

## SCHEDULE OF BENEFITS

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

### BASIC INFORMATION

Maximum Lifetime Benefit for all Covered Services

Unlimited

*Selected benefits under this Health Plan contain an annual or Lifetime Maximum benefit. Refer to the Evidence of Coverage and/or benefit descriptions contained within this Schedule for benefit details.*

Coinsurance

Subject to applicable coinsurance amounts, as stated herein

Deductible per Calendar Year

None

Maximum Copayment Expense per Calendar Year

Limited to stated Copayments \$1,000 single, \$2,000 family per Calendar Year (excluding Copayment for pharmacy benefits and physician office visits)

Maximum Age for Eligible Dependent Children

- Does not apply to totally disabled children
- Limiting age for Dependent coverage is 26 years of age, unless otherwise stated in the Group Enrollment Agreement
- Dependent children are covered through the end of the month in which they reach the limiting age

## SCHEDULE OF BENEFITS

### **Your Group Enrollment Agreement is based on a Calendar Year**

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

Health Net believes this Health Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Health Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to **Health Net's Customer Contact Center at 1-800-289-2818..**

## SCHEDULE OF BENEFITS

### HOSPITAL SERVICES

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

Inpatient

\$250 Copayment per admission

Outpatient (including Outpatient Surgical Facility)including surgical or ambulatory services

\$15 Copayment per visit

### OFFICE VISITS

- Maternity visits ❶
- Allergy testing / serum ❷
- Visits for injury or illness
- Home visits at Physician's discretion are subject to a \$15 Copayment per visit

\$15 per Primary Care Physician visit, \$15 per Specialist Physician visit

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

### PREVENTIVE CARE

- Preventive health exams
- Immunizations
- Gynecological examinations
- Well baby care
- Hearing screening ❸
- Vision screening ❸
- Flu shot ❹

\$15 per Primary Care Physician visit, \$15 per Specialist Physician visit

- ❶ Copayment and/or Coinsurance applies to the initial office visit. Once diagnosis is confirmed, Outpatient pre-natal and post-partum office visit Copayments and/or Coinsurance will be waived.
- ❷ Copayment waived for routine allergy injections received in the Physician's office and performed by non-Physician personnel.
- ❸ Hearing and Vision screenings by the Primary Care Physician are covered for all Members at the Office Visit Copayment and/or Coinsurance indicated. Referrals to Specialists for injury or illness related conditions are covered at the Office Visit Copayment and/or Coinsurance indicated.
- ❹ Copayment waived for an annual flu shot when performed by non-Physician personnel in the Primary Care Physician's office, or when received at an affiliated flu shot clinic sponsored by the Primary Care Physician or Health Net.

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

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### AMBULANCE SERVICES

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

No charge

### CHIROPRACTIC SERVICES

- Limited to 12 medically necessary visits per Calendar Year.
- Services are provided through American Specialty Health Network (ASHN). For a list of participating Providers, call ASHN at 1-800-848-3555.

\$15 Copayment per visit

### DENTAL SERVICES

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

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

### DIABETIC SUPPLIES, EQUIPMENT AND DEVICES

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

- Diabetic *medications and supplies* are subject to the Copayment and/or Coinsurances described in the *Outpatient Prescription Drug Benefit*.
- Diabetic *equipment*, other than Blood glucose monitors, is covered under the *Durable Medical Equipment* benefit. Covered equipment is subject to applicable DME Copayment and/or Coinsurance.

### DURABLE MEDICAL EQUIPMENT

- *Lifetime Maximum* benefit for wheelchairs is 1 standard size manual wheelchair(s) per Member when determined to be Medically Necessary. If a Member requires an electric or specialized wheelchair, then the Member may receive reimbursement for a standard size manual wheelchair to use towards the cost of the electric or specialized wheelchair in accordance with Health Net's rules and regulations.
- Deluxe, electric, model upgrades, specialized, customized or "sport" equipment are not covered under your Health Plan.

No charge

### EMERGENCY SERVICES

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

\$75 Copayment per visit

### FAMILY PLANNING SERVICES

- Refer to the *Family Planning Services Benefit* for a description of Covered Services, including any restrictions and limitations that may apply.
- Contraceptive implants, insertions, and devices are covered at 50% Coinsurance and are limited to 1 every 36 months.
- Contraceptive implant removals are covered at no charge and are limited to 1 removal every 36 months.
- *Lifetime Maximum* benefit for elective abortions performed during the first trimester is limited to 2 per Member.

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

### HEALTH EDUCATION/DISEASE MANAGEMENT SERVICES

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

No charge

## SCHEDULE OF BENEFITS

### HEARING SERVICES

- Hearing screenings by the Primary Care Physician are covered.
- Referrals to Specialist for Members over the age of 18 years, are limited to injury or illness related conditions.
- Members age 18 or younger may be referred to a Specialist when determined to be Medically Necessary by the Primary Care Physician.
- Hearing aids are not covered under this Health Plan.

\$15 Copayment per Primary Care Physician visit, \$15 Copayment per Specialist Physician visit

### HOME HEALTH CARE SERVICES

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

No charge

### HOSPICE CARE

Inpatient Facility or home Hospice for life expectancy of 6 months or less.

No charge

### MAMMOGRAMS

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

Routine and diagnostic mammograms to reduce the risk or determine the presence of breast cancer are a combined benefit.

Refer to the *Mammograms benefit* in the Evidence of Coverage for a description of Covered Services.

Performed at a Physician's office

No charge

Performed at an independent, freestanding Facility

No charge

Performed at a Hospital

No charge

### MATERNITY SERVICES

- Coverage includes Medically Necessary services relating to prenatal, delivery and post-partum care.
- *Office Visit* Copayment and/or Coinsurance applies to the initial outpatient office visit only. Once diagnosis is confirmed, obstetrical pre-natal and post-partum office visit Copayments and or Coinsurance will be waived.

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

## SCHEDULE OF BENEFITS

### MEDICAL SUPPLIES

No charge

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

- casting materials.
- surgical dressings only when provided under the supervision of a Home Health Agency and prescribed by the Primary Care Physician.
- colostomy supplies and urinary catheters (are limited as defined by Medicare guidelines).
- medical supplies that are necessary to operate and/or maintain a covered prosthesis or item of Durable Medical Equipment, subject to the limitations stated herein.
- most medical supplies are issued for a 30-31 day supply as defined by Medicare guidelines.

### MENTAL HEALTH SERVICES

- Call MHN at 1-800-977-0281 to access these services. Refer to the *Mental Health Services Benefit* following this Schedule for a description of Covered Services.
- Services are limited to short term evaluation or crisis intervention.
- Psychiatric medication follow-ups (med-checks) are subject to the mental health outpatient *Copayment and/or Coinsurance* for individual therapy. Med checks do not count towards the maximum visit limitations.

#### Inpatient Services

\$250 Copayment per admission

#### Outpatient Services

\$15 Copayment per visit

### OUTPATIENT LABORATORY AND X-RAY SERVICES

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

- Performed at a Physician's office

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

No charge

- Performed at an independent, freestanding facility
- Performed at a hospital, outpatient surgery or ambulatory surgical facility

No charge

\$100 copayment per visit

### OUTPATIENT IMAGING AND TESTING SERVICES

(including but not limited to CT scans, MRIs, MRAs, and PET/SPECT scans)

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

\$25 Copayment per visit

\$25 Copayment per visit

## SCHEDULE OF BENEFITS

- Performed at a hospital, outpatient surgery or ambulatory surgical facility \$200 Copayment per visit

### OUTPATIENT DIALYSIS CHEMOTHERAPY AND RADIATION THERAPY SERVICES

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

Outpatient Dialysis \$15 Copayment per visit

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

Outpatient Chemotherapy and Radiation Therapy \$15 Copayment per visit

### PROSTHETICS AND SUPPORT DEVICES

- Mastectomy bras are limited to 1 per calendar year.

No charge

### RECONSTRUCTIVE SURGICAL SERVICES

- Limited to illness or injury related conditions as defined in the Evidence of Coverage.

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

### REHABILITATION SERVICES

(Includes Speech and Language Services)

- Rehabilitation Services and Speech and Language Services are a combined benefit and are limited to a total of 60 days per Calendar Year, all therapies combined (physical, occupational, speech and language, etc.)

Inpatient:

\$250 Copayment per admission

Outpatient

\$15 per visit

### SKILLED NURSING SERVICES

Inpatient services are limited to 100 days per Calendar Year.

No Charge

### SUBSTANCE ABUSE SERVICES

Covered Services are limited to *detoxification* only.

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

#### Inpatient Services

\$250 Copayment per admission

#### Outpatient Services

\$15 Copayment per visit

## **SCHEDULE OF BENEFITS**

### **TRANSPLANT SERVICES – ORGAN AND TISSUE**

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

### **URGENT CARE SERVICES**

\$50 Copayment per visit

### **VISION SERVICES**

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

Eye Exam every 24 months

No charge

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

## FAMILY PLANNING SERVICES BENEFIT

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

### COVERED SERVICES

Covered Services include:

#### Abortions

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

#### Contraceptives – Implants, Insertions, Devices and Removals

- Contraceptive implants, insertions, devices and removals are limited to the following:
  - Implants, insertions and devices are limited as shown in the *Schedule of Benefits* while covered under the Health Plan;
  - Refer to the *Schedule of Benefits* for applicable *Copayment and/or Coinsurance*.
  - Removals are limited as shown in the *Schedule of Benefits* while covered under the Health Plan.

#### Contraceptives – Oral and Injection

- Prescribed diaphragms and oral contraceptives, including birth control pills, are covered under the *Outpatient Prescription Drug Benefit* and subject to the Preferred Drug List.
- DepoProvera injections are covered when preauthorized through the Primary Care Physician. The *Copayment and/or Coinsurance* for *Office Visit* will apply. Refer to the *Schedule of Benefits* for applicable *Copayment and/or Coinsurance*.

#### Genetic Testing

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

#### Sterilization Procedures

- Sterilization procedures, including tubal ligation and vasectomy are covered. *Copayment and/or Coinsurance* will correspond to the charge associated with the Facility in which services are received.

### GENERAL PROVISIONS

The Health Plan reserves the right to waive any of the program limitations, if in the opinion of the Provider, it is necessary for the Member's welfare. All other provisions of the Group Enrollment Agreement and Evidence of Coverage, including any amendments thereto, shall apply to this Family Planning Services Benefit. This Family Planning Services Benefit will terminate upon termination of the Group Enrollment Agreement.

## MENTAL HEALTH SERVICES BENEFIT

The following Mental Health Services Benefit is hereby added and shall become a part of the Evidence of Coverage.

**Except for Emergency conditions, Covered Services for inpatient Mental Health benefits must be preauthorized through MHN, the designated behavioral health representative for this Health Plan. To access benefits, please contact MHN directly at 1-800-977-0281.**

### DEFINITIONS

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

### COVERED SERVICES

Mental Health Services are provided for those illnesses, which are responsive to short-term crisis intervention and are not organic in origin. Physician visits for psychiatric medicine level checks (med checks) are covered as shown in the *Schedule of Benefits*.

#### Inpatient Services

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

- Inpatient Mental Health Services must be received in a Participating Hospital or Facility. Hospitalization will be subject to review proceedings by the designated behavioral health representative.
- If partial hospitalization/Intensive Outpatient Programs are provided, the benefit will be calculated as follows:
  - Partial Hospitalization will equal one-half (1/2) of an inpatient day
  - Intensive Outpatient Programs will equal one-fourth (1/4) of an inpatient day
  - Four (4) or less hours a day will equal one-fourth (1/4) of an inpatient day
  - Five (5) or more hours a day will equal one-half (1/2) of an inpatient day
- If hospitalization is due to an Emergency condition, the Member must contact MHN's Utilization Management Department within 48 hours of admission, or as soon as is reasonably possible to ensure Coverage. Emergency Services, which are preauthorized, will not be retrospectively denied.
- Refer to the *Schedule of Benefits* to determine whether your Health Plan provides coverage for Inpatient Mental Health Services.

#### Outpatient Services

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

### COPAYMENT, COINSURANCE AND MAXIMUM BENEFITS

**Copayment and/or Coinsurance.** The Member is required to pay a predetermined *Copayment and/or Coinsurance* for Covered Services. Refer to the *Schedule of Benefits* to determine the applicable *Copayment and/or Coinsurance* under your Health Plan. *Copayment and/or Coinsurance* will correspond to the charge associated with the Facility in which Covered Services are received.

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

### MISSED / CANCELED APPOINTMENTS

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

### LIMITATIONS AND EXCLUSIONS

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

## MENTAL HEALTH SERVICES BENEFIT

- treatment for chronic or organic conditions, including Alzheimer's, dementia or delirium;
- ongoing treatment for mental disorders that are long-term or chronic in nature for which there is little or no reasonable expectation for improvement. These disorders include mental retardation, personality disorders, and organic brain disease. *This exclusion does not apply to the initial assessment for diagnosis of the condition.*
- psychosexual disorders or transexualism. *The exclusion does not apply to the initial assessment for diagnosis of the condition.*
- psychotherapy. *This exclusion does not apply to the initial assessment for diagnosis of the condition.*
- counseling, testing, evaluation, treatment or other services in connection with the following: learning disorders and/or disabilities, disruptive behavior disorders, conduct disorders, eating disorders, motor skill disorders, communication disorders, and attention deficit disorders. *This exclusion does not apply to the initial assessment for diagnosis of the condition.*
- psychological testing or evaluation specifically for ability, aptitude, intelligence, interest or competency.
- psychiatric evaluation, therapy, counseling or other services in connection with the following: child custody, parole and/or probation, and other court ordered related issues.
- residential treatment.
- therapy, counseling or other services related to relationship and/or communication issues.
- marriage counseling, unless otherwise specifically stated as a Covered Service in the *Schedule of Benefits*.
- services that exceed a Member's maximum allowable benefit as described in the *Schedule of Benefits*.
- charges incurred for missed appointments or appointments not canceled within 24 hours of appointment.
- Prior Authorization is required for Neuropsychology Rehabilitation and Testing.

### **GENERAL PROVISIONS**

The Health Plan reserves the right to waive any of the program limitations, if in the opinion of the Provider, it is necessary for the Member's welfare. All other provisions of the Group Enrollment Agreement and Evidence of Coverage, including any amendments thereto, shall apply to this Mental Health Services Benefit. This Mental Health Services Benefit will terminate upon termination of the Group Enrollment Agreement.

## SUBSTANCE ABUSE SERVICES BENEFIT

The following Substance Abuse Services Benefit is hereby added and shall become a part of the Evidence of Coverage.

**Except for Emergency conditions, Covered Services for inpatient Substance Abuse benefits must be preauthorized.**

- Services relating to detoxification only and fall under the *medical* portion of your health plan. Contact your Primary Care Physician and/or Health Net for preauthorization requirements.
- All other services for inpatient Substance Abuse must be preauthorized through MHN, the designated behavioral health representative for this Health Plan. To access benefits; please contact MHN directly at 1-800-977-0281.

### COVERED SERVICES

#### Inpatient Services

The following provisions apply Inpatient Substance Abuse Services,:

- Inpatient services must be received in a Participating Hospital or Facility. Hospitalization will be subject to review proceedings by MHN's Utilization Management Department and/or MHN.
- If partial hospitalization/Intensive Outpatient Programs are provided, the benefit will be calculated as follows:
  - Partial Hospitalization will equal one-half (1/2) of an inpatient day
  - Intensive Outpatient Programs will equal one-fourth (1/4) of an inpatient day.
- If hospitalization is due to an Emergency condition, the Member must contact MHN at 1-800-977-0281 within 48 hours of admission, or as soon as is reasonably possible to ensure Coverage. Emergency Services, which are preauthorized, will not be retrospectively denied.
- Refer to the *Schedule of Benefits* to determine whether your Health Plan provides coverage for Inpatient Substance Abuse Services.

#### Outpatient Services

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

### COPAYMENT, COINSURANCE AND MAXIMUM BENEFITS

**Copayment and/or Coinsurance.** The Member is required to pay a predetermined *Copayment and/or Coinsurance* for Covered Services. Refer to the *Schedule of Benefits* to determine the applicable *Copayment and/or Coinsurance* under your particular Health Plan. *Copayment and/or Coinsurance* will correspond to the charge associated with the Facility in which Covered Services are received.

#### Maximum Benefits.

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

### LIMITATIONS AND EXCLUSIONS

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

- Treatment for chronic conditions
- Drugs used for opiate dependency
- Long term services
- Residential treatment
- Continuation in a course of counseling for patients who are disruptive or physically abusive
- House calls
- Referral for non-Medically Necessary ancillary services such as vocational programs or employment counseling
- Court ordered testing
- Services which exceed the Member's maximum allowable benefit

## SUBSTANCE ABUSE SERVICES BENEFIT

### **GENERAL PROVISIONS**

The Health Plan reserves the right to waive any of the program limitations, if in the opinion of the Provider, it is necessary for the Member's welfare. All other provisions of the Group Enrollment Agreement and Evidence of Coverage, including any amendments thereto, shall apply to this Substance Abuse Services Benefit. This Substance Abuse Services Benefit will terminate upon termination of the Group Enrollment Agreement.