits for eligible Members under this plan.

- Benefits payable under this Agreement are subject to the deductible shown in the Copayment and Coinsurance Schedule which must be satisfied each Calendar Year before benefits will be paid.

  Except for a high deductible health plan, the annual out-of-pocket maximum does not include 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.

  When this Agreement immediately replaces a Subscriber Group's previous HNOR PPO Plan Agreement in the middle of a Calendar Year, we will credit amounts accumulated toward annual deductibles and out-of-pocket maximums.

- 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.

Medical Loss Ratio (MLR) Rebates

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

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION AND NONPUBLIC PERSONAL FINANCE INFORMATION* ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE ALSO DESCRIBES 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. We must follow the terms of this Notice while it is in effect. 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.

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 coverage or 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.** If you are enrolled through a group health plan, we may provide non-identifiable summaries of claims and expenses for enrollees in your group health plan to the plan sponsor, which is usually the employer. If the plan sponsor provides plan administration services, we may also provide access to identifiable health information to support its performance of such services which may include but are not limited to claims audits or customer services functions. Health Net will only share health information upon a certification from the plan sponsor representing there are restrictions in place to ensure that only plan sponsor employees with a legitimate need to know will have access to health information in order to provide plan administration functions.

  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.

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.

Other uses or disclosures with an authorization

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. 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.

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 records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.

- **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 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 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 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.

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.

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.

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 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.***

Contact the plan

If you have any complaints or 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: Director, Information Privacy
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

** Nonpublic personal financial information includes personally identifiable financial information that you provided to us to obtain health plan coverage or we obtained in providing benefits to you. Examples include Social Security numbers, account balances and payment history. We do not disclose any nonpublic personal information about you to anyone, except as permitted by law.*

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

Hearing and Speech Assistance
Monday - Friday 8:00 a.m. to 5:00 p.m.
TTY 888.802.7122

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

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Health Net Health Plan of Oregon, Inc.
Washington PPO Advantage Plan
Copayment and Coinsurance Schedule WPT152V2LX/12 Pacific Trust

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

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

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

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 a fixed percentage of Maximum Allowable Amount (MAA) rates for other services. We pay Out-of-Network Providers based on MAA rates, not on billed amounts. MAA rates may often be less than the amount a Provider bills for a service. Out-of-Network Providers may therefore hold you responsible for amounts they charge that exceed the MAA rates we pay. Amounts that exceed our MAA rates are not covered and do not apply to your annual out-of-pocket maximum. *Your responsibility for any amounts that exceed our MAA payment is shown on this Schedule as* **MAA**.

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

The deductible is waived for preventive care services covered under the "Preventive Care" section of the Basic Benefit Schedule.

	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible per person	$250 PPO Network and Out-of-Network combined [1, 2]	
Annual deductible per family	$750 PPO Network and Out-of-Network combined [1, 2]	
Physician/Professional/Outpatient Care		
Physician services, office visit [4]	$15 per visit [3]	40% MAA
Physician services, preventive care [4]	No charge [3]	40% MAA [3]
Physician services, urgent care center [4]	$50 per visit [3]	$50 per visit MAA [3]
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/mammography /EKG/Ultrasound	20% contract rate [3]	40% MAA
Diagnostic laboratory tests	20% contract rate [3]	40% MAA
CT/MRI/PET/SPECT/EEG/Holter monitor/Stress test	20% contract rate [3]	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 [8]	20% contract rate	40% MAA
Inpatient rehabilitation therapy - 30 days/year max	20% contract rate	40% MAA
Emergency Services		
Outpatient emergency room services	$150 per visit, then 20% contract rate [3]	$150 per visit, then 20% [3]
Inpatient admission from emergency room	20% contract rate	20% MAA

Washington PPO Advantage Plan WPT152V2LX/12 Pacific Trust

For covered services, you are responsible for:

	PPO Network	Out-of-Network
Emergency ground ambulance transport – 3 trips/year max	20% (MAA applies to Out-of-Network Providers)	
Emergency air ambulance transport - $10,000/year max	20% (MAA applies to Out-of-Network Providers)	
Behavioral Health Services		
Outpatient mental health [5]	$15 per visit [3]	40% MAA
Inpatient mental health [5]	20% contract rate	40% MAA
Outpatient Chemical Dependency [5]	$15 per visit [3]	40% MAA
Inpatient Chemical Dependency [5]	20% contract rate	40% MAA
Other Services		
Durable Medical Equipment –$5,000/year max [6]	20% contract rate	40% MAA
Prosthetic Devices/Orthotic Devices	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% MAA
Diabetes management	$15 per program [3]	40% MAA
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
TMJ services - $500/lifetime max	50% contract rate [2]	50% MAA [2]
Home infusion therapy	20% contract rate	40% MAA
Outpatient chemotherapy (non-self administered anticancer medications and administration)	20% contract rate	40% MAA
Skilled Nursing Facility care - 60 days/year max	20% contract rate	40% MAA
Hospice services	20% contract rate	40% MAA
Home health visits	20% contract rate	40% MAA
Neurodevelopmental therapy, under age 7	20% contract rate	40% MAA
Health education - $150/year combined max	Any charges over maximum reimbursement of $50/qualifying class [2]	
Spinal and other manipulations (any provider: MD, DO, chiropractor) - 15 manipulations/year max	$15 per visit [3]	40% MAA
Acupuncture Care - 15 visits/year max	$15 per visit [3]	40% MAA
Naturopathic Care	$15 per visit [3]	40% MAA
Massage Therapy - 15 visits/year max	$15 per visit [3]	40% MAA
Benefit Maximums		
Annual out-of-pocket maximum per person [7]	$1,000 PPO Network and Out-of-Network combined	
Annual out-of-pocket maximum per family [7]	$3,000 PPO Network and Out-of-Network combined	
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

1. You must meet the specified deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.
2. Your payments do not apply to the annual out-of-pocket maximum.
3. Deductible is waived.
4. Office visit Copayment includes physician services only. Other services are subject to Copayments and Coinsurance as listed.
5. To Prior Authorize mental health or Chemical Dependency services, call 800-977-8216.
6. The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice care, or when Home Health Care or Hospice care are being provided under case management in lieu of Hospitalization.
7. The annual out-of-pocket maximum does not include 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.

[8] 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.

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

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Health Net Health Plan of Oregon, Inc.
Washington PPO Advantage Plan
Copayment and Coinsurance Schedule WPT155V2DX/12 Pacific Trust

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

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

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

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 a fixed percentage of Maximum Allowable Amount (MAA) rates for other services. We pay Out-of-Network Providers based on MAA rates, not on billed amounts. MAA rates may often be less than the amount a Provider bills for a service. Out-of-Network Providers may therefore hold you responsible for amounts they charge that exceed the MAA rates we pay. Amounts that exceed our MAA rates are not covered and do not apply to your annual out-of-pocket maximum. *Your responsibility for any amounts that exceed our MAA payment is shown on this Schedule as* **MAA**.

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

The deductible is waived for preventive care services covered under the "Preventive Care" section of the Basic Benefit Schedule.

	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible per person	$500 PPO Network and Out-of-Network combined [1, 2]	
Annual deductible per family	$1,500 PPO Network and Out-of-Network combined [1, 2]	
Physician/Professional/Outpatient Care		
Physician services, office visit [4]	$15 per visit [3]	40% MAA
Physician services, preventive care [4]	No charge[3]	40% MAA [3]
Physician services, urgent care center [4]	$50 per visit [3]	$50 per visit MAA [3]
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/mammography /EKG/Ultrasound	20% contract rate [3]	40% MAA
Diagnostic laboratory tests	20% contract rate[3]	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 [8]	20% contract rate	40% MAA
Inpatient rehabilitation therapy - 30 days/year max	20% contract rate	40% MAA
Emergency Services		
Outpatient emergency room services	$150 per visit, then 20% contract rate [3]	$150 per visit, then 20% [3]
Inpatient admission from emergency room	20% contract rate	20% MAA

Washington PPO Advantage Plan WPT155V2DX/12 Pacific Trust

	For covered services, you are responsible for:	
	PPO Network	**Out-of-Network**
Emergency ground ambulance transport – 3 trips/year max	20% (MAA applies to Out-of-Network Providers)	
Emergency air ambulance transport - $10,000/year max	20% (MAA applies to Out-of-Network Providers)	
Behavioral Health Services		
Outpatient mental health [5]	$15 per visit [3]	40% MAA
Inpatient mental health [5]	20% contract rate	40% MAA
Outpatient Chemical Dependency [5]	$15 per visit [3]	40% MAA
Inpatient Chemical Dependency [5]	20% contract rate	40% MAA
Other Services		
Durable Medical Equipment –$5,000/year max [6]	20% contract rate	40% MAA
Prosthetic Devices/Orthotic Devices	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% MAA
Diabetes management	$15 per program [3]	40% MAA
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
TMJ services - $500/lifetime max	50% contract rate [2]	50% MAA [2]
Home infusion therapy	20% contract rate	40% MAA
Outpatient chemotherapy (non-self administered anticancer medications and administration)	20% contract rate	40% MAA
Skilled Nursing Facility care - 60 days/year max	20% contract rate	40% MAA
Hospice services	20% contract rate	40% MAA
Home health visits	20% contract rate	40% MAA
Neurodevelopmental therapy, under age 7	20% contract rate	40% MAA
Health education - $150/year combined max	Any charges over maximum reimbursement of $50/qualifying class [2]	
Spinal and other manipulations (any provider: MD, DO, chiropractor) - 15 manipulations/year max	$15 per visit [3]	40% MAA
Acupuncture Care - 15 visits/year max	$15 per visit [3]	40% MAA
Naturopathic Care	$15 per visit [3]	40% MAA
Massage Therapy - 15 visits/year max	$15 per visit [3]	40% MAA
Benefit Maximums		
Annual out-of-pocket maximum per person [7]	$1,500 PPO Network and Out-of-Network combined	
Annual out-of-pocket maximum per family [7]	$4,500 PPO Network and Out-of-Network combined	
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

1. You must meet the specified deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.
2. Your payments do not apply to the annual out-of-pocket maximum.
3. Deductible is waived.
4. Office visit Copayment includes physician services only. Other services are subject to Copayments and Coinsurance as listed.
5. To Prior Authorize mental health or Chemical Dependency services, call 800-977-8216.
6. The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice care, or when Home Health Care or Hospice care are being provided under case management in lieu of Hospitalization.
7. The annual out-of-pocket maximum does not include 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.

[8] 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.

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

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

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

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 a fixed percentage of Maximum Allowable Amount (MAA) rates for other services. We pay Out-of-Network Providers based on MAA rates, not on billed amounts. MAA rates may often be less than the amount a Provider bills for a service. Out-of-Network Providers may therefore hold you responsible for amounts they charge that exceed the MAA rates we pay. Amounts that exceed our MAA rates are not covered and do not apply to your annual out-of-pocket maximum. *Your responsibility for any amounts that exceed our MAA payment is shown on this Schedule as* **MAA**.

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

The deductible is waived for preventive care services covered under the "Preventive Care" section of the Basic Benefit Schedule.

	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible per person	$750 PPO Network and Out-of-Network combined [1, 2]	
Annual deductible per family	$2,250 PPO Network and Out-of-Network combined [1, 2]	
Physician/Professional/Outpatient Care		
Physician services, office visit [4]	$20 per visit [3]	40% MAA
Physician services, preventive care [4]	No charge [3]	40% MAA [3]
Physician services, urgent care center [4]	$50 per visit [3]	$50 per visit MAA [3]
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/mammography /EKG/Ultrasound	20% contract rate [3]	40% MAA
Diagnostic laboratory tests	20% contract rate[3]	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 [8]	20% contract rate	40% MAA
Inpatient rehabilitation therapy - 30 days/year max	20% contract rate	40% MAA
Emergency Services		
Outpatient emergency room services	$150 per visit, then 20% contract rate [3]	$150 per visit, then 20% [3]
Inpatient admission from emergency room	20% contract rate	20% MAA

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	For covered services, you are responsible for:	
	PPO Network	**Out-of-Network**
Emergency ground ambulance transport – 3 trips/year max	20% (MAA applies to Out-of-Network Providers)	
Emergency air ambulance transport - $10,000/year max	20% (MAA applies to Out-of-Network Providers)	
Behavioral Health Services		
Outpatient mental health [5]	$20 per visit [3]	40% MAA
Inpatient mental health [5]	20% contract rate	40% MAA
Outpatient Chemical Dependency [5]	$20 per visit [3]	40% MAA
Inpatient Chemical Dependency [5]	20% contract rate	40% MAA
Other Services		
Durable Medical Equipment –$5,000/year max [6]	20% contract rate	40% MAA
Prosthetic Devices/Orthotic Devices	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% MAA
Diabetes management	$20 per program [3]	40% MAA
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
TMJ services - $500/lifetime max	50% contract rate [2]	50% MAA [2]
Home infusion therapy	20% contract rate	40% MAA
Outpatient chemotherapy (non-self administered anticancer medications and administration)	20% contract rate	40% MAA
Skilled Nursing Facility care - 60 days/year max	20% contract rate	40% MAA
Hospice services	20% contract rate	40% MAA
Home health visits	20% contract rate	40% MAA
Neurodevelopmental therapy, under age 7	20% contract rate	40% MAA
Health education - $150/year combined max	Any charges over maximum reimbursement of $50/qualifying class [2]	
Spinal and other manipulations (any provider: MD, DO, chiropractor) - 15 manipulations/year max	$20 per visit [3]	40% MAA
Acupuncture Care - 15 visits/year max	$20 per visit [3]	40% MAA
Naturopathic Care	$20 per visit [3]	40% MAA
Massage Therapy - 15 visits/year max	$20 per visit [3]	40% MAA
Benefit Maximums		
Annual out-of-pocket maximum per person [7]	$2,500 PPO Network and Out-of-Network combined	
Annual out-of-pocket maximum per family [7]	$7,500 PPO Network and Out-of-Network combined	
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

1. You must meet the specified deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.
2. Your payments do not apply to the annual out-of-pocket maximum.
3. Deductible is waived.
4. Office visit Copayment includes physician services only. Other services are subject to Copayments and Coinsurance as listed.
5. To Prior Authorize mental health or Chemical Dependency services, call 800-977-8216.
6. The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice care, or when Home Health Care or Hospice care are being provided under case management in lieu of Hospitalization.
7. The annual out-of-pocket maximum does not include 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.

[8] 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.

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

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

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

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 a fixed percentage of Maximum Allowable Amount (MAA) rates for other services. We pay Out-of-Network Providers based on MAA rates, not on billed amounts. MAA rates may often be less than the amount a Provider bills for a service. Out-of-Network Providers may therefore hold you responsible for amounts they charge that exceed the MAA rates we pay. Amounts that exceed our MAA rates are not covered and do not apply to your annual out-of-pocket maximum. *Your responsibility for any amounts that exceed our MAA payment is shown on this Schedule as* **MAA**.

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

The deductible is waived for preventive care services covered under the "Preventive Care" section of the Basic Benefit Schedule.

	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible per person	$1,500 PPO Network and Out-of-Network combined [1, 2]	
Annual deductible per family	$4,500 PPO Network and Out-of-Network combined [1, 2]	
Physician/Professional/Outpatient Care		
Physician services, office visit [4]	$25 per visit [3]	40% MAA
Physician services, preventive care [4]	No charge [3]	40% MAA [3]
Physician services, urgent care center [4]	$50 per visit [3]	$50 per visit MAA [3]
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/mammography /EKG/Ultrasound	20% contract rate [3]	40% MAA
Diagnostic laboratory tests	20% contract rate [3]	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 [8]	20% contract rate	40% MAA
Inpatient rehabilitation therapy - 30 days/year max	20% contract rate	40% MAA
Emergency Services		
Outpatient emergency room services	$150 per visit, then 20% contract rate [3]	$150 per visit, then 20% [3]
Inpatient admission from emergency room	20% contract rate	20% MAA

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For covered services, you are responsible for:

	PPO Network	Out-of-Network
Emergency ground ambulance transport – 3 trips/year max	20% (MAA applies to Out-of-Network Providers)	
Emergency air ambulance transport - $10,000/year max	20% (MAA applies to Out-of-Network Providers)	
Behavioral Health Services		
Outpatient mental health [5]	$25 per visit [3]	40% MAA
Inpatient mental health [5]	20% contract rate	40% MAA
Outpatient Chemical Dependency [5]	$25 per visit [3]	40% MAA
Inpatient Chemical Dependency [5]	20% contract rate	40% MAA
Other Services		
Durable Medical Equipment –$5,000/year max [6]	20% contract rate	40% MAA
Prosthetic Devices/Orthotic Devices	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% MAA
Diabetes management	$25 per program [3]	40% MAA
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
TMJ services - $500/lifetime max	50% contract rate [2]	50% MAA [2]
Home infusion therapy	20% contract rate	40% MAA
Outpatient chemotherapy (non-self administered anticancer medications and administration)	20% contract rate	40% MAA
Skilled Nursing Facility care - 60 days/year max	20% contract rate	40% MAA
Hospice services	20% contract rate	40% MAA
Home health visits	20% contract rate	40% MAA
Neurodevelopmental therapy, under age 7	20% contract rate	40% MAA
Health education - $150/year combined max	Any charges over maximum reimbursement of $50/qualifying class [2]	
Spinal and other manipulations (any provider: MD, DO, chiropractor) - 15 manipulations/year max	$25 per visit [3]	40% MAA
Acupuncture Care - 15 visits/year max	$25 per visit [3]	40% MAA
Naturopathic Care	$25 per visit [3]	40% MAA
Massage Therapy - 15 visits/year max	$25 per visit [3]	40% MAA
Benefit Maximums		
Annual out-of-pocket maximum per person [7]	$2,500 PPO Network and Out-of-Network combined	
Annual out-of-pocket maximum per family [7]	$7,500 PPO Network and Out-of-Network combined	
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

1. You must meet the specified deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.
2. Your payments do not apply to the annual out-of-pocket maximum.
3. Deductible is waived.
4. Office visit Copayment includes physician services only. Other services are subject to Copayments and Coinsurance as listed.
5. To Prior Authorize mental health or Chemical Dependency services, call 800-977-8216.
6. The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice care, or when Home Health Care or Hospice care are being provided under case management in lieu of Hospitalization.

[7] The annual out-of-pocket maximum does not include 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.

[8] 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.

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

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

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

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

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 a fixed percentage of Maximum Allowable Amount (MAA) rates for other services. We pay Out-of-Network Providers based on MAA rates, not on billed amounts. MAA rates may often be less than the amount a Provider bills for a service. Out-of-Network Providers may therefore hold you responsible for amounts they charge that exceed the MAA rates we pay. Amounts that exceed our MAA rates are not covered and do not apply to your annual out-of-pocket maximum. *Your responsibility for any amounts that exceed our MAA payment is shown on this Schedule as* **MAA**.

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

The deductible is waived for preventive care services covered under the "Preventive Care" section of the Basic Benefit Schedule.

	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible per person	$2,500 PPO Network and Out-of-Network combined [1, 2]	
Annual deductible per family	$7,500 PPO Network and Out-of-Network combined [1, 2]	
Physician/Professional/Outpatient Care		
Physician services, office visit [4]	$30 per visit [3]	40% MAA
Physician services, preventive care [4]	No charge [3]	40% MAA [3]
Physician services, urgent care center [4]	$50 per visit [3]	$50 per visit MAA [3]
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/mammography/EKG/Ultrasound	20% contract rate [3]	40% MAA
Diagnostic laboratory tests	20% contract rate[3]	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 [8]	20% contract rate	40% MAA
Inpatient rehabilitation therapy - 30 days/year max	20% contract rate	40% MAA
Emergency Services		
Outpatient emergency room services	$150 per visit, then 20% contract rate [3]	$150 per visit, then 20% [3]
Inpatient admission from emergency room	20% contract rate	20% MAA

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For covered services, you are responsible for:

	PPO Network	Out-of-Network
Emergency ground ambulance transport –3 trips/year max	20% (MAA applies to Out-of-Network Providers)	
Emergency air ambulance transport - $10,000/year max	20% (MAA applies to Out-of-Network Providers)	
Behavioral Health Services		
Outpatient mental health [5]	$30 per visit [3]	40% MAA
Inpatient mental health [5]	20% contract rate	40% MAA
Outpatient Chemical Dependency [5]	$30 per visit [3]	40% MAA
Inpatient Chemical Dependency [5]	20% contract rate	40% MAA
Other Services		
Durable Medical Equipment –$5,000/year max [6]	20% contract rate	40% MAA
Prosthetic Devices/Orthotic Devices	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% MAA
Diabetes management	$30 per program [3]	40% MAA
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
TMJ services - $500/lifetime max	50% contract rate [2]	50% MAA [2]
Home infusion therapy	20% contract rate	40% MAA
Outpatient chemotherapy (non-self administered anticancer medications and administration)	20% contract rate	40% MAA
Skilled Nursing Facility care - 60 days/year max	20% contract rate	40% MAA
Hospice services	20% contract rate	40% MAA
Home health visits	20% contract rate	40% MAA
Neurodevelopmental therapy, under age 7	20% contract rate	40% MAA
Health education - $150/year combined max	Any charges over maximum reimbursement of $50/qualifying class [2]	
Spinal and other manipulations (any provider: MD, DO, chiropractor) - 15 manipulations/year max	$30 per visit [3]	40% MAA
Acupuncture Care - 15 visits/year max	$30 per visit [3]	40% MAA
Naturopathic Care	$30 per visit [3]	40% MAA
Massage Therapy - 15 visits/year max	$30 per visit [3]	40% MAA
Benefit Maximums		
Annual out-of-pocket maximum per person [7]	$2,500 PPO Network and Out-of-Network combined	
Annual out-of-pocket maximum per family [7]	$7,500 PPO Network and Out-of-Network combined	
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

1. You must meet the specified deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.
2. Your payments do not apply to the annual out-of-pocket maximum.
3. Deductible is waived.
4. Office visit Copayment includes physician services only. Other services are subject to Copayments and Coinsurance as listed.
5. To Prior Authorize mental health or Chemical Dependency services, call 800-977-8216.
6. The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice care, or when Home Health Care or Hospice care are being provided under case management in lieu of Hospitalization.
7. The annual out-of-pocket maximum does not include 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.

[8] 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.

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

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Washington PPO Advantage Plan

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

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

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 a fixed percentage of Maximum Allowable Amount (MAA) for other services. We pay Out-of-Network Providers based on MAA rates, not on billed amounts. MAA rates may often be less than the amount a Provider bills for a service. Out-of-Network Providers may therefore hold you responsible for amounts they charge that exceed the MAA rates we pay. Amounts that exceed our MAA rates are not covered and do not apply to your annual out-of-pocket maximum. *Your responsibility for any amounts that exceed our MAA payment is shown on this Schedule as* **MAA**.

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

The deductible is waived for preventive care services covered under the "Preventive Care" section of the Basic Benefit Schedule.

	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible per person	$250 PPO Network and Out-of-Network combined [1, 2]	
Annual deductible per family	$750 PPO Network and Out-of-Network combined [1, 2]	
Physician/Professional/Outpatient Care		
Physician services, office visit [4]	$20 per visit [3]	40% MAA
Physician services, preventive care [4]	No charge [3]	40% MAA [3]
Physician services, urgent care center [4]	$50 per visit [3]	$50 per visit MAA [3]
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/mammography/EKG/Ultrasound	20% contract rate [3]	40% MAA
Diagnostic laboratory tests	20% contract rate [3]	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 [8]	20% contract rate	40% MAA
Inpatient rehabilitation therapy - 30 days/year max	20% contract rate	40% MAA
Emergency Services		
Outpatient emergency room services	$150 per visit, then 20% contract rate [3, 9]	$150 per visit, then 20% [3, 9]
Inpatient admission from emergency room	20% contract rate	20% MAA

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For covered services, you are responsible for:

	PPO Network	Out-of-Network
Emergency ground ambulance transport - 3 trips/year max	20% (MAA applies to Out-of-Network Providers)	
Emergency air ambulance transport - $10,000/year max	20% (MAA applies to Out-of-Network Providers)	
Behavioral Health Services		
Outpatient mental health [5]	$20 per visit [3]	40% MAA
Inpatient mental health [5]	20% contract rate	40% MAA
Outpatient Chemical Dependency [5]	$20 per visit [3]	40% MAA
Inpatient Chemical Dependency [5]	20% contract rate	40% MAA
Other Services		
Durable Medical Equipment $5,000/year max [6]	20% contract rate	40% MAA
Prosthetic Devices/Orthotic Devices	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% MAA
Diabetes management	$20 per program [3]	40% MAA
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
TMJ services - $500/lifetime max	50% contract rate [2]	50% MAA [2]
Home infusion therapy	20% contract rate	40% MAA
Outpatient chemotherapy (non-self administered anticancer medications and administration)	20% contract rate	40% MAA
Skilled Nursing Facility care - 60 days/year max	20% contract rate	40% MAA
Hospice services	20% contract rate	40% MAA
Home health visits	20% contract rate	40% MAA
Neurodevelopmental therapy, under age 7	20% contract rate	40% MAA
Health education - $150/year combined max	Any charges over maximum reimbursement of $50/qualifying class [2]	
Spinal and other manipulations (any provider: MD, DO, chiropractor) - 15 manipulations/year max	$20 per visit [3]	40% MAA
Acupuncture Care -15 visits/year max	$20 per visit [3]	40% MAA
Naturopathic Care	$20 per visit [3]	40% MAA
Massage Therapy - 15 visits/year max	$20 per visit [3]	40% MAA
Benefit Maximums		
Annual out-of-pocket maximum per person [7]	$2,500	$7,500
Annual out-of-pocket maximum per family [7]	$7,500	$22,500
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

[1] You must meet the specified deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.
[2] Your payments do not apply to the annual out-of-pocket maximum.
[3] Deductible is waived.
[4] Office visit Copayment includes physician services only. Other services are subject to Copayments and Coinsurance as listed.
[5] To Prior Authorize mental health or Chemical Dependency services, call 800-977-8216.
[6] The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice care, or when Home Health Care or Hospice care are being provided under case management in lieu of Hospitalization.
[7] The annual out-of-pocket maximum does not include 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.

[8] 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.

[9] Copayment is waived if you are admitted.

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Washington PPO Advantage Plan

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

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

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 a fixed percentage of Maximum Allowable Amount (MAA) for other services. We pay Out-of-Network Providers based on MAA rates, not on billed amounts. MAA rates may often be less than the amount a Provider bills for a service. Out-of-Network Providers may therefore hold you responsible for amounts they charge that exceed the MAA rates we pay. Amounts that exceed our MAA rates are not covered and do not apply to your annual out-of-pocket maximum. *Your responsibility for any amounts that exceed our MAA payment is shown on this Schedule as* **MAA**.

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

The deductible is waived for preventive care services covered under the "Preventive Care" section of the Basic Benefit Schedule.

	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible per person	$500 PPO Network and Out-of-Network combined [1, 2]	
Annual deductible per family	$1,500 PPO Network and Out-of-Network combined [1, 2]	
Physician/Professional/Outpatient Care		
Physician services, office visit [4]	$20 per visit [3]	40% MAA
Physician services, preventive care [4]	No charge [3]	40% MAA [3]
Physician services, urgent care center [4]	$50 per visit [3]	$50 per visit MAA [3]
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/mammography/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 [8]	20% contract rate	40% MAA
Inpatient rehabilitation therapy - 30 days/year max	20% contract rate	40% MAA
Emergency Services		
Outpatient emergency room services	$150 per visit, then 20% contract rate [3, 9]	$150 per visit, then 20% [3, 9]
Inpatient admission from emergency room	20% contract rate	20% MAA

Health Net

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	For covered services, you are responsible for:	
	PPO Network	**Out-of-Network**
Emergency ground ambulance transport - 3 trips/year max	20% (MAA applies to Out-of-Network Providers)	
Emergency air ambulance transport - $10,000/year max	20% (MAA applies to Out-of-Network Providers)	
Behavioral Health Services		
Outpatient mental health [5]	$20 per visit [3]	40% MAA
Inpatient mental health [5]	20% contract rate	40% MAA
Outpatient Chemical Dependency [5]	$20 per visit [3]	40% MAA
Inpatient Chemical Dependency [5]	20% contract rate	40% MAA
Other Services		
Durable Medical Equipment $5,000/year max [6]	20% contract rate	40% MAA
Prosthetic Devices/Orthotic Devices	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% MAA
Diabetes management	$20 per program [3]	40% MAA
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
TMJ services - $500/lifetime max	50% contract rate [2]	50% MAA [2]
Home infusion therapy	20% contract rate	40% MAA
Outpatient chemotherapy (non-self administered anticancer medications and administration)	20% contract rate	40% MAA
Skilled Nursing Facility care - 60 days/year max	20% contract rate	40% MAA
Hospice services	20% contract rate	40% MAA
Home health visits	20% contract rate	40% MAA
Neurodevelopmental therapy, under age 7	20% contract rate	40% MAA
Health education - $150/year combined max	Any charges over maximum reimbursement of $50/qualifying class [2]	
Spinal and other manipulations (any provider: MD, DO, chiropractor) - 15 manipulations/year max	$20 per visit [3]	40% MAA
Acupuncture Care -15 visits/year max	$20 per visit [3]	40% MAA
Naturopathic Care	$20 per visit [3]	40% MAA
Massage Therapy - 15 visits/year max	$20 per visit [3]	40% MAA
Benefit Maximums		
Annual out-of-pocket maximum per person [7]	$2,500	$7,500
Annual out-of-pocket maximum per family [7]	$7,500	$22,500
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

1. You must meet the specified deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.
2. Your payments do not apply to the annual out-of-pocket maximum.
3. Deductible is waived.
4. Office visit Copayment includes physician services only. Other services are subject to Copayments and Coinsurance as listed.
5. To Prior Authorize mental health or Chemical Dependency services, call 800-977-8216.
6. The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice care, or when Home Health Care or Hospice care are being provided under case management in lieu of Hospitalization.
7. The annual out-of-pocket maximum does not include 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.

[8] 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.

[9] Copayment is waived if you are admitted.

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Copayment and Coinsurance Schedule WA25-500-2-3500D/12 Pacific Trust

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

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

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

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 a fixed percentage of Maximum Allowable Amount (MAA) for other services. We pay Out-of-Network Providers based on MAA rates, not on billed amounts. MAA rates may often be less than the amount a Provider bills for a service. Out-of-Network Providers may therefore hold you responsible for amounts they charge that exceed the MAA rates we pay. Amounts that exceed our MAA rates are not covered and do not apply to your annual out-of-pocket maximum. *Your responsibility for any amounts that exceed our MAA payment is shown on this Schedule as* **MAA**.

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

The deductible is waived for preventive care services covered under the "Preventive Care" section of the Basic Benefit Schedule.

	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible per person	$500 PPO Network and Out-of-Network combined [1, 2]	
Annual deductible per family	$1,500 PPO Network and Out-of-Network combined [1, 2]	
Physician/Professional/Outpatient Care		
Physician services, office visit [4]	$25 per visit [3]	40% MAA
Physician services, preventive care [4]	No charge [3]	40% MAA [3]
Physician services, urgent care center [4]	$50 per visit [3]	$50 per visit MAA [3]
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/mammography/EKG/Ultrasound	20% contract rate [3]	40% MAA
Diagnostic laboratory tests	20% contract rate [3]	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 [8]	20% contract rate	40% MAA
Inpatient rehabilitation therapy - 30 days/year max	20% contract rate	40% MAA
Emergency Services		
Outpatient emergency room services	$150 per visit, then 20% contract rate [3, 9]	$150 per visit, then 20% [3, 9]
Inpatient admission from emergency room	20% contract rate	20% MAA

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For covered services, you are responsible for:

	PPO Network	Out-of-Network
Emergency ground ambulance transport - 3 trips/year max	20% (MAA applies to Out-of-Network Providers)	
Emergency air ambulance transport - $10,000/year max	20% (MAA applies to Out-of-Network Providers)	
Behavioral Health Services		
Outpatient mental health [5]	$25 per visit [3]	40% MAA
Inpatient mental health [5]	20% contract rate	40% MAA
Outpatient Chemical Dependency [5]	$25 per visit [3]	40% MAA
Inpatient Chemical Dependency [5]	20% contract rate	40% MAA
Other Services		
Durable Medical Equipment –$5,000/year max [6]	20% contract rate	40% MAA
Prosthetic Devices/Orthotic Devices	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% MAA
Diabetes management	$25 per program [3]	40% MAA
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
TMJ services - $500/lifetime max	50% contract rate [2]	50% MAA [2]
Home infusion therapy	20% contract rate	40% MAA
Outpatient chemotherapy (non-self administered anticancer medications and administration)	20% contract rate	40% MAA
Skilled Nursing Facility care - 60 days/year max	20% contract rate	40% MAA
Hospice services	20% contract rate	40% MAA
Home health visits	20% contract rate	40% MAA
Neurodevelopmental therapy, under age 7	20% contract rate	40% MAA
Health education - $150/year combined max	Any charges over maximum reimbursement of $50/qualifying class [2]	
Spinal and other manipulations (any provider: MD, DO, chiropractor) - 15 manipulations/year max	$25 per visit [3]	40% MAA
Acupuncture Care -15 visits/year max	$25 per visit [3]	40% MAA
Naturopathic Care	$25 per visit [3]	40% MAA
Massage Therapy - 15 visits/year max	$25 per visit [3]	40% MAA
Benefit Maximums		
Annual out-of-pocket maximum per person [7]	$3,500	$10,500
Annual out-of-pocket maximum per family [7]	$10,500	$31,500
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

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

[2] Your payments do not apply to the annual out-of-pocket maximum.

[3] Deductible is waived.

[4] Office visit Copayment includes physician services only. Other services are subject to Copayments and Coinsurance as listed.

[5] To Prior Authorize mental health or Chemical Dependency services, call 800-977-8216.

[6] The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice care, or when Home Health Care or Hospice care are being provided under case management in lieu of Hospitalization.

[7] The annual out-of-pocket maximum does not include 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.

[8] 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.

[9] Copayment is waived if you are admitted.

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

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

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 a fixed percentage of Maximum Allowable Amount (MAA) rates for other services. We pay Out-of-Network Providers based on MAA rates, not on billed amounts. MAA rates may often be less than the amount a Provider bills for a service. Out-of-Network Providers may therefore hold you responsible for amounts they charge that exceed the MAA rates we pay. Amounts that exceed our MAA rates are not covered and do not apply to your annual out-of-pocket maximum. *Your responsibility for any amounts that exceed our MAA payment is shown on this Schedule as* **MAA**.

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

The deductible is waived for preventive care services covered under the "Preventive Care" section of the Basic Benefit Schedule.

	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible per person	$1,000 PPO Network and Out-of-Network combined [1, 2]	
Annual deductible per family	$3,000 PPO Network and Out-of-Network combined [1, 2]	
Physician/Professional/Outpatient Care		
Physician services, office visit [4]	$25 per visit [3]	40% MAA
Physician services, preventive care [4]	No charge [3]	40% MAA [3]
Physician services, urgent care center [4]	$50 per visit [3]	$50 per visit MAA [3]
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/mammography /EKG/Ultrasound	20% contract rate [3]	40% MAA
Diagnostic laboratory tests	20% contract rate [3]	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 [8]	20% contract rate	40% MAA
Inpatient rehabilitation therapy - 30 days/year max	20% contract rate	40% MAA
Emergency Services		
Outpatient emergency room services	$150 per visit, then 20% contract rate [3, 9]	$150 per visit, then20% [3, 9]
Inpatient admission from emergency room	20% contract rate	20% MAA

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For covered services, you are responsible for:

	PPO Network	Out-of-Network
Emergency ground ambulance transport – 3 trips/year max	20% (MAA applies to Out-of-Network Providers)	
Emergency air ambulance transport - $10,000/year max	30% (MAA applies to Out-of-Network Providers)	
Behavioral Health Services		
Outpatient mental health [5]	$25 per visit [3]	40% MAA
Inpatient mental health [5]	20% contract rate	40% MAA
Outpatient Chemical Dependency [5]	$25 per visit [3]	40% MAA
Inpatient Chemical Dependency [5]	20% contract rate	40% MAA
Other Services		
Durable Medical Equipment –$5,000/year max [6]	20% contract rate	40% MAA
Prosthetic Devices/Orthotic Devices	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% MAA
Diabetes management	$25 per program [3]	40% MAA
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
TMJ services - $500/lifetime max	50% contract rate [2]	50% MAA [2]
Home infusion therapy	20% contract rate	40% MAA
Outpatient chemotherapy (non-self administered anticancer medications and administration)	20% contract rate	40% MAA
Skilled Nursing Facility care - 60 days/year max	20% contract rate	40% MAA
Hospice services	20% contract rate	40% MAA
Home health visits	20% contract rate	40% MAA
Neurodevelopmental therapy, under age 7	20% contract rate	40% MAA
Health education - $150/year combined max	Any charges over maximum reimbursement of $50/qualifying class [2]	
Spinal and other manipulations (any provider: MD, DO, chiropractor) - 15 manipulations/year max	$25 per visit [3]	40% MAA
Acupuncture Care -15 visits/year max	$25 per visit [3]	40% MAA
Naturopathic Care	$25 per visit [3]	40% MAA
Massage Therapy - 15 visits/year max	$25 per visit [3]	40% MAA
Benefit Maximums		
Annual out-of-pocket maximum per person [7]	$2,500	$7,500
Annual out-of-pocket maximum per family [7]	$7,500	$22,500
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

1. You must meet the specified deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.
2. Your payments do not apply to the annual out-of-pocket maximum.
3. Deductible is waived.
4. Office visit Copayment includes physician services only. Other services are subject to Copayments and Coinsurance as listed.
5. To Prior Authorize mental health or Chemical Dependency services, call 800-977-8216.
6. The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice care, or when Home Health Care or Hospice care are being provided under case management in lieu of Hospitalization.
7. The annual out-of-pocket maximum does not include 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.

[8] 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.

[9] Copayment is waived if you are admitted.

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

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

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

The deductible is waived for preventive care services covered under the "Preventive Care" section of the Basic Benefit Schedule.

	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible per person	$2,000 PPO Network and Out-of-Network combined [1, 2]	
Annual deductible per family	$6,000 PPO Network and Out-of-Network combined [1, 2]	
Physician/Professional/Outpatient Care		
Physician services, office visit [4]	$25 per visit [3]	40% MAA
Physician services, preventive care [4]	No charge [3]	40% MAA [3]
Physician services, urgent care center [4]	$50 per visit [3]	$50 per visit MAA [3]
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/mammography /EKG/Ultrasound	20% contract rate [3]	40% MAA
Diagnostic laboratory tests	20% contract rate [3]	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 [8]	20% contract rate	40% MAA
Inpatient rehabilitation therapy - 30 days/year max	20% contract rate	40% MAA
Emergency Services		
Outpatient emergency room services	$150 per visit, then 20% contract rate [3, 9]	$150 per visit, then20% [3, 9]
Inpatient admission from emergency room	20% contract rate	20% MAA
Emergency ground ambulance transport – 3 trips/year max	20% (MAA applies to Out-of-Network Providers)	

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For covered services, you are responsible for:

	PPO Network	Out-of-Network
Emergency air ambulance transport - $10,000/year max	20% (MAA applies to Out-of-Network Providers)	
Behavioral Health Services		
Outpatient mental health [5]	$25 per visit [3]	40% MAA
Inpatient mental health [5]	20% contract rate	40% MAA
Outpatient Chemical Dependency [5]	$25 per visit [3]	40% MAA
Inpatient Chemical Dependency [5]	20% contract rate	40% MAA
Other Services		
Durable Medical Equipment –$5,000/year max [6]	20% contract rate	40% MAA
Prosthetic Devices/Orthotic Devices	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% MAA
Diabetes management	$25 per program [3]	40% MAA
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
TMJ services - $500/lifetime max	50% contract rate [2]	50% MAA [2]
Home infusion therapy	20% contract rate	40% MAA
Outpatient chemotherapy (non-self administered anticancer medications and administration)	20% contract rate	40% MAA
Skilled Nursing Facility care - 60 days/year max	20% contract rate	40% MAA
Hospice services	20% contract rate	40% MAA
Home health visits	20% contract rate	40% MAA
Neurodevelopmental therapy, under age 7	20% contract rate	40% MAA
Health education - $150/year combined max	Any charges over maximum reimbursement of $50/qualifying class [2]	
Spinal and other manipulations (any provider: MD, DO, chiropractor) - 15 manipulations/year max	$25 per visit [3]	40% MAA
Acupuncture Care -15 visits/year max	$25 per visit [3]	40% MAA
Naturopathic Care	$25 per visit [3]	40% MAA
Massage Therapy - 15 visits/year max	$25 per visit [3]	40% MAA
Benefit Maximums		
Annual out-of-pocket maximum per person [7]	$2,500	$7,500
Annual out-of-pocket maximum per family [7]	$7,500	$22,500
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

1. You must meet the specified deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.
2. Your payments do not apply to the annual out-of-pocket maximum.
3. Deductible is waived.
4. Office visit Copayment includes physician services only. Other services are subject to Copayments and Coinsurance as listed.
5. To Prior Authorize mental health or Chemical Dependency services, call 800-977-8216.
6. The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice care, or when Home Health Care or Hospice care are being provided under case management in lieu of Hospitalization.
7. The annual out-of-pocket maximum does not include 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.
8. 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.
9. Copayment is waived if you are admitted.

Health Net Health Plan of Oregon, Inc.
Washington PPO Advantage Plan
Copayment and Coinsurance Schedule WA30-1000-3-3500V/12 Pacific Trust

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

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

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

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 a fixed percentage of Maximum Allowable Amount (MAA) for other services. We pay Out-of-Network Providers based on MAA rates, not on billed amounts. MAA rates may often be less than the amount a Provider bills for a service. Out-of-Network Providers may therefore hold you responsible for amounts they charge that exceed the MAA rates we pay. Amounts that exceed our MAA rates are not covered and do not apply to your annual out-of-pocket maximum. *Your responsibility for any amounts that exceed our MAA payment is shown on this Schedule as* **MAA**.

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

The deductible is waived for preventive care services covered under the "Preventive Care" section of the Basic Benefit Schedule.

	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible per person	$1,000 PPO Network and Out-of-Network combined [1, 2]	
Annual deductible per family	$3,000 PPO Network and Out-of-Network combined [1, 2]	
Physician/Professional/Outpatient Care		
Physician services, office visit [4]	$30 per visit [3]	50% MAA
Physician services, preventive care [4]	No charge [3]	50% MAA [3]
Physician services, urgent care center [4]	$50 per visit [3]	$50 per visit MAA [3]
Physician Hospital visits	30% contract rate	50% MAA
Diagnostic X-ray/mammography/EKG/Ultrasound	30% contract rate	50% MAA
Diagnostic laboratory tests	30% contract rate	50% MAA
CT/MRI/PET/SPECT/EEG/Holter monitor/Stress test	30% contract rate	50% MAA
Allergy and therapeutic injections	30% contract rate	50% MAA
Maternity delivery care (professional services only)	30% contract rate	50% MAA
Outpatient rehabilitation therapy – 30 days/year max	30% contract rate	50% MAA
Outpatient at Ambulatory Surgery Center	25%contract rate	50% MAA
Outpatient at Hospital-based facility	30% contract rate	50% MAA
Hospital Care		
Inpatient services [8]	30% contract rate	50% MAA
Inpatient rehabilitation therapy - 30 days/year max	30% contract rate	50% MAA
Emergency Services		
Outpatient emergency room services	$150 per visit, then 30% contract rate [3, 9]	$150 per visit, then 30% [3, 9]
Inpatient admission from emergency room	30% contract rate	30% MAA

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	For covered services, you are responsible for:	
	PPO Network	**Out-of-Network**
Emergency ground ambulance transport – 3 trips/year max	30% (MAA applies to Out-of-Network Providers)	
Emergency air ambulance transport - $10,000/year max	30% (MAA applies to Out-of-Network Providers)	
Behavioral Health Services		
Outpatient mental health [5]	$30 per visit [3]	50% MAA
Inpatient mental health [5]	30% contract rate	50% MAA
Outpatient Chemical Dependency [5]	$30 per visit [3]	50% MAA
Inpatient Chemical Dependency [5]	30% contract rate	50% MAA
Other Services		
Durable Medical Equipment –$5,000/year max [6]	30% contract rate	50% MAA
Prosthetic Devices/Orthotic Devices	30% contract rate	50% MAA
Medical supplies (including allergy serum and injected substances)	30% contract rate	50% MAA
Diabetes management	$30 per program [3]	50% MAA
Blood, blood plasma, blood derivatives	30% contract rate	50% MAA
TMJ services - $500/lifetime max	50% contract rate [2]	50% MAA [2]
Home infusion therapy	30% contract rate	50% MAA
Outpatient chemotherapy (non-self administered anticancer medications and administration)	30% contract rate	50% MAA
Skilled Nursing Facility care - 60 days/year max	30% contract rate	50% MAA
Hospice services	30% contract rate	50% MAA
Home health visits	30% contract rate	50% MAA
Neurodevelopmental therapy, under age 7	30% contract rate	50% MAA
Health education - $150/year combined max	Any charges over maximum reimbursement of $50/qualifying class [2]	
Spinal and other manipulations (any provider: MD, DO, chiropractor) - 15 manipulations/year max	$30 per visit [3]	50% MAA
Acupuncture Care -15 visits/year max	$30 per visit [3]	50% MAA
Naturopathic Care	$30 per visit [3]	50% MAA
Massage Therapy - 15 visits/year max	$30 per visit [3]	50% MAA
Benefit Maximums		
Annual out-of-pocket maximum per person [7]	$3,500	$10,500
Annual out-of-pocket maximum per family [7]	$10,500	$31,500
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

1 You must meet the specified deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.
2 Your payments do not apply to the annual out-of-pocket maximum.
3 Deductible is waived.
4 Office visit Copayment includes physician services only. Other services are subject to Copayments and Coinsurance as listed.
5 To Prior Authorize mental health or Chemical Dependency services, call 800-977-8216.
6 The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice care, or when Home Health Care or Hospice care are being provided under case management in lieu of Hospitalization.
7 The annual out-of-pocket maximum does not include 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.

[8] 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.

[8] Copayment is waived if you are admitted.

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The deductible is waived for preventive care services covered under the "Preventive Care" section of the Basic Benefit Schedule.

	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible per person	$2,000 PPO Network and Out-of-Network combined [1,2]	
Annual deductible per family	$6,000 PPO Network and Out-of-Network combined [1,2]	
Physician/Professional/Outpatient Care		
Physician services, office visit [4]	$35 per visit [3]	50% MAA
Physician services, preventive care [4]	No charge [3]	50% MAA [3]
Physician services, urgent care center [4]	$50 per visit [3]	$50 per visit MAA [3]
Physician Hospital visits	30% contract rate	50% MAA
Diagnostic X-ray/mammography/EKG/Ultrasound	30% contract rate	50% MAA
Diagnostic laboratory tests	30% contract rate	50% MAA
CT/MRI/PET/SPECT/EEG/Holter monitor/Stress test	30% contract rate	50% MAA
Allergy and therapeutic injections	30% contract rate	50% MAA
Maternity delivery care (professional services only)	30% contract rate	50% MAA
Outpatient rehabilitation therapy – 30 days/year max	30% contract rate	50% MAA
Outpatient at Ambulatory Surgery Center	25%contract rate	50% MAA
Outpatient at Hospital-based facility	30% contract rate	50% MAA
Hospital Care		
Inpatient services [8]	30% contract rate	50% MAA
Inpatient rehabilitation therapy - 30 days/year max	30% contract rate	50% MAA
Emergency Services		
Outpatient emergency room services	$150 per visit, then 30% contract rate [3,9]	$150 per visit, then 30% [3,9]
Inpatient admission from emergency room	30% contract rate	30% MAA

Health Net

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	For covered services, you are responsible for:	
	PPO Network	**Out-of-Network**
Emergency ground ambulance transport – 3 trips/year max	30% (MAA applies to Out-of-Network Providers)	
Emergency air ambulance transport - $10,000/year max	30% (MAA applies to Out-of-Network Providers)	
Behavioral Health Services		
Outpatient mental health [5]	$35 per visit [3]	50% MAA
Inpatient mental health [5]	30% contract rate	50% MAA
Outpatient Chemical Dependency [5]	$35 per visit [3]	50% MAA
Inpatient Chemical Dependency [5]	30% contract rate	50% MAA
Other Services		
Durable Medical Equipment –$5,000/year max [6]	30% contract rate	50% MAA
Prosthetic Devices/Orthotic Devices	30% contract rate	50% MAA
Medical supplies (including allergy serum and injected substances)	30% contract rate	50% MAA
Diabetes management	$35 per program [3]	50% MAA
Blood, blood plasma, blood derivatives	30% contract rate	50% MAA
TMJ services - $500/lifetime max	50% contract rate [2]	50% MAA [2]
Home infusion therapy	30% contract rate	50% MAA
Outpatient chemotherapy (non-self administered anticancer medications and administration)	30% contract rate	50% MAA
Skilled Nursing Facility care - 60 days/year max	30% contract rate	50% MAA
Hospice services	30% contract rate	50% MAA
Home health visits	30% contract rate	50% MAA
Neurodevelopmental therapy, under age 7	30% contract rate	50% MAA
Health education - $150/year combined max	Any charges over maximum reimbursement of $50/qualifying class [2]	
Spinal and other manipulations (any provider: MD, DO, chiropractor) - 15 manipulations/year max	$35 per visit [3]	50% MAA
Acupuncture Care -15 visits/year max	$35 per visit [3]	50% MAA
Naturopathic Care	$35 per visit [3]	50% MAA
Massage Therapy - 15 visits/year max	$35 per visit [3]	50% MAA
Benefit Maximums		
Annual out-of-pocket maximum per person [7]	$3,500	$10,500
Annual out-of-pocket maximum per family [7]	$10,500	$31,500
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

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

[2] Your payments do not apply to the annual out-of-pocket maximum.

[3] Deductible is waived.

[4] Office visit Copayment includes physician services only. Other services are subject to Copayments and Coinsurance as listed.

[5] To Prior Authorize mental health or Chemical Dependency services, call 800-977-8216.

[6] The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice care, or when Home Health Care or Hospice care are being provided under case management in lieu of Hospitalization.

[7] The annual out-of-pocket maximum does not include 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.

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	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible per person	$3,000 PPO Network and Out-of-Network combined [1,2]	
Annual deductible per family	$9,000 PPO Network and Out-of-Network combined [1,2]	
Physician/Professional/Outpatient Care		
Physician services, office visit [4]	$35 per visit [3]	50% MAA
Physician services, preventive care [4]	No charge [3]	50% MAA [3]
Physician services, urgent care center [4]	$50 per visit [3]	$50 per visit MAA [3]
Physician Hospital visits	30% contract rate	50% MAA
Diagnostic X-ray/mammography/EKG/Ultrasound	30% contract rate	50% MAA
Diagnostic laboratory tests	30% contract rate	50% MAA
CT/MRI/PET/SPECT/EEG/Holter monitor/Stress test	30% contract rate	50% MAA
Allergy and therapeutic injections	30% contract rate	50% MAA
Maternity delivery care (professional services only)	30% contract rate	50% MAA
Outpatient rehabilitation therapy – 30 days/year max	30% contract rate	50% MAA
Outpatient at Ambulatory Surgery Center	25%contract rate	50% MAA
Outpatient at Hospital-based facility	30% contract rate	50% MAA
Hospital Care		
Inpatient services [8]	30% contract rate	50% MAA
Inpatient rehabilitation therapy - 30 days/year max	30% contract rate	50% MAA
Emergency Services		
Outpatient emergency room services	$150 per visit, then 30% contract rate [3,9]	$150 per visit, then 30% [3,9]
Inpatient admission from emergency room	30% contract rate	30% MAA

Washington PPO Advantage Plan WA35-3000-3-3500V/12 Pacific Trust

	For covered services, you are responsible for:	
	PPO Network	**Out-of-Network**
Emergency ground ambulance transport – 3 trips/year max	30% (MAA applies to Out-of-Network Providers)	
Emergency air ambulance transport - $10,000/year max	30% (MAA applies to Out-of-Network Providers)	
Behavioral Health Services		
Outpatient mental health [5]	$35 per visit [3]	50% MAA
Inpatient mental health [5]	30% contract rate	50% MAA
Outpatient Chemical Dependency [5]	$35 per visit [3]	50% MAA
Inpatient Chemical Dependency [5]	30% contract rate	50% MAA
Other Services		
Durable Medical Equipment –$5,000/year max [6]	30% contract rate	50% MAA
Prosthetic Devices/Orthotic Devices	30% contract rate	50% MAA
Medical supplies (including allergy serum and injected substances)	30% contract rate	50% MAA
Diabetes management	$35 per program [3]	50% MAA
Blood, blood plasma, blood derivatives	30% contract rate	50% MAA
TMJ services - $500/lifetime max	50% contract rate [2]	50% MAA [2]
Home infusion therapy	30% contract rate	50% MAA
Outpatient chemotherapy (non-self administered anticancer medications and administration)	30% contract rate	50% MAA
Skilled Nursing Facility care - 60 days/year max	30% contract rate	50% MAA
Hospice services	30% contract rate	50% MAA
Home health visits	30% contract rate	50% MAA
Neurodevelopmental therapy, under age 7	30% contract rate	50% MAA
Health education - $150/year combined max	Any charges over maximum reimbursement of $50/qualifying class [2]	
Spinal and other manipulations (any provider: MD, DO, chiropractor) - 15 manipulations/year max	$35 per visit [3]	50% MAA
Acupuncture Care -15 visits/year max	$35 per visit [3]	50% MAA
Naturopathic Care	$35 per visit [3]	50% MAA
Massage Therapy - 15 visits/year max	$35 per visit [3]	50% MAA
Benefit Maximums		
Annual out-of-pocket maximum per person [7]	$3,500	$10,500
Annual out-of-pocket maximum per family [7]	$10,500	$31,500
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

1. You must meet the specified deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.
2. Your payments do not apply to the annual out-of-pocket maximum.
3. Deductible is waived.
4. Office visit Copayment includes physician services only. Other services are subject to Copayments and Coinsurance as listed.
5. To Prior Authorize mental health or Chemical Dependency services, call 800-977-8216.
6. The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice care, or when Home Health Care or Hospice care are being provided under case management in lieu of Hospitalization.
7. The annual out-of-pocket maximum does not include 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.

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	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible per person	$5,000 PPO Network and Out-of-Network combined [1, 2]	
Annual deductible per family	$15,000 PPO Network and Out-of-Network combined [1, 2]	
Physician/Professional/Outpatient Care		
Physician services, office visit [4]	$35 per visit [3]	50% MAA
Physician services, preventive care [4]	No charge [3]	50% MAA [3]
Physician services, urgent care center [4]	$50 per visit [3]	$50 per visit MAA [3]
Physician Hospital visits	30% contract rate	50% MAA
Diagnostic X-ray/mammography/EKG/Ultrasound	30% contract rate	50% MAA
Diagnostic laboratory tests	30% contract rate	50% MAA
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Allergy and therapeutic injections	30% contract rate	50% MAA
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Outpatient at Hospital-based facility	30% contract rate	50% MAA
Hospital Care		
Inpatient services [8]	30% contract rate	50% MAA
Inpatient rehabilitation therapy - 30 days/year max	30% contract rate	50% MAA
Emergency Services		
Outpatient emergency room services	$150 per visit, then 30% contract rate [3, 9]	$150 per visit, then 30% [3, 9]
Inpatient admission from emergency room	30% contract rate	30% MAA

Washington PPO Advantage Plan WA35-5000-3-3500V/12 Pacific Trust

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	PPO Network	**Out-of-Network**
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Emergency air ambulance transport - $10,000/year max	30% (MAA applies to Out-of-Network Providers)	
Behavioral Health Services		
Outpatient mental health [5]	$35 per visit [3]	50% MAA
Inpatient mental health [5]	30% contract rate	50% MAA
Outpatient Chemical Dependency [5]	$35 per visit [3]	50% MAA
Inpatient Chemical Dependency [5]	30% contract rate	50% MAA
Other Services		
Durable Medical Equipment –$5,000/year max [6]	30% contract rate	50% MAA
Prosthetic Devices/Orthotic Devices	30% contract rate	50% MAA
Medical supplies (including allergy serum and injected substances)	30% contract rate	50% MAA
Diabetes management	$35 per program [3]	50% MAA
Blood, blood plasma, blood derivatives	30% contract rate	50% MAA
TMJ services - $500/lifetime max	50% contract rate [2]	50% MAA [2]
Home infusion therapy	30% contract rate	50% MAA
Outpatient chemotherapy (non-self administered anticancer medications and administration)	30% contract rate	50% MAA
Skilled Nursing Facility care - 60 days/year max	30% contract rate	50% MAA
Hospice services	30% contract rate	50% MAA
Home health visits	30% contract rate	50% MAA
Neurodevelopmental therapy, under age 7	30% contract rate	50% MAA
Health education - $150/year combined max	Any charges over maximum reimbursement of $50/qualifying class [2]	
Spinal and other manipulations (any provider: MD, DO, chiropractor) - 15 manipulations/year max	$35 per visit [3]	50% MAA
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Naturopathic Care	$35 per visit [3]	50% MAA
Massage Therapy - 15 visits/year max	$35 per visit [3]	50% MAA
Benefit Maximums		
Annual out-of-pocket maximum per person [7]	$3,500	$10,500
Annual out-of-pocket maximum per family [7]	$10,500	$31,500
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

1. You must meet the specified deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.
2. Your payments do not apply to the annual out-of-pocket maximum.
3. Deductible is waived.
4. Office visit Copayment includes physician services only. Other services are subject to Copayments and Coinsurance as listed.
5. To Prior Authorize mental health or Chemical Dependency services, call 800-977-8216.
6. The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice care, or when Home Health Care or Hospice care are being provided under case management in lieu of Hospitalization.
7. The annual out-of-pocket maximum does not include 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.

[8] 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.

[9] Copayment is waived if you are admitted.

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

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Health Net Health Plan of Oregon, Inc.
Preventive Prescription Benefits
WA Supplemental Benefit Schedule
WNM10-20-40/12 (No MAC) Pacific Trust

In this Supplemental Benefit Schedule, 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 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 Basic Benefit Schedule.

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

Benefits

Coverage includes all Medically Necessary legend drugs, compounded medications of which at least one ingredient is a prescription legend drug, self-administered anticancer medications, preventive pharmacy 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 is subject to the qualifications, limitations and exclusions below:

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

- All drugs, including insulin and diabetic supplies, must be dispensed by a Participating Provider pharmacy, except for Emergency Medical Care rendered outside the Service Area.

- Copayments shall be as follows for each prescription or refill. Prescription Copayments and other amounts you pay for prescription drugs do not apply toward your plan's medical out-of-pocket maximum.

	In Pharmacy (Per Fill Up to a 30-day Supply)	**Mail Order (Per Fill Up to a 90-day Supply)**
Tier 1	$10	$20
Tier 2	$20	$40
Tier 3	$40	$80
Prescribed, self-administered anticancer medications	No Copayment	Mail order not available
Preventive Pharmacy and Women's contraception methods	No Copayment and/ or Coinsurance. Deductible waived	No Copayment and/ or Coinsurance. Deductible waived

This pharmacy plan provides creditable coverage for Medicare Part D.

- The level of benefit you receive is based on the Preferred Drug List (PDL) status of the drug at the time your prescription is filled. The PDL 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 PDL will be communicated to Participating Providers. Compounded medications are subject to the Tier 3 Copayment. Brand name drugs with generic equivalents are subject to the Tier 3 Copayment as soon as a generic becomes available.

- 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: www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. 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 Non-Participating Provider pharmacy are not covered.

- Women's contraception methods. Generic class Food and Drug Administration approved contraceptive methods, patient education and counseling for all women with reproductive capacity are covered when dispensed by a Participating Provider pharmacy. 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.

  Abortifacient drugs, compounded medications, over-the-counter methods, devices and supplies, and prescriptions or refills dispensed by a Non-Participating Provider pharmacy are not covered.

- Reimbursement (minus the Copayment) 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 Oregon and sufficient documentation to establish the need for Emergency Medical Care.

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.
- Over-the-counter drugs other than insulin and preventive pharmacy medications as noted above in this Schedule.
- Any prescription drug for which an over-the-counter therapeutic equivalent is available.
- 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 as injections on the PDL.
- Dental only drugs.
- Dietary supplements, food, health and beauty aids, and vitamin preparations other than legend prenatal vitamins and legend vitamins with fluoride, except for phenylketonuria and enteral formulas.
- Drugs for the treatment of onychomycosis (nail fungus), nocturnal enuresis (bed-wetting), sexual dysfunction, or infertility; drugs used for weight loss, sexual enhancement, or sexual performance improvement; growth hormone therapy; oral nystatin powder.
- Prescription refills due to loss or theft.
- Non-hormonal contraceptive devices, IUDs, contraceptive implants, and contraceptive injectables other than Depo Provera 150mg injection are excluded under this Supplemental Prescription Benefits Schedule. Diaphragms and non-hormonal contraceptive devices, IUDs, contraceptive implants, contraceptive injectables, and Norplant are covered under the Basic Benefit Schedule when provided in the doctor's office.
- Drugs and medicines used for diagnostic purposes.
- Methadone maintenance treatment for the purpose of long term opiate craving reduction.

This pharmacy plan provides creditable coverage for Medicare Part D.

Health Net Health Plan of Oregon, Inc.
Preventive Prescription Benefits
WA Supplemental Benefit Schedule
WNM15-30-50/12 (No MAC) Pacific Trust

In this Supplemental Benefit Schedule, 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 to each Enrolled Dependent unless otherwise specified.

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Benefits

Coverage includes all Medically Necessary legend drugs, compounded medications of which at least one ingredient is a prescription legend drug, self-administered anticancer medications, preventive pharmacy 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 is subject to the qualifications, limitations and exclusions below:

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- All drugs, including insulin and diabetic supplies, must be dispensed by a Participating Provider pharmacy, except for Emergency Medical Care rendered outside the Service Area.

- Copayments shall be as follows for each prescription or refill. Prescription Copayments and other amounts you pay for prescription drugs do not apply toward your plan’s medical out-of-pocket maximum.

	In Pharmacy (Per Fill Up to a 30-day Supply)	**Mail Order (Per Fill Up to a 90-day Supply)**
Tier 1	$15	$30
Tier 2	$30	$60
Tier 3	$50	$100
Prescribed, self-administered anticancer medications	No Copayment	Mail order not available
Preventive Pharmacy and Women’s contraception methods	No Copayment and/ or Coinsurance. Deductible waived	No Copayment and/ or Coinsurance. Deductible waived

This pharmacy plan provides creditable coverage for Medicare Part D.

- The level of benefit you receive is based on the Preferred Drug List (PDL) status of the drug at the time your prescription is filled. The PDL 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 PDL will be communicated to Participating Providers. Compounded medications are subject to the Tier 3 Copayment. Brand name drugs with generic equivalents are subject to the Tier 3 Copayment as soon as a generic becomes available.

- 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: www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. 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, over-the-counter methods, devices and supplies, and prescriptions or refills dispensed by a Non-Participating Provider pharmacy are not covered.

- Women's contraception methods. Generic class Food and Drug Administration approved contraceptive methods, patient education and counseling for all women with reproductive capacity are covered when dispensed by a Participating Provider pharmacy. 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.

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- Reimbursement (minus the Copayment) 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 Oregon and sufficient documentation to establish the need for Emergency Medical Care.

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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.
- Over-the-counter drugs other than insulin and preventive pharmacy medications as noted above in this Schedule.
- Any prescription drug for which an over-the-counter therapeutic equivalent is available.
- 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 as injections on the PDL.
- Dental only drugs.
- Dietary supplements, food, health and beauty aids, and vitamin preparations other than legend prenatal vitamins and legend vitamins with fluoride, except for phenylketonuria and enteral formulas.
- Drugs for the treatment of onychomycosis (nail fungus), nocturnal enuresis (bed-wetting), sexual dysfunction, or infertility; drugs used for weight loss, sexual enhancement, or sexual performance improvement; growth hormone therapy; oral nystatin powder.
- Prescription refills due to loss or theft.
- Non-hormonal contraceptive devices, IUDs, contraceptive implants, and contraceptive injectables other than Depo Provera 150mg injection are excluded under this Supplemental Prescription Benefits Schedule. Diaphragms and non-hormonal contraceptive devices, IUDs, contraceptive implants, contraceptive injectables, and Norplant are covered under the Basic Benefit Schedule when provided in the doctor's office.
- Drugs and medicines used for diagnostic purposes.
- Methadone maintenance treatment for the purpose of long term opiate craving reduction.

This pharmacy plan provides creditable coverage for Medicare Part D.

Health Net Health Plan of Oregon, Inc.
Preventive Prescription Benefits
WA Supplemental Benefit Schedule
WNM15-30%-50%5000M/12 (No MAC) Pacific Trust

In this Supplemental Benefit Schedule, 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 to each Enrolled Dependent unless otherwise specified.

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Benefits

Coverage includes all Medically Necessary legend drugs, compounded medications of which at least one ingredient is a prescription legend drug, self-administered anticancer medications, preventive pharmacy 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 is subject to the qualifications, limitations and exclusions below:

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- All drugs, including insulin and diabetic supplies, must be dispensed by a Participating Provider pharmacy, except for Emergency Medical Care rendered outside the Service Area.

- Copayments shall be as follows for each prescription or refill. Prescription Copayments and other amounts you pay for prescription drugs do not apply toward your plan's medical and out-of-pocket maximum.

  Annual out-of-pocket maximum for Prescription Benefits: $5,000 per Member per Calendar Year

	In Pharmacy (Per Fill Up to a 30-day Supply)	**Mail Order (Per Fill Up to a 90-day Supply)**
Tier 1	$15	$30
Tier 2	30%	30%
Tier 3	50%	50%
Prescribed, self-administered anticancer medications	No Copayment	Mail order not available
Preventive Pharmacy and Women's contraception methods	No Copayment and/ or Coinsurance. Deductible waived	No Copayment and/ or Coinsurance. Deductible waived

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- Injectable medications other than those listed as injections on the PDL.
- Dental only drugs.
- Dietary supplements, food, health and beauty aids, and vitamin preparations other than legend prenatal vitamins and legend vitamins with fluoride, except for phenylketonuria and enteral formulas.
- Drugs for the treatment of onychomycosis (nail fungus), nocturnal enuresis (bed-wetting), sexual dysfunction, or infertility; drugs used for weight loss, sexual enhancement, or sexual performance improvement; growth hormone therapy; oral nystatin powder.
- Prescription refills due to loss or theft.
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- Drugs and medicines used for diagnostic purposes.
- Methadone maintenance treatment for the purpose of long term opiate craving reduction.

This pharmacy plan provides creditable coverage for Medicare Part D.

Health Net Health Plan of Oregon, Inc.
Preventive Prescription Benefits
WA Supplemental Benefit Schedule
WNM15-35-60-5000M/12 (No MAC) Pacific Trust

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  Annual out-of-pocket maximum for Prescription Benefits: $5,000 per Member per Calendar Year

	In Pharmacy (Per Fill Up to a 30-day Supply)	Mail Order (Per Fill Up to a 90-day Supply)
Tier 1	$15	$30
Tier 2	$35	$70
Tier 3	$60	$120
Prescribed, self-administered anticancer medications	No Copayment	Mail order not available
Preventive Pharmacy and Women's contraception methods	No Copayment and/ or Coinsurance. Deductible waived	No Copayment and/ or Coinsurance. Deductible waived

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- Dental only drugs.
- Dietary supplements, food, health and beauty aids, and vitamin preparations other than legend prenatal vitamins and legend vitamins with fluoride, except for phenylketonuria and enteral formulas.
- Drugs for the treatment of onychomycosis (nail fungus), nocturnal enuresis (bed-wetting), sexual dysfunction, or infertility; drugs used for weight loss, sexual enhancement, or sexual performance improvement; growth hormone therapy; oral nystatin powder.
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Health Net Health Plan of Oregon, Inc.
Prescription Benefits
YOUR RIGHT TO SAFE AND EFFECTIVE PHARMACY SERVICES

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

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

"Does this plan limit or exclude certain drugs my health care provider may prescribe, or encourage substitutions for some drugs?"

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

Formulary and drug product decisions are based on the following:

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

The term “Medically Necessary” as used in the Prescription Benefits Supplemental Benefit Schedule follows the same definition as indicated in your plan contract.

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

If a generic equivalent exists, but a brand name drug is requested you pay the applicable Tier 3 Copayment.

Your out-of-pocket expense will not exceed the pharmacy’s retail price for the drug.

Please refer to your Prescription Benefits Supplemental Benefit Schedule for specific information regarding limitations, exclusions, and substitutions for drugs.

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

The PDL (formulary) is reviewed and updated on an ongoing basis, and it may be revised up to four times per year based on the recommendations of the Pharmacy and Therapeutics Committee. Most changes involve the addition of new drugs to the formulary. Changes to existing formulary drugs may impact a drug you are using and may require a higher copayment.

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

If you receive a denial or partial denial of an authorization request you may contact a Pharmacy Services representative to discuss the determination. If additional information is presented or may be obtained from your physician for consideration

against the prior authorization criteria, a second review may be requested. You may contact a Pharmacy Services representative at (888) 802-7001 between the hours of 8:30-5:00 Monday through Thursday and 9:30-5:00 on Friday, excluding holidays. You have the right to appeal the denial or partial denial of an authorization request. The appeal must be submitted either orally or in writing within 180 days of the date of the denial notice. We will resolve and respond in writing to appeals within 14 days. If a delay could seriously jeopardize your life or health you may request an expedited review in writing or over the phone by contacting a Customer Contact Center representative. Expedited reviews are completed not later than 72 hours following receipt. Send written appeals to:

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

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

- Tier 1 is the lowest Copayment/Coinsurance level. This level includes but is not limited to most generic drugs.
- Tier 2 is the intermediate Copayment/Coinsurance level. This level includes but is not limited to preferred brand name drugs that have no generic equivalent.
- Tier 3 is the highest Copayment/Coinsurance level. This level includes but is not limited to generic and brand name drugs that are not listed in Tier 1 or Tier 2. In most cases there are alternatives in Tier 1 or 2 for drugs found in this highest tier.

Please refer to your Prescription Benefits Supplemental Benefit Schedule for specific information on your prescription drug costs.

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

Prescriptions must be purchased at a Participating Pharmacy in order to be covered under the prescription benefit. Most major pharmacy chains are part of the Health Net Network. There are approximately 1,200 independent and chain pharmacies in the state of Washington that are participating with Health Net. If you need to verify that a specific pharmacy is participating with Health Net, please call the Customer Contact Center at (888) 802-7001 or visit our website at www.healthnet.com.

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

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

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

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

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

Please refer to your Prescription Benefits Supplemental Benefit Schedule for information on the days’ supply available under your benefit.

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

There are no additional pharmacy services covered under the Policy.

Health Net Health Plan of Oregon, Inc.
PPO Single High Deductible Health Plan
Copayment and Coinsurance Schedule W1HD20008060/12 Pacific Trust

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

PPO Benefits: When you receive covered services from Providers in our PPO network, your expenses include a Calendar Year deductible, and a fixed percentage that is applied to our contracted rates with PPO Providers. *The percentage of our contracted rate that is your responsibility is shown on this Schedule as* **% contract rate**.

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

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, and a fixed percentage of Maximum Allowable Amount (MAA) for other services. We pay Out-of-Network Providers based on MAA rates, not on billed amounts. MAA rates may often be less than the amount a Provider bills for a service. Out-of-Network Providers may therefore hold you responsible for amounts they charge that exceed the MAA rates we pay. Amounts that exceed our MAA rates are not covered and do not apply to your annual out-of-pocket maximum. *Your responsibility for any amounts that exceed our MAA payment is shown on this Schedule as* **MAA**.

Your benefits are subject to deductibles and Coinsurance amounts listed in this Schedule.

The deductible is waived for preventive care services covered under the "Preventive Care" section of the Basic Benefit Schedule.

	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible: Single coverage	$2,000 [1]	$4,000 [1]
Physician/Professional/Outpatient Care		
Physician services, office visit [2]	20% contract rate	40% MAA
Physician services, preventive care [2]	No charge [3]	40% MAA [3]
Physician services, urgent care center [2]	20% contract rate	20% MAA
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/mammography/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 [7]	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% MAA
Emergency ground ambulance transport – 3 trips/year max	20% (MAA applies to Out-of-Network Providers)	

PPO Single High Deductible Health Plan
W1HD20008060/12 Pacific Trust

	For covered services, you are responsible for:	
	PPO Network	**Out-of-Network**
Emergency air ambulance transport - $10,000/year max	20% (MAA applies to Out-of-Network Providers)	
Behavioral Health Services		
Outpatient mental health [4]	20% contract rate	40% MAA
Inpatient mental health [4]	20% contract rate	40% MAA
Outpatient Chemical Dependency [4]	20% contract rate	40% MAA
Inpatient Chemical Dependency [4]	20% contract rate	40% MAA
Other Services		
Durable Medical Equipment –$5,000/year max [5]	20% contract rate	40% MAA
Prosthetic Devices/Orthotic Devices	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% MAA
Diabetes management	20% contract rate	40% MAA
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
TMJ services - $500/lifetime max	50% contract rate	50% MAA
Home infusion therapy	20% contract rate	40% MAA
Outpatient chemotherapy (non-self administered anticancer medications and administration)	20% contract rate	40% MAA
Skilled Nursing Facility care - 60 days/year max	20% contract rate	40% MAA
Hospice services	20% contract rate	40% MAA
Home health visits	20% contract rate	40% MAA
Neurodevelopmental therapy, under age 7	20% contract rate	40% MAA
Health education	Not covered	Not covered
Spinal and other manipulations (any provider: MD, DO, chiropractor) - 15 manipulations/year max	20% contract rate	40% MAA
Acupuncture Care - 15 visits/year max	20% contract rate	40% MAA
Naturopathic Care	20% contract rate	40% MAA
Massage Therapy - 15 visits/year max	20% contract rate	40% MAA
Benefit Maximums		
Annual out-of-pocket maximum: Single coverage [6]	$4,000	$8,000
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

1. You must meet the specified deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.
2. Office visit includes physician services only. Other services are subject to Coinsurance as listed.
3. Deductible is waived.
4. To Prior Authorize mental health or Chemical Dependency services, call 800-977-8216.
5. The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice care, or when Home Health Care or Hospice care are being provided under case management in lieu of Hospitalization.
6. 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.
7. 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.

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

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Health Net Health Plan of Oregon, Inc.
PPO Family High Deductible Health Plan
Copayment and Coinsurance Schedule WFHD40008060/12 Pacific Trust

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

PPO Benefits: When you receive covered services from Providers in our PPO network, your expenses include a Calendar Year deductible, and a fixed percentage that is applied to our contracted rates with PPO Providers. *The percentage of our contracted rate that is your responsibility is shown on this Schedule as* **% contract rate**.

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

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, and a fixed percentage of Maximum Allowable Amount (MAA) for other services. We pay Out-of-Network Providers based on MAA rates, not on billed amounts. MAA rates may often be less than the amount a Provider bills for a service. Out-of-Network Providers may therefore hold you responsible for amounts they charge that exceed the MAA rates we pay. Amounts that exceed our MAA rates are not covered and do not apply to your annual out-of-pocket maximum. *Your responsibility for any amounts that exceed our MAA payment is shown on this Schedule as* **MAA**.

Your benefits are subject to deductibles and Coinsurance amounts listed in this Schedule. The deductible is waived for preventive care services covered under the "Preventive Care" section of the Basic Benefit Schedule.

	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible: Family coverage	$4,000 [1]	$8,000 [1]
Physician/Professional/Outpatient Care		
Physician services, office visit [2]	20% contract rate	40% MAA
Physician services, preventive care [2]	No charge [3]	40% MAA [3]
Physician services, urgent care center [2]	20% contract rate	20% MAA
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/mammography/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 [7]	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% MAA
Emergency ground ambulance transport – 3 trips/year max	20% (MAA applies to Out-of-Network Providers)	
Emergency air ambulance transport - $10,000/year max	20% (MAA applies to Out-of-Network Providers)	

Health Net

PPO Family High Deductible Health Plan WFHD40008060/12 Pacific Trust

For covered services, you are responsible for:

Behavioral Health Services	PPO Network	Out-of-Network
Outpatient mental health [4]	20% contract rate	40% MAA
Inpatient mental health [4]	20% contract rate	40% MAA
Outpatient Chemical Dependency [4]	20% contract rate	40% MAA
Inpatient Chemical Dependency [4]	20% contract rate	40% MAA
Other Services		
Durable Medical Equipment –$5,000/year max [5]	20% contract rate	40% MAA
Prosthetic Devices/Orthotic Devices	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% MAA
Diabetes management	20% contract rate	40% MAA
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
TMJ services - $500/lifetime max	50% contract rate	50% MAA
Home infusion therapy	20% contract rate	40% MAA
Outpatient chemotherapy (non-self administered anticancer medications and administration)	20% contract rate	40% MAA
Skilled Nursing Facility care - 60 days/year max	20% contract rate	40% MAA
Hospice services	20% contract rate	40% MAA
Home health visits	20% contract rate	40% MAA
Neurodevelopmental therapy, under age 7	20% contract rate	40% MAA
Health education	Not covered	Not covered
Spinal and other manipulations (any provider: MD, DO, chiropractor) - 15 manipulations/year max	20% contract rate	40% MAA
Acupuncture Care - 15 visits/year max	20% contract rate	40% MAA
Naturopathic Care	20% contract rate	40% MAA
Massage Therapy - 15 visits/year max	20% contract rate	40% MAA
Benefit Maximums		
Annual out-of-pocket maximum: Family coverage [6]	$8,000	$16,000
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

[1] 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.

[2] Office visit includes physician services only. Other services are subject to Coinsurance as listed.

[3] Deductible is waived.

[4] To Prior Authorize mental health or Chemical Dependency services, call 800-977-8216.

[5] The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice care, or when Home Health Care or Hospice care are being provided under case management in lieu of Hospitalization.

[6] 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.

[7] 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.

This Schedule presents general information only. Certain services require Prior Authorization or must be performed by a Specialty Care Provider. Refer to your certificate 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.
Preventive Prescription Benefits
WA Supplemental Benefit Schedule WNMHD80/12 (No MAC) Pacific Trust

In this Supplemental Benefit Schedule, 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 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 Basic Benefit Schedule.

Subject to all terms, conditions, exclusions and definitions in the Health Net Health Plan of Oregon, Inc. Group Medical and Hospital Service Agreement and its attachments, except the exclusion of prescription drugs in the Exclusions and Limitations section of the Basic Benefit Schedule, You are entitled to receive benefits set forth in this Schedule upon payment of the relevant premium, deductible and coinsurance.

Benefits

Coverage includes all Medically Necessary legend drugs, compounded medications of which at least one ingredient is a prescription legend drug, self-administered anticancer medications, preventive pharmacy 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 is subject to the qualifications, limitations and exclusions below:

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

- All drugs, including insulin and diabetic supplies, must be dispensed by a Participating Provider pharmacy, except for Emergency Medical Care rendered outside the Service Area.

- Coinsurance shall be as follows for each prescription or refill. Deductible and Coinsurance amounts you pay for prescription drugs do apply toward your medical plan deductible and out-of-pocket maximum.

Calendar Year Deductible for Prescription Benefits: Refer to your medical plan deductible.

	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%
Prescribed, self-administered anticancer medications	No Copayment	Mail order not available
Preventive Pharmacy and Women's contraception methods	No Copayment and/ or Coinsurance. Deductible waived	No Copayment and/ or Coinsurance. Deductible waived

This pharmacy plan provides creditable coverage for Medicare Part D if you are not currently enrolled in Medicare. If you are currently enrolled in Medicare, please call our Customer Contact Center to find out if your specific plan provides creditable coverage.

- The level of benefit you receive is based on the Preferred Drug List (PDL) status of the drug at the time your prescription is filled. The PDL 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 PDL will be communicated to Participating Providers. Compounded medications are subject to the Tier 3 Coinsurance. Brand name drugs with generic equivalents are subject to the Tier 3 Coinsurance as soon as a generic becomes available.

- 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: www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. 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 Non-Participating Provider pharmacy are not covered.

- Women's contraception methods. Generic class Food and Drug Administration approved contraceptive methods, patient education and counseling for all women with reproductive capacity are covered when dispensed by a Participating Provider pharmacy. 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.

  Abortifacient drugs, compounded medications, over-the-counter methods, devices and supplies, and prescriptions or refills dispensed by a Non-Participating Provider pharmacy are not covered.

- Reimbursement (minus the 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 Oregon and sufficient documentation to establish the need for Emergency Medical Care.

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.
- Over-the-counter drugs other than insulin and preventive pharmacy medications as noted above in this Schedule.
- Any prescription drug for which an over-the-counter therapeutic equivalent is available.
- 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 as injections on the PDL.
- Dental only drugs.
- Dietary supplements, food, health and beauty aids, and vitamin preparations other than legend prenatal vitamins and legend vitamins with fluoride.
- Drugs for the treatment of onychomycosis (nail fungus), nocturnal enuresis (bed-wetting), sexual dysfunction, or infertility; drugs used for weight loss, sexual enhancement, or sexual performance improvement; growth hormone therapy; oral nystatin powder.
- Prescription refills due to loss or theft.
- Non-hormonal contraceptive devices, IUDs, contraceptive implants, and contraceptive injectables other than Depo Provera 150mg injection are excluded under this Supplemental Prescription Benefits Schedule. Diaphragms and non-

This pharmacy plan provides creditable coverage for Medicare Part D if you are not currently enrolled in Medicare. If you are currently enrolled in Medicare, please call our Customer Contact Center to find out if your specific plan provides creditable coverage.

hormonal contraceptive devices, IUDs, contraceptive implants, contraceptive injectables, and Norplant are covered under the Basic Benefit Schedule when provided in the doctor's office.

- Drugs and medicines used for diagnostic purposes.
- Methadone maintenance treatment for the purpose of long term opiate craving reduction.

This pharmacy plan provides creditable coverage for Medicare Part D if you are not currently enrolled in Medicare. If you are currently enrolled in Medicare, please call our Customer Contact Center to find out if your specific plan provides creditable coverage.

Health Net Health Plan of Oregon, Inc.
24-Hour Coverage
Supplemental Benefit Schedule

Purpose and Function of this Schedule

The purpose of this schedule is to provide benefits for work related conditions to certain Members of Subscriber Groups selecting this supplemental benefit in addition to the basic benefits. This schedule is an amending attachment to the Basic Benefit Schedule.

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

Benefits

Any illness, condition or injury occurring in or arising out of the course of employment suffered by a Member who is a sole proprietor, partner or corporate officer of the Subscriber Group who is not a worker subject to mandatory workers' compensation coverage and who in fact does not have workers' compensation coverage, shall be covered to the same extent as if it had not occurred in or arisen out of the course of employment.

Exclusions

Any illness, condition or injury occurring in or arising out of the course of employment suffered by a Member who does not meet the requirements described above is excluded from coverage.

Health Net Health Plan of Oregon, Inc.
Non-Registered Domestic Partner Eligibility
Amending Attachment

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 and Copayments and/or Coinsurance.

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 State 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 (QMCSO) requiring the Subscriber to provide health coverage for the child. The QMCSO must be furnished to us to initiate Enrollment.

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

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 who are not related by blood closer than first cousins.

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

c. A partnership that includes joint financial accounts and joint financial responsibilities.

The partnership must meet the eligibility requirements established by the Subscriber Group and agreed to by us and the Subscriber and Non-Registered Domestic Partner must complete an affidavit form approved by us declaring that the relationship meets the definition of Domestic Partnership. The Subscriber is required to provide notice of termination of the relationship.

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 Non-Registered Domestic Partnership is not entitled to Federal Continuation of Coverage under the "Federal Continuation of Coverage" section of the Group Medical and Hospital Service Agreement.

Health Net Health Plan of Oregon, Inc.
Preventive Limited Prescription Benefits
SUPPLEMENTAL BENEFIT SCHEDULE:
Outpatient Prescription Drug
LIMITED RX/12 PACIFIC TRUST

In this Amending Attachment, 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 to each Enrolled Dependent unless otherwise specified.

Purpose and Function of this Schedule

The purpose of this Schedule is to provide specific and limited required prescription benefits to Subscriber Groups not otherwise selecting prescription supplemental benefits. This Schedule is an amending attachment to the Basic Benefit Schedule.

Subject to all terms, conditions, exclusions and definitions in the Health Net Health Plan of Oregon, Inc. Group Medical and Hospital Service Agreement and its attachments, except the exclusion of prescription drugs in the Exclusions and Limitations section of the Basic Benefit Schedule, You are entitled to receive benefits set forth in this Schedule upon payment of the relevant premium, deductibles and Copayments or Coinsurance (if any).

Benefits

Coverage is provided as follows:

- Self-Administered Anticancer Drugs. Medically Necessary self-administered anticancer drugs used to kill or slow the growth of cancerous cells which under law may only be dispensed by written prescription of a duly licensed health care provider are covered. Copayments or Coinsurance are required, as shown on the Copayment and Coinsurance Schedule.

- Women's contraception methods. Generic class Food and Drug Administration approved contraceptive methods, patient education and counseling for all women with reproductive capacity are covered when dispensed by a Participating Provider pharmacy. 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.

  Brand name drugs that have generic equivalents, mail order prescriptions, abortifacient drugs, compounded medications, over-the-counter methods, devices and supplies, and prescriptions or refills dispensed by a Non-Participating Provider pharmacy are not covered.

- 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: www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. 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.

  Brand name drugs that have generic equivalents, Mail order prescriptions, compounded medications, and prescriptions or refills dispensed by a Non-Participating Provider pharmacy are not covered.

Coverage is subject to the following provisions:

- The amount of drug to be dispensed per filled prescription shall be for such quantities as directed by the Physician, but in no event shall the quantity exceed a 30-day supply when filled in a pharmacy . 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.

- Reimbursement 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 Health Plan of Oregon and sufficient documentation to establish the need for Emergency Medical Care.

- Reimbursement 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 the purposes of this section, "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.

Exclusions

- Drugs and medicines prescribed or dispensed other than the self-administered anticancer medications, preventive pharmacy medications, and women's contraception methods described in this Schedule.

- Injectable medications other than women's contraception methods.

- Early refills other than for changes in directions.

- Over-the-counter drugs.

- Any prescription drug for which an over-the-counter therapeutic equivalent is available.

- Prescription refills due to loss or theft.

- Drugs and medicines used for diagnostic purposes.

- Mail order prescriptions.