Health Net of Arizona, Inc. (Health Net)
Individual & Family Plans
Health Insurance Marketplace

Health Net

Plan Overview

Health Net CommunityCare HMO Gold $30 / $60 / $6,000 / $375

Benefits	*Member pays*[1,4]
Deductible per calendar year.	$500 single / $1,000 family
Coinsurance	10%
Out-of-pocket maximum including all deductibles, copays and coinsurance	$6,000 single / $12,000 family
Maximum benefits in-network	Unlimited
Professional services Primary care physician (PCP)	$30 copay/visit
Specialist physician	$60 copay/visit
Preventive care[2]	No charge
Prenatal care and postpartum care	$30 copay/visit (PCP) / $60 copay/visit (Specialist)
Hearing exam / Hearing aid Hearing exam	$60 copay/visit. One routine hearing exam/year.
Hearing aid	10% coinsurance after ded. One hearing aid per ear/per plan yr.
Laboratory services Physician's office or independent facility[3]	$0 copay/visit after deductible
Hospital	10% coinsurance after deductible
X-ray services Physician's office or independent facility[3]	$60 copay/visit after deductible
Hospital	10% coinsurance after deductible
Imaging and testing services (including but not limited to MRIs, MRAs, and PET / SPECT, ECT, and BEAM scans) Physician's office or independent facility[3]	$250 copay/visit after deductible
Hospital	10% coinsurance after deductible
Hospital services Inpatient hospital services (including physician, facility, surgery and labor/delivery)	$375 copay/day, up to 3 days after deductible
Outpatient hospital / ambulatory surgical center services	10% coinsurance after deductible
Skilled nursing facility (100 days max/calendar year)	$375 copay/day, up to 3 days after deductible

[1] Certain services require precertification from Health Net. Without precertification, the benefit is reduced by 50%.

[2] Preventive care services: This plan provides all coverage as required under the ACA including evidence-based screening and counseling, routine immunizations, childhood preventive services, and preventive services for women, at no cost to members with an in-network provider. This coverage includes services such as preventive office visits, preventive lab and X-ray, Pap test and mammogram, prostate screening, immunizations, and colorectal cancer screening. You can find all the details on the government's website at www.healthcare.gov.

Women's preventive services include screening for gestational diabetes; human papillomavirus (HPV) DNA testing for women 30 years and older; sexually-transmitted infection counseling; and human immunodeficiency virus (HIV) screening and counseling. These services also include FDA-approved contraception methods and sterilization procedures, and contraceptive counseling for women with reproductive capacity; breastfeeding support, supplies and counseling; and interpersonal and domestic violence screening and counseling.

[3] Some facilities are affiliated with a hospital. You may be charged a higher copayment or coinsurance for services at a hospital-affiliated facility. Contact the place of service for more information or the Customer Contact Center at the number on the back of your ID card.

[4] In accordance with the Affordable Care Act, American Indians and Alaskan Natives, as determined eligible by the Exchange and regardless of income, have no cost sharing obligation under this Policy for items or services that are Essential Health Benefits if the items or services are provided by a provider of the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services, as defined by Federal law. Cost sharing means

Benefits	*Member pays*[1,4]
Emergency and urgent care services	
Emergency room services (copayment waived if admitted)	$150 copay after deductible
Urgent care services	$50 copay/visit
Ambulance services (medical emergencies only)	$0 copay/visit after deductible
In-store health care clinic	$30 copay/visit
Rehabilitative services	
Inpatient	$375 copay/day, up to 3 days after deductible
Outpatient (max 60 days/calendar year for all therapies combined – physical, occupational, speech, and language, etc.)	$60 copay/visit after deductible
Habilitative services	
Inpatient	$375 copay/day, up to 3 days after deductible
Outpatient (max 60 days/calendar year for all therapies combined – physical, occupational, speech, and language, etc.)	$60 copay/visit after deductible
Outpatient prescription drug services[5]	
Brand name calendar year deductible (per insured)	$0
Prescription drugs (up to a 30-day supply) – generic / preferred brand / non-preferred	$20 / $50 / $70
Specialty pharmacy (most self-injectables)	20%
Mail order program (90-day supply) – generic / preferred brand / non-preferred	$60 / $150 / $210
Mental health / Substance abuse services	
Inpatient	$375 copay/day, up to 3 days after deductible
Outpatient physician office visit	$30 copay/visit
Outpatient services other than physician office visit	10% coinsurance after deductible
Durable medical equipment (DME)	10% coinsurance after deductible
Home health care services (Limited to part-time and intermittent care. Up to 60 days or longer when precertified. Limit in-network and out-of-network combined.)	$0 copay/visit after deductible.
Hospice care services	$375 copay/day, up to 3 days after deductible
Chiropractic services Max. 20 visits/calendar year.	$60 copay/visit
Allergy testing / treatment	
Allergy testing	No charge after deductible
Allergy serum	20% coinsurance after deductible
Allergy injection administrative charges	$30 copay/visit (PCP) / $60 copay/visit (Specialist)
Pediatric dental services (Only for plans with Pediatric Dental) This plan is offered **with** and **without** pediatric dental service benefits. If you purchased this plan from Health Net with pediatric dental coverage, then pediatric dental services for covered members up to age 19 are included as indicated. If you purchased this plan from Health Net without pediatric dental coverage, then this Health Net plan does not include pediatric dental services.	One exam every six months. Diagnostic and preventive services: No charge after $100 deductible per person. Basic and major services + medically necessary orthodontics: 50% after $100 deductible per person.

[5] The three prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary.

The Essential Rx Drug List is a list of prescription drugs that are covered by this plan. Some drugs require precertification from Health Net. For a copy of the Essential Rx Drug List, go to Health Net's website. Refer to your *Schedule of Benefits* and coverage documents for complete information on prescription drugs. Plans will cover most female prescription contraceptives at $0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your plan documents and Health Net's Essential Rx Drug List for coverage, cost-share and tier information. Prescription drugs can be filled through mail order (up to a 90-day supply).

Benefits	*Member pays* [1,4]
Pediatric vision services and medically necessary supplies	Covered for children up to age 19. $0. One routine eye exam and one pair of eyeglasses (lenses and frames) or contact lenses per year. Exclusions and limitations apply.

For more information, visit Health Net's website at www.healthnet.com, or call Health Net at 1-888-463-4875.

Exclusions and limitations

The following services and/or procedures are either limited in coverage or excluded from coverage under this health plan:

Abortions

Abortions are not covered, except when necessary to avert death or substantial and irreversible impairment of a major bodily function of the member or when the pregnancy is the result of rape or incest.

Altered Gender Characteristics

Any procedure or treatment designed to alter physical characteristics of the member from the member's biologically determined gender to those of another gender, regardless of any diagnosis of gender role disorientation or psychosexual orientation. Treatment for hermaphroditism and any studies or treatment related to gender transformation or hermaphroditism.

Alternative Therapies

Acupuncture, acupressure, hypnotherapy, biofeedback, (for reasons other than pain management, and for pain management related to Mental Health and Substance Abuse), behavior training, educational, recreational, art, dance, sex, sleep or music therapies, and other forms of holistic treatment or alternative therapies, unless otherwise specifically stated as a covered benefit in the coverage documents.

Applied Behavioral Health Therapy (ABA)

ABA is only covered for the treatment of Autism Spectrum Disorder. Sensory integration, Lovaas therapy, and music therapy are not covered.

Bariatric Surgery

Health Net provides benefits for Medically Necessary and not experimental or investigational services. These covered services must be preauthorized by Health Net in accordance with Health Net's evidence based criteria for this intervention contained in Health Net's National Medical Policy on Bariatric Surgery which can be found at https://www.healthnet.com under the medical policies link. Benefits are not payable for expenses excluded in the coverage documents or for the following:

- Jejunoileal bypass (jejuno-colic bypass).
- Loop gastric bypass (i.e., "Mini-Gastric Bypass").
- Open sleeve gastrectomy.
- Gastric balloon, gastric wrapping, gastric imbrication and gastric pacing.
- Fobi pouch.

Benefits or Services (Non-Covered)

Services, supplies, treatments or accommodations which:

- are not Medically Necessary except as specifically described in the coverage documents;
- are not specifically listed as a covered service in the coverage documents, whether or not such services are Medically Necessary;
- are incident or related to a non-covered service;
- are not considered generally accepted health care practices;
- are considered cosmetic as determined by us, unless specifically listed as a covered service in the coverage documents;
- are provided prior to the effective date of coverage hereunder, or after the termination date of coverage hereunder;
- are provided under Medicare or any other government program except Medicaid;
- the person is not required to pay, or for which no charge is made.

Blood Products

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

Braces

Over-the-counter braces, prophylactic braces and braces used primarily for sports activities.

Breast Implants, Prostheses

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

Chiropractic Care

- Any services provided by a non-participating chiropractor regardless of whether the services were obtained within or outside of the health plan's service area.
- Any services, including consultations (except for the initial evaluation visit), that are not preauthorized by the designated chiropractic provider.
- Any treatments or services, including X-rays, determined to not be related to neuromusculoskeletal disorders as defined by the designated chiropractic provider.
- Services which are not provided in a participating chiropractor's office.
- Services or charges which exceed the member's maximum allowable benefit. Services which exceed the member's maximum allowable benefit will be the member's financial responsibility.
- Expenses incurred for any services provided before coverage begins or after coverage ends.
- Preventive care, educational programs, non-medical self-care, self-help training, or any related diagnostic testing, except that which occurs during the normal course of covered chiropractic treatment.
- Prescription medications. Vitamins, nutritional supplements, or related products, even if they are prescribed or recommended by a participating chiropractor.
- Services provided on an inpatient basis.
- Rental or purchase of durable medical equipment, air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices, appliances or equipment as ordered by the participating chiropractor even if their use or installation is for the purpose of providing therapy or easy access.
- Expenses resulting from a missed appointment which the member failed to cancel.
- Treatment primarily for purposes of obesity or weight control.
- Vocational rehabilitation and long-term rehabilitation.
- Hypnotherapy, acupuncture, behavior training, sleep therapy, massage, or biofeedback.
- Radiological procedures performed on equipment not certified, registered or licensed by the State of Arizona, and/or radiological procedures that, when reviewed by the designated chiropractic provider or Health Net, are determined to be of such poor quality that they cannot safely be utilized in diagnosis or treatment.
- Services, lab tests, X-rays and other treatments not documented as clinically necessary as appropriate or classified as experimental or investigational and/or as being in the research stage.
- Services and/or treatments that are not documented as medically necessary services, as determined by us.
- All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids.
- Adjunctive therapy not associated with spinal, muscle or joint manipulation.
- Manipulation under anesthesia.

Circumcision

Non-Medically Necessary circumcisions after the newborn period, including cases of premature birth.

Communications and Accessibility Services

Provider charges for interpretation, translation, accessibility, or special accommodations.

Complications of Non-Covered Expenses

Complications of an ineligible or excluded condition, procedure or service (non-covered expenses), including services received without preauthorization.

Cosmetic Surgery or Reconstructive Surgery

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

- Rhinoplasty and associated surgery, rhytidectomy or rhytidoplasty, breast augmentation/implantation.
- Blepharoplasty without visual impairment.
- Breast reduction which is not Medically Necessary, as determined by us.
- Otoplasty, skin lesions without functional impairment, suspicion of malignancy or located in an area of high friction, and keloids.
- Procedures utilizing an implant which does not alter physiologic function.
- Treatment or surgery for sagging or extra skin.

- Liposuction.
- Non-Medically Necessary removal or replacement of breast implants, as determined by us.

Cosmetic or reconstructive surgery performed, in Health Net's opinion, to correct injuries that are the result of accidental injury is a covered services. In addition, this exclusion does not apply to breast reconstruction incidental to a covered mastectomy for either the breast on which the mastectomy has been performed or for surgery and reconstruction of the other breast to produce a symmetrical appearance. This exclusion also does not apply to surgery required due to accident or injury. Reconstructive surgery incidental to birth abnormalities of a covered dependent is limited to the Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn, adopted child or child placed for adoption. Surgery will be covered past the newborn period if Medically Necessary and medical criteria are met.

Counseling Services
- Counseling for conditions that DSM identifies as relational problems (e.g., couples counseling, family counseling for relationship problems).
- Counseling for conditions that the DSM identifies as additional conditions that may be a focus of clinical attention (e.g., educational, social, occupational, religious, or other maladjustments).
- Sensitivity or stress-management training, and self-help training

These exclusions do not apply to counseling as required by ACA.

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

Custodial Care
Any service, supply, care, or treatment that Health Net determines to be incurred for rest, domiciliary, convalescent, or custodial care. Examples of non-covered services include:
- Any assistance with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medications.
- Any care that can be performed safely and effectively by a person who does not require a license or certification or the presence of a supervisory nurse.
- Non-covered custodial care services no matter who provides, prescribes, recommends, or performs those services.
- Services of a person who resides in the member's home, or a person who qualifies as a family member.
- The fact that certain covered services are provided while the member is receiving custodial care does not require Health Net to cover custodial care.

Dental Services
The medical portion of your health plan covers only those dental services specifically stated in the section titled, "Description of Benefits" in the coverage documents. All other dental services are excluded.

If you purchased pediatric dental benefits, exclusions and limitations apply as stated under the Pediatric Dental section in the *Schedule of Benefits.*

Devices
Bionic and hydraulic devices, except when otherwise specifically described in the coverage documents.

Diabetic Supplies, Equipment, and Devices
Non-covered services include the following:
- Supplies, medication and equipment labeled "Caution – Limited by Federal Law to Investigational Use".
- Any non-prescription or over-the-counter drug that can be purchased without a prescription or physician order is not covered, unless otherwise specifically stated in the *Schedule of Benefits*, even if the physician writes a prescription or order for such drug.
- Supplies, medication and equipment deemed experimental, unproved or investigational by us.
- Take-home medications, supplies and equipment after discharge from a hospital, nursing home, skilled nursing facility, or other inpatient or outpatient facility. Supplies dispensed while in an inpatient facility will only be covered as part of the inpatient benefit.
- Supplies, medications and equipment that are consumed or dispensed at the place where they are dispensed or are administered by the physician.
- Supplies, medication and equipment for other than FDA-approved indications.
- Replacement prescriptions for any reason.

- Over-the-counter supplies, medications and equipment, except as indicated under the benefit description titled diabetic supplies, equipment and devices, or in the *Schedule of Benefits*.
- Supplies, medication and equipment that are not Medically Necessary replacement prescriptions for any reason.
- Supplies, medication and equipment purchased before a member's effective date of coverage under this benefit, or after the member's coverage terminates. If supplies, medication and equipment are dispensed after the member's coverage terminates, the subscriber will be held responsible for all claims made after the date of termination, including claims paid on behalf of a subscriber's covered dependents.

Dietary Food or Nutritional Supplements

Non-covered services include the following:

- Dietary food, nutritional supplements, special formulas, and special diets provided in an outpatient, ambulatory or home setting.
- Food supplements and formulas, including enteral nutrition formula, provided in an outpatient, ambulatory or home setting.
- Nutritional supplementation ordered primarily to boost protein-caloric intake or the mainstay of a daily nutritional plan in the absence of other pathology, except as otherwise stated in the coverage documents or in the *Schedule of Benefits*. This includes those nutritional supplements given between meals to increase daily protein and caloric intake.
- Services of nutritionists and dietitians, except as incidentally provided in connection with other covered services.

Disability Certifications

- Disability certifications, if not required by Health Net.

Durable Medical Equipment

Durable medical equipment that fails to meet the criteria as established by Health Net. Examples of non-covered services include, but are not limited to, the following:

- Exercise equipment, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses, or waterbeds, escalators or elevators, ramps, automobile modifications, safety bars, saunas, swimming pools, Jacuzzis, or whirlpools, and hygienic equipment.
- Equipment for a patient in an institution that is ordinarily provided by an institution, such as wheelchairs, hospital beds and oxygen tents, unless these items have been preauthorized by Health Net.
- More than one DME device designed to provide essentially the same function.
- Foot orthotics, except when attached to a permanent brace (refer to the exclusion titled Orthotics) (This exclusion does not apply to coverage of special shoes and inserts for certain patients with diabetes. Please refer to your diabetic benefits for further specification.)
- Deluxe, electric, model upgrades, specialized, customized, or other non-standard equipment.
- Repair or replacement of deluxe, electric, specialized, or customized equipment, model upgrades, and portable equipment for travel.
- Transcutaneous electrical nerve stimulation (TENS) units.
- Scooters and other power-operated vehicles.
- Warning devices, stethoscopes, blood pressure cuffs, or other types of apparatus used for diagnosis or monitoring, except as specifically listed as being covered as stated in the coverage documents.
- Model upgrades and duplicates, except as specifically listed as being covered as stated in the coverage documents.
- Repair, replacement or routine maintenance of equipment or parts due to misuse or abuse.
- Over-the counter braces, prophylactic braces, braces used primarily for sports activities, and other DME devices, except as specifically listed as being covered as stated in the coverage documents.
- Pulse oximeters.
- ThAIRapy vests, except when Health Net medical criteria is met, as determined by Health Net.
- Communication devices (speech generating devices) and/or training to use such devices.

Emergency Services

Use of emergency facilities for non-emergency purposes. Routine care, follow-up care or continuing care provided in an emergency facility, unless such services were preauthorized by the primary care physician or Health Net.

Exercise Programs

Exercise programs, equipment, clothing, or devices.

Ex-Member (Services for)

Benefits and services provided to an ex-member after termination of the ex-member.

Experimental, Investigational Procedures, Devices, Equipment, and Medications

Experimental, unproved and/or investigational medical, surgical or other experimental health care procedures, services, supplies, medications, devices, equipment, or substances. Experimental, unproved and/or investigational procedures, services or supplies are those which, in the judgment of Health Net:

- are in a testing stage or in field trials on animals or humans;

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

This exclusion does not apply to coverage provided to members participating in cancer clinical trials as required by state and federal law.

Family Member (Services Provided by)

Professional services, supplies or provider referrals received from or rendered by an immediate family member (spouse, domestic partner, child, parent, grandparent, or sibling related by blood, marriage or adoption) or prescribed or ordered by an immediate family member of the member. Services provided by a member's immediate family, (or a spouse's immediate family if applicable). Member self-treatment including, but not limited to self-prescribed medications and medical self-ordered services.

Fraudulent Services

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

Gastric Stapling/Gastroplasty

Open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy, and open adjustable gastric banding.

Genetic Testing, Amniocentesis

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

Government Hospital Services

Services provided by any governmental unit except as required by federal law for treatment of veterans in Veterans Administration or armed forces facilities for non-service related medical conditions. Care for conditions that federal, state, or local law requires treatment in a public facility.

Growth Hormone

Human growth hormone except for children or adolescents who have one of the following conditions:

- Documented growth hormone deficiency causing slow growth.
- Documented growth hormone deficiency causing infantile hypoglycemia.
- Short stature and slow growth due to Turner syndrome, Prader-Willi syndrome, chronic renal insufficiency prior to transplantation, and a central nervous system tumor treated with radiation.
- Documented growth hormone deficiency due to a hypothalamic or pituitary condition.

Habilitative Services

- Habilitative services when medical documentation does not support the medical necessity because of the member's inability to progress toward the treatment plan goals or when a member has already met the treatment plan goals.
- Speech therapy is not covered for occupational or recreational voice strain that could be needed by professional or amateur voice users, including, but not limited to, public speakers, singers, cheerleaders. Examples of health care services that are not habilitative include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training.

Hair Analysis, Treatment and Replacement

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

Heavy Metal Screening and Mineral Studies

Heavy metal screenings and mineral studies. Screening for lead poisoning is covered when directed through the primary care physician.

Home Maternity Services

Services or supplies for maternity deliveries at home.

Household and Automobile Equipment and Fixtures

Purchase or rental of household equipment or fixtures having customary purposes that are not medical. Examples of non-covered services include: exercise equipment, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses or waterbeds,

escalators or elevators, ramps, automobile modifications, safety bars, saunas, swimming pools, Jacuzzis, or whirlpools, hygienic equipment, or other household fixtures.

Immunizations
Immunizations that are not Medically Necessary or medically indicated.

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

Ineligible Status
Services or supplies provided before the effective date of coverage are not covered. Services or supplies provided after midnight on the effective date of cancellation of coverage are not covered. A service is considered provided on the day it is performed. A supply is considered provided on the day it is dispensed.

Infertility
Services associated with infertility are limited to diagnostic service, rendered for infertility evaluation. The following services and treatments are not covered:
- Artificial insemination services.
- Reversal of voluntary sterilization procedures.
- In vitro fertilization.
- Embryo or ovum transfer, zygote transfers, gamete transfers, and GIFT procedure.
- Cost of donor sperm or sperm banking and foams and condoms.
- Medications used to treat infertility or impotence.
- Services, procedures, devices, and medications associated with impotence and/or erectile dysfunction unless otherwise specifically stated in the coverage documents or in the *Schedule of Benefits*.

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

Intoxicated or Impaired
Services or supplies for any illness, injury or condition caused in whole or in part by or related to the member's use of a motor vehicle when tests show the member had a blood alcohol level in excess of that permitted to legally operate a motor vehicle under the laws of the state in which the accident occurred, except in cases in which the illness, injury or condition was the result of a mental health or substance abuse disorder.

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

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

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

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

Medical Supplies
Consumable or disposable medical supplies, except as specifically provided as stated in the coverage documents. Examples of non-covered services include bandages, gauze, alcohol swabs and dressings, elastic stockings, compression hose, support hose, foot coverings, leotards, elastic knee and elbow supports, and pressure garments for the arms and hands, not provided in the primary care physician's office, except as required by state or federal law. Medical supplies necessary to operate a non-covered prosthetic device or item of DME.

Mental Health Services
- Treatment for chronic or organic conditions, including Alzheimer's, dementia or delirium. Delirium will not be excluded when reported as a symptom of treatment for a Mental Disorder or Substance Use Disorder according to DSM-5/ICD-10.

- Ongoing treatment for mental disorders that is 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, unless reported as symptoms of treatment for a mental disorder or substance use disorder according to DSM-5/ICD-10. *This exclusion does not apply to the initial assessment for diagnosis of the condition.*
- Psychosexual disorders or transsexualism are not covered unless as symptoms of treatment for a mental disorder or substance use disorder according to DSM-5/ICD-10*. This exclusion does not apply to the initial assessment for diagnosis of the condition.*
- Counseling, testing, evaluation, treatment, or other services in connection with the following: learning disorders and/or disabilities, disruptive behavioral disorders, conduct disorders, transsexualism, motor skill disorders, and communication disorders unless reported as symptoms of treatment for a mental disorder or substance use disorder according to DSM-5/ICD-10. *This exclusion does not apply to the initial assessment for diagnosis of the condition.*
- Psychological testing or evaluation specifically for ability, aptitude, intelligence, interest, or competency.
- Psychiatric evaluation, therapy, counseling, or other services in connection with the following: Child custody, parole and/or probation, and other court ordered related issues.
- Therapy, counseling or other services related to relationship and/or communication issues unless reported as symptoms of treatment for a mental disorder or substance use disorder according to DSM-5/ICD-10.
- Marriage counseling unless otherwise specifically stated as a covered service in the *Schedule of Benefits.*
- Expenses incurred for missed appointments or appointments not canceled within 24 hours of appointment.
- Wilderness programs and/or therapeutic boarding schools that are not licensed as residential treatment centers.

Missed Appointments, Telephone and Other Expenses

Expenses made to member by a provider for not keeping or the late cancellation of appointments. Charges by members or providers for telephone consultations, except for services provided through telemedicine, if such services are otherwise covered when provided in person, and clerical services for completion of special reports or forms of any type, including but not limited to disability certifications, unless otherwise specifically stated in the *Schedule of Benefits.* Expenses by members or providers for copies of medical records supplied by a health care provider to the member.

Non-Medically Necessary Services

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

Nonparticipating Pharmacy

Benefits and services from nonparticipating pharmacies (any pharmacy that has not contracted with Health Net to provide prescription medications to members covered under the *coverage documents*) are not covered. This can include specific stores within a chain of stores.

Nonparticipating Provider (Services Rendered By)

Benefits and services from nonparticipating providers, except in the case of a medical emergency.

Nutritionists

Services of nutritionists and dietitians, except as incidentally provided in connection with other covered services.

Obesity (Treatment Of)

Treatment of obesity is covered as specifically stated in the *Schedule of Benefits and* coverage documents.

Orthotics

- Repair, maintenance and repairs due to misuse and/or abuse.
- Over-the-counter items, except as specifically listed as being covered as stated in the coverage documents.
- Prophylactic braces or braces used primarily for sports activities.
- Foot orthotics, except when attached to a permanent brace or when prescribed for the treatment of diabetes.

Out-of-Service Area Services

Unauthorized services outside of the service area, except for emergency services as defined in this document, unless preauthorized in advance by Health Net. Examples of non-covered services include the following:

- Services or treatments which could have been provided by Health Net within the service area.
- Services which were furnished after the member's condition would permit the member to return to the service area for continued care.
- Services which were connected with conditions resulting during travel which had been advised against because of health reasons such as impending surgery and/or delivery. This does not apply to emergency services treatment in progress by a participating provider.
- Treatment in progress by a participating provider.

Over-the-Counter Items and Medications

Over-the-counter items and medications, except as specifically listed as a covered benefit. Exceptions covered as stated in the coverage documents include covered preventive medications, and medications as indicated under the provisions titled Diabetic Supplies, Equipment and Devices. For purposes of this document, over-the-counter is defined as any item, supply or medication which can be purchased or obtained from a vendor or without a prescription.

Oxygen

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

Paternity Testing

Diagnostic testing to establish paternity of a child.

Penile Implants

Any costs or charges for or related to penile implants.

Personal Comfort Items

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

Physical and Psychiatric Exams

(Physical and psychiatric exams are covered once per calendar year.)

Physical health examinations in connection with the following:

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

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

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

Physical Conditioning

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

Prescription Medications

- Drugs obtained out of the service area.
- Take-home prescription drugs and medications from a hospital or other inpatient or outpatient facility.
- Supplies, medications and equipment dispensed by nonparticipating providers unless preauthorized by us.
- Supplies, medications and equipment labeled “Caution - Limited by Federal Law to Investigational Use”.
- Drugs or dosage amounts determined by Health Net to be ineffective, unproven or unsafe for the indication for which they have been prescribed, regardless of whether the drugs or dosage amounts have been approved by any governmental regulatory body for that use.
- Supplies, medications and equipment deemed experimental, unproved or investigational by us.
- Except for covered preventive medications determined to be preventive as recommended by the United States Preventive Services Task Force (USPSTF) A and B recommendations (medications listed at **www.uspreventiveservicestaskforce.org/usptsf/uspsabrecs.htm**), any non-prescription or over-the-counter drugs, devices and supplies that can be purchased without a prescription or physician order is not covered, even if the physician writes a prescription or order for such drug. Additionally, any prescription drug for which there is a therapeutic interchangeable non-prescription or over-the-counter drug or combination of non-prescription or over-the-counter drugs is not covered, except as prescribed for treatment of diabetes (including over-the-counter insulin) and for smoking cessation.
- Supplies, medications and equipment for other than FDA-approved indications.
- “Off label” use of medications, except for certain FDA-approved drugs used:
  1. For the treatment of cancer in accordance with state law provided that the drug is not contraindicated by the FDA for the off-label use prescribed.
  2. For the treatment of other specific medical conditions provided the drug is not contraindicated by the FDA for the off-label use prescribed and such use has been proven safe, effective and accepted for the treatment of the condition as evidenced by supporting documentation in any one of the following: (a) the American Hospital Formulary Service Drug Information or the United States Pharmacopeia Drug Information; or (b) results of controlled clinical studies published in at least two peer-reviewed national professional medical journals.

- Any drug consumed at the place where it is dispensed or that is dispensed or administered by the physician.
- Supplies, medications and equipment that are not Medically Necessary; as determined by us.
- Replacement prescriptions for any reason.
- Medications for sexual dysfunction or infertility.
- Medications purchased before a member's effective date of coverage or after the member's termination date of coverage.
- Medications used for cosmetic purposes as determined by us.
- Vitamins, except those included on Health Net's Preferred Drug List.
- Drugs, weight reduction programs and related supplies to treat obesity.
- Human growth hormone except for children or adolescents who have one of the following conditions:
  1. Documented growth hormone deficiency causing slow growth.
  2. Documented growth hormone deficiency causing infantile hypoglycemia.
  3. Short stature and slow growth due to Turner syndrome, Prader-Willi syndrome, chronic renal insufficiency prior to transplantation, or a central nervous system tumor treated with radiation.
- Documented growth hormone deficiency due to a hypothalamic or pituitary condition.
- Enteral nutrition when adequate nutrition is possible by dietary adjustment, counseling and/or oral supplements.
- Drugs that require a prescription by their manufacturer, but are otherwise regulated by the FDA as a medical food product and not listed for a covered indication listed in this document.

Private Duty Nursing

Private duty nursing and private rooms except when determined to be Medically Necessary as determined by Health Net. Private duty nursing does not include non-skilled care, custodial care or respite care.

Public or Private School

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

Radial Keratotomy, LASIK

Radial keratotomy, LASIK surgery and other refractive eye surgery.

Reconstructive Surgery

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

Rehabilitation Services and Habilitation Services

Maintenance and/or non-Acute therapies, or therapies where a significant and measurable improvement of condition cannot be expected in a reasonable and generally predictable period of time. Any combination of therapies (including rehabilitation and speech and language therapies) that exceed the maximum allowable number of days per year. Rehabilitative services related to 1) developmental delay; 2) maintaining physical condition; 3) maintenance therapy for a chronic condition are not covered services. However, rehabilitation and habilitation therapy for physical impairments in members with autism spectrum disorders that develops or restores, to the maximum extent practicable, the functioning of an individual, is considered Medically Necessary when criteria for rehabilitation and habilitation therapy are met.

Residential Treatment Center

Residential Treatment Centers that are not Medically Necessary are excluded.

Admissions that are not considered medically appropriate and are not covered include admissions for wilderness center training; for custodial care, for a situational or environmental change; or as an alternative to placement in a foster home or halfway house.

Reversal of voluntary sterilization procedures

Expenses for services to reverse voluntary sterilization.

Riots, War, Misdemeanor, Felony

Illness or injury sustained by a member caused by or arising out of riots, war (whether declared or undeclared), insurrection, rebellion, armed invasion, or aggression. Illness or injury sustained by a member while in the act of committing a misdemeanor, felony, or any illegal act, unless the condition was an injury resulting from an act of domestic violence or an injury resulting from a medical condition, mental health condition or substance abuse disorder.

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

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

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

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

Speech and Language Services
Speech therapy services, maintenance and/or non-acute therapies, or therapies where a significant and measurable improvement of condition cannot be expected in a reasonable and generally predictable period of time as determined by Health Net in consultation with the treating provider. Any combination of therapies (including rehabilitation and speech, and language therapies) that exceed the maximum allowable benefits. Rehabilitative services relating to developmental delay, provided for the purpose of maintaining physical condition, or maintenance therapy for a chronic condition are not covered. Communication devices (speech generating devices). However, rehabilitation and habilitation therapy for physical impairments in members with autism spectrum disorders that develops or restores, to the maximum extent practicable, the functioning of an individual, is considered Medically Necessary when criteria for rehabilitation and habilitation therapy are met.

Substance Abuse Services
Covered services do not include:

- Court ordered testing and/or evaluation, unless determined Medically Necessary by Health Net.
- Referral for non-Medically Necessary services such as vocational programs or employment counseling.
- Continuation in a course of counseling for patients who are disruptive or physically abusive.
- House calls.

Temporomandibular Joint Disorder (Treatment of)
Covered services under the medical portion of your health plan do not include the following:

- Dental prosthesis or any treatment on or to the teeth, gums or jaws and other services customarily provided by a dentist or dental specialist.
- Treatment of pain or infection due to a dental cause, surgical correction of malocclusion, maxilla facial orthognathic and prognathic surgery, orthodontia treatment, including hospital and related costs resulting from these services when determined to relate to malocclusion.
- Services related to injuries caused by or arising out of the act of chewing.
- Treatment of obstructive sleep apnea.

Thermography
Thermography or thermograms and related expenses.

Transplant Services
Donor searches are not covered. Services, supplies and medications provided to a donor of organs and/or tissue, for transplants where the recipient is not a Health Net member. Transplants which are considered experimental, unproved or investigational. Non-human or artificial organs and the related implantation services. VADs when used as an artificial heart.

Transportation Services
Transportation of a member to or from any location for treatment or consultation, except for ambulance services associated with a medically necessary emergency condition and travel services associated with organ transplant benefits. Travel and lodging are not covered if the member is a donor.

Travel Expenses
Travel and room and board, even if prescribed by a physician for the purpose of obtaining covered services.

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

Vision Services

Pediatric vision services and supplies, when Medically Necessary, are covered for children up to age 19 as described in the *Schedule of Benefits* under Pediatric Vision Services.

The following adult vision services are not covered:

- Eye examinations required by an employer as a condition of employment.
- Services or materials provided as a result of any workers' compensation law, or required by any government agency.
- Radial keratotomy and other refractive eye surgery.
- Orthoptics and any other vision training.
- Eyeglasses and contact lenses, and the vision examination for prescribing and fitting of same, except as specifically listed as a covered benefit.

Vitamin B-12 injections

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

Vocational Programs/Employment Counseling

Vocational programs and counseling for employment, including counseling during mental or substance abuse rehabilitation.

Work-Related Injuries

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

Health Net of Arizona, Inc. is a Qualified Health Plan issuer on the Health Insurance Marketplace.

Health Net of Arizona, Inc. and Health Net Life Insurance Company do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

In Arizona, Health Net of Arizona, Inc. underwrites benefits for HMO plans. Health Net of Arizona, Inc. is a subsidiary of Health Net, Inc. Health Net is a registered service mark of Health Net, Inc. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.