



FROM | Health Net®

Arizona Individual & Family Plans  
 Available through the Health Insurance Marketplace  
 Ambetter from Health Net, offered by  
 Health Net of Arizona, Inc. (Health Net)

# Plan Overview

## Ambetter Secure Care 4 (2017)

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PLAN CONTRACT AND EVIDENCE OF COVERAGE (EOC) SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments are usually billed after the service is received.

Benefit description	Member(s) responsibility <sup>1</sup>
<b>Deductible per calendar year</b>	\$1,400 single / \$2,800 family
<b>Coinsurance</b>	10%
<b>Out-of-pocket maximum</b> Including all deductibles, copays and coinsurance	\$5,750 single / \$11,500 family
<b>Maximum benefits in-network</b>	Unlimited
<b>Professional services</b>	
Primary care physician (PCP)	\$10 copay/visit
Specialist physician	\$30 copay/visit
Preventive care <sup>2</sup>	No charge
Prenatal care and postpartum care	\$10 copay/visit (PCP)
<b>Hearing exam / Hearing aid</b>	
Hearing exam	\$30 copay/visit. One routine hearing exam/year.
Hearing aid	10% coinsurance after ded. One hearing aid per ear/per plan year.
<b>Laboratory services</b>	
Physician's office or independent facility <sup>3</sup>	\$0 copay/visit after deductible
Hospital	10% coinsurance after deductible
<b>X-ray services</b>	
Physician's office or independent facility <sup>3</sup>	\$60 copay/visit after deductible
Hospital	10% coinsurance after deductible
<b>Imaging and testing services</b> (including but not limited to MRIs, MRAs, and PET / SPECT, ECT, and BEAM scans)	
Physician's office or independent facility <sup>3</sup>	\$250 copay/visit after deductible
Hospital	10% coinsurance after deductible
<b>Hospital services</b>	
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

(continued)

Benefit description	Member(s) responsibility <sup>1</sup>
<b>Emergency and urgent care services</b>	
Emergency room services (copay waived if admitted)	\$150 copay after deductible
Urgent care services	\$50 copay/visit
Ambulance services (medical emergencies only)	No charge
In-store health care clinic	\$10 copay/visit
<b>Rehabilitative services</b>	
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
<b>Habilitative services</b>	
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
<b>Outpatient prescription drug services<sup>4</sup></b>	
Brand-name calendar year deductible (per insured)	\$1,400 single / \$2,800 family – waived for generic and preferred brands
Prescription drugs (up to a 30-day supply) – generic / preferred brand / non-preferred	\$15 / \$50 / \$70
Specialty pharmacy (most self-injectables)	50% coinsurance after deductible
Mail order program (90-day supply) –generic / preferred brand / non-preferred	\$45 / \$150 / \$210
<b>Mental health / Substance abuse services</b>	
Inpatient	\$375 copay/day, up to 3 days after deductible
Outpatient physician office visit	\$10 copay/visit
Outpatient services other than physician office visit	10% coinsurance after deductible
<b>Durable medical equipment (DME)</b>	10% coinsurance after deductible
<b>Home health care services</b> (Limited to part-time and intermittent care. Up to 60 days or longer when precertified. Limit in-network and out-of-network combined.)	No charge
<b>Hospice care services</b>	\$375 copay/day, up to 3 days after deductible
<b>Chiropractic services</b> Max. 20 visits/calendar year.	\$30 copay/visit
<b>Allergy testing / treatment</b>	
Allergy testing	No charge
Allergy serum	20% coinsurance after deductible
Allergy injection administrative charges	\$10 copay/visit (PCP) / \$30 copay/visit (specialist)
<b>Pediatric vision services and medically necessary supplies</b>	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 Ambetter from Health Net’s website at [www.AmbetterHealthNet.com](http://www.AmbetterHealthNet.com), or call Ambetter from Health Net at 1-888-926-5057.**

<sup>1</sup>Certain services require precertification from Health Net. Without precertification, the benefit is reduced by 50%.

<sup>2</sup>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](http://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.

<sup>3</sup>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.

<sup>4</sup>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 Ambetter from Health Net’s website. Refer to your *Schedule of Benefits* and coverage documents for complete information about 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).

# Ambetter from Health Net Exclusions and Limitations

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

## Abortions

Elective abortions are not covered under this Health Plan. Abortions which are determined to be medically necessary to save the life of the woman, or due to rape, incest, life-endangerment, or necessary to avert substantial and irreversible impairment of a major bodily function of the woman having the abortion are covered.

## Alternative therapies

Acupuncture, acupressure, hypnotherapy, biofeedback, (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 [www.healthnet.com](http://www.healthnet.com) under the *Medical Policies* link. Benefits are not payable for expenses excluded in the coverage documents or for the following:

- Jejunioleal bypass (jejunocolic 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 incidental 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; or
- 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.

(continued)

Cosmetic or reconstructive surgery performed, in Health Net's opinion, to correct injuries that are the result of accidental injury is a covered service. 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 order-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**

The following are specific requirements for coverage:

- Diabetic supplies must have a written prescription from a provider, when medically necessary, as determined by Health Net.
- Refills are covered only when authorized by a provider, when medically necessary, as determined by Health Net.
- Covered services must be obtained from a provider unless otherwise precertified by Health Net.
- Plan-approved standard blood glucose monitors are covered for both insulin-dependent and non-insulin-dependent members when necessary for medical management as determined by Health Net in consultation with your physician. Blood glucose monitors require a prescription from a physician and must be obtained at a pharmacy.
- Plan-approved blood glucose monitors for the legally blind are covered when medically necessary and the member has been diagnosed with diabetes. Blood glucose monitors require a written prescription from a physician and must be obtained at a pharmacy.

### **Dietary food or nutritional supplements**

Non-covered services include the following:

- 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, hypoallergenic 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, yoga, hiking, rock climbing and any other types of sports activity, equipment, clothing, or devices.

### **Ex-member (Services for)**

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

(continued)

### **Experimental or 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) and member self-treatment**

Professional services, supplies or provider referrals received from or rendered by a non-Health Net contracted 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 non-contracted 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, 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. Implants and 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, hypoallergenic 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 and devices 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**

Services associated with infertility are limited to diagnostic services, 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.

(continued)

## 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 order-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 members 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-licensed providers

Treatment or services rendered by non-licensed health care providers and treatment or services outside the scope of a license or a licensed health care provider or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed physician, except for services related to behavioral health treatment for pervasive developmental disorder or autism.

## Non-medically necessary services

Services, supplies, treatments, or accommodations which are not medically necessary except as specifically described herein.

## 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 or surgery for obesity, weight reduction or weight control, except for morbid obesity or as a preventive service.

## 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, non-qualified 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.

(continued)

## 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 <http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>), 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 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.
- 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.
  4. 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; or 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 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.

(continued)

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.
- Expenses related to a stay at sober living facility.

### 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. This exclusion does not apply to coverage for routine patient costs provided to members participating in clinical trials as required by state and federal law.

### 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. This exclusion does not apply to qualified travel expenditures.

### 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 complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at **1-888-926-5057 (TTY: 711)**.

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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

Health Net of Arizona, Inc. does 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.

Ambetter from Health Net is underwritten by Health Net of Arizona, Inc. © 2016 Health Net of Arizona, Inc. All rights reserved.

FLY010506EL00 (1/17)

HNMM001506



## English

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card. Applicants call 1-877-609-8712 (TTY: 711).

## Arabic

خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية. على مقدمي الطلبات الاتصال على الرقم 1-877-609-8712 (TTY: 711).

## Chinese

免費語言服務。您可使用口譯員。您可請人將文件內容唸給您聽。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡。申請人請致電 1-877-609-8712 (TTY: 711)。

## French

Services linguistiques sans frais. Vous pouvez obtenir un interprète. Les documents peuvent vous être lus. Pour obtenir de l'aide, appelez-nous au numéro indiqué sur votre carte d'identité. Les demandeurs composent le 1-877-609-8712 (TTY: 711).

## German

Kostenloser Sprachendienst. Dolmetscher sind verfügbar. Dokumente können Ihnen vorgelesen werden. Wenn Sie Hilfe benötigen, rufen Sie uns unter der Nummer auf Ihrer ID-Karte an. Antragsteller rufen unter 1-877-609-8712 (TTY: 711) an.

## Japanese

無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話ください。申込者の方は、1-877-609-8712 (TTY: 711) までお電話ください。

## Korean

무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 문서 낭독 서비스를 받으실 수 있습니다. 도움을 원하시면, 보험 ID에 수록된 번호로 전화해 주십시오. 신청자분은 1-877-609-8712 (TTY: 711)번으로 전화해 주십시오.

## Navajo

Saad Bee Áká E'eyeed T'áá Jíík'e. Ata' halne'ígíí hólq. T'áá hó hazaad k'ehjí naaltsoos hach'í' wóltah. Shíká a'doowoł nínízingo naaltsoos bee néího'dólzínígíí bikáa'gi béesh bee hane'í bikáa' áajj'í hodíílnih. Naaltsoos nidasoołtsoozígíí kojí' dahołne' 1-877-609-8712 (TTY: 711).

## Persian (Farsi)

خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد برای شما قرائت شوند. برای کسب اطلاعات، با ما به شماره ای که در کارت شناسایی شما قید شده تماس بگیرید. درخواست کنندگان با شماره 1-877-609-8712 (TTY: 711) تماس بگیرند.

## Russian

Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Если вы хотите стать участником плана, звоните по телефону 1-877-609-8712 (TTY: 711).

