This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthnet.com or by calling 1-800-522-0088.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For preferred providers $1,500 per person / $3,000 per family. For out-of-network providers $3,000 per person / $6,000 per family. Does not apply to preventive care, physician office visits, prescription drugs, pediatric dental and vision, and outpatient surgery.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. Preferred pharmacy deductible $250 per person / $500 per family per calendar year. There are no other specific **deductibles.**	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For preferred providers $6,500 per person / $13,000 per family. For out-of-network providers $13,000 per person / $26,000 per family per calendar year.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, infertility services, balance-billed charges, penalties for non-certification and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see www.healthnet.com or call 1-800-522-0088.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45/visit deductible waived	50% co-ins	——none——
	Specialist visit	$70/visit deductible waived	50% co-ins	——none——
	Other practitioner office visit	$45/visit deductible waived	Not covered	Acupuncture requires certification or a $250 penalty will apply. Chiropractic care is not covered.
	Preventive care/screening/immunization	No charge	Not covered	——none——
If you have a test	Diagnostic test (x-ray, blood work)	X-ray - $65 Lab - $35 deductible waived	50% co-ins	——none——
	Imaging (CT/PET scans, MRIs)	20% co-ins	50% co-ins	If certification is not obtained a $250 penalty will apply.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthnet.com	Preferred generic drugs	$15/retail order $30/mail order deductible waived	Not covered	Supply/order: up to 30 day (retail); 35-90 day (mail), except where quantity limits apply. Prior authorization is required for select drugs. If prior authorization is not obtained a penalty of 50% of the average wholesale price will apply, except for emergency or urgently needed care. Pharmacy deductible applies $250 per member / $500 per family (waived for Tier 1).
	Non-preferred generic and preferred brand drugs	$55/retail order $110/mail order	Not covered	
	Non-preferred brand drugs	$75/retail order $150/mail order	Not covered	
	Specialty drugs	20% co-ins up to a maximum of $250 per 30 day script after pharmacy deductible is satisfied	Not covered	Supply/order: 30 day supply from specialty pharmacy except where quantity limits apply. Prior authorization is required for select drugs. If prior authorization is not obtained a penalty of 50% of the average wholesale price will apply, except for emergency or urgently needed care. Pharmacy deductible applies $250 per member / $500 per family.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins deductible waived	50% co-ins	Some outpatient surgical procedures require certification or a $250 penalty will apply.
	Physician/surgeon fees	20% co-ins deductible waived	50% co-ins	——————none——————
If you need immediate medical attention	Emergency room services	Facility fee - $250/visit Physician fee – $50/visit	Facility fee - $250/visit Physician fee – $50/visit	The deductible applies and once satisfied, the copayment applies. Copay waived if admitted into the hospital.
	Emergency medical transportation	$250/transport	$250/transport	The deductible applies and once satisfied, the copayment applies.
	Urgent care	$90/visit deductible waived	50% co-ins	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins	50% co-ins	If certification is not obtained a $250 penalty will apply.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Physician/surgeon fee	20% co-ins	50% co-ins	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office visit - $45/visit deductible waived; Other than office visit – No charge	50% co-ins	Certification required for behavioral health treatment for pervasive developmental disorder or autism beyond initial 6 months of treatment or a $250 penalty will apply.
	Mental/Behavioral health inpatient services	20% co-ins	50% co-ins	If certification is not obtained a $250 penalty will apply.
	Substance use disorder outpatient services	Office visit - $45/visit deductible waived; Other than office visit – No charge	50% co-ins	——————none——————
	Substance use disorder inpatient services	20% co-ins	50% co-ins	If certification is not obtained a $250 penalty will apply.
If you are pregnant	Prenatal and postnatal care	Prenatal - No charge Postnatal - $45/visit	50% co-ins	Deductible waived for postnatal visits to a preferred provider.
	Delivery and all inpatient services	20% co-ins	50% co-ins	Deductible waived for professional or physician/surgeon fees from a preferred provider. Coverage includes abortion services.
If you need help recovering or have other special health needs	Home health care	20% co-ins deductible waived	50% co-ins	Limited to 100 visits per year.
	Rehabilitation services	$45/visit deductible waived	Not covered	If certification is not obtained a $250 penalty will apply.
	Habilitation services	$45/visit deductible waived	Not covered	If certification is not obtained a $250 penalty will apply.
	Skilled nursing care	20% co-ins	50% co-ins	If certification is not obtained a $250 penalty will apply.
	Durable medical equipment	20% co-ins deductible waived	Not covered	If certification is not obtained a $250 penalty will apply.
	Hospice service	No charge	50% co-ins	If certification is not obtained a $250 penalty will apply.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No charge	Not covered	Limited to 1 visit per year.
	Glasses	No charge	Not covered	Provider selected frames; 1 per calendar year.
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture (covered when medically necessary)
- Bariatric surgery (covered through the preferred provider network if deemed medically necessary)
- Infertility treatment (limited to a lifetime limit of $2,000. ZIFT, invitro fertilization & intrafallopian transfers are not covered).
- Routine eye care (Adult) (screenings/eye refraction for vision correction purposes)

Your Rights to Continue Coverage: If you lose coverage under this plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium,** which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-522-0088. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Health Net's Customer Contact Center at 1-800-522-0088, submit a grievance form through www.healthnet.com, or file your complaint in writing to, Health Net Appeals and Grievance Department, P.O. Box 10348, Van Nuys, CA 91410-0348. For information about group health care coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444 (EBSA (3272) or www.dol.gov/ebsa/healthreform. If you have a grievance against Health Net, you can also contact the California Department of Insurance, Consumer Communications Bureau Health Unit, 300 South Spring Street, South Tower, Los Angeles, CA 90013 or at 1-800-927-HELP (4357), 1-800 482-4833 TDD or at www.insurance.ca.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Insurance at the contact information provided above.

Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-522-0088.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-522-0088.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-800-522-0088.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-522-0088.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,440
- **Patient pays** $3,100

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$400
Coinsurance	$1,000
Limits or exclusions	$200
Total	**$3,100**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,790
- **Patient pays** $1,610

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$1,200
Coinsurance	$10
Limits or exclusions	$100
Total	**$1,610**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call the number on your Health Net ID card (current members) or 1-800-522-0088 or visit us at www.healthnet.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at http://cciio.cms.gov or call 1-800-522-0088 or the number on your Health Net ID card to request a copy.

CERTIFICATE OF INSURANCE

A complete explanation of your plan

Silver PPO Plan

Important benefit information – please read

COVERED CALIFORNIA

Health Net®
LIFE INSURANCE COMPANY

C20601(CA 1/16)SHOP

INTRODUCTION TO HEALTH NET PREFERRED PROVIDER ORGANIZATION (PPO)

Plan CCF

2ODV

HEALTH NET PPO CERTIFICATE OF INSURANCE

ISSUED IN CONNECTION WITH THE HEALTH NET PPO GROUP INSURANCE POLICY

UNDERWRITTEN
BY

HEALTH NET LIFE INSURANCE COMPANY
Los Angeles, California

Benefits may be modified by *Certificate* amendments which may provide greater or lesser benefits. Any *Certificate* amendments issued to You should be attached to this *Certificate*.

HEALTH NET LIFE INSURANCE COMPANY (herein called HNL**)** agrees to provide benefits as described in this *Certificate* to You and Your eligible Dependents, subject to the terms and conditions of the Health Net PPO Insurance Policy (the Policy) which is incorporated herein and issued to the Group.

The coverage described in this *Certificate* shall be consistent with the Essential Health Benefits coverage requirements in accordance with the Affordable Care Act (ACA). The Essential Health Benefits are not subject to any annual dollar limits.

The benefits described under this *Certificate* do not discriminate on the basis of race, ethnicity, color, nationality, ancestry, gender, gender identity, gender expression, age, disability, sexual orientation, genetic information, marital status, domestic partner status or religion, and are not subject to any pre-existing condition or exclusion period.

PLEASE READ THE FOLLOWING INFORMATION TO KNOW FROM WHOM OR WHICH GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Preferred Providers are providers who have agreed to participate in HNL's Preferred Provider Organization program (PPO), which is called Health Net PPO. They have agreed to provide You Covered Services and Supplies as explained in this *Certificate* and accept a special Contracted Rate, called the Contracted Rate, as payment in full. Your share of costs is based on this contracted rate. Preferred Providers are listed on the HNL website at www.healthnet.com and selecting “Provider Search”, or You can contact the Customer Contact Center at the telephone number on Your HNL ID Card to obtain a copy of the Preferred Provider Directory at no cost.

Out-of-Network Providers have not agreed to participate in the Health Net PPO program. You may choose to obtain Covered Services and Supplies from an Out-of-Network Provider. WHEN YOU USE AN OUT-OF-NETWORK PROVIDER, BENEFITS ARE SUBSTANTIALLY REDUCED AND YOU WILL INCUR A SIGNIFICANTLY HIGHER OUT-OF-POCKET EXPENSE. Your out-of-pocket expense is greater because: (i) You are responsible for a higher percentage cost of the benefits in comparison to the cost of benefits when services are provided by Preferred Providers; (ii) HNL's benefit for Out-of-Network Providers is based on HNL’s Limited Fee Schedule; and (iii) You are financially responsible for any amounts these providers charge in excess of this amount. Please refer to the "HNL's Limited Fee Schedule for Out-of-Network Providers" subsection of the “Plan Benefits” section for details. Covered Services and Supplies received from Out-of-Network Providers will be payable at the Preferred Provider level of coverage when medically appropriate care is not available within the network.

This benefit plan does not provide Preferred Provider benefits for services (including services for behavioral health treatment) provided outside the United States, except for Emergency Care. Outside the United States, coverage is limited to Emergency Care, as described below under "Foreign Travel or Work Assignment" in this "Miscellaneous Provisions" section.

To maximize the benefits received under this Health Net PPO insurance plan, You must use Preferred Providers. When contacting a provider, please identify Yourself as a person covered under Health Net PPO.

HNL applies certain payment policies and rules to determine appropriate reimbursement that may affect Your responsibility (including, but not limited to, rules affecting reductions in reimbursement for charges for multiple procedures, services of an assistant surgeon, unbundled or duplicate items, and services covered by a global charge for the primary procedure). See the "Outpatient Surgery and Services" and "Hospital Stay" portions of the "Schedule of Benefits" section and the "Professional Surgical Services" portion of the "Plan Benefits" section for additional details. Additional information about HNL's reimbursement policies is available on the HNL website at www.healthnet.com or by contacting HNL's Customer Contact Center at the telephone number listed on Your Health Net PPO Identification Card.

Some Hospitals and other providers do not provide one or more of the following services that may be covered under this *Certificate* and that You might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. In order to determine from whom the above health care services may be available, HNL suggests You obtain this information prior to enrollment by calling prospective Physicians, Hospitals or clinics which contract with HNL or any other provider of choice. You may also obtain this information by calling HNL's Customer Contact Center at 1-800-361-3366.

Telephone triage or screening services to assess a Covered Person's health concerns and symptoms are available 24 hours per day, 7 days per week by contacting the Customer Contact Center at the telephone number on the HNL ID Card. Health assessments will be performed by a Physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage an insured who may need care, for the purpose of determining the urgency of the Covered Person's need for care and arranging for care in a timely manner appropriate for the nature of the Covered Person's condition.

THE CONTINUED PARTICIPATION OF ANY ONE PHYSICIAN, HOSPITAL, OR OTHER PROVIDER CANNOT BE GUARANTEED.

THE FACT THAT A PHYSICIAN OR OTHER PROVIDER MAY PERFORM, PRESCRIBE, ORDER, RECOMMEND OR APPROVE A SERVICE, SUPPLY OR HOSPITALIZATION DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY, OR MAKE IT A COVERED SERVICE.

IF YOU HAVE QUESTIONS ABOUT COVERAGE, PLEASE CONTACT OUR MEMBER SERVICES DEPARTMENT BEFORE YOU RECEIVE SERVICES FROM A PROVIDER.

THE TERMS "YOU" OR "YOUR," WHEN THEY APPEAR IN THIS CERTIFICATE, REFER TO THE PRINCIPAL COVERED PERSON (THE ENROLLED EMPLOYEE). THE TERMS "WE," "OUR," OR "US," WHEN THEY

APPEAR IN THIS CERTIFICATE, REFER TO HNL. PLEASE REFER TO "COVERED PERSON" AND "HNL" IN THE "DEFINITIONS" SECTION FOR MORE INFORMATION.

If You Are Enrolled In A Plan That Is Subject To ERISA, 29 U.S.C. 1001 et seq., a federal law regulating some plans:

IN ADDITION TO THE RIGHTS SET FORTH IN THIS CERTIFICATE, YOU MAY HAVE RIGHTS UNDER APPLICABLE STATE LAW OR REGULATIONS AND/OR UNDER THE FEDERAL ERISA STATUTE.

If You Are Enrolled In A Plan That Is Not Subject To ERISA:

IN ADDITION TO THE RIGHTS SET FORTH IN THIS CERTIFICATE, YOU MAY HAVE RIGHTS UNDER APPLICABLE STATE OR FEDERAL LAWS OR REGULATIONS.

Contact Your Employer to determine if You are enrolled in a Plan that is subject to ERISA.

Important Notice To California Certificate Holders

In the event that You need to contact someone about Your insurance coverage for any reason, please contact:

Health Net Life Insurance Company
P.O. Box 10196
Van Nuys, CA 91410-0196

1-800-361-3366

If You have been unable to resolve a problem concerning Your insurance coverage or a complaint regarding Your ability to access needed health care in a timely manner, after discussions with Health Net Life Insurance Company, or its agent or other representative, You may contact:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
South Tower
Los Angeles, CA 90013
1-800-927-HELP or 1-800-927-4357
TDD: 1-800-482-4TDD
www.insurance.ca.gov

Table of Contents

INTRODUCTION TO HEALTH NET PREFERRED PROVIDER ORGANIZATION (PPO) 3

SCHEDULE OF BENEFITS 9

Copayments and Coinsurance 9

Out-of-Pocket Limits on Expenses 9

Medical Deductible 10

Noncertification Penalties 10

Visits to a Health Care Provider's Office or Clinic 11

Tests 11

Outpatient Surgery and Services 12

Need Immediate Attention 13

Hospital Stay 13

Mental Health, Behavioral Health or Substance Abuse Needs 14

Pregnancy 14

Help Recovering or Other Special Health Needs 15

Outpatient Prescription Drugs 16

Child Needs Eye Care 19

ELIGIBILITY, ENROLLMENT AND TERMINATION 21

Who Is Eligible For Coverage 21

How to Enroll for Coverage 21

When Coverage Ends 27

Coverage Options Following Termination 27

Small Employer Cal-COBRA Continuation Coverage 30

Extension of Benefits 33

PLAN BENEFITS 35

How Covered Expenses Are Determined 35

Certification Requirement 35

Out-of-Pocket Limits on Expenses 39

Medical Deductibles 39

Visits to a Health Care Provider's Office or Clinic 39

Tests 41

Outpatient Surgery and Services 41

Need Immediate Attention 44

Hospital Stay 44

Mental Health, Behavioral Health or Substance Abuse Needs 48

Pregnancy 50

Help Recovering or Other Special Health Needs 50

Outpatient Prescription Drug Benefits 58

Child Needs Eye Care 65

HNL Limited Fee Schedule for Out-of-Network Providers 66

GENERAL LIMITATIONS AND EXCLUSIONS 69

Medical Services and Supplies 69

Outpatient Prescription Drug Benefits 76

Pediatric Vision Services 78

GENERAL PROVISIONS 79

Term Of Certificate 79

Customer Contact Center Interpreter Services 79

Covered Persons' Rights and Responsibilities Statement 79

Coordination of Benefits 80

Grievance and Appeals Process 82

Independent Medical Review of Grievances Involving a Disputed 83

Health Care Service 83

Independent Medical Review of Investigational or Experimental 84

Therapies 84

Arbitration 85

Medical Malpractice Disputes 87

SPECIFIC PROVISIONS 88

Recovery of Benefits Paid by HNL 88

Surrogacy Arrangements 89

Refund To HNL of Overpayment Of Benefits 90

Out-of-State Providers 90

Second Medical Opinion 91

MISCELLANEOUS PROVISIONS 92

NOTICE OF PRIVACY PRACTICES 98

DEFINITIONS 102

INFERTILITY SERVICES 112

NOTICE OF LANGUAGE SERVICES 113

PPO SILVER

SCHEDULE OF BENEFITS

Health Net PPO
Plan CCF

The following is only a brief summary of the benefits covered under this *Certificate*. Please read the entire *Certificate* for complete information about the benefits, conditions, limitations and exclusions of this Health Net PPO insurance plan.

You will always be responsible for all expenses incurred for services or supplies that are not covered or that exceed the benefit maximums or other limitations of this plan.

COPAYMENTS AND COINSURANCE

You may be required to pay out-of-pocket charges for specific services and supplies after all appropriate Deductibles have been satisfied. These charges are known as Copayments and Coinsurance.

Copayments: Copayments are fixed dollar amount charges, shown below, for which You are responsible. We will pay 100% of Covered Expenses for the services listed below after the Copayment is made. The Covered Person's out-of-pocket charge will never exceed the cost of the benefit to HNL. You will be responsible for paying Copayments until the amount paid during a Calendar Year is equal to the Out-of-Pocket Maximum shown below.

Coinsurance: Coinsurance is the percentage, shown below, of Covered Expenses (as defined) for which You are responsible. After Your Deductible(s) have been satisfied, You will be responsible for paying Coinsurance until the amount paid during a Calendar Year is equal to the Out-of-Pocket Maximum.

Notes:

- You will also be required to pay any charges billed by an Out-of-Network Provider that exceed Covered Expenses (Schedule Amount). You will not be reimbursed for any amount in excess of Covered Expenses (Schedule Amount). Any Copayment or Coinsurance paid for the services of a Preferred Provider will apply toward the out-of-pocket Covered Expenses (as defined).
- Certification of Covered Expenses is required in some instances or benefits may be reduced as shown under "Noncertification Penalties" below. Please see the "Certification Requirement" portion of the "Plan Benefits" section of this Certificate for a list of services and supplies which require Certification.
- **UNLESS OTHERWISE NOTED, ALL BENEFIT MAXIMUMS WILL BE COMBINED FOR COVERED SERVICES AND SUPPLIES PROVIDED BY PREFERRED PROVIDERS AND OUT-OF-NETWORK PROVIDERS.**

OUT-OF-POCKET LIMITS ON EXPENSES

Individual Out-of-Pocket Maximum: Except as noted below in "Exceptions to the Out-of-Pocket Maximum," after You have paid Deductibles, Copayments and Coinsurance equal to the Out-of-Pocket Maximum shown below, You will have satisfied the Out-of-Pocket requirement and will not be required to pay further Deductibles, Copayments, or Coinsurance for Covered Expenses incurred during the remainder of the Calendar Year. You will continue to be responsible for any charges billed in excess of Covered Expenses (Schedule Amount) for the services of Out-of-Network Providers and You will not be reimbursed for any amounts in excess of Schedule Amount.

For services or supplies provided by a Preferred Provider $6,500
For services or supplies provided by an Out-of-Network Provider.....$13,000

Family Out-of-Pocket Maximum: Each Covered Person is responsible only for meeting his or her individual Out-of Pocket Maximum. However, if enrolled Covered Persons of the same family have paid Deductibles, Copayments and Coinsurance equal to the amounts shown below, the Out-of-Pocket Maximum will be considered

to have been met for the entire family. No Deductible, Copayment or Coinsurance for Covered Expenses shall be required from any enrolled Covered Person in that family for the remainder of that Calendar Year.

For services or supplies provided by a Preferred Provider $13,000
For services or supplies provided by an Out-of-Network Provider.....$26,000

Note: Any Deductibles, Copayments, or Coinsurance paid for the services of a Preferred Provider which are Covered Expenses will apply toward the Out-of-Pocket Maximum for Preferred Providers but will not apply toward the Out-of-Pocket Maximum for Out-of-Network Providers. In addition, Deductibles, Copayments, or Coinsurance paid for the services of an Out-of-Network Provider will apply toward the Out-of-Pocket Maximum for Out-of-Network Providers but will not apply toward the Out-of-Pocket Maximum for Preferred Providers. However, Deductibles, Copayments, or Coinsurance paid for Out-of-Network Emergency Care (including emergency medical transportation and emergency Hospital care) will be applied to the Out-of-Pocket Maximum for Preferred Providers.

Exceptions to the Out-of-Pocket Maximum: Only Covered Expenses will be applied to the Out-of-Pocket Maximum. However, the following expenses will not be counted, nor will these expenses be paid at 100% after the Out-of-Pocket Maximum is reached:

- Penalties paid for services for which Certification was required but not received.
- Expenses paid by the Covered Person for Infertility services.

MEDICAL DEDUCTIBLE

The following Calendar Year Deductibles apply to the medical benefits. It applies to all services unless specifically noted otherwise below. Once Your payment for medical Covered Expenses equals the amount shown below, the medical benefits will become payable by Us (subject to any additional Deductible, Copayment or Coinsurance as described herein).

Calendar Year Deductibles

Calendar Year Deductible (for Preferred Provider services, per Covered Person) ..... $1,500, medical only
Calendar Year Deductible (for Out-of-Network services, per Covered Person)..... $3,000, medical only
Family Calendar Year Deductible (all enrolled members of a family, for Preferred Provider services, during a Calendar Year) ..... $3,000, medical only
Family Calendar Year Deductible (all enrolled members of a family, for Out-of-Network services, during a Calendar Year) ..... $6,000, medical only

Note: Any amount applied toward the Calendar Year Deductible for Covered Services and Supplies received from a Preferred Provider will apply toward the Calendar Year Deductible for Preferred Providers but will not apply toward the Calendar Year Deductible for Out-of-Network Providers. In addition, any amount applied toward the Calendar Year Deductible for Covered Services and Supplies received from an Out-of-Network Provider will apply toward the Calendar Year Deductible for Out-of-Network Providers but will not apply toward the Calendar Year Deductible for Preferred Providers.

Each Covered Person is responsible only for meeting his or her individual Calendar Year Deductible. However, if enrolled Covered Persons of the same family have met the Family Calendar Year Deductible shown above, no additional Calendar Year Deductible shall be required from any enrolled Covered Person in that family for the remainder of that Calendar Year.

Your payments under the Outpatient Prescription Drug Benefits section are not applied to the Medical Deductible.

NONCERTIFICATION PENALTIES

	Preferred Providers	Out-of-Network
Medically Necessary services for which Certification was required but not obtained	$250	$250

Notes:

- **The noncertification penalty will not exceed the cost of the benefit to HNL.**
- **Certification is NOT a determination of benefits. Some of these services or supplies may not be covered under Your Plan. Even if a service or supply is certified, eligibility rules and benefit limitations will still apply.**

VISITS TO A HEALTH CARE PROVIDER'S OFFICE OR CLINIC

	Preferred Providers	Out-of-Network
Primary care visits to treat an injury or illness		
In a Physician's office	$45, Deductible waived	50%
At a Covered Person's home	$45, Deductible waived	50%
Postnatal office visits	$45, Deductible waived	50%
Specialist consultation		
In a Physician's office	$70, Deductible waived	50%
At a Covered Person's home	$70, Deductible waived	50%
Hearing examination (for diagnosis or treatment)	$45, Deductible waived	Not Covered
Vision examination (for refractive eye exams at an ophthalmologist) (age 19 and over; for birth to age 19, see "Child Needs Eye Care" below)	$70, Deductible waived	Not Covered
Vision examination (refractive eye exams at an optometrist) (age 19 and over; for birth to age 19, see "Child Needs Eye Care" below)	$45, Deductible waived	Not Covered
Allergy testing, serum and injections	$70, Deductible waived	50%
Other practitioner office visit (acupuncturist)*	$45, Deductible waived	Not Covered
Medical social services	$45, Deductible waived	Not Covered
Patient education		
Diabetes education	$0, Deductible waived	50%
Asthma education	$0, Deductible waived	50%
Weight management education	$0, Deductible waived	50%
Stress management education	$0, Deductible waived	50%
Tobacco cessation education	$0, Deductible waived	50%
Preventive Care Services	$0, Deductible waived	Not Covered

Notes

Preventive Care Services are covered at no cost to You and are not subject to any Deductible. Covered Services and Supplies include, but are not limited to, annual preventive physical examinations, immunizations, screening and diagnosis of prostate cancer, well-woman examinations, preventive services for pregnancy, other women's preventive services as supported by the Health Resources and Services Administration (HRSA), breast feeding support and supplies and preventive vision and hearing screening examinations. Refer to the "Preventive Care Services" portion of the "Plan Benefits" section for details. If You receive any other Covered Services and Supplies in addition to Preventive Care Services during the same visit, You will also pay the applicable Copayment or Coinsurance for those services.

Hearing examinations for newborns are covered at no cost to You and are not subject to any Deductible.

* Certification may be required. Please refer to the "Certification Requirements" section for details. Payment of benefits will be reduced as set forth herein if Certification is required but not obtained.

TESTS

	Preferred Providers	Out-of-Network
Laboratory tests	$35, Deductible waived	50%
X-rays and diagnostic imaging	$65, Deductible waived	50%

Imaging (CT, PET,MRI)*	20%	50%

* Certification may be required. Please refer to the "Certification Requirements" section for details. Payment of benefits will be reduced as set forth herein if Certification is required but not obtained.

OUTPATIENT SURGERY AND SERVICES

	Preferred Providers	Out-of-Network
Facility fee		
Outpatient surgery and services*	20%, Deductible waived	50%
Physician/surgeon fees		
Surgery*	20%, Deductible waived	50%
Anesthetics	20%, Deductible waived	50%
Sterilization of male	20%, Deductible waived	50%
Sterilization of females**	$0, Deductible waived	Not Covered
Outpatient infusion therapy*	20%, Deductible waived	50%
Blood or Blood Products (except for drugs used to treat hemophilia, including blood factors)*,***	20%, Deductible waived	50%
Drugs used to treat hemophilia, including blood factors*,***	See note below	Not Covered
Chemotherapy and radiation therapy*	20%, Deductible waived	50%
Nuclear medicine	20%, Deductible waived	50%
Organ, stem cell or tissue transplant (not Experimental or Investigational)*	20%, Deductible waived	Not Covered
Renal dialysis	20%, Deductible waived	50%

Note

- Other professional services performed in the outpatient department of a Hospital, Outpatient Surgical Center or other licensed outpatient facility such as a visit to a Physician (office visit), laboratory and x-ray services, physical therapy, etc., may require a Copayment or Coinsurance when these services are performed. Look under the headings for the various services such as office visits, neuromuscular rehabilitation and other services to determine any additional Copayments or Coinsurances that may apply.
- Screening colonoscopy and sigmoidoscopy procedures (for the purposes of colorectal cancer screening) will be covered under "Preventive Care Services" in the "Visit to a Health Care Provider's Office or Clinic" provision above. Diagnostic endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an outpatient facility require the Copayment or Coinsurance applicable for outpatient facility services.

* Certification may be required. Please refer to the "Certification Requirements" section for details. Payment of benefits will be reduced as set forth herein if Certification is required but not obtained.

**Sterilization of females and women's contraception methods and counseling, as supported by HRSA guidelines, are covered under "Preventive Care Services" in the "Visit to a Health Care Provider's Office or Clinic" provision in this section.

*** Drugs used to treat hemophilia, including blood factors, are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefit even if they are administered in a Physician's office. If You need to have the provider administer the Specialty Drug, You can coordinate delivery of the Specialty Drug directly to the provider's office through the Specialty Pharmacy Vendor. Please refer to the "Specialty Pharmacy Vendor" portion of this "Schedule of Benefits" section for the applicable Copayment or Coinsurance.

NEED IMMEDIATE ATTENTION

Services in an Emergency Room or Urgent Care Center

	Preferred Providers	Out-of-Network
Emergency room care facility	$250	$250
Emergency room care professional services	$50	$50
Emergency medical transportation (air Ambulance or group Ambulance)	$250	$250
Urgent care services	$90, Deductible waived	50%

Note

- For all services which meet the criteria for Emergency Care, the Copayment or Coinsurance will be the amount shown for Preferred Providers, even if the services were provided by an Out-of-Network Provider. HNL uses a prudent layperson standard to determine whether the criteria for Emergency Care have been met. HNL applies the prudent layperson standard to evaluate the necessity of medical services which a Covered Person accesses in connection with a condition that the Covered Person perceives to be an emergency situation. Please refer to “Emergency Care” in the "Definitions" section to see how the prudent layperson standard applies to the definition of "Emergency Care."

- The emergency room facility and professional Copayments will not apply if the Covered Person is admitted to a Hospital directly from an emergency room. Non-emergency Hospital stays at an Out-of-Network Hospital will be subject to the Out-of-Network Coinsurance. See “Hospital Stay” below for applicable Coinsurance.

HOSPITAL STAY

	Preferred Providers	Out-of-Network
Facility fee*	20%	50%
Confinement for bariatric (weight loss) surgery*	20%	Not Covered
Physician/surgeon fees		
Surgery*	20%	50%
Anesthetics	20%	50%
Physician visit to Hospital	20%	50%
Blood or Blood Products (except for drugs used to treat hemophilia, including blood factors)*,**	20%, Deductible waived	50%
Drugs used to treat hemophilia, including blood factors*,**	See note below	Not Covered
Chemotherapy and radiation therapy*	20%, Deductible waived	50%
Nuclear medicine	20%, Deductible waived	50%
Organ, stem cell or tissue transplant (not Experimental or Investigational)*	20%	Not Covered
Renal dialysis	20%, Deductible waived	50%

Notes:

- The Preferred Provider Coinsurance will apply if the Covered Person is admitted to a Hospital directly from an emergency room or urgent care center. The Covered Person will remain responsible for amounts billed in excess of Covered Expenses (Schedule Amount) for the inpatient stay by an Out-of-Network Provider. You will not be reimbursed for any amounts in excess of Schedule Amount billed by an Out-of-Network Provider.

- The above Coinsurance for inpatient Hospital or Special Care Unit services is applicable for each admission for the hospitalization of an adult, pediatric or newborn patient. If a newborn patient requires admission to a Special Care Unit, a separate Coinsurance for inpatient Hospital services for the newborn patient will apply.

* Certification may be required. Please refer to the "Certification Requirements" section for details. Payment of benefits will be reduced as set forth herein if Certification is required but not obtained.

** Drugs used to treat hemophilia, including blood factors, are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefit even if they are administered in a Physician's office. If You need to have the provider administer the Specialty Drug, You can coordinate delivery of the Specialty Drug directly to the provider's office through the Specialty Pharmacy Vendor. Please refer to the "Specialty Pharmacy Vendor" portion of this "Schedule of Benefits" section for the applicable Copayment or Coinsurance.

MENTAL HEALTH, BEHAVIORAL HEALTH OR SUBSTANCE ABUSE NEEDS

Covered services provided for the treatment of Mental Disorders (mental health and behavioral health) and Chemical Dependency (substance abuse) are subject to the same Deductible(s) and Copayments as required for the services when provided for a medical condition.

Mental Disorders	***Preferred Providers***	***Out-of-Network***
Outpatient office visits (psychological evaluation or therapeutic session in an office or other outpatient setting, including individual and group therapy sessions, medication management and drug therapy monitoring)	$45, Deductible waived	50%
Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care program, day treatment, partial hospitalization and other outpatient procedures including behavioral health treatment for pervasive developmental disorder or autism)	0%, Deductible waived	50%
Inpatient facility*	20%	50%
Physician visit to Hospital, behavioral health facility or Residential Treatment Center	20%	50%

Chemical Dependency	**Preferred Providers**	**Out-of-Network**
Outpatient office visits (psychological evaluation or therapeutic session in an office or other outpatient setting, including individual and group therapy sessions, medication management and drug therapy monitoring)	$45, Deductible waived	50%
Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care program, day treatment, partial hospitalization, medical treatment for withdrawal symptoms, Medically Necessary methadone treatment including during pregnancy and after delivery and other outpatient services)	0%, Deductible waived	50%
Inpatient facility*	20%	50%
Physician visit to Hospital, behavioral health facility or Residential Treatment Center	20%	50%
Inpatient detoxification*	20%	50%

Notes:

- The applicable Copayment or Coinsurance for outpatient services is required for each visit.

* Certification may be required. Please refer to the "Certification Requirements" section for details. Payment of benefits will be reduced as set forth herein if Certification is required but not obtained.

PREGNANCY

	Preferred Providers	**Out-of-Network**
Prenatal care and preconception visits	$0, Deductible waived	50%
Delivery and all inpatient services		
Hospital*	20%	50%

Professional (including terminations of pregnancy, genetic testing of fetus and circumcision of newborn**)	20%	50%

Notes:

- Applicable Deductible, Copayment or Coinsurance requirements apply to any services and supplies required for the treatment of an illness or condition, including but not limited to, complications of pregnancy. For example, if the complication requires an office visit, then the office visit Copayment or Coinsurance will apply.

- Prenatal, postnatal and newborn care that are Preventive Care Services are covered in full by Preferred Providers and the Calendar Year Deductible does not apply. See "Preventive Care Services" in the "Visit to a Health Care Provider's Office or Clinic" provision above. If other non-Preventive Care Services are received during the same office visit, the above Copayment or Coinsurance will apply for the non-preventive services. Refer to “Preventive Care Services” and “Pregnancy” in the “Plan Benefits” section for more details.

* HNL does not require Certification for maternity care. Certification is not needed for the first 48 hours of inpatient Hospital services following a vaginal delivery nor the first 96 hours following a cesarean section. However, please notify HNL within 24 hours following birth, or as soon as reasonably possible. Certification must be obtained if the Physician determines that a longer Hospital stay is Medically Necessary either prior to or following the birth.

**Circumcisions for Covered Persons aged 31 days and older are covered when Medically Necessary under “Outpatient Surgery and Services.” Refer to the “Outpatient Surgery and Services” section for applicable Copayments and Coinsurance.

HELP RECOVERING OR OTHER SPECIAL HEALTH NEEDS

	Preferred Providers	Out-of-Network
Home Health Care Services	20%, Deductible waived	50%
*Number of visits covered during a Calendar Year (combined for Preferred Providers and Out-of-Network Providers)***	100	100
Rehabilitation services (physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy)*	$45, Deductible waived	Not Covered
Habilitative services (physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy)*	$45, Deductible waived	Not Covered
Confinement in a Skilled Nursing Facility		
Facility*	20%	50%
Physician visit to Skilled Nursing Facility	20%	50%
Durable Medical Equipment*	20%, Deductible waived	Not Covered
Orthotics (such as bracing, supports and casts)*	20%, Deductible waived	Not Covered
Corrective Footwear*	20%, Deductible waived	Not Covered
Diabetic equipment (including footwear)	20%, Deductible waived	50%
Prostheses*	20%, Deductible waived	50%
Hospice*	$0, Deductible waived	50%
Self-injectable drugs***	See note below	See note below

Notes:

- Confinement in a Skilled Nursing Facility is not subject to a maximum number of days.
- Diabetic equipment and Orthotics which are covered under the medical benefit include blood glucose monitors, insulin pumps and Corrective Footwear.

- Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under “Preventive Care Services” in "Visit to a Health Care Provider's Office or Clinic" in this section. For additional information, please refer to the "Preventive Care Services" provision in the "Plan Benefits" section.
- Durable Medical Equipment is covered when Medically Necessary and acquired or supplied by an HNL designated contracted vendor for Durable Medical Equipment. Preferred Providers that are not designated by HNL as a contracted vendor for Durable Medical Equipment are considered Out-of-Network Providers for purposes of determining coverage and benefits. Durable Medical Equipment is not covered if provided by an Out-of-Network Provider. Certification may be required. Please refer to the "Certification Requirement" portion of this section for details. Payment of benefits will be reduced as set forth herein if Certification is required but not obtained. For information about HNL's designated contracted vendors for Durable Medical Equipment, please contact the Customer Contact Center at the telephone number on Your HNL ID Card.
- The amount covered for services of a Home Health Care Agency which is an Out-of-Network Provider is the Maximum Allowable Amount. Please refer to "Maximum Allowable Amount" in the "Definitions" section.

* Certification may be required. Please refer to the "Certification Requirements" section for details. Payment of benefits will be reduced as set forth herein if Certification is required but not obtained.

**Home Health Care visits are limited to 3 visits per day, up to 2 hours per visit by a nurse, medical social worker, physical/occupational/speech therapist, or up to 3 hours per visit by a home health aide.

***Certain injectable drugs which are considered self-administered are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefits even if they are administered in a Physician’s office. You can coordinate delivery of the Specialty Drug directly to the provider office through the Specialty Pharmacy Vendor. Please refer to the "Specialty Pharmacy Vendor" portion under "Outpatient Prescription Drugs" of this "Schedule of Benefits" section for the applicable Copayment or Coinsurance.

OUTPATIENT PRESCRIPTION DRUGS

Subject to the provisions of the "Outpatient Prescription Drugs" portion of the "Plan Benefits" section, all Medically Necessary Prescription Drugs are covered.

The outpatient Prescription Drug benefits are subject to the Out-of-Pocket Maximums as described at the beginning of this section. The outpatient Prescription Drug benefits are not subject to the Calendar Year Deductible as described at the beginning of this section.

Your financial responsibility for covered Prescription Drugs varies by the type of drug dispensed, and whether the drug was dispensed by a Participating Pharmacy or a Nonparticipating Pharmacy. See the "Definitions" section and the "Outpatient Prescription Drug Benefits" portion of the "Plan Benefits" and "General Limitations and Exclusions" sections for more information about what benefits are provided.

Pharmacy Deductible

Pharmacy Deductible required for Tier II, Tier III and Tier IV Drugs (per Covered Person, per Calendar Year).....$250

Pharmacy Drug Deductible required for Tier II, Tier III and Tier IV Drugs (per family, per Calendar Year).....$500

If you are a Covered Person in a family of two or more members, You reach the Pharmacy Deductible either when You meet the amount for any one Covered Person, or when Your entire family reaches the family amount.

The Pharmacy Deductible applies to Tier II, Tier III and Tier IV Drugs, insulin, and diabetic supplies. Once Your payment of Prescription Drug Covered Expenses for Tier II, Tier III and Tier IV Drugs, insulin, and diabetic supplies equals the Pharmacy Deductible shown above, You are only responsible for the applicable retail pharmacy Coinsurance as described herein.

Benefit Maximums

	Maximum
Number of days per Prescription Drug Order for drugs from a retail Pharmacy	30
Number of days per Prescription Drug Order for Maintenance Drugs through the Mail Order Program	90
Number of days per Prescription Drug Order for drugs for Specialty Drugs	30
Number of days per Prescription Drug Order for insulin needles and syringes from a retail Pharmacy	30
Number of days per Prescription Drug Order for blood glucose monitoring test strips and lancets from a retail Pharmacy	30

Notes:

- Except for insulin, diabetic supplies (blood glucose testing strips, lancets, disposable needles & syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (i.e. opened in order to dispense the product in quantities other than those packaged). When a prescription is dispensed, You will receive the size of package and/or number of packages required for You to test the number of times Your Physician has prescribed for up to a 30-day period.

Copayments and Coinsurance

You will be charged a Copayment or Coinsurance for each Prescription Drug Order.

Retail Pharmacy

	Participating Pharmacy	Nonparticipating Pharmacy
Tier I Drugs (most Generic Drugs and low-cost preferred Brand Name Drugs when listed in the Essential Rx Drug List)	$15, Deductible waived	Not Covered
Tier II Drugs (non-preferred Generic Drugs and preferred Brand Name Drugs, insulin and diabetic supplies when listed in the Essential Rx Drug List)	$55	Not Covered
Tier III Drugs (non-preferred Brand Name Drugs, Brand Name Drugs with generic equivalent (when Medically Necessary), drugs listed as Tier III Drugs in the Essential Rx Drug List or drugs not listed in the Essential Rx Drug List)	$75	Not Covered
Preventive drugs and women's contraceptives	$0, Deductible waived	Not Covered

Specialty Pharmacy Vendor

	Specialty Pharmacy
Tier IV Drugs (Specialty Drugs, includes self-administered injectable drugs (excluding insulin) and high cost drugs used to treat complex or chronic conditions when listed in the Essential Rx Drug List)	20%

Maintenance Drugs through the Mail Order Program

	Mail Order Program
Tier I Drugs (most Generic Drugs and low-cost preferred Brand Name Drugs when listed in the Essential Rx Drug List)	$30, Deductible waived
Tier II Drugs (non-preferred Generic Drugs and preferred Brand Name Drugs, insulin and diabetic supplies when listed in the Essential Rx Drug List)	$110
Tier III Drugs (non-preferred Brand Name Drugs, Brand Name Drugs with generic equivalent (when Medically Necessary), drugs listed as Tier III Drugs in the Essential Rx Drug List or drugs not listed in the Essential Rx Drug List)	$150
Preventive drugs and women's contraceptives	$0, Deductible waived

Notes:

- Orally administered anti-cancer drugs will have a Copayment and Coinsurance maximum of $200 for an individual prescription of up to a 30-day supply or $600 for a 90-day supply through mail order.
- After the Pharmacy Deductible has been met, Tier IV Drugs will have a Copayment and Coinsurance maximum of $250 for an individual prescription of up to a 30-day supply.
- If the pharmacy's retail price is less than the applicable Copayment or Coinsurance, You will pay the pharmacy's retail price.
- Generic Drugs will be dispensed when a Generic Drug equivalent is available. We will cover Brand Name Drugs, including Tier IV (Specialty Drugs), that have a generic equivalent only when the Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from HNL. Covered Brand Name Drugs are subject to the applicable Copayment or Coinsurance for Tier II Drugs, Tier III Drugs or Tier IV (Specialty Drugs).
- Preventive drugs and women's contraceptives that are approved by the Food and Drug Administration are covered as shown above. Please see the "Preventive Drugs and Women's Contraceptives" provision in the "Outpatient Prescription Drug Benefits" portion of the "Plan Benefits" section for additional details. If Your Physician determines that none of the methods designated by HNL are medically appropriate for You, We shall cover some other FDA-approved prescription contraceptive method.
- If a Medically Necessary Brand Name Drug is dispensed, and there is a generic equivalent commercially available, You must obtain Prior Authorization for the Brand Name Drug to be covered.
- **The Pharmacy Deductible does not apply to preventive drugs and women's contraceptives.**
- Some drugs may require Prior Authorization from HNL to be covered. You will be subject to a penalty of 50% of the Average Wholesale Price if Prior Authorization was not obtained, except for Emergency or Urgently Needed care.
- Generic or Brand Name Drugs not listed in the Essential Rx Drug List which are prescribed by Your Physician and not excluded or limited from coverage are subject to the Tier III Drug or Specialty Drug Copayment or Coinsurance, as applicable.
- Up to a 90-consecutive-calendar-day-supply of covered Maintenance Drugs will be dispensed at the applicable mail order Copayment or Coinsurance when ordered through HNL's contracted mail service vendor. Some Specialty Drugs listed in the Essential Rx Drug List are not available through mail order.

CHILD NEEDS EYE CARE

Pediatric Vision Services

We provide toll-free access to our Customer Service Associates to assist you with benefit coverage questions, resolving problems or changing your vision office. Customer Service can be reached Monday through Friday at **(866) 392-6058** from 5:00 a.m. to 8:00 p.m. Pacific Standard Time. Automated service is also provided after hours for eligibility verification and vision office transfers.

All of the following services must be provided by a Health Net Participating Vision Provider in order to be covered. Refer to the "Pediatric Vision Services" portion of the "General Limitations and Exclusions" section for limitation on covered vision services.

The vision services benefits are provided by Health Net. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the vision services benefits.

Routine eye exam limit: 1 per Calendar Year Exam Options: Standard Contact Lens Fit including Follow-up visit (routine applications of soft, spherical daily wear contact lenses for single vision prescriptions) Premium Contact Lens Fit including Follow-up visit (more complex applications, including, but not limited to toric, bifocal/multifocal, cosmetic color, post-surgical and gas permeable)	$0 Copayment, Deductible waived
Lenses limit: 1 pair per Calendar Year, including • Single vision, bifocal, trifocal, lenticular • Glass, or Plastic, including polycarbonate • Oversized and glass-grey #3 prescription sunglass lenses	$0 Copayment, Deductible waived
Provider selected frames limit: 1 per Calendar Year	$0 Copayment, Deductible waived
Optional Lenses and Treatments including • UV Treatment • Tint (Fashion & Gradient & Glass-Grey) • Standard Plastic Scratch Coating • Standard Polycarbonate – • Photocromatic / Transitions Plastic • Standard, Premium and Ultra Anti-Reflective Coating • Polarized • Standard, Premium, Select, and Ultra Progressive Lens • Hi-Index Lenses • Blended segment Lenses • Intermediate vision Lenses • Select or ultra progressive lenses	$0 Copayment, Deductible waived

• Premium Progressive Lens	$0 Copayment, Deductible waived
Provider selected contact lenses, a one year supply is covered every Calendar Year (in lieu of eyeglass lenses): • Disposables • Conventional • Medically Necessary*	$0 Copayment, Deductible waived
Subnormal or Low Vision Services and Aids - one comprehensive low vision evaluation every 5 years; low vision aids, including high-power spectacles, magnifiers or telescopes (limited to one aid per year) and follow-up care (limited to 4 visits every 5 years).	$0 Copayment, Deductible waived

***Medically Necessary Contact Lenses:**
Contact Lenses may be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, Contact Lenses may be Medically Necessary and appropriate when the use of Contact Lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

Contact Lenses may be Medically Necessary for the treatment of conditions, including, but not limited to: keratoconus, pathological myopia, aphakia, anisometropia, aniridia, corneal disorders, post-traumatic disorders and irregular astigmatism.

Medically Necessary Contact Lenses are dispensed in lieu of other eyewear. Participating providers will obtain the necessary pre-authorization for these services.

ELIGIBILITY, ENROLLMENT AND TERMINATION

WHO IS ELIGIBLE FOR COVERAGE

The Covered Services and Supplies of this plan are available to the following individuals as long as they live in the United States, and meet the additional eligibility requirements of the Group:

- The principal Covered Person (employee);
- Spouse: Your lawful spouse as defined by California law.
- Domestic Partner: The registered Domestic Partner, as defined by California law.
- Children: The children of the principal Covered Person or his or her spouse or Domestic Partner (including legally adopted children, stepchildren and wards, as defined in the following provision); and
- Wards: Children for whom the principal Covered Person or his or her spouse or Domestic Partner is a court-appointed guardian.
- Foster child: Children for whom the principal Covered Person or his or her spouse or Domestic Partner is a foster parent.
- Other child: Any child that You have assumed a parent-child relationship, in lieu of a parent-child relationship described above, as indicated by intentional assumption of parental status, or assumption of parental duties by You, as certified by You at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled.

Children of the principal Covered Person or his or her spouse or Domestic Partner who are the subject of a Medical Child Support Order, according to state or federal law, are also eligible. Coverage of care received outside the United States will be limited to services provided in connection with Emergency Care.

Age Limit for Children

Each child is eligible until the age of 26 (the limiting age).

Disabled Child

Children who reach age 26 are eligible to continue coverage if all of the following conditions apply:

- The child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and
- The child is chiefly dependent upon the principal Covered Person for support and maintenance.

If You are *enrolling* a disabled child for new coverage, You must provide HNL with proof of incapacity and dependency within 120 days of the date You receive a request for such information about the dependent child from HNL.

HNL must provide You notice at least 90 days prior to the date Your enrolled child reaches the age limit at which the dependent child's coverage will terminate You must provide HNL with proof of Your child's incapacity and dependency during the period commencing 60 days before and ending 60 days after the Dependent Child's 26th birthday in order to continue coverage for a disabled child past the age limit. Coverage will continue until HNL makes a determination as to the child's disability and dependency.

You must provide the proof of incapacity and dependency at no cost to HNL.

Following the disabled child's 28th birthday and no more often than annually thereafter, HNL may request that the Policyholder provide satisfactory evidence of the child's disability, and the Policyholder shall have 60 days to respond. A disabled child may remain covered by this plan for as long as he or she remains incapacitated and continues to meet the eligibility criteria described above.

HOW TO ENROLL FOR COVERAGE

Notify the Group that You want to enroll an eligible person. The Group will send the request to HNL according to current procedures.

Employee

Each new employee entering employment subsequent to the Effective Date of the Group's initial enrollment period shall be permitted, without proof of insurability, to apply for coverage for himself or herself and eligible Dependents within 30 days of becoming eligible, subject to the enrollment regulations in effect with the Group. Such enrollments, if accepted by HNL, become effective when any waiting or probationary period (of up to 60 days) required by the Group is completed.

When the employee is not subject to a probationary period, the enrollment becomes effective, in accordance with established Group eligibility rules, either on the date of hire or on the first day of the calendar month following the month in which the employee was hired.

Eligible employees who enroll in this plan are called principal Covered Persons.

A person cannot be denied coverage due to present medical conditions at enrollment.

Newly Acquired Dependents

You are entitled to enroll newly acquired Dependents as follows:

Spouse: If You marry while You are covered by this plan, You may enroll Your new spouse (and Your spouse's eligible children) within 60 days of the date of marriage. Coverage begins either on the date of marriage or on the first day of the calendar month following the date of marriage, according to the rules established by the Group.

Domestic Partner: If You are the principal Covered Person and You enter into a domestic partnership while You are covered by this plan, You may enroll Your new Domestic Partner (and his or her eligible children) within 60 days of the date a Declaration of Domestic Partnership is filed with the Secretary of State or other recognized state or local agency, or within 60 days of the formation of the domestic partnership according to Your Group's eligibility rules. Coverage begins either on the date the Domestic Partnership is filed or formed, or on the first day of the calendar month following the date the Domestic Partnership is filed or formed, depending on Your Group's enrollment rules.

Newborn Child: Coverage for newborn children will be effective upon birth and during the first 31 days following birth or the first day of the following month if requested by the principal Covered Person. However, coverage after 31 days is contingent upon You enrolling the newborn within 60 days following birth. If a newborn is enrolled within 60 days following birth, coverage will be continuous from birth.

Adopted Child: A newly adopted child, or a child who is being adopted, becomes eligible on the date of adoption or the date You or Your spouse or Domestic Partner receive physical custody of the child or the first day of the following month after the date of adoption or receiving physical custody, if requested by the principal Covered Person.

Coverage begins automatically and will continue for 31 days from the date of eligibility. You must enroll the child within 60 days for coverage to continue beyond the first 31 days. Covered California will require written proof of the right to control the child's health care when such child is enrolled. If an adopted child is enrolled within 60 days following adoption or date of placement for adoption (date of physical custody), coverage will be continuous from the date of adoption or date of placement for adoption (date of physical custody).

Legal Ward (Guardianship): If You or Your spouse or Domestic Partner becomes the legal guardian of a child, the child is eligible to enroll on the effective date of the court order, but coverage is not automatic. The child must be enrolled within 60 days of the effective date of the guardianship. Coverage will begin on the first day of the month after Covered California receives the enrollment request.

Covered California will require proof that You or Your spouse or Domestic Partner is the court-appointed legal guardian.

Foster Child: If You or Your spouse or Domestic Partner becomes the foster parent of a child, the child is eligible to enroll on the effective date of the foster care, but coverage is not automatic. The child must be enrolled within 60 days of the effective date of the foster care. Coverage will begin on the date of placement in foster care or the first day of the following month if requested by the principal Covered Person.

Covered California will require proof that You or Your spouse or Domestic Partner is the foster parent.

Other Child: Any child that You have assumed a parent-child relationship, in lieu of a parent-child relationship described above, as indicated by intentional assumption of parental status, or assumption of parental duties by

You, as certified by You at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled.

The child must be enrolled within 60 days of the effective date of the assumption of parental status. Coverage will begin on the first day of the month after Covered California receives the enrollment request.

Open Enrollment Period

An Open Enrollment Period shall be held annually, at which time potential Covered Persons may enroll under this *Certificate*. Upon receipt of enrollment changes and corresponding payment of dues for an enrollment, such enrollment changes shall, if accepted by Covered California, become effective on the first day of the calendar month for which the change is submitted, unless otherwise approved by Covered California.

Late Enrollment Rule

HNL's late enrollment rule requires that if an individual does not enroll within 30 days of becoming eligible for coverage, he or she must wait until the next Open Enrollment Period to enroll. (Time limits for enrolling are explained in the "Employee" and "Newly Acquired Dependents" provisions above.)

The term "form" within this section may include electronic enrollment forms or enrollment over the phone. Electronic or phone enrollments are deemed signed when You use Your employer's enrollment system to make or confirm changes to Your benefit enrollment.

A Late Enrollee may be excluded from coverage until the next Open Enrollment Period unless a special enrollment triggering event occurs.

You may have decided not to enroll upon first becoming eligible. At that time, the Group should have given You a form to review and sign. It would have contained information to let You know that there are circumstances when You will not be considered a late enrollee.

If You later change Your mind and decide to enroll, Covered California can impose its late enrollment rule. This means that individuals identified as declining coverage on the form the employee signed will not be allowed to enroll before the next Open Enrollment Period. There are, however, exceptions to this rule.

Exceptions to Late Enrollment Rule

If any of the circumstances below are true, the late enrollment rule will not apply:

1. **You Did Not Receive a Form To Sign or A Signed Form Cannot Be Produced**
   If You chose not to enroll when first eligible, the late enrollment rule will not apply to You:
   - If You never received from the Group or signed a form explaining the consequences of Your decision; or
   - Your signed form exists but cannot be produced as evidence of Your informed decision.
2. **You Did Not Enroll Because of Other Coverage, and Later the Other Coverage is Lost**
   If You declined coverage in this plan, and You stated on the form the reason You were not enrolling was because of coverage through another Group health plan, and the other coverage is or will be lost, the late enrollment exclusion will not apply to You. Reasons for the loss of coverage include, but are not limited to:
   - The principal enrollee of the other plan has ceased being covered by that other plan, (except for either failure to pay premium contributions, or a "for cause" termination, such as fraud or misrepresentation of an important fact);
   - Loss of coverage because of termination of employment or reduction in the number of hours of employment;
   - Loss of coverage through an HMO or other individual arrangement because an individual ceases to reside, live or work in the service area;
   - Loss of coverage through an HMO or other arrangement in the group market because an individual ceases to reside, live or work in the service are, and no other benefit package is available to the individual;
   - The other plan was terminated and not replaced with other Group coverage;
   - The other Group stops making contributions toward employee's or dependent's coverage;

- When the individual's plan ceases to offer any benefits to the class of similarly situated individuals that includes the individual;
- The other principal enrollee or employee dies;
- The principal enrollee and spouse or Domestic Partner are divorced or legally separated and this causes loss of the Group coverage;
- Loss of coverage because cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan);
- The other coverage was federal COBRA or Small Employer Cal COBRA, and the period of coverage ends; or
- Loss of minimum essential coverage for any other reason except failure to pay premiums or when the coverage is rescinded for fraud or intentional misrepresentation of material fact.

3. You Lose Eligibility from an Access for Infants or Mothers Program (AIM) or a Medi-Cal Plan
If You become ineligible and lose coverage under the Access for Infants or Mothers Program (AIM) or Medi-Cal, You and/or Your Dependent(s) will be eligible to enroll in this plan upon submitting a completed application form within 60 days of losing such coverage. If You and/or Your Dependent(s) wait longer than 60 days to enroll, You and/or Your Dependent(s) may not enroll until the next Open Enrollment period.

4. Multiple Health Plans
If You are enrolled as a dependent in a health plan (not HNL), and the enrollee of that other plan, during open enrollment, chooses a different type of plan (such as moving from an HMO plan to a fee-for-service plan), and You do not wish to continue to be covered by the original plan, You will not be considered a late enrollee, should You decide to enroll in this plan.

5. Court Orders
If a court orders You to provide coverage for a current spouse or Domestic Partner (not a former spouse or Domestic Partner), or orders You or Your enrolled spouse or Domestic Partner to provide coverage to a minor child through HNL, that spouse or Domestic Partner or child will not be treated as a late enrollee.

6. Other Special Enrollment Triggering Events
We shall allow an individual to enroll as a result of the following triggering events:

- The individual was released from incarceration;
- The individual's prior plan substantially violated a material provision of the health coverage contract;
- The individual gains access to new health benefit plans as a result of a permanent move;
- The individual was receiving services from a contracting provider under another health plan for one of the conditions described below and the provider is no longer participating in that health benefit plan:
  a) An acute condition. (An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.) Completion of covered services shall be provided for the duration of the acute condition.
  b) A serious chronic condition. (A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.) Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health insurer in consultation with the insured and the terminated provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered insured.
  c) A pregnancy. (A pregnancy is the three trimesters of pregnancy and the immediate postpartum period.) Completion of covered services shall be provided for the duration of the pregnancy.

d) A terminal illness. (A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less.) Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new insured.

e) The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered insured.

f) Performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured.

- The individual was a member or the reserve forces of the United States military or a member of the California National Guard returning from active duty.
- The individual demonstrates to the Exchange (Covered California™), with respect to health benefit plans offered through Covered California, or to the California Department of Insurance, with respect to health benefit plans offered outside Covered California, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under minimum essential coverage.
- Were not previously a citizen, national or lawfully present individual and gained such status.
- Enrollment or non-enrollment in the health benefit plan was unintentional, inadvertent or erroneous and is the result of the error, misrepresentation or inaction of an officer, employee or agent of Covered California or the health benefit plan, or its instrumentalities as evaluated and determined by Covered California. In such cases, Covered California may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or inaction;
- Adequately demonstrated to Covered California that the health benefit plan substantially violated a material provision of its contract in relation to the enrollee;
- The individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a health benefit plan. Covered California must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act may enroll in a health benefit plan or change from one plan to another one time per month;
- Were enrolled in any non-Calendar Year policy that expired in 2014, even if You or Your Dependent had the option to renew the policy. The date of the loss of coverage shall be the date in 2014 of the expiration of the non-Calendar Year policy;
- Lost Medi-Cal coverage for pregnancy-related services;
- Lost Medi-Cal coverage for medically needy, only once per Calendar Year'
- It is determined by Covered California that the qualified individual or enrollee, or his or her Dependents, was (1) not enrolled, (2) not enrolled in the plan selected, or (3) did not receive advance payments of the premium tax credit or cost sharing reductions although he or she was eligible, as a result of misconduct on the part of a non-Covered California entity providing enrollment assistance or conducting enrollment activities.
- It is demonstrated to Covered California, in accordance with guidelines issued by the Department of Health and Human Services, that the individual or enrollee meets other exceptional circumstances as Covered California may provide.

If the exceptions in 2 applies, You must enroll within 60 days of the loss of coverage. If the exception in 4 applies, You must enroll within 30 days of the loss of coverage. If You wait longer than 30 days to enroll, You will be a late enrollee and may not enroll until the next Open Enrollment Period. A court ordered dependent may be added

without any regard to Open Enrollment restrictions within 60 days of the court order.

Special Enrollment Rule For Newly Acquired Dependents

If an employee gains new dependents due to childbirth, adoption, placement in foster care, assumption of a parent-child relationship, domestic partnership or marriage the following rules apply:

If the Employee Is Enrolled in this Plan

If You are covered by this plan as an employee of the Group, You can enroll a new dependent if You request enrollment within 60 days after childbirth, marriage, domestic partnership, adoption, placement for adoption (receiving physical custody), placement in foster care, or assumption of a parent-child relationship. In addition, a court ordered dependent may be added without any regard to open enrollment restrictions.

More information about enrolling new dependents and their Effective Date of coverage is available above under the heading "How to Enroll For Coverage" and subheading "Newly Acquired Dependents."

If the Employee Declined Enrollment in this Plan

If You previously declined enrollment in this plan because of other Group coverage, and You gain a new dependent due to childbirth, marriage, adoption, placement for adoption or assumption of a parent-child relationship, You can enroll Yourself and the dependent within 60 days of childbirth, marriage, adoption or placement for adoption.

If You gain a new dependent due to a court order and You did not previously enroll in this plan, You may enroll Yourself and Your court ordered dependent(s) without any regard to open enrollment restrictions.

In addition any other Family Covered Persons who are eligible for coverage may enroll at the same time as You and the new dependent. You no longer have to wait for the next Open Enrollment Period, and whether or not You are covered by another Group plan has no effect on this right.

If You do not enroll Yourself, the new dependent and any other family members within 60 days of acquiring the new dependent, You will have to wait until the next Open Enrollment Period to do so.

The Effective Date of coverage for You and all Dependents who enroll within 60 days of childbirth, marriage, adoption or placement for adoption will be the same as for the new dependent.

- In the case of childbirth, the Effective Date will be the moment of birth or the first day of the following month if requested by the principal Covered Person;
- For marriage or domestic partnership, the Effective Date will be either on the date of marriage or entry into domestic partnership, or the first of the month following the date of marriage or entry into domestic partnership, according to the rules established by the Group;
- Regarding adoption, the Effective Date will be the date of adoption or the date the employee or his or her spouse or Domestic Partner receives physical custody of the child or the first day of the following month after the date of adoption or receiving physical custody, if requested by the principal Covered Person; and
- Regarding foster care, the Effective Date will be the date of placement in foster care or the first day of the following month if requested by the principal Covered Person; and
- Following assumption of a parent-child relationship, the Effective Date will be the first day of the month following the enrollment request.
- In the case of a Medical Child Support Order, the Effective Date will be the date the Group is notified of the court order.

Note: When You are not enrolled in this plan, and You wish to have coverage for a newborn or adopted child who is ill, please contact the Group as soon as possible and ask that You (the employee) and the newborn be enrolled. You must be enrolled in order for Your eligible dependent to be enrolled.

While You have 60 days within which to enroll the child, until You and Your child are formally enrolled and recorded as Covered Persons in HNL's computer system, We cannot verify coverage to any inquiring medical provider.

Special Reinstatement Rule For Reservists Returning From Active Duty

Reservists ordered to active duty on or after January 1, 2007 who were covered under this *Certificate* at the time they were ordered to active duty and their eligible dependents will be reinstated without waiting periods. A reservist means a member of the U.S. Military Reserve or California National Guard called to active duty as a result of the Iraq conflict pursuant to Public Law 107-243 or the Afghanistan conflict pursuant to Presidential Order No. 13239. Please notify the Group when you return to employment if you want to reinstate your coverage under the *Certificate*.

Special Reinstatement Rule Under USERRA

USERRA, a federal law, provides service members returning from a period of uniformed service who meet certain criteria with reemployment rights, including the right to reinstate their coverage without pre-existing exclusions or waiting periods, subject to certain restrictions. Please check with your Group to determine if you are eligible.

WHEN COVERAGE ENDS

You must notify the Group of changes that will affect Your eligibility. The Group will send the appropriate request to HNL according to current procedures.

All Covered Persons

All Covered Persons of a Group become ineligible for coverage under this *Certificate* at the same time if the Policy (between the Group and HNL) is terminated, including termination due to nonpayment of premiums by the Group.

Individual Covered Persons

Individual Covered Persons become ineligible on the date any of the following occurs:

- The Covered Person no longer meets the eligibility requirements established by the Group and Covered California.

  This will include a child subject to a Medical Child Support Order, according to state or federal law, who becomes ineligible on the earlier of:

  1. The date established by the order; or
  2. The date the order expired.

- The Covered Person establishes primary residency outside the continental United States; or
- Your marriage or domestic partnership ends by divorce, annulment, or some other form of dissolution. Eligibility for Your enrolled spouse or Domestic Partner (now former spouse or Domestic Partner) and that spouse's or Domestic Partner's enrolled dependents, who were related to You only because of the marriage, will end.

Notice Of Ineligibility

It shall be Your responsibility to notify the Group of any changes that will affect Your eligibility or that of Your Dependents for services or benefits under this *Certificate*. HNL shall provide notification of ineligibility or termination of coverage to individual Covered Persons.

COVERAGE OPTIONS FOLLOWING TERMINATION

Please examine Your options carefully before declining coverage. To request a Certificate of Creditable Coverage, please contact the Customer Contact Center at the phone number on Your Health Net Life ID card.

If coverage through this *Certificate* ends, the terminated Covered Person may be eligible for additional periods of coverage under this or other types of plans through HNL as follows:

COBRA Continuation Coverage

Many Groups are required to offer continuation coverage by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside California. Please check with the Group to determine if You and Your Dependents are eligible for COBRA continuation.

Cal-COBRA Continuation Coverage

If You have exhausted COBRA and you live in the United States, You may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if You have had less than 36 months of COBRA coverage and you are not entitled to Medicare. If you are eligible, You have the opportunity to continue group coverage under this *Certificate* through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.

HNL Will Offer Cal-COBRA to Covered Persons: HNL will send Covered Persons whose federal COBRA coverage is ending information on Cal-COBRA rights and obligations along with the necessary premium information, enrollment forms, and instructions to formally choose Cal-COBRA Continuation Coverage. This information will be sent by U.S. mail with the notice of pending termination of federal COBRA.

Choosing Cal-COBRA: If an eligible Covered Person wishes to choose Cal-COBRA Continuation Coverage, he or she must deliver the completed enrollment form (described immediately above) to HNL by first class mail, personal delivery, express mail, or private courier company. The address appears on the back cover of this *Certificate*.

The Covered Person must deliver the enrollment form to HNL within 60 days of the later of (1) the Covered Person's termination date for COBRA coverage or (2) the date he or she was sent a notice from HNL that he or she may qualify for Cal-COBRA Continuation.

Payment for Cal-COBRA: The Covered Person must pay HNL 110% of the applicable group rate charged for employees and their dependents.

The Covered Person must submit the first payment within 45 days of delivering the completed enrollment form to HNL in accordance with the terms and conditions of the health plan contract. The first payment must cover the period from the last day of prior coverage to the present. There can be no gap between prior coverage and Cal-COBRA Continuation Coverage. The Covered Person's first payment must be delivered to HNL by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company. If the payment covering the period from the last day of prior coverage to the present is not received within 45 days of providing the enrollment form to HNL, the Covered Person's Cal-COBRA election is not effective and no coverage is provided.

All subsequent payments must be made on the first day of each month. If the payment is late, the Covered Person will be allowed a grace period of 30 days. Fifteen days from the due date (the first of the month), HNL will send a letter warning that coverage will terminate 15 days from the date on the letter. If the Covered Person fails to make the payment within 15 days of the notice of termination, enrollment will be canceled by HNL. If the Covered Person makes the payment before the termination date, coverage will be continued with no break in coverage. Amounts received after the termination date will be refunded to the Covered Person by HNL within 20 business days.

Employer Replaces Previous Plan: There are two ways the Covered Person may be eligible for Cal-COBRA Continuation Coverage if the employer replaces the previous plan:

1. If the Covered Person had chosen Cal-COBRA Continuation Coverage through a previous plan provided by his or her current employer and replaced by this plan because the previous policy was terminated, or
2. If the Covered Person selects this plan at the time of the employer's open enrollment.

The Covered Person may choose to continue to be covered by this plan for the balance of the period that he or she could have continued to be covered by the prior group plan. In order to continue Cal-COBRA coverage under the new plan, the Covered Person must request enrollment and pay the required premium within 30 days of receiving notice of the termination of the prior plan. If the Covered Person fails to request enrollment and pay the premium within the 30-day period, Cal-COBRA Continuation Coverage will terminate.

Employer Replaces this Plan: If the Policy between HNL and the employer terminates, coverage with HNL will end. However, if the employer obtains coverage from another insurer or HMO, the Covered Person may choose to continue to be covered by that new plan for the balance of the period that he or she could have continued to be covered by the HNL plan.

When Does Cal-COBRA Continuation Coverage End? When a Qualified Beneficiary has chosen Cal-COBRA Continuation Coverage, coverage will end due to any of the following reasons:

1. You have been covered for 36 months from Your original COBRA effective date (under this or any other plan)*.
2. The Covered Person becomes entitled to Medicare, that is, enrolls in the Medicare program.
3. The Covered Person moves outside the United States.
4. The Covered Person fails to pay the correct premium amount on the first day of each month as described above under "Payment for Cal-COBRA."
5. Your Group's Policy with HNL terminates. (See "Employer Replaces this Plan.")
6. The Covered Person becomes covered by another group health plan that does not contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan.

If the Covered Person becomes covered by another group health plan that does contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan, coverage through this plan will continue. Coordination of Benefits will apply, and Cal-COBRA plan will be the primary plan.

*The COBRA effective date is the date the Covered Person first became covered under COBRA continuation coverage.

Small Employer Cal-COBRA Continuation Coverage
For groups with fewer than 20 employees who were eligible to enroll in the employer's health plan on 50% of the employer's business days in the preceding year, HNL is required by state law to offer continuation coverage. This subject is detailed below in the subsection titled "Small Employer Cal-COBRA Continuation Coverage."

USERRA Coverage
Under a federal law known as the Uniformed Services Employment and Reemployment Rights Act (USERRA), employers are required to provide employees who are absent from employment to serve in the uniformed services and their dependents who would lose their group health coverage the opportunity to elect continuation coverage for a period of up to 24 months. Please check with Your Group to determine if You are eligible.

Extension of Benefits
Described below in the subsection titled "Extension of Benefits."

Continuation Of Coverage During A Labor Dispute
If You cease to work because of a labor dispute and Your Employer is paying all or a portion of the premium for Your coverage pursuant to the terms of a collective bargaining agreement, You may continue Your coverage subject to the following terms and conditions:

- Continuation of coverage requires:
    1. Your payment to the union which represents You of the monthly premium required for this coverage;
    2. the union collecting such payments from at least 75% of the persons who cease to work because of the labor dispute; and
    3. the timely payment of premiums to Us by the union or unions as required under the Policy for proper payment of premiums.
- If any premium due is unpaid on the date work ceases, there will be no continuation unless such premium is paid by Your Employer or the union prior to the next premium due date.
- The amount of Your monthly payment for continued coverage will be equal to the full group monthly cost for the coverage, including any portion usually paid by the Employer, and, except as provided the bullet item immediately below, such premium rate will be the applicable rate then in effect for coverage under the Policy, on the date work ceases.
- The premium rates for coverage may be increased by 20% on the premium due date on or next after the date work ceases due to the labor dispute. Such increase will apply during the time coverage is continued under this provision. We still have the right to increase the premium rates before, during and after the date work ceases, if We would have had the right to increase rates under the Policy, had work not ceased.
- Your continued coverage under this provision will cease on the earliest of:

1. the end of the period of time for which the union has made payment for Your coverage, if the next premium due is not made;
2. the premium due date for which premiums are received for less than 75% of the persons eligible to continue coverage because of the labor dispute;
3. the premium due date on or following the date that You start full-time work with another Employer;
4. the premium due date on or after the date You ceased to be at work because of the labor dispute for 6 months; or
5. the premium due date on or after the labor dispute is resolved.

- If You have Dependents insured on the date You cease work, You must also continue their coverage in order to continue coverage for You.

SMALL EMPLOYER CAL-COBRA CONTINUATION COVERAGE

If a Covered Person or Dependent is about to lose coverage through this plan for reasons other than the Group's nonpayment of premiums, and is interested in choosing continuation coverage, the Covered Person or Dependent needs to ask the employer whether the employer is subject to federal COBRA law. If the employer is subject to federal COBRA law, the employer will be the primary source of information about continuation coverage. If the employer is a Small Employer as defined below, contact HNL's Customer Contact Center at the telephone number on the HNL ID Card.

Definitions

Small Employer Cal-COBRA Continuation Coverage means extended coverage by this plan that is chosen by the Qualified Beneficiary following loss of coverage due to a Qualifying Event, but only if the employer is a Small Employer.

However, if this plan has been terminated by HNL or the employer and replaced by the employer, the continuation coverage is provided by the group health plan that is currently offered by the employer.

Also, if, during Small Employer Cal-COBRA Continuation Coverage, the Covered Person chooses other coverage during the employer's open enrollment period, continuation coverage is provided by that plan.

Qualified Beneficiary means anyone who, on the date of a Qualifying Event, is or was validly enrolled in this plan or another group health plan sponsored by the employee's current employer.

Qualifying Event means any of the following events that, except for the choosing of Small Employer Cal-COBRA Continuation Coverage through this plan, would result in loss of coverage for one or all enrolled Covered Persons:

- Termination of employment for reasons other than gross misconduct. (For individuals who began receiving Small Employer Cal-COBRA continuation coverage prior to January 1, 2003, 18 months of coverage is available. For individuals who began receiving their Small Employer Cal-COBRA coverage on or after January 1, 2003, 36 months of coverage is available.)
- Reduction in hours worked. (For individuals who began receiving Small Employer Cal-COBRA continuation coverage prior to January 1, 2003, 18 months of coverage is available. For individuals who began receiving their Cal-COBRA coverage on or after January 1, 2003, 36 months of coverage is available.)
- Death of the employee or Covered Person. (36 months of coverage is available.)
- Divorce or legal separation of the enrolled employee from his or her enrolled spouse or Domestic Partner. (36 months of coverage is available.)
- A dependent child ceases to be a dependent child according to the eligibility rules of the plan. (36 months of coverage is available.)
- A Dependent ceases to be eligible when the employee or Covered Person becomes entitled to Medicare coverage (enrolls in Medicare). (36 months of coverage is available.)

Small Employer means an employer that meets the definition of Small Employer as described in Section 1357 of the California Health and Safety Code or Section 10700 of the California Insurance Code. For Small Employer Cal-COBRA Continuation, the following must also be true of the employer:

- Employed fewer than 20 employees who were eligible to enroll in the company's health plan on at least 50% of its working days during the preceding Calendar Year,
- Has contracted for health care coverage through a group benefit plan offered by a health care service plan or a disability insurer, and
- Is not subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C., Section 1161 et seq. (these describe federal COBRA).

Who Is Eligible For Small Employer Cal-COBRA Continuation Coverage?

Qualifying Event: If the Covered Person is validly enrolled through this plan, and he or she experiences a Qualifying Event (as described above), and as a result of that event loses coverage through this plan, that Covered Person has the right to choose to continue to be covered by this plan.

Employer Replaces Previous Plan: There are two ways the Covered Person may be eligible for Small Employer Cal-COBRA Continuation Coverage if the employer replaces the previous plan:

- If the Covered Person had chosen Small Employer Cal-COBRA Continuation Coverage through a previous plan provided by his or her current employer and replaced by this plan because the previous policy was terminated, or
- If the Covered Person selects this plan at the time of the employer's open enrollment.

The Covered Person may choose to continue to be covered by this plan for the balance of the period that he or she could have continued to be covered by the prior group plan. In order to continue Cal-COBRA coverage under the new plan, the Covered Person must request enrollment and pay the required premium within 30 days of receiving notice of the termination of the prior plan. If the Covered Person fails to request enrollment and pay the premium within the 30-day period, Cal-COBRA continuation coverage will terminate.

Employer Replaces This Plan: If the agreement between HNL and the employer terminates, coverage with HNL will end. However, if the employer obtains coverage from another insurer or HMO, the Covered Person may choose to continue to be covered by that new plan for the balance of the period that he or she could have continued to be covered by the HNL plan.

Newborns And Adoptions During Small Employer Cal-COBRA Continuation Coverage: If a child is born to or placed for adoption with the former employee, the child shall have the status of Qualified Beneficiary. This means the child will have the same rights as all other Qualified Beneficiaries. Children who began receiving Cal-COBRA continuation coverage prior to January 1, 2003 could experience a second Qualifying Event during their initial 18 months of Small Employer Cal-COBRA Continuation Coverage. For example, the death of the principal Covered Person would entitle the child to an additional period of coverage. The additional period of coverage would be 18 months. The total period of coverage would be 36 months.

These newborns and adopted children are covered from the moment of birth or physical placement with the former employee for adoption, but the Covered Person must formally enroll the child within 60 days of birth or placement in order for coverage to continue beyond 31 days. To do this, contact HNL to request an enrollment form. HNL must receive the enrollment form within 60 days of birth or placement, or coverage will not continue beyond 31 days.

Who May Choose Small Employer Cal-COBRA Continuation Coverage?

If the Covered Person experiences a Qualifying Event, he or she may choose Small Employer Cal-COBRA for himself or herself alone, or for any one or all of the other Dependents who are enrolled at the time of the Qualifying Event. In addition, any individual who is enrolled at that time may choose Small Employer Cal-COBRA for himself or herself alone. In other words, the Covered Person does not have to be among the persons who choose Small Employer Cal-COBRA Continuation Coverage. Further, a Covered Person may choose coverage for one or more minor children without an adult being included.

Who May Not Choose Small Employer Cal-COBRA Continuation Coverage

An Individual may not choose Small Employer Cal-COBRA if the individual:

- Is enrolled in Medicare;

- Is covered by another group health plan that does not contain a pre-existing condition limitation that prevents the individual from receiving the full benefits of such plan. (A group conversion plan is not a group health plan);

  If the individual is covered by another group health plan that does contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan, the individual may choose Small Employer Cal-COBRA Continuation Coverage. Coordination of benefits will apply, and this Small Employer Cal-COBRA plan will be the primary plan;
- Is covered or could become covered by any federal laws regarding continuation of group health plan coverage;
- Fails to notify HNL of a Qualifying Event according to the requirements described below under "Notify HNL of Small Employer Cal-COBRA Qualifying Event;" or
- Fails to submit the initial premium payment in the correct amount as described below under "Payment for Small Employer Cal-COBRA."

Notify HNL Of Small Employer Cal-COBRA Qualifying Event

If the Covered Person loses coverage through this plan due to a Qualifying Event, and wishes to choose Small Employer Cal-COBRA Continuation Coverage, he or she must notify HNL in writing within 60 days of the Qualifying Event. The Covered Person must deliver the notice to Covered California by first class mail, personal delivery, express mail or private courier company to the address that appears on the ID card and on the back cover of this *Certificate*.

If the Covered Person fails to notify HNL of a Qualifying Event within 60 days of the event, that Covered Person will be disqualified from receiving Small Employer Cal-COBRA Continuation Coverage.

HNL Will Offer Small Employer Cal-COBRA To Covered Persons

If a Covered Person notifies HNL in writing within 60 days of a Qualifying Event, HNL will send that Covered Person by U.S. mail information about his or her Small Employer Cal-COBRA rights and obligations along with the necessary premium information, enrollment forms, and instructions to formally choose Small Employer Cal-COBRA Continuation Coverage.

Choosing Small Employer Cal-COBRA

If a Covered Person wishes to formally choose Small Employer Cal-COBRA Continuation Coverage, he or she must deliver the completed enrollment form (described immediately above) to HNL by first class mail, personal delivery, express mail or private courier company. The address appears on the ID card and on the back cover of this *Certificate*.

The Covered Person must deliver the enrollment form to HNL within 60 days of the later of (1) the Qualifying Event or (2) the date he or she received a notice from HNL that he or she has the right to continue Small Employer Cal-COBRA Continuation Coverage or (3) the date that coverage through the employer plan terminated.

Payment For Small Employer Cal-COBRA

The Covered Person must pay HNL 110% of the applicable group rate charged for employees and their Dependents.

For individuals who began receiving Small Employer Cal-COBRA continuation coverage prior to Jan. 1, 2003, the maximum period of coverage is extended beyond the initial 18 months due to a determination by the Social Security Administration that the Qualified Beneficiary is totally disabled, pursuant to Title II or Title XVI of the Social Security Act, the Covered Person must pay 150% of the applicable group rate for the additional months of coverage.

The Covered Person must submit the first payment within 45 days of delivering the completed enrollment form to HNL in accordance with the terms and conditions of the Policy. The first payment must cover the period from the last day of prior coverage to the present. There can be no gap between prior coverage and Small Employer Cal-COBRA Continuation Coverage. The Covered Person's first payment must be delivered to HNL by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company. If the payment covering the period from the last day of prior coverage to the present is not received

within 45 days of providing the enrollment form to HNL, the Covered Person's Cal-COBRA election is not effective and no coverage is provided.

All subsequent payments must be made on the first day of each month. If the payment is late, the Covered Person will be allowed a grace period of 30 days. Fifteen days from the due date (the first of the month), HNL will send a letter warning that coverage will terminate 15 days from the date on the letter. If the Covered Person fails to make the payment within 15 days of the notice of termination, enrollment will be canceled by HNL. If the Covered Person makes the payment before the termination date, coverage will be continued with no break in coverage. Amounts received after the termination date will be refunded to the Covered Person by HNL within 20 business days.

When Does Small Employer Cal-COBRA Continuation Coverage End?

When a Qualified Beneficiary has chosen Small Employer Cal-COBRA Continuation Coverage, coverage will end due to any of the following reasons:

- 36 months from the date coverage would ordinarily have ended due to termination of employment for reasons other than gross misconduct for individuals who began their Cal-COBRA continuation coverage on or after January 1, 2003, and 18 months for individuals who began receiving their Cal-COBRA continuation coverage prior to January 1, 2003.*
- 36 months from the date coverage would ordinarily have ended due to reduction in hours worked for individuals who began their Cal-COBRA continuation coverage on or after January 1, 2003, and 18 months for individuals who began receiving their Cal-COBRA continuation coverage prior to January 1, 2003.
- 36 months from the date coverage would ordinarily have ended due to:
    1. Death of the covered employee or principal Covered Person;
    2. Divorce or separation of the covered employee or principal Covered Person from his or her spouse or Domestic Partner;
    3. Loss of dependent status by a covered Dependent child; or
    4. The Covered Person becomes entitled to Medicare, that is, enrolls in the Medicare program.
- The Covered Person becomes or could become covered, in accordance with any federal laws regarding continuation of Group health plan coverage.
- The Covered Person fails to pay the correct premium amount on the first day of each month as described above under "Payment for Small Employer Cal-COBRA."
- The Covered Person becomes covered by another group health plan that does not contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan.
- If the Covered Person becomes covered by another group health plan that does contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan, coverage through this plan will continue. Coordination of Benefits will apply, and this Small Employer Cal-COBRA plan will be the primary plan.

*The COBRA effective date is the date the Covered Person first became covered under COBRA continuation coverage.

Under no circumstances may a Qualified Beneficiary be covered by Small Employer Cal-COBRA Continuation Coverage for more than 36 months.

EXTENSION OF BENEFITS

If You are totally disabled when the Group Policy ends and are under the treatment of a Physician, the benefits of this *Certificate* may continue to be provided for services treating the totally disabling illness or injury. No benefits are provided for services treating any other illness, injury or condition.

You must submit a written request for these total disability benefits, which must include written certification by Your Physician that You are totally disabled. Covered California must receive this certification within 90 days of the date coverage ends under this *Certificate*. At least once every 90 days while benefits are extended, Covered California must receive proof that Your total disability is continuing. It shall be Your responsibility to ensure that

Covered California is notified of any requested extension of benefits prior to the required 90-day intervals. Benefits are provided until whichever of the following occurs first:

- You are no longer totally disabled;
- The maximum benefits of this *Certificate* are paid;
- You become covered under another group health plan that provides coverage without limitation on the disabling illness or injury; or
- A period of 12 consecutive months has passed since the date coverage ended.

For the purpose of this extension, the term “total disability” is defined as a disability that renders You unable to perform with reasonable continuity the substantial and material acts necessary to pursue Your usual occupation in the usual or customary way or to engage with reasonable continuity in another occupation in which You could reasonably be expected to perform satisfactorily in light of Your age, education, training, experience, station in life, physical and mental capacity.

PLAN BENEFITS

The services and supplies described below will be covered for the Medically Necessary treatment of a covered illness, injury or condition. These benefits are subject to all provisions of this *Certificate*.

In addition, many of the Covered Services and Supplies listed herein are subject to Certification in many instances, prior to the expenses being incurred. If Certification is not obtained, the available benefits will be reduced. Please refer to the "Certification Requirement" subsection for further details.

An expense is incurred on the date You receive the service or supply for which the charge is made. HNL shall not pay for expenses incurred for any services or supplies in excess of any visit or benefit maximum described in the "Schedule of Benefits" section or elsewhere in this *Certificate*, nor for any service or supply excluded herein.

Services by certain providers may be covered only when a medical doctor (M.D.) or doctor of osteopathy (D.O.) refers You to them. Please refer to the definition of "Physician" in the "Definitions" section for more information.

The fact that a Physician or other provider may perform, prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary, or make it a covered service.

HOW COVERED EXPENSES ARE DETERMINED

HNL will pay for Covered Expenses You incur under this plan. Covered Expenses are based on the maximum charge HNL will accept from each type of provider, not necessarily the amount a Physician or other health care provider bills for the service or supply. Other limitations on Covered Expenses may apply. See “Schedule of Benefits,” “Plan Benefits,” and “General Limitations and Exclusions” sections for specific benefit limitations, maximums, pre-certification requirements and payment policies that limit the amount HNL pays for certain Covered Services and Supplies.

Preferred Providers

The maximum amount of Covered Expenses for a service or supply provided by a Preferred Provider is the lesser of the billed charge or the amount contracted in advance by HNL, referred to in this *Certificate* as the Contracted Rate.

Since the Preferred Provider has agreed to accept the Contracted Rate as payment in full, You will not be responsible for any amount billed in excess of the Contracted Rate. However, You are responsible for any applicable Deductible(s), Copayments or Coinsurance payment required. You are always responsible for services or supplies not covered by this plan.

Out-of-Network Provider

The maximum amount HNL will pay for Covered Expenses when services or supplies are received from an Out-of-Network Provider is the lesser of the billed charge or the Schedule Amount as defined in the “Definitions” section.

Since the Out-of-Network Provider has **not** agreed to accept the Schedule Amount as payment in full, the amount billed by the Out-of-Network Provider may exceed the Schedule Amount. You will need to pay that excess amount, in addition to any applicable Deductible(s), Copayments or Coinsurance payment required. You are always responsible for services or supplies not covered by this plan.

Important Note: Even if a Hospital is a Preferred Provider, You should not assume that all Physicians and other individual providers of health care at the Hospital are Preferred Providers. If You are admitted to a Hospital You should request that all services be performed by Preferred Providers whenever You enter a Hospital.

CERTIFICATION REQUIREMENT

Some of the Covered Expenses under this plan are subject to a requirement of Certification in order for the noncertification penalty to not apply. All Certifications are performed by HNL or an authorized designee.

Certification is NOT a determination of benefits. Some of these services or supplies may not be covered under Your Plan. Even if a service or supply is certified, eligibility rules and benefit limitations will still apply.

Services Requiring Certification

- Inpatient admissions

  Any type of facility, including but not limited to:

  1. Acute rehabilitation center
  2. Chemical Dependency facility, except in an emergency
  3. Hospice
  4. Hospital, except in an emergency
  5. Mental health facility, except in an emergency
  6. Skilled Nursing Facility

- Acupuncture visits
- Ambulance: non-emergency, air or ground Ambulance services
- Back surgery
- Bariatric procedures
- Behavioral health treatment for pervasive developmental disorder or autism beyond the initial 6 months of treatment
- Blepharoplasty (includes brow ptosis)
- Breast reduction and augmentation
- Chondrocyte implants
- Clinical trials
- Cochlear implants
- Custom Orthotics
- Dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
- Dermatology in a Physician's office

  1. Skin injections and implants
  2. Dermabrasions and chemical peels
  3. Laser treatment
  4. Chemical exfoliation and electrolysis

- Durable Medical Equipment:

  1. Bone growth stimulator
  2. Continuous positive airway pressure (CPAP)
  3. Custom-made items
  4. Hospital beds
  5. Power wheelchairs
  6. Scooters

- Enhanced external counterpulsation (EECP)
- Excision, excessive skin and subcutaneous tissue (including lipectomy) of the abdomen, thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad, and other area
- Experimental/Investigational services and new technologies.
- Genetic testing
- Liposuction

- Mastectomy for gynecomastia
- Neuro or spinal cord stimulator
- Occupational therapy (includes home setting).
- Organ, tissue and stem cell transplant services, including pre-evaluation and pre-treatment services and the transplant procedure
- Orthognathic procedures including TMJ treatment
- Otoplasty
- Outpatient Diagnostic Procedures:
  1. Cardiac catheterization
  2. CT (Computerized Tomography)
  3. Echocardiography
  4. MRA (Magnetic Resonance Angiography)
  5. MRI (Magnetic Resonance Imaging)
  6. Nuclear cardiology procedures, including SPECT (Single Photon Emission Computed Tomography)
  7. PET (Positron Emission Tomography)
  8. Sleep studies
- Outpatient pharmaceuticals
  1. Self-injectables
  2. Hemophilia factors and intravenous immunoglobulin (IVIG)
  3. IV and infusion medications
  4. Certain Physician-administered drugs, whether administered in a Physician office, free-standing infusion center, home infusion, ambulatory surgery center, outpatient dialysis center or outpatient Hospital. Refer to the Health Net Life website, www.healthnet.com, for a list of Physician-administered drugs that require Certification.
  5. All Specialty Drugs must have Prior Authorization through the Outpatient Prescription Drug benefit and be obtained through the Specialty Pharmacy Vendor.
- Panniculectomy
- Physical therapy (exceeding 12 visits, includes home setting).
- Prosthesis over $2,500 in billed charges
- Radiation therapy
- Rhinoplasty
- Septoplasty
- Speech therapy (includes home setting).
- Total joint replacements (hip, knee, shoulder)
- Treatment of varicose veins
- Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
- Vermilionectomy with mucosal advancement
- Vestibuloplasty
- X-Stop

HNL will consider the Medical Necessity of Your proposed treatment, Your proposed level of care (inpatient or outpatient) and the duration of Your proposed treatment.

In the event of an admission to a Hospital, a concurrent review of the hospitalization will be performed. Confinement in excess of the number of days initially approved must be authorized by HNL.

Exceptions

Certification is not needed for the first 48 hours of inpatient Hospital services following a vaginal delivery nor the first 96 hours following a cesarean section. However, please notify HNL within 24 hours following birth or as soon as reasonably possible. Certification must be obtained if the Physician determines that a longer Hospital stay is Medically Necessary either prior to or following the birth.

Certification is not required for the length of a Hospital stay for reconstructive surgery incident to a mastectomy (including lumpectomy).

Prior Certification is not required for the first six months of behavioral health treatment for pervasive developmental disorder or autism, however prior notification is required. Notification must include documentation that a licensed Physician or licensed psychologist has established the diagnosis of pervasive developmental disorder or autism. In addition, the Qualified Autism Service Provider must submit the initial treatment plan to HNL. After six months of treatment, Certification is required.

Prior Authorization by HNL may be required for certain drugs. Please refer to “Prior Authorization Process” in the “Outpatient Prescription Drug Benefits” section. You may refer to our website at www.healthnet.com to review the drugs that require a Prior Authorization as noted in the Essential Rx Drug List.

Certification Procedure

Certification must be requested by You within the following periods:

- Five or more business days before the proposed admission date or the commencement of treatment, except when due to a medical emergency;
- In the event of being admitted into a Hospital or outpatient emergency room or urgent care center for Emergency Care; within 24 hours or as soon as reasonably possible; or
- Before admission to a Skilled Nursing Facility or Hospice Care program.

In order to obtain Certification, You or Your Physician are responsible for contacting HNL as shown on Your HNL Identification Card before receiving any service requiring Certification. If You receive any such service and do not follow the procedures set forth in this section, a penalty may apply as stated in the “Schedule of Benefits”. However, for services that require notification only, the penalty will not apply.

Verbal Certification may be given for the service. Written Certification for inpatient services will be sent to You and the provider of service.

If Certification is denied for a covered service, HNL will send a written notice to You and to the provider of the service.

Effect on Benefits

If Certification is obtained and services are rendered within the scope of the Certification, benefits for Covered Expenses will be provided in accordance with this "Plan Benefits" section of this *Certificate*.

If Certification is not obtained, an additional penalty will be applied to Covered Expenses as shown in the "Schedule of Benefits" section. A Noncertification Penalty will not be imposed if the benefit is not listed in the “Services Requiring Prior Certification” provision above. Failure to obtain Certification for an Essential Health Benefit, as defined under California Insurance Code section 10112.27, will not result in denial of coverage for that benefit.

Resolution of Disputes

In the event that You or Your Physician should disagree with any Certification decision made, the following dispute resolution procedure must be followed:

- Either You or Your Physician must contact HNL to request reconsideration of the decision. Additional information may be requested or the treating Physician may be consulted in any reconsideration. A written reconsideration decision will be provided; and
- If You remain dissatisfied with the reconsideration decision, You may request an independent review or go through the binding arbitration remedy set forth in the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" and "Arbitration" provisions of the "General Provisions" section of this *Certificate*.

OUT-OF-POCKET LIMITS ON EXPENSES

Out-of-Pocket Maximum: When Your total Deductibles, Copayments or Coinsurance payments, during any Calendar Year, equal the Out-of-Pocket Maximum set forth in the "Schedule of Benefits" section, no further Deductibles, Copayments or Coinsurance will be required from You for the remainder of that Calendar Year. (See the "Schedule of Benefits" section for exceptions.)

Deductibles, Copayments, or Coinsurance paid for the services of a Preferred Provider will apply toward the Out-of-Pocket Maximum for Preferred Providers but will not apply toward the Out-of-Pocket Maximum for Out-of-Network Providers. Similarly, Deductibles, Copayments, or Coinsurance paid for the services of an Out-of-Network Provider will apply toward the Out-of-Pocket Maximum for Out-of-Network Providers but will not apply toward the Out-of-Pocket Maximum for Preferred Providers. However, Deductibles, Copayments or Coinsurance paid for Out-of-Network Emergency Care (including emergency medical transportation and emergency Hospital care) will be applied to the Out-of-Pocket Maximum for Preferred Providers.

MEDICAL DEDUCTIBLES

- After HNL determines the amount of Covered Expenses, HNL will subtract the applicable Deductible(s) and either the Copayment or the Coinsurance that applies to the covered service or supply. HNL will then pay up to the benefit limit shown in the "Schedule of Benefits" section.
- Only Covered Expenses will be applied to the satisfaction of the Deductible(s) shown in this *Certificate.*
- Prior Deductible carryover credit applies if this Policy is replacing a similar policy that had been issued to the Group Policyholder. If a Covered Person has satisfied any portion of the Deductible under the prior carrier plan, the credit shall apply to the satisfaction of the Covered Person's initial Calendar Year Deductible under this *Certificate*. Proof of Deductible satisfaction under the prior carrier plan will be required upon submission of the initial claim for benefits to be payable under this *Certificate*.

Please read this description of plan benefits carefully. Please also read the "Schedule of Benefits" section to understand Your out-of-pocket expenses and the "General Limitations and Exclusions" section for details of any restrictions placed on the benefits.

VISITS TO A HEALTH CARE PROVIDER'S OFFICE OR CLINIC

Professional Services

Necessary services of a Physician, including office visits and consultations, Hospital and Skilled Nursing Facility visits, and visits to Your home.

Vision and Hearing Examinations

Vision and hearing examinations for diagnosis and treatment, including refractive eye examinations, are covered as shown in the "Schedule of Benefits" section.

Allergy Testing and Treatment

The testing and treatment of allergies is covered. This includes allergy serum.

Acupuncture

Medically Necessary acupuncture services.

Patient Education

HNL will pay for a diabetes instruction program supervised by a licensed or registered health care professional. A diabetes instruction program is a program designed to teach You (the diabetic) and Your covered Dependent about the disease process and the daily management of diabetic therapy.

In addition, HNL will cover tobacco cessation, asthma education, weight management classes and stress management classes that are provided by nonphysician providers.

Preventive Care Services

The coverage described below shall be consistent with the requirements of the Affordable Care Act (ACA).

Preventive Care Services are covered for children and adults, as directed by Your Physician, based on the guidelines from the following resources:

- U.S. Preventive Services Task Force Grade A & B recommendations (http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/)
- The Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Center for Disease Control and Prevention (http://www.cdc.gov/vaccines/schedules/index.html)
- Guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA) (www.hrsa.gov/womensguidelines/)
- For infants, children and adolescents, please refer to the American of Pediatrics Bright Futures Recommendations for Pediatric Preventive Health Care (http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf), and the Uniform Screening Panel recommended by the U.S. Department of Health and Human Services Secretary's Discretionary Advisory Committee on Heritable Disorders in Newborn and Children (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/).

Your Physician will evaluate Your health status (including, but not limited to, Your risk factors, family history, gender and/or age) to determine the appropriate Preventive Care Services and frequency. The list of Preventive Care Services are available through https://www.healthcare.gov/preventive-care-benefits/. Examples of Preventive Care Services include, but are not limited to:

- Periodic health evaluations
- Vision and hearing testing
- Blood pressure, diabetes, and cholesterol tests
- Screening for depression
- USPSTF and HRSA recommended cancer screenings, including FDA-approved human papillomavirus (HPV) screening test, screening and diagnosis of prostate cancer (including prostate-specific antigen testing and digital rectal examinations), screening for breast, cervical and colorectal cancer, human immunodeficiency virus (HIV) screening, mammograms and colonoscopies
- Developmental screenings to diagnose and assess potential developmental delays
- Counseling on such topics as quitting smoking, lactation, losing weight, eating healthfully, prevention of sexually-transmitted diseases and reducing alcohol use
- Smoking cessation programs; for information regarding smoking cessation behavioral modification support programs available through HNL, contact the Customer Contact Center at the telephone number on the HNL ID card or visit Our website at www.healthnet.com
- Routine immunizations against diseases such as measles, polio, or meningitis
- Flu and pneumonia shots
- Vaccination for acquired immune deficiency disorder (AIDS) that is approved for marketing by the FDA and that is recommended by the United States Public Health Service

- Counseling, screening, and immunizations to ensure healthy pregnancies
- Regular well-baby and well-child visits
- Well-woman visits
- Routine prenatal care office visits

Preventive Care Services for women also include screening for gestational diabetes; sexually-transmitted infection counseling; human immunodeficiency virus (HIV) counseling; all FDA-approved contraceptive drugs, devices and other products for women, including all FDA-approved contraceptive drugs, devices and other products available over-the-counter (including, but not limited to, IUDs, injectable and implantable contraceptives); and contraceptive counseling (including, but not limited to, follow-up and management of side effects of contraceptives, counseling for continued adherence and contraceptive device placement and removal); sterilization procedures, breastfeeding support, supplies and counseling; and domestic violence screening and counseling.

One breast pump and the necessary supplies to operate it (as prescribed by Your Physician) will be covered for each pregnancy at no cost to You. This includes one retail-grade or Hospital-grade breast pump (either a manual pump or a standard electric pump) as prescribed by Your Physician. Breast pumps can be obtained by calling the Customer Contact Center at the phone number on Your Health Net Life ID card.

Preventive Care Services are covered as shown in the "Schedule of Benefits" section.

TESTS

Diagnostic Imaging (Including X-Ray) and Laboratory Procedures

All Medically Necessary prescribed diagnostic imaging (including x-ray) and laboratory procedures, services and materials, including cancer screening tests; mammography for purposes other than Preventive Care Services; electrocardiography; electroencephalography; ultrasounds; effectiveness of dialysis; fecal occult blood test; tests for specific genetic disorders for which genetic counseling is available; alpha feta protein testing; CT and PET scans; MRIs; ultraviolet light treatments; and bone density scans (CT and DEXA). Mammography for purposes of Preventive Care Services and human immunodeficiency virus (HIV) screening are covered under the "Preventive Care Services" provision in this section.

OUTPATIENT SURGERY AND SERVICES

Professional Surgical Services

All covered surgical procedures, including the services of the surgeon or Specialist, assistant surgeon, and anesthetist or anesthesiologist, together with preoperative and postoperative care. Surgery includes surgical reconstruction of a breast incident to a mastectomy (including lumpectomy), including surgery to restore symmetry; it also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema.

HNL uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement. HNL uses Medicare guidelines to determine the circumstances under which claims for assistant surgeon services and co-surgeon and team surgeon services will be eligible for reimbursement, in accordance with HNL's normal claims filing requirements.

When adjudicating claims for Covered Services for the postoperative global period for surgical procedures, HNL applies Medicare's global surgery periods to the American Medical Association defined Surgical Package. The Surgical Package includes typical postoperative care. These criteria include consideration of the time period for recovery following surgery and the need for any subsequent services or procedures which are part of routine postoperative care.

When multiple procedures are performed at the same time, Covered Expenses include the Contracted Rate or Schedule Amount (as applicable) for the first (or major) procedure and one-half the Contracted Rate or Schedule Amount for each additional procedure. HNL uses Medicare guidelines to determine the circumstances under which claims for multiple surgeries will be eligible for reimbursement, in accordance with HNL's normal claims filing requirements. No benefit is payable for incidental surgical procedures, such as an appendectomy performed during gall bladder surgery.

HNL uses Medicare guidelines to determine which services and procedures are eligible for payment separately or as part of a bundled package, including but not limited to, which items are separate professional or technical components of services and procedures. HNL also uses proprietary guidelines to identify potential billing inaccuracies.

Payment of benefits for surgical expenses will be reduced as set forth in this *Certificate* if Certification is not obtained for the surgery.

Outpatient Services

Covered Expenses include:

- Use of a Hospital emergency room or urgent care facility, supplies, ancillary services, laboratory and X-ray services, drugs and medicines administered by the Hospital emergency room or urgent care facility;
- Use of outpatient Hospital facility services. Examples are the use of Hospital centers in which ambulatory patients receive the following services: surgery, rehabilitation therapy (including physical, occupational and speech therapy), pulmonary rehabilitation therapy and cardiac rehabilitation therapy, laboratory tests, X-rays, radiation therapy and chemotherapy; and
- Use of the facilities of an outpatient surgical unit including operating and recovery rooms, supplies, ancillary services, laboratory and X-ray services, drugs and medicines administered by the unit.

Certification may be required. Please refer to the "Certification Requirement" portion of this "Plan Benefits" section for details. Payment of benefits for outpatient services will be reduced as set forth herein if Certification is not obtained.

Benefits will be provided for Hospital services when it is necessary to perform dental services in a Hospital, either as an inpatient or an outpatient, due to an unrelated medical condition which would threaten Your health if the dental services are not performed and when use of the Hospital setting has been ordered by both a medical doctor and a dentist. Certification will be required.

Outpatient Surgical Center

Outpatient diagnostic, therapeutic and surgical services and supplies for surgery performed at an Outpatient Surgical Center.

Payment of benefits for outpatient surgery will be reduced as set forth herein if Certification is not obtained for the surgery.

Outpatient Infusion Therapy

Outpatient infusion therapy used to administer covered drugs and other substances by injection or aerosol is covered when appropriate for Your illness, injury or condition and will be covered for the number of days necessary to treat the illness, injury or condition.

Infusion therapy includes: total parenteral nutrition (TPN) (nutrition delivered through the vein); injected or intravenous antibiotic therapy; chemotherapy; injected or intravenous Pain management; intravenous hydration (substances given through the vein to maintain the patient's fluid and electrolyte balance, or to provide access to the vein); aerosol therapy (delivery of drugs or other Medically Necessary substances through an aerosol mist); and tocolytic therapy to stop premature labor.

Covered services include professional services (including clinical pharmaceutical support) to order, prepare, compound, dispense, deliver, administer or monitor covered drugs or other covered substances used in infusion therapy.

Covered supplies include injectable prescription drugs or other substances which are approved by the California Department of Health or the Food and Drug Administration for general use by the public. Other Medically Necessary supplies and Durable Medical Equipment necessary for infusion of covered drugs or substances are covered.

Certain drugs that are administered as part of outpatient infusion therapy require Certification. Refer to the Health Net Life website, www.healthnet.com, for a list of services and infused drugs that require Certification.

All services must be billed and performed by a provider licensed by the state. Only a 30-day supply will be dispensed per delivery.

Infusion therapy benefits will not be covered in connection with the following:

- Non-prescription drugs or medications;
- Any drug labeled "Caution, limited by Federal Law to Investigational use" or Investigational drugs not approved by the FDA;
- Drugs or other substances obtained outside of the United States;
- Homeopathic or other herbal medications not approved by the FDA;
- Drugs or devices not approved by the Food and Drug Administration (FDA) requiring a prescription either by federal or California law; however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set for in California Health and Safety Code, Section 1367.21 have been met; or
- Supplies used by a health care provider that are incidental to the administration of infusion therapy, including but not limited to: cotton swabs, bandages, tubing, syringes, medications and solutions.

Payment of benefits will be reduced as set forth herein if Certification is not obtained for the therapy.

Radiation Therapy, Chemotherapy and Renal Dialysis Treatment

Radiation therapy and nuclear medicine, chemotherapy and renal dialysis treatment are covered when Medically Necessary. We also cover inpatient dialysis; routine outpatient visits with multidisciplinary nephrology team for a consultation, exam, or treatment; hemodialysis; and home hemodialysis and peritoneal dialysis and necessary equipment and medical supplies provided the Covered Person receives appropriate training at a dialysis facility.

Organ, Tissue and Stem Cell Transplants

Organ, tissue and stem cell transplants that are not Experimental or Investigational are covered, only if the transplant is authorized and certified by HNL. The transplant must be Medically Necessary and the Covered Person must qualify for the transplant. Please refer to the "Certification Requirement" portion of this section for information on how to obtain Certification.

HNL has a specific network of designated Transplant Performance Centers to perform organ, tissue and stem cell transplants. Your Physician can provide You with information about this network. You will be directed to a Transplant Performance Center at the time Certification is obtained. Preferred Providers that are not designated as part of HNL's network of Transplant Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for transplants and transplant-related services.

Medically Necessary services, in connection with organ, tissue or stem cell transplants, are covered as follows:

- For the enrolled Covered Person who receives the transplant; and
- For the donor (whether or not an enrolled Covered Person). Benefits are reduced by any amounts paid or payable by the donor's own coverage. Only Medically Necessary services related to the organ donation are covered, including, but not limited to harvesting the organ, tissue or bone marrow and treatment of complications.

Evaluation of potential candidates is subject to the Certification Requirement. More than one evaluation (including tests) at more than one transplant center will not be authorized unless it is Medically Necessary. Organ, tissue and stem cell transplants will be covered regardless of the Covered Person's human immunodeficiency virus (HIV) status.

Organ donation extends and enhances lives and is an option that You may want to consider. For more information on organ donations, including how to elect to be an organ donor, please contact the Customer Contact Center at the telephone number on Your HNL ID Card, or visit the Department of Health and Human Services organ donation website at www.organdonor.gov.

If You receive services which are not certified by HNL for an organ, tissue or stem cell transplant, You will incur the noncertification penalties described in the "Schedule of Benefits" section.

Travel expenses and hotel accommodations associated with organ, tissue and stem cell transplants are not covered.

If You disagree with a determination by HNL, you can appeal the determination. The complaint and appeals process, including independent medical review from the California Department of Insurance, is described in the "Grievance and Appeals Process" and "Independent Medical Review of Grievances Involving a Disputed Health Care Service " provisions in the “General Provisions” section of this *Certificate*. You may also call HNL at the telephone number on Your ID card.

NEED IMMEDIATE ATTENTION

Emergency Care

HNL uses a prudent layperson standard to determine whether the criteria for Emergency Care have been met. HNL applies the prudent layperson standard to evaluate the necessity of medical services which a Covered Person accesses in connection with a condition that the Covered Person perceives to be an emergency situation. Please refer to “Emergency Care” in the "Definitions" section to see how the prudent layperson standard applies to the definition of "Emergency Care."

Emergency Care is available and accessible to all Covered Persons in the Service Area 24 hours a day, seven days a week. Emergency Care is also covered outside the Service Area, including outside the United States. See "Foreign Travel or Work Assignment" in the "Miscellaneous Provisions" section for more details. Please see the "Schedule of Benefits" for the applicable Copayments.

Urgent Care

Urgent care is covered as long as services would have otherwise been covered under this *Certificate*.

Ambulance Services

Air or ground Ambulance and Ambulance transport services, provided through a Preferred Provider or an Out-of-Network Provider as a result of a **“911”** emergency response system call will be covered when either of the following conditions apply:

- The request was made for an emergency medical condition and Ambulance transport services were required; or
- The Covered Person reasonably believed that his or her medical condition was an emergency medical condition and required Ambulance transport services.

Paramedic and Ambulance services that do not meet these conditions or which do not result in a transportation will be covered only if Certification is obtained and the services are Medically Necessary.

Non-emergency Ambulance and psychiatric transport van services are covered if a Physician determines that the Covered Person's condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger the Covered Person's health. Services are only covered when the vehicle transports insured to or from covered services. Non-emergency ambulance services do not include transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), even if it is the only way to travel to a provider.

Please refer to the "Certification Requirement" provision of this section and the "Ambulance Services" provision of the "General Limitations and Exclusions" section for additional information.

HOSPITAL STAY

Covered Expenses include:

- Accommodations as an inpatient in a room of two or more beds, at the Hospital's most common semi-private room rate with customary furnishings and equipment (including special diets as Medically Necessary);
- Services in Special Care Units;

- Private rooms, when Medically Necessary
- Physician services
- Specialized and critical care
- General nursing care
- Special duty nursing as Medically Necessary);
- Operating, delivery and special treatment rooms;
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services;
- Physical, speech, occupational and respiratory therapy;
- Radiation therapy, chemotherapy and renal dialysis treatment;
- Other diagnostic, therapeutic and rehabilitative services, as appropriate;
- Biologicals and radioactive materials;
- Anesthesia and oxygen services,
- Durable Medical Equipment and supplies;
- Medical social services
- Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Hospital for use during Your stay;
- Blood transfusions, including blood processing, the cost of blood and unreplaced blood and Blood Products are covered. Self-donated (autologous) blood transfusions are covered only for a scheduled surgery that has been certified. ; and
- Coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

Payment of benefits for hospitalizations will be reduced as set forth herein if Certification is not obtained for the hospitalization.

Bariatric (Weight Loss) Surgery

Bariatric surgery (modifying the gastrointestinal tract to reduce nutrient absorption) provided for the treatment of morbid obesity is covered when Medically Necessary and the Covered Person has completed a pre-surgical education program. The surgery must be authorized by HNL and performed at a Bariatric Surgery Performance Center by an HNL Bariatric Surgery Performance Center network surgeon who is affiliated with the HNL Bariatric Surgery Performance Center. Preferred Providers that are not designated as part of HNL's network of Bariatric Surgery Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for weight loss surgery.

Bariatric Surgery Performance Centers are HNL's designated network of bariatric surgical centers and surgeons to perform weight loss surgery. Your Physician can provide You with information about this network. You will be directed to an HNL Bariatric Surgery Performance Center at the time authorization is obtained. All clinical work-up, diagnostic testing and preparatory procedures must be acquired through a HNL Bariatric Surgery Performance Center by an HNL Bariatric Surgery Performance Center network surgeon. Coverage for the surgery includes Hospital inpatient care (room and board, imaging, laboratory, special procedures, and Physician services).

If You live 50 miles or more from the nearest HNL designated bariatric surgical center, You are eligible to receive travel expense reimbursement including clinical work-up, diagnostic testing and preparatory procedures, when necessary for the safety of the Covered Person and for the prior approved bariatric weight loss surgery.. All requests for travel expense reimbursement must be prior approved by HNL.

Covered travel-related expenses will be reimbursed as follows:

- Transportation for the Covered Person to and from the Bariatric Surgery Performance Center up to $130 per trip for a maximum of four (4) trips (pre-surgical work-up visit, one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion (whether or not an enrolled Covered Person) to and from the Bariatric Surgery Performance Center up to $130 per trip for a maximum of three (3) trips (pre-surgical work-up visit, the initial surgery and one follow-up visit).
- Hotel accommodations for the Covered Person not to exceed $100 per day for the pre-surgical work-up visit, pre-surgical visit and the follow-up visit, up to two (2) days per trip or as Medically Necessary. Limited to one room, double occupancy.
- Hotel accommodations for one companion (whether or not an enrolled Covered Person) not to exceed $100 per day, up to four (4) days for the Covered Person's pre-surgical work-up visit and initial surgery stay and up to two (2) days for the initial follow-up visit. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed $25 per day, up to two (2) days per trip for the pre-surgical work-up visit, pre-surgical visit and follow-up visit and up to four (4) days for the surgery visit.

The following items are specifically excluded and will not be reimbursed:

- Expenses for tobacco, alcohol, telephone, television, and recreation are specifically excluded.

Submission of adequate documentation including receipts is required to receive travel expense reimbursement from HNL.

If You disagree with a determination by HNL, you can appeal the determination. The complaint and appeals process, including independent medical review from the California Department of Insurance, is described in the "Grievance and Appeals Process" and "Independent Medical Review of Grievances Involving a Disputed Health Care Service " provisions in the "General Provisions" section of this *Certificate*. You may also call HNL at the telephone number on Your ID card.

Bariatric surgery is not covered if provided by an Out-of-Network Provider.

Approved travel-related expenses will be reimbursed as follows:

- Transportation for the Covered Person to and from the designated bariatric surgical center up to $130 per trip for a maximum of four (4) trips (pre-surgical work-up visit, one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion (whether or not an enrolled Covered Person) to and from the designated bariatric surgical center up to $130 per trip for a maximum of three (3) trips (pre-surgical work-up visit, the initial surgery and one follow-up visit).
- Hotel accommodations for the Covered Person not to exceed $100 per day for the pre-surgical work-up visit, pre-surgical visit and the follow-up visit, up to two (2) days per trip or as Medically Necessary. Limited to one room, double occupancy.
- Hotel accommodations for one companion (whether or not an enrolled Covered Person) not to exceed $100 per day, up to four (4) days for the Covered Person's pre-surgical work-up and initial surgery stay and up to two (2) days for the follow-up visit. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed $25 per day, up to two (2) days per trip for the pre-surgical work-up visit, pre-surgical visit and follow-up visit and up to four (4) days for the surgery visit.

The following items are specifically excluded and will not be reimbursed:

- Expenses for tobacco, alcohol, telephone, television, and recreation are specifically excluded.

Submission of adequate documentation including receipts is required to receive travel expense reimbursement from HNL.

If You disagree with a determination by HNL, you can appeal the determination. The complaint and appeals process, including independent medical review from the California Department of Insurance, is described in the

"Grievance and Appeals Process" and "Independent Medical Review of Grievances Involving a Disputed Health Care Service " provisions in the “General Provisions” section of this *Certificate*. You may also call HNL at the telephone number on Your ID card.

Bariatric surgery is not covered if provided by an Out-of-Network Provider.

Radiation Therapy, Chemotherapy and Renal Dialysis Treatment

Radiation therapy and nuclear medicine, chemotherapy and renal dialysis treatment are covered when Medically Necessary. We also cover inpatient dialysis; routine outpatient visits with multidisciplinary nephrology team for a consultation, exam, or treatment; hemodialysis; and home hemodialysis and peritoneal dialysis and necessary equipment and medical supplies provided the Covered Person receives appropriate training at a dialysis facility.

Organ, Tissue and Stem Cell Transplants

Organ, tissue and stem cell transplants that are not Experimental or Investigational are covered, only if the transplant is authorized and certified by HNL. The transplant must be Medically Necessary and the Covered Person must qualify for the transplant. Please refer to the "Certification Requirement" portion of this section for information on how to obtain Certification.

HNL has a specific network of designated Transplant Performance Centers to perform organ, tissue and stem cell transplants. Your Physician can provide You with information about this network. You will be directed to a Transplant Performance Center at the time Certification is obtained. Preferred Providers that are not designated as part of HNL’s network of Transplant Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for transplants and transplant-related services.

Medically Necessary services, in connection with organ, tissue or stem cell transplants, are covered as follows:

- For the enrolled Covered Person who receives the transplant; and
- For the donor (whether or not an enrolled Covered Person). Benefits are reduced by any amounts paid or payable by the donor's own coverage. Only Medically Necessary services related to the organ donation are covered, including, but not limited to harvesting the organ, tissue or bone marrow and treatment of complications.

Evaluation of potential candidates is subject to the Certification Requirement. More than one evaluation (including tests) at more than one transplant center will not be authorized unless it is Medically Necessary. Organ, tissue and stem cell transplants will be covered regardless of the Covered Person's human immunodeficiency virus (HIV) status.

Organ donation extends and enhances lives and is an option that You may want to consider. For more information on organ donations, including how to elect to be an organ donor, please contact the Customer Contact Center at the telephone number on Your HNL ID Card, or visit the Department of Health and Human Services organ donation website at www.organdonor.gov.

If You receive services which are not certified by HNL for an organ, tissue or stem cell transplant, You will incur the noncertification penalties described in the "Schedule of Benefits" section.

Travel expenses and hotel accommodations associated with organ, tissue and stem cell transplants are not covered.

If You disagree with a determination by HNL, you can appeal the determination. The complaint and appeals process, including independent medical review from the California Department of Insurance, is described in the "Grievance and Appeals Process" and "Independent Medical Review of Grievances Involving a Disputed Health Care Service " provisions in the “General Provisions” section of this *Certificate*. You may also call HNL at the telephone number on Your ID card.

MENTAL HEALTH, BEHAVIORAL HEALTH OR SUBSTANCE ABUSE NEEDS

The coverage described below is intended to comply with requirements under the Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Certain limitations or exclusions may apply. Please read the "General Exclusions and Limitations" section of this Certificate.

Payment of benefits for Mental Disorders and Chemical Dependency services will be reduced as set forth herein if Certification is required but not obtained for the services.

The following benefits are provided:

The diagnosis of and all Medically Necessary treatment of Severe Mental Illnesses of a person of any age, and of Serious Emotional Disturbances of a Child are covered by this *Certificate*.

Serious Emotional Disturbances of a Child - The treatment and diagnosis of Serious Emotional Disturbances of a Child under the age of 18 is covered as shown in the "Schedule of Benefits" section.

Severe Mental Illness - Treatment of Severe Mental Illness is covered as shown in the "Schedule of Benefits" section.

Covered services include treatment of:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition of the *Diagnostic and Statistical Manual for Mental Disorders*)
- Autism
- Anorexia nervosa
- Bulimia nervosa

Mental Disorders - Treatment of Mental Disorders is covered as shown in the "Schedule of Benefits" section under "Mental Health, Behavioral Health or Substance Abuse Needs."

Outpatient Services - Outpatient services are covered as shown in the "Schedule of Benefits" section under "Mental Health, Behavioral Health or Substance Abuse Needs."

Covered services include:

- Outpatient office visits for Mental Disorders and Chemical Dependency: Includes outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy, individual and group mental health evaluation and treatment, medication management and drug therapy monitoring.
- Outpatient services other than office visits, including Mental Disorders and Chemical Dependency: Includes psychological and neuropsychological testing when necessary to evaluate a Mental Disorder, intensive outpatient care program, day treatment programs, partial hospitalization programs, medical treatment for withdrawal symptoms, Medically Necessary methadone treatment including during pregnancy and after delivery and other outpatient procedures.
- Intensive outpatient care program is a treatment program that is utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week.

- Partial hospitalization/day treatment program is a treatment program that may be free-standing or Hospital-based and provides services at least four (4) hours per day and at least four (4) days per week.
- Intensive psychiatric treatment programs, including short-term Hospital-based intensive outpatient care (partial hospitalization), short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program, short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis, and psychiatric observation for an acute psychiatric crisis.
- Behavioral Health Treatment (BHT) for Pervasive Developmental Disorder or Autism: Professional services for behavioral health treatment, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Covered Person diagnosed with the Severe Mental Illnesses of pervasive developmental disorder or autism, are covered as shown in the "Schedule of Benefits" section under "Mental Health, Behavioral Health or Substance Abuse Needs."
    - The treatment must be prescribed by a licensed Physician, or developed by a licensed psychologist, and must be provided under a documented treatment plan prescribed, developed and approved by a Qualified Autism Service Provider providing treatment to the Covered Person for whom the treatment plan was developed. The treatment must be administered by the Qualified Autism Service Provider or by qualified autism service professionals and paraprofessionals who are supervised and employed by the treating Qualified Autism Service Provider.
    - A licensed Physician or licensed psychologist must establish the diagnosis of pervasive development disorder or autism. In addition, the Qualified Autism Service Provider must submit the initial treatment plan to HNL.
    - Prior Certification is not required for these outpatient services, however, prior notification is required. Notification must include documentation that a licensed Physician or licensed psychologist has established the diagnosis of pervasive developmental disorder or autism. In addition, the Qualified Autism Service Provider must submit the initial treatment plan to HNL.
    - The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated, and must be reviewed by the Qualified Autism Service Provider at least once every six months and modified whenever appropriate. The treatment plan must not be used for purposes of providing or for the reimbursement of respite, day care or educational services, or to reimburse a parent for participating in a treatment program.
    - The Qualified Autism Service Provider must submit updated treatment plans to HNL for continued behavioral health treatment beyond the initial six months and at ongoing intervals of no more than six-months thereafter. The updated treatment plan must include an evaluation of the patient's progress toward the goals set forth in the initial treatment plan.
    - HNL may deny coverage for continued treatment if the ongoing Medical Necessity is not demonstrated. HNL will not deny coverage for Medically Necessary BHT for lack of cognitive, developmental, or IQ testing; or because services are available from a California Regional Center.

Inpatient Services - Inpatient services are covered as shown in the "Schedule of Benefits" section under "Mental Health, Behavioral Health or Substance Abuse Needs."

Covered Services and Supplies include:

- Accommodations in a room of two or more beds, including special treatment units, such as intensive care units and psychiatric care units, unless a private room is Medically Necessary.
- Supplies and ancillary services normally provided by the facility, including professional services, laboratory services, drugs and medications dispensed for use during the confinement, psychological testing and individual, family or group therapy or counseling.
- Medically Necessary services in a Residential Treatment Center are covered except as stated in the "General Exclusions and Limitations" section.

Detoxification - Inpatient services for acute detoxification and treatment of acute medical conditions relating to Chemical Dependency are covered. Inpatient detoxification includes hospitalization only for medical management of withdrawal symptoms, including room and board, Physician services, drugs, dependency recovery services, education and counseling.

PREGNANCY

Care for Conditions of Pregnancy

Hospital and professional services will be covered, including prenatal and postnatal care, and delivery. Covered Expenses include prenatal diagnostic procedures in the case of high-risk pregnancies.

Birthing Center services are covered when authorized by HNL and provided by a Preferred Provider. A Birthing Center is a homelike facility accredited by the Commission for Accreditation of Birth Centers (CABC) that is equipped, staffed and operated to provide maternity-related care, including prenatal, labor, delivery and postpartum care. Services provided by other than a CABC-accredited designated center will not be covered.

Preventive services for pregnancy, as listed in the U.S. Preventive Services Task Force A&B recommendations and Health Resources and Services Administration's ("HRSA") Women's Preventive Service are covered as Preventive Care Services.

Terminations of pregnancy (surgical or drug) are covered whether they are Medically Necessary or elective.

Your Physician will not be required to obtain Certification for a Hospital stay that is equal to or less than 48 hours following vaginal delivery or 96 hours following cesarean section. Longer stays in the Hospital and scheduled cesarean section must be certified. If Certification is not obtained, payment of benefits will be reduced as set forth herein.

If You are discharged earlier than 48 hours after a vaginal delivery or 96 hours after a cesarean section, Your Physician may arrange a home visit during the first 48 hours following discharge by a licensed health care provider whose scope of practice includes postpartum care and newborn care. This home visit does not require Certification.

See "Chemical Dependency" under the "Mental Health, Behavioral Health or Substance Abuse Needs" portion of the "Schedule of Benefits" for information regarding coverage of methadone maintenance during pregnancy.

HNL care managers are available to coordinate care for high-risk pregnancy. You can contact a care manager by calling the treatment review telephone number listed on Your Health Net PPO Identification Card.

Please notify HNL at the time of the first prenatal visit.

The coverage described above meets requirements for Hospital length of stay under the ***Newborns' and Mothers' Health Protection Act of 1996***, which requires that:

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HELP RECOVERING OR OTHER SPECIAL HEALTH NEEDS

Home Health Care Services

The services of a Home Health Care Agency in the Covered Person's home are covered when provided by a registered nurse or licensed vocational nurse and /or licensed physical, occupational, speech therapist or respiratory therapist. These services are in the form of visits that may include, but are not limited to, skilled nursing services, medical social services, rehabilitation therapy (including physical, speech and occupational), pulmonary rehabilitation therapy and cardiac rehabilitation therapy.

Home Health Care Services include diagnostic and treatment services which can reasonably be provided in the home, including nursing care, performed by a registered nurse, public health nurse, licensed vocational nurse or licensed home health aide. House calls by a Physician or registered nurse are covered when care can best be provided in the home as determined by the Physician.

Home Health Care Services must be ordered by your Physician and approved by HNL. The following conditions must be met in order to receive Home Health Care Services:

- The skilled nursing care is appropriate for the medical treatment of a condition, illness, disease or injury;
- The Covered Person is homebound (this means that the Covered Person is normally unable to leave home unassisted, and, when the Covered Person does leave home, it must be to obtain medical care, or for short, infrequent non-medical reasons such as a trip to get a haircut, or to attend religious services or adult day care);

Home Health Care visits are limited to 3 visits per day, up to 2 hours per visit by a nurse, medical social worker, physical/occupational/speech therapist, or up to 3 hours per visit by a home health aide. Home Health Care Services do not include Private Duty Nursing or shift care in excess of these visit maximums . Private Duty Nursing (or shift care, including any portion of shift care services) is not a covered benefit in excess of these maximum even if it is available through a Home Health Care Agency or is Medically Necessary. See the “Definitions” section. In addition, care that an unlicensed family member or layperson could provide safely and effectively or care in the home if the home is not a safe and effective treatment setting is excluded.

The maximum number of covered visits per Calendar Year is set forth in the "Schedule of Benefits" section.

In addition, Medically Necessary coverage will be provided for therapies in the home, when determined medically appropriate as an alternative to inpatient care, upon prior written approval by HNL. All home health services and supplies directly related to infusion therapy are payable as stated in the "Outpatient Infusion Therapy" provision above, and are not payable under this Home Health Care Services benefit.

Payment of benefits will be reduced as set forth herein if Certification is not obtained for home-based physical, speech or occupational therapy.

Rehabilitative Services

Rehabilitative services (including physical, occupational and speech therapy) when Medically Necessary, in accordance with the "Schedule of Benefits" section, except as stated in the "General Limitations and Exclusions" section. Certification is required for physical therapy, occupation therapy, and speech therapy.

Habilitative Services

Habilitative services and devices are health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Coverage is provided for habilitative services and/or therapy and devices, including physical therapy, acupressure, occupational therapy, speech therapy, cardiac therapy, pulmonary therapy, inhalation therapy, Durable Medical Equipment and Prostheses. Certification is required for physical therapy, occupation therapy, speech therapy, Durable Medical Equipment and Prostheses, as described in the “Certification Requirement” portion of this “Plan Benefits” section.

If You disagree with a determination by HNL, you can appeal the determination. The complaint and appeals process, including independent medical review from the California Department of Insurance, is described in the "Grievance and Appeals Process" and "Independent Medical Review of Grievances Involving a Disputed Health Care Service " provisions in the “General Provisions” section of this *Certificate*. You may also call HNL at the telephone number on Your ID card

Cardiac Rehabilitation Therapy

Cardiac rehabilitation therapy, when Medically Necessary, in accordance with the "Schedule of Benefits" section, except as stated in the "General Limitations and Exclusions" section.

Pulmonary Rehabilitation Therapy

Pulmonary rehabilitation therapy, when Medically Necessary, in accordance with the "Schedule of Benefits" section, except as stated in the "General Limitations and Exclusions" section.

Skilled Nursing Facility

You must be referred to the Skilled Nursing Facility by a Physician and must remain under the active supervision of a Physician. Your condition must be such that skilled care is Medically Necessary.

Covered Expenses include:

- Physician and nursing services.
- Accommodations in a room of two or more beds. Payment will be made based on the Skilled Nursing Facility's prevailing charge for two-bed room accommodations. If Medically Necessary, private rooms will be covered;
- Special treatment rooms;
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services;
- Physical, occupational, respiratory and speech therapy;
- Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Skilled Nursing Facility for use during Your stay;
- Durable Medical Equipment if the Skilled Nursing Facility ordinarily furnishes the equipment;
- Medical social services; and
- Blood transfusions, including blood processing, the cost of blood and unreplaced blood and Blood Products are covered. Self-donated (autologous) blood transfusion are covered only for a scheduled surgery that has been certified.

Payment of benefits will be reduced as set forth herein if Certification is not obtained for the confinement.

Durable Medical Equipment

Rental or purchase of Durable Medical Equipment which is ordered or prescribed by a Physician and is manufactured primarily for medical use. Durable Medical Equipment which is used for infusion therapy will be payable only as stated in the "Outpatient Infusion Therapy" provision.

Durable Medical Equipment includes, but is not limited to, wheelchairs, crutches, bracing, supports, casts and Hospital beds. Durable Medical Equipment also includes Orthotics (such as bracing, supports and casts) that are custom made for the Covered Person. In addition, the following items are covered:

- Tracheostomy equipment: artificial larynx; replacement battery for artificial larynx; tracheo-esophageal voice prosthesis; tracheostomy supplies, including: adhesive disc, filter, inner cannula, tube, tube plug/stop, tube collar/holder, cleaning brush, mask, speaking valve, gauze, sterile water, waterproof tape, and tracheostomy care kits.
- Canes and crutches: adjustable and fixed canes, including standard curved handle and quad canes; adjustable and fixed crutches, including underarm and forearm crutches; replacement supplies for canes and crutches, including handgrips, tips and underarm pads
- Dry pressure pad for a mattress
- Cervical traction equipment (over door)
- Osteogenesis stimulation devices: non-invasive electrical osteogenesis stimulators, for spinal and non-spinal applications; non-invasive low density ultrasound osteogenesis stimulator.
- Respiratory drug delivery devices: large and small volume nebulizers; disposable and non-disposable administration sets; aerosol compressors; aerosol mask; disposable and non-disposable corrugated tubing for nebulizers; disposable and non-disposable filters for aerosol compressors; peak expiratory flow rate meter; distilled water for nebulizer; water collection device for nebulizer.
- IV Pole
- Enteral and parenteral nutrition: enteral formula and additives, adult and pediatric, including for inherited diseases of metabolism; enteral feeding supply kits; enteral nutrition infusion pump; enteral tubing;

gastrostomy/jejunostomy tube and tubing adaptor; nasogastric tubing; parenteral nutrition infusion pump; parenteral nutrition solutions; stomach tube; supplies for self-administered injections.

- Phototherapy (bilirubin) light with photometer
- Lymphedema garments
- Non-segmental home model pneumatic compressor for the lower extremities

Except for podiatric devices to prevent or treat diabetes-related complications as discussed below, Corrective Footwear (including specialized shoes, arch supports and inserts) is only covered when all of the following circumstances are met:

- The Corrective Footwear is Medically Necessary;
- The Corrective Footwear is custom made for the Covered Person
- The Corrective Footwear is permanently attached to a Medically Necessary Orthotic device that is also a covered benefit under this plan.

Corrective Footwear for the management and treatment of diabetes-related medical conditions is covered under the “Diabetic Equipment” benefit as Medically Necessary.

Covered Durable Medical Equipment will be repaired or replaced when necessary. However, repair or replacement for loss or misuse is not covered. HNL will decide whether to replace or repair an item. HNL will also determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it.

HNL applies nationally recognized Durable Medical Equipment coverage guidelines as defined by the Medicare Durable Medical Equipment Regional Administrative Contracts (DME MAC), Healthcare Common Procedure Coding System (HCPCS) Level II and Medicare National Coverage Determinations (NCD) in assessing Medical Necessity for coverage.

Some Durable Medical Equipment may have specific quantity limits or may not be covered as they are considered primarily for non-medical use. Orthotics are not subject to such quantity limits.

Certification is required. Please refer to the "Certification Requirement" portion of this section for details. Payment of benefits will be reduced as set forth herein if Certification is required but not obtained.

We also cover up to two Medically Necessary Contact Lenses per eye (including fitting and dispensing) in any 12-month period to treat conditions of aniridia (missing iris). An aniridia Contact Lens will not be covered if we covered more than one aniridia contact lens for that eye within the previous 12 months.

Coverage for Durable Medicare Equipment is subject to the limitations described in the "Noncovered Items" portion of the "General Limitations and Exclusions" section. Please refer to the "Schedule of Benefits” section for applicable Copayment or Coinsurance.

Breastfeeding devices and supplies, including Hospital-grade breast pumps and double breast pump kit, as supported by HRSA guidelines, are covered as Preventive Care Services. For additional information, please refer to the "Preventive Care Services" provision in this “Plan Benefits” section.

Diabetic Equipment

Equipment and supplies for the management and treatment of diabetes are covered, as Medically Necessary, including:

- Insulin pumps and all related necessary supplies
- Corrective Footwear to prevent or treat diabetes-related complications
- Specific brands of blood glucose monitors and blood glucose testing strips*
- Blood glucose monitors designed to assist the visually impaired
- Ketone urine testing strips*
- Lancets and lancet puncture devices*
- Specific brands of pen delivery systems for the administration of insulin, including pen needles*
- Specific brands of disposable insulin needles and syringes*
- Glucagon*

* These items (as well as insulin and Prescription Drugs for the treatment and management of diabetes) are covered under the Prescription Drug benefits. Please refer to the "Outpatient Prescription Drug Benefits" portion of this section for additional information.

Additionally, the following supplies are covered under the medical benefit as specified:

- Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin are provided through the prostheses benefit (see the "Prostheses" provision of this section).
- Self-management training, education and medical nutrition therapy will be covered, only when provided by licensed or registered health care professionals with expertise in the management or treatment of diabetes. Please refer to the "Patient Education" provision of this section for more information.

Prostheses

Prostheses are covered as follows:

- Internally implanted devices, such as pacemakers, devices to restore speaking after a laryngectomy and hip joints, which are medically indicated and consistent with accepted medical practice and approved for general use by the Federal Food and Drug Administration;
- External prostheses and the fitting and adjustment of these devices; and
- Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin.

For the purpose of this section, external prostheses are those which are:

- Required to replace all or any part of any body organ or extremity; or
- Affixed to the body externally.

In the event that more than one type of prosthesis is available, benefits will be provided only for the device or appliance which is medically and reasonably indicated in accordance with accepted medical practice.

In addition, the following prostheses are covered:

- If all or part of a breast is surgically removed for Medically Necessary reasons, reconstructive surgery and a prosthesis incident to the mastectomy (including lumpectomy), including custom-made prostheses when Medically Necessary; adhesive skin supports for external prostheses; and brassieres to hold a breast prosthesis;
- Intraocular lenses, cochlear implants and osseointegrated hearing devices;
- Prostheses to replace all or part of an external facial body part that has been removed or impaired by disease, injury or congenital defect;
- Medically Necessary compression burn garments and lymphedema wraps; light compression bandage; manual compression bandage; moderate compression bandage;
- Prostheses for restoring a method of speaking following a laryngectomy; and
- Ostomy and urological supplies, including the following:
    - Adhesives -liquid, brush, tube, disc or pad
    - Adhesive removers
    - Belts - ostomy
    - Belts – hernia
    - Catheters
    - Catheter Insertion Trays
    - Cleaners
    - Drainage Bags/Bottles -bedside and leg
    - Dressing Supplies
    - Irrigation Supplies
    - Lubricants

- Miscellaneous Supplies -urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; soma caps tape; colostomy plugs; ostomy inserts; irrigation syringes, bulbs and pistons; tubing; catheter clamps, leg straps and anchoring devices; penile or urethral clamps and compression devices
- Pouches -urinary. drainable, ostomy
- Rings - ostomy rings
- Skin barriers
- Tape -all sizes, waterproof and non-waterproof

Repair or replacement of prostheses is covered unless necessitated by misuse or loss. HNL may, at its option, pay for replacement rather than the repair of an item. Expenses for replacement are covered only when a prosthesis is no longer functional.

Certification is required. Please refer to the "Certification Requirement" portion of this section for details. Payment of benefits will be reduced as set forth herein if Certification is required but not obtained.

Hospice Care

Hospice Care is care that is reasonable and necessary to control or manage terminal illness or related conditions. Hospice Care benefits are designed to be provided primarily in Your home. To be considered terminally ill, a Covered Person must have been given a medical prognosis of one year or less to live. The Hospice entity must be licensed in accordance with California Hospice Licensure Act of 1990 or a licensed home health agency with federal I certification and must provide interdisciplinary team care with development and maintenance of an appropriate plan of care.

If You receive Hospice Care benefits You are entitled to the following:

- All Medically Necessary services and supplies furnished by the Hospice. This includes doctors' and nurses' services; homemaker services and drugs; and incontinence supplies;
- Bereavement services;
- Social and counseling services with medical social services provided by a qualified social worker. Dietary counseling, when necessary, provided by a qualified provider;
- Medical direction with the medical director also responsible for meeting general medical needs to the extent that these needs are not met by the attending Physician;
- Volunteer services;
- Short-term inpatient care;
- Physical, occupational and speech therapy for the purposes of symptom control or enable the Covered Person to maintain activities of daily living and basic functional skills;
- During periods of crisis (a period in which the Covered Person requires continuous care to achieve palliation or management of acute medical symptoms), nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain the Covered Person at home. Hospitalization will be covered when inpatient skilled nursing care is required at a level that cannot be provided in the home; and
- Up to five consecutive days of respite care. Respite care is furnished to a person in an inpatient setting in order to provide relief for family members or others caring for that person.

All of these services and supplies will be provided or arranged by the Hospice.

Payment of benefits will be reduced as set forth herein if Certification is not obtained for the care.

Family Planning

Sterilization of females, patient education and counseling are covered as Preventive Care Services.

Contraceptives that are covered under the medical benefit include all FDA-approved contraceptive devices and other products for women for women, including all FDA-approved contraceptive devices and other products available over-the-counter (including, but not limited to, intrauterine devices (IUDs), injectable contraceptives and implantable contraceptives and prescribed over-the-counter contraceptives); and contraceptive counseling (including, but not limited to, follow-up and management of side effects of contraceptives, counseling for

continued adherence and contraceptive device placement and removal). Prescribed contraceptives for women are covered as described in the "Outpatient Prescription Drug Benefits" portion of this "Plan Benefits" section of this *Certificate*.

Services in relation to conception by artificial means are not covered. (See the "Conception by Medical Procedures" provision in the "General Limitations and Exclusions" section for more information.)

This Plan also covers Medically Necessary services and supplies for standard fertility preservation treatments, when a cancer treatment may directly or indirectly cause iatrogenic Infertility. Iatrogenic Infertility is Infertility that is caused by a medical intervention, including reactions from prescribed drugs or from medical or surgical procedures that may be provided for cancer treatment. This benefit is subject to the applicable Copayments shown in the “Schedule of Benefits” section as would be required for covered services to treat any illness or condition under this Plan.

Implanted Lens(es) Which Replace the Organic Eye Lens

Implanted lens(es) which replace the organic eye lens are covered when Medically Necessary.

Reconstructive Surgery

Reconstructive surgery to restore and achieve symmetry including surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or create a normal appearance to the extent possible, unless the surgery offers only a minimal improvement in Your appearance. This includes reconstructive surgery to restore and achieve symmetry incident to mastectomy (including lumpectomy) and Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate. This does not include cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance or dental services or supplies or treatment for disorders of the jaw except as set out under the "Dental Services" and "Temporomandibular (Jaw) Joint Disorders" portions of the "General Limitations and Exclusions" section.

The coverage described above in relation to a Medically Necessary mastectomy complies with requirements under the ***Women’s Health and Cancer Rights Act of 1998.*** *In compliance with the Women’s Health Cancer Rights Act of 1998, this Plan provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. See also “Prostheses” in this “Plan Benefits” section for a description of coverage for prostheses.*

Phenylketonuria (PKU)

Coverage for testing and treatment of phenylketonuria (PKU) includes formulas and special food products that are part of a diet prescribed by a Physician and managed by a licensed health care professional in consultation with a Physician who specializes in the treatment of metabolic disease. The diet must be deemed Medically Necessary to prevent the development of serious physical or mental disabilities or to promote normal development or function. Coverage is provided only for those costs which exceed the cost of a normal diet.

"Formula" is an enteral product for use at home that is prescribed by a Physician.

"Special food product" is a food product that is prescribed by a Physician for treatment of PKU and used in place of normal food products, such as grocery store foods. It does not include a food that is naturally low in protein.

Other specialized formulas and nutritional supplements are not covered.

Pediatric Asthma

Services and supplies related to the diagnosis, treatment and appropriate management of pediatric asthma are covered. Covered services and supplies may include, but are not limited to, nebulizers (including face masks and tubing), inhaler spacers, peak flow meters and education for the management of pediatric asthma.

AIDS Vaccine

HNL will cover a vaccine for acquired immune deficiency syndrome (AIDS) that is approved for marketing by the federal Food and Drug Administration (FDA) and that is recommended by the United States Public Health Service.

Osteoporosis

Services related to the diagnosis, treatment and appropriate management of osteoporosis. Covered services may include, but are not limited to, all FDA-approved technologies, including bone mass measurement technologies as deemed medically appropriate.

Degenerative Illness

HNL shall provide coverage for Covered Persons diagnosed as having any significant destruction of brain tissue with resultant loss of brain function (progressive, degenerative, and dementing illnesses such as Alzheimer's disease).

Surgically Implanted Drugs

Surgically implanted drugs are covered under the medical benefit when Medically Necessary, and may be provided in an inpatient or outpatient setting.

Dental Injury

Emergency Care of a Physician, while You are covered under this *Certificate,* treating an Accidental Injury to the natural teeth. You must be covered under this *Certificate* at the time such services are rendered. Medically Necessary related Emergency Hospital services will also be covered. Damage to natural teeth due to chewing or biting is not Accidental Injury. Dental appliances are not a Covered Expense.

Dental Services

Except as specifically stated elsewhere in this *Certificate* dental services are limited to the services stated in "Dental Injury" above and in the following situations:

- General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the Covered Person requires that an ordinarily non-covered dental service which would normally be treated in a dentist's office and without general anesthesia must instead be treated in a Hospital or Outpatient Surgical Center. Such services, including general anesthesia and associated facility services, must be Medically Necessary and subject to the other limitations and exclusions of this *Certificate* and will be covered for Covered Persons under any of the following circumstances (a) Covered Person s who are under seven years of age, (b) developmentally disabled or (c) whose health is compromised and general anesthesia is Medically Necessary.
- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck.

Clinical Trials

Routine patient care costs for patients' items and services furnished in connection with participation in an approved clinical trial are covered when Medically Necessary, either recommended by the Covered Person's treating Physician or the Covered Person provides medical and scientific information establishing eligibility for the trial, and authorized by HNL. Clinical trial services performed by Out-of-Network Providers are covered only when the protocol for the trial is not available through Preferred Providers. Services rendered as part of a clinical trial are subject to the reimbursement guidelines as specified in the law.

The following definition applies to the terms mentioned in the above provision only.

"Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The treatment shall be provided in a clinical trial that involves either a drug that is exempt from federal regulation in relation to a new drug application, or is approved by one of the following:

- The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare & Medicaid Services, the United States Department of Defense, or the United States Department of Veterans Affairs
- A cooperative group or center of any of the entities described above; or
- The FDA as an Investigational new drug application;

"Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Routine patient care costs" are the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under this *Certificate,* if those health care services were not provided in connection with a clinical trials program.

Routine patient care costs include the following:

- Health care services typically provided absent a clinical trial.
- Health care services required solely for the provision of the Investigational drug, item, device or service.
- Health care services required for the clinically appropriate monitoring of the Investigational item or service.
- Health care services provided for the prevention of complications arising from the provision of the Investigational drug, item, device or service.
- Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device or service, including the diagnosis or treatment of the complications.

Routine patient care costs do not include:

- Drugs or devices that have not been approved by the FDA and that are associated with the clinical trial.
- Services other than health care services, such as travel, housing, companion expenses, and other nonclinical expenses, that the Covered Person may require as a result of the treatment being provided for purposes of the clinical trial.
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the Covered Person.
- Health care services which, except for the fact that they are not being provided in a clinical trial, are otherwise specifically excluded from coverage under this *Certificate*.
- Health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Please refer to the "Medical Services and Supplies" portion of the "General Limitations and Exclusions" section for more information.

If You disagree with a determination by HNL, you can appeal the determination. The complaint and appeals process, including independent medical review from the California Department of Insurance, is described in the "Grievance and Appeals Process" and "Independent Medical Review of Grievances Involving a Disputed Health Care Service " provisions in the "General Provisions" section of this *Certificate*. You may also call HNL at the telephone number on Your ID card.

OUTPATIENT PRESCRIPTION DRUG BENEFITS

The preceding sections of this *Certificate* provide coverage for Prescription Drugs obtained while an inpatient in a Hospital or Skilled Nursing Facility. This plan also includes coverage for Prescription Drugs outside a Hospital or Skilled Nursing Facility setting. This outpatient Prescription Drug benefit is subject to a specific set of terms and conditions documented in this *Certificate* which You must be informed about in order to obtain the highest level of

coverage under this benefit. The provisions which follow are in addition to, and do not replace, any other provision under this *Certificate* which may apply to Prescription Drugs. **Subject to the following provisions, all Medically Necessary Prescription Drugs are covered.**

Covered Drugs and Supplies

Outpatient Prescription Drug Benefits shall be provided if You, while covered under this *Certificate*, incur an expense for Prescription Drugs which were prescribed by any Physician who is either a Preferred Provider or Out-of-Network Provider. You are responsible for the applicable Pharmacy Deductible, Copayment or Coinsurance, as shown in the "Schedule of Benefits" section of this *Certificate*.

Coverage includes disposable devices that are Medically Necessary for the administration of a covered outpatient Prescription Drug.

Tier I Drugs (Generic Drugs excluding Specialty Drugs) and Tier II Drugs (Preferred Brand Name Drugs)

Tier I Drugs are most Generic Drugs and low-cost preferred Brand Name Drugs when listed in the Essential Rx Drug List. Tier II Drugs are non-preferred Generic Drugs and preferred Brand Name Drugs, insulin, and diabetic supplies when listed in the Essential Rx Drug List. Prescription Drugs listed in the Health Net Essential Rx Drug List are covered, when prescribed by a Physician, an authorized referral Specialist or an emergent or urgent care Physician. Some Tier I and Tier II Drugs require Prior Authorization from HNL to be covered. The fact that a drug is listed in the Essential Rx Drug List does not guarantee that Your Physician will prescribe it for You for a particular medical condition.

Tier III Drugs

Tier III Drugs are Prescription Drugs that non-preferred Brand Name Drugs, Brand Name Drugs with generic equivalent (when Medically Necessary), drugs listed as Tier III Drugs in the Essential Rx Drug List or drugs not listed in the Essential Rx Drug List.

Some Prescription Drugs that are not on the Essential Rx Drug List require Prior Authorization from HNL to be covered.

Please refer to the “Essential Rx Drug List” portion of this subsection for more details.

Specialty Drugs (Tier IV Drugs)

Specialty Drugs listed in the Health Net Essential Rx Drug List are covered when Prior Authorization is obtained from HNL and the drugs are dispensed through HNL’s Specialty Pharmacy Vendor. These drugs include self-administered injectable and other drugs that have significantly higher cost than traditional pharmacy benefit drugs. Please note that needles and syringes required to administer the self-injected medications are covered only when obtained through the Specialty Pharmacy Vendor.

Self-administered injectable medications are defined as drugs that are:

- Medically Necessary;
- Administered by the patient or family member; either subcutaneously or intramuscularly;
- Deemed safe for self-administration as determined by Health Net’s Pharmacy and Therapeutics Committee;
- Included in the Health Net Essential Rx Drug List; and
- Shown on the Essential Rx Drug List as requiring Prior Authorization.

Certain specified *specialty drugs or drugs with limited distribution* must be obtained through a contracted specialty pharmacy. These specified *specialty drugs* that must be obtained through the Specialty Pharmacy Program are limited up to a 30-day supply. The Specialty Pharmacy Program will deliver your medication to you by mail or common carrier. These drugs are subject to the applicable Copayments or Coinsurances listed under "Outpatient Prescription Drugs" in the "Schedule of Benefits."

If you are out of a specialty drug which must be obtained through the specialty pharmacy program, HNL will authorize an override of the specialty pharmacy program requirement for 72-hours, or until the next business day following a holiday or weekend, to allow you to get an emergency supply of medication if your doctor decides that it is appropriate and medically necessary. You may have to pay the applicable Copayment.

Generic Equivalents to Brand Name Drugs
When a Medically Necessary Brand Name Drug is dispensed has an equivalent generic drug, You must obtain Prior Authorization for the Brand Name Drug to be covered.

Off-Label Drugs
A Prescription Drug prescribed for a use that is not stated in the indications and usage information published by the manufacturer is covered only if the drug meets all of the following coverage criteria:

1. The drug is approved by the Food and Drug Administration; AND
2. The drug meets one of the following conditions:
   A. The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition; OR
   B. The drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is Medically Necessary to treat such condition and the drug is either on the Essential Rx Drug List or Prior Authorization by HNL has been obtained; AND
3. The drug is recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following:
   A. The American Hospital Formulary Service Drug Information; OR
   B. One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer therapeutic regimen:
      i. The Elsevier Gold Standard's Clinical Pharmacology.
      ii. The National Comprehensive Cancer Network Drug and Biologics Compendium.
      iii. The Thomson Micromedex DrugDex; OR
   C. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

The following definitions apply to the terms mentioned in this provision only.

"Life-threatening" means either or both of the following:

A. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted;
B. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

"Chronic and seriously debilitating" refers to diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

Any coverage required for Off-Label Drugs shall also include Medically Necessary services associated with the administration of a drug, subject to the conditions of the *Certificate*.

Diabetic Drugs and Supplies

Prescription Drugs for the treatment of diabetes (including insulin) are covered as stated in the Essential Rx Drug List. Diabetic supplies are also covered, including, but not limited to, specific brands of pen delivery systems, specific brands of disposable insulin needles and syringes, disposable insulin pen needles, specific brands of blood glucose monitors and test strips (specific brand only); Ketone test strips; lancet puncture devices and lancets when used in monitoring blood glucose levels. Additional supplies are covered under the medical benefit; please refer to the "Diabetic Equipment" provision above in this section; please refer to the "Schedule of Benefits" section for details about the supply amounts that are covered at the applicable Copayment.

Preventive Drugs and Women's Contraceptives

Preventive drugs, including smoking cessation drugs, and women's contraceptives are covered as shown in the "Schedule of Benefits" section of this *Certificate*. Covered preventive drugs are over-the-counter drugs or

Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations.

Covered contraceptives are all FDA-approved contraceptives for women that are either available over-the-counter or are only available with a Prescription Drug Order, including, but not limited to, diaphragms, sponges, female condoms, cervical caps and spermicide. Women's contraceptives that are covered under this Prescription Drug benefit include vaginal, oral, transdermal and emergency contraceptives. For a complete list of contraceptive products covered under the Prescription Drug benefit, please refer to the Essential Rx Drug List.

Over-the-counter preventive drugs and women's contraceptives that are covered under this Plan require a Prescription Drug Order. You must present the Prescription Drug Order at a Health Net Participating Pharmacy to obtain such drugs or contraceptives.

Intrauterine devices (IUDs), injectable and implantable contraceptives are covered as a medical benefit when administered by a Physician. Please refer to the "Preventive Care Services" and "Family Planning" provisions in this section for information regarding contraceptives covered under the medical benefit.

Smoking Cessation Coverage

Over-the-counter drugs and drugs on the Essential Rx Drug List that require a prescription in order to be dispensed by a retail pharmacy for the relief of nicotine withdrawal symptoms are covered.

Over-the-counter smoking cessation drugs that are covered under this Plan require a Prescription Drug Order. You must present the Prescription Drug Order at a Health Net Participating Pharmacy to obtain such drugs.

Smoking cessation programs are covered by HNL. For information regarding smoking cessation behavioral modification support programs available through HNL, contact the Customer Contact Center at the telephone number on Your HNL ID Card or visit Our website at www.healthnet.com (see "Wellsite").

Compounded Drugs

Compounded Drugs are prescription orders that have at least one ingredient that is Federal Legend or state restricted in a therapeutic amount as Medically Necessary and are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form and require a prescription order for dispensing. Compounded Drugs (that use FDA approved drugs for an FDA approved indication) are covered if at least one of the main ingredients is on the Essential Rx Drug List and there is no similar commercially available product. Refer to the "Off-Label Drugs" provision in this section for information about FDA approved drugs for off-label use. Coverage for Compounded Drugs requires the Tier III Drug Copayment and is subject to Prior Authorization by HNL and Medical Necessity.

The Essential Rx Drug List

What Is the Health Net Essential Rx Drug List?
HNL developed the Essential Rx Drug List to identify the safest and most effective medications for HNL Covered Persons while attempting to maintain affordable pharmacy benefits. We specifically suggest to all Preferred Providers that they refer to this Essential Rx Drug List when choosing drugs for patients who are HNL Covered Persons. When Your Physician prescribes medications listed in the Essential Rx Drug List, it is ensured that You are receiving a high quality and high value prescription medication. In addition, the Essential Rx Drug List identifies whether a Generic version of a Brand Name Drug exists, and whether the drug requires Prior Authorization. If the Generic version exists, it will be dispensed instead of the Brand Name version.

HNL also covers drugs that are not on the Essential Rx Drug List at the Tier III Drug Copayment level. If a drug is not on the Essential Rx Drug List, and is not specifically excluded from coverage, Prior Authorization is required as shown in "Prior Authorization Process" below.

You may call the Customer Contact Center at the telephone number on Your HNL ID Card to find out if a particular drug is listed in the Essential Rx Drug List. You may also request a copy of the current Essential Rx Drug List, and it will be mailed to You. The current Essential Rx Drug List is also available on the HNL website at www.healthnet.com under the pharmacy information

How are Drugs Chosen for the Health Net Essential Rx Drug List?
The Essential Rx Drug List is created and maintained by the Health Net Pharmacy and Therapeutics Committee. Before deciding whether to include a drug on the Essential Rx Drug List, the committee reviews medical and scientific publications, relevant utilization experience and Physician recommendations to assess the drug for its:

- Safety
- Effectiveness
- Cost-effectiveness (when there is a choice between two drugs having the same effect, the less costly drug will be listed)
- Side effect profile
- Therapeutic outcome

This Committee has quarterly meetings to review medications and to establish policies and procedures for drugs included in the Essential Rx Drug List. The Essential Rx Drug List is updated as new clinical information and medications are approved by the FDA.

Who is on the Health Net Pharmacy and Therapeutics Committee and How are Decisions Made?
The Committee is made up of actively practicing Physicians of various medical specialties from Health Net contracting Physician groups, as well as clinical pharmacists. Voting members are recruited from contracting Physician groups throughout California based on their experience, knowledge and expertise. In addition, the Pharmacy and Therapeutics Committee frequently consults with other medical experts to provide additional input to the Committee. A vote is taken before a drug is added to the Essential Rx Drug List. The voting members are not employees of HNL. This ensures that decisions are unbiased and without conflict of interest.

Prior Authorization Process

Prior Authorization status is included in the Essential Rx Drug List. The Essential Rx Drug List identifies which drugs require Prior Authorization. A Physician must get approval from HNL before writing a Prescription Drug Order for a drug that is listed as requiring Prior Authorization, in order for the drug to be covered by HNL. You may refer to our website at www.healthnet.com to review the drugs that require a Prior Authorization as noted in the Essential Rx Drug List.

Requests for Prior Authorization may be submitted electronically or by telephone or facsimile. Urgent requests from Physicians (including Pain medications for terminally ill Covered Persons) for authorization will be determined as soon as possible, not to exceed 24 hours, after HNL's receipt of the request. Routine requests from Physicians are processed in a timely fashion, not to exceed 2 business days or 72 hours following receipt of the request, whichever is less, as appropriate and Medically Necessary, for the nature of the Covered Person's condition after HNL's receipt of the request.

If a drug is not on the Essential Rx Drug List, and is not specifically excluded from coverage, your Physician can ask for an exception. To request an exception, your Physician can submit a Prior Authorization request along with a statement supporting the request. Requests for Prior Authorization may be submitted electronically or by telephone or facsimile. If we approve an exception for a drug that is not on the Essential Rx Drug List, the non-preferred Brand Name Drug tier (Tier III) or Specialty Copayment applies. If You are suffering from a condition that may seriously jeopardize Your life, health, or ability to regain maximum function, or if You are undergoing a current course of treatment using a drug that is not on the Essential Rx Drug List, then You, Your designee or Your Physician can request an expedited review. Expedited requests for prior authorization will be determined within 24 hours after HNL's receipt of the request.

If a drug is eliminated from the Essential Rx Drug List, HNL will continue to cover the drug for Covered Persons who were taking the drug when it was eliminated, provided that the drug is appropriately prescribed and is safe and effective for treating the Covered Person's medical condition.

You may use the Prior Authorization process to obtain coverage at no cost for a prescription contraceptive that is not on the Essential Rx Drug List or the brand name equivalent of a covered generic contraceptive that is unavailable. HNL will cover the contraceptive if the Your Physician determines that it is Medically Necessary and submits a Prior Authorization request. This request is not subject to denial by HNL.

HNL will evaluate the submitted information upon receiving Your Physician's request for Prior Authorization and make a determination based on established clinical criteria for the particular medication. The criteria used for Prior Authorization are developed and based on input from the Health Net Pharmacy and Therapeutics Committee as well as Physician experts. Your Physician may contact HNL to obtain the usage guidelines for specific medications.

Once a medication is approved, its authorization becomes effective immediately. The approval will be for the duration of the prescription, including refills.

If you do not receive Prior Authorization for a medication, You will need to pay the full cost of the Prescription Drug dispensed and submit a claim to HNL for reimbursement. You will be reimbursed at HNL's contracted rate less the Copayment or Coinsurance shown in the "Schedule of Benefits" section. You will be subject to a penalty of 50% of the Average Wholesale Price if prior authorization was not obtained, except for Emergency or Urgently Needed care.

If you are denied Prior Authorization, you may request an independent review or go through the binding arbitration remedy set forth in the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" and "Arbitration" provisions of the "General Provisions" section of this *Certificate*.

Retail Pharmacies and the Mail Order Program

Tier I, Tier II and Tier III Drugs Dispensed by a Participating Pharmacy

Except for Emergency Care or in urgent situations, covered drugs must be dispensed by a Participating Pharmacy in order to be covered. HNL is contracted with many major pharmacy chains, supermarket based pharmacies and privately owned neighborhood pharmacies in California. To find a conveniently located Participating Pharmacy, please visit Our website at www.healthnet.com or call the Customer Contact Center at the telephone number on Your HNL ID Cardhttp:///. Present the HNL ID Card and pay the appropriate Copayment when the drug is dispensed.

If refills are stipulated on the Prescription Drug Order, a Participating Pharmacy may dispense up to a 30-consecutive-calendar-day supply for each Prescription Drug Order or for each refill at the appropriate time interval.

In some cases, a 30-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan according to the Food and Drug Administration (FDA) or HNL's usage recommendation. If this is the case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply.

Except as described below in "When the Health Net PPO Identification Card is not in Your Possession", if you elect to pay out-of-pocket and submit a prescription claim directly to HNL instead of having the Participating Pharmacy submit to HNL, you will be reimbursed based on the Prescription Drug Covered Expense, less any applicable Copayment, Coinsurance or Deductible.

(If the Health Net PPO identification card has not been received or if it has been lost, refer to the provision below, "When the Health Net PPO Identification Card is not in Your Possession.")

Preferred Providers and Participating Pharmacies prescribe and dispense Prescription Drugs listed in the Essential Rx Drug List.

Specialty Drugs Dispensed by the Specialty Pharmacy Vendor

Specialty Drugs must be obtained through the Specialty Pharmacy Vendor when indicated in the Essential Rx Drug List. Once the Prior Authorization request has been approved by HNL, HNL will forward the prescription order to the Specialty Pharmacy Vendor. The Specialty Pharmacy Vendor may contact You directly to coordinate the delivery of Your medications.

The Specialty Pharmacy Vendor may dispense up to a 30-consecutive-calendar-day supply for each Prescription Drug Order or for each refill at the appropriate time interval. In some cases, a 30-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan according to the Food and Drug Administration (FDA) or HNL's usage recommendation. If this is the case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply.

Tier I, Tier II and Tier III Drugs or Specialty Drugs Dispensed by a Nonparticipating Pharmacy

The maximum charge HNL will allow for a Prescription Drug Order is the Prescription Drug Covered Expense, as defined in the "Definitions" section. It is not necessarily the amount a Nonparticipating Pharmacy will charge. You are financially responsible for any amount charged by a Nonparticipating Pharmacy which exceeds the amount of Prescription Drug Covered Expense in addition to the appropriate Copayment or Coinsurance. If You present a Prescription Drug Order for a Brand Name Drug, pharmacists will offer a Generic Drug equivalent if commercially available. At the time of the Emergency or Urgent Care visit, You should advise the treating Physician of any drug allergies or reactions, including to any Generic Drugs.

When Prescription Drugs are dispensed by a Nonparticipating Pharmacy for an urgent or Emergency Care situation, You will be required to:

- Pay the full cost of the Prescription Drug that is dispensed; and
- Submit a claim to HNL for reimbursement of a Covered Expense.

You may then be entitled to reimbursement, minus the applicable Copayment, Coinsurance and/or Deductible, in accordance with the terms of this *Certificate*.

Claim forms will be provided by HNL upon request.

Facilities not authorized by HNL to be Participating Pharmacies are covered only for Emergency Care.

Tier I, Tier II and Tier III Drugs Dispensed Through the Mail Service Prescription Drug Program

If Your prescription is for a Maintenance Drug, You shall be entitled to have a Prescription Drug Order filled through a mail delivery program selected by HNL. Through this program You can receive through the mail up to a 90-consecutive-calendar-day supply of a Maintenance Drug when so prescribed. In some cases a 90-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan, according to FDA or HNL usage guidelines. The lesser of the applicable mail order Copayments or Coinsurance or the mail order pharmacy's retail price will be required for drugs listed in the Essential Rx Drug List.

To use this program, You must place an order through the mail by completing a Prescription Mail Order Form. It must be accompanied by the original Prescription Drug Order, not a copy. The Prescription Mail Order Form and an explanation of how to use the program will be provided by HNL upon request. Please call the Customer Contact Center at the phone number on Your HNL ID card.

Note: Schedule II narcotic, analgesics, sexual dysfunction and smoking cessation drugs and specialty drugs are not covered through the mail order program. Refer to the "Outpatient Prescription Drug Benefits" portion of the “General Limitations and Exclusions” section for more information.

When the Health Net PPO Identification Card Is Not In Your Possession

If You need to have a Prescription Drug Order filled by a Participating Pharmacy and have not received a Health Net PPO Identification Card, or it has been lost, or eligibility cannot be determined, You must pay for the drug(s). You may then be entitled to reimbursement, minus the applicable Copayment, Coinsurance and/or Deductible, in accordance with the terms of this *Certificate*. After the Health Net PPO Identification Card has been received, You must file a claim. Claim forms will be provided by HNL upon request.

If You need to have a Prescription Drug Order filled by a Nonparticipating Pharmacy and have not received a Health Net PPO Identification Card, or it has been lost, or eligibility cannot be determined You must pay for the drug(s). For urgent or Emergency Care, You may then be entitled to reimbursement, minus the applicable Copayment, Coinsurance and/or Deductible, in accordance with the terms of this *Certificate*. However, if it is not an urgent or Emergency Care situation, You will be responsible for the full cost of the Prescription Drug.

CHILD NEEDS EYE CARE

Pediatric Vision Services

The services and supplies described in this section are covered when provided by a Participating Vision Provider. The amount covered may vary based on the type of provider used and on the type of Eyewear obtained.

Pediatric vision services are covered until the last day of the month in which the individual turns nineteen years of age.

The following services and supplies are covered under this *Certificate*, subject to all provisions of this *Certificate:*

Examination: Routine optometric or ophthalmic vision examinations (including refractions) by a licensed Optometrist or Ophthalmologist, for the diagnosis and correction of vision, up to the maximum number of visits stated in the "Schedule of Benefits" section.

Frame: One Frame for Eyeglasses, up to the maximum number described in the "Schedule of Benefits" section.

Eyeglass Lenses: Eyeglass Lenses subject to the benefit maximums described in the "Schedule of Benefits" section.

Cosmetic Contact Lenses: When Contact Lenses are chosen for nonmedical or cosmetic reasons, the Lenses are payable only as a replacement of benefits for other Eyewear.

Medically Necessary Contact Lenses: Contact Lenses may be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, Contact Lenses may be Medically Necessary and appropriate when the use of Contact Lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

Contact Lenses may be Medically Necessary for the treatment of conditions, including, but not limited to: keratoconus, pathological myopia, aphakia, anisometropia, aniridia, corneal disorders, post-traumatic disorders and irregular astigmatism.

Medically Necessary Contact Lenses are dispensed in lieu of other eyewear. Participating providers will obtain the necessary pre-authorization for these services.

Subnormal or Low Vision Services and Aids: HNL covers one comprehensive low vision evaluation every 5 years; low vision aids, including high-power spectacles, magnifiers or telescopes (limited to one aid per year) and follow-up care (limited to 4 visits every 5 years).

Notice and Proof of Claim and Claim Forms
Claims for pediatric vision services should be submitted by the Participating Vision Provider, however, if the Covered Person needs to submit a claim, written notice of a claim must be given to HNL within 90 days after the occurrence or commencement of any covered loss, or as soon thereafter as reasonably possible. Notice may be given to HNL of a vision claim at P.O. Box 8504, Mason, OH 45040-7111.

Upon enrollment HNL will furnish the Covered Person with HNL's usual forms for filing proof of loss. If HNL does not furnish the Covered Person with the usual form, the Covered Person can comply with the requirements for furnishing proof of loss by submitting written proof within the 90 day period stipulated above. Such written proof must cover the occurrence, the character and the extent of the loss.

The Covered Person must submit proof of loss for Covered Services provided by a Provider.

Written notice of claim or proof of loss must be submitted no later than one year after the occurrence.

HNL's Vision Claim address is:
Health Net Vision/Claims
P.O. Box 8504
Mason, OH 45040-7111

Covered Persons are required to submit to HNL in writing an itemized statement of the charges incurred by the Member, along with a completed claim form, to request reimbursement. Claim forms can be obtained by calling HNL Customer Contact Center. HNL will furnish the Covered Person a claim form within 15 days of the Covered Person's request. If HNL does not furnish the claim form within 15 days, the Covered Person shall be deemed to have complied with the requirements of this *Certificate* as to proof of loss upon submitting, within the time fixed in this *Certificate* for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. Pharmacy claims do not require a completed claim form, but must have an original receipt for the prescription with the patient's name and must be in English and in U.S. currency.

Proof of payment must accompany the request for reimbursement. Covered Person requests for reimbursement must be forwarded to HNL within 90 days of the date Covered Services were received. If it is not reasonably possible for a Covered Person to submit proof of payment at the time the request for reimbursement is made, proof of payment must be submitted to HNL as soon thereafter as is reasonably possible. Failure to provide proof of loss within the required time does not invalidate the claim if it was filed as soon as reasonably possible.

Payment of Claims
Benefits will be paid directly to the Covered Person, unless otherwise directed by the Covered Person, for Covered Services.

HNL LIMITED FEE SCHEDULE FOR OUT-OF-NETWORK PROVIDERS

Benefits payable for Covered Services and Supplies obtained from Out-of-Network Providers are subject to all the provisions of this *Certificate*, including but not limited to, the Calendar Year Deductible, Coinsurance and the benefit maximums. No benefits are payable unless Your coverage is in force at the time the services are provided. The payment of benefits is subject to all the terms, conditions, limitations and exclusions of this *Certificate*.

WHEN YOU USE AN OUT-OF-NETWORK PROVIDER, BENEFITS ARE SUBSTANTIALLY REDUCED AND YOU WILL INCUR A SIGNIFICANTLY HIGHER OUT-OF-POCKET EXPENSE. To maximize the benefits received under this Health Net PPO insurance plan, You must use Preferred Providers.

For services or supplies provided by an Out-of-Network Provider, the amount payable is based on HNL's Limited Fee Schedule for Out-of-Network Providers, as described below.

HNL's Limited Fee Schedule is based on Relative Value Unit Schedule and Dollar Amount Conversion Factors.

Note: HNL's Limited Fee Schedule does not apply to Hospitals, Home Health Care Agencies or Skilled Nursing Facilities, Home Health Care Agencies, and Emergency Care received during foreign travel or work assignment. An illustration on how amounts payable are calculated for these services follows the Limited Fee Schedule. For all services received from an inpatient Hospital, Skilled Nursing Facility, Home Health Care Agency, for Outpatient surgery or for Emergency Care received during Foreign Travel or Work Assignment, Maximum Allowable Amount is determined by applying a percentage of what Medicare would allow (known as the Medicare allowable amount). The Maximum Allowable Amount for such services is 190% of the Medicare allowable amount.

HNL bases Covered Expenses for the services and supplies provided by an Out-of-Network Provider on Medicare's Resource Based Relative Value System (RBRVS). The Relative Value Units vary by the geographic area in which the service or supply is provided. Covered Expenses for Out-of-Network Providers will not exceed 75% of the product of the applicable Relative Value Unit of Medicare's RBRVS multiplied by the appropriate dollar amount conversion factor.

In addition, HNL applies certain payment policies and rules to determine appropriate reimbursement that may affect Your responsibility (including, but not limited to, policies and rules described under the "Professional Services" portion of the "Plan Benefits" section). Additional information about HNL's reimbursement policies is available on the HNL website at www.healthnet.com or by contacting HNL's Customer Contact Center at the telephone number listed on Your Health Net PPO Identification Card.

The dollar amount conversion factor of the RBRVS schedule is subject to automatic annual adjustment by the Center for Medicare and Medicaid Services (CMS), an agency of the federal government which regulates

Medicare. The following schedule shows representative procedures with Relative Value Units ranging from the lowest to the highest for geographic areas in California, followed by some sample calculations of Covered Expenses for services of Out-of-Network Providers under the plan.

You may call HNL's Customer Contact Center to request the amount of Covered Expenses payable under this Limited Fee Schedule. Please call the telephone number listed on the Health Net PPO Identification Card.

		Relative Value Unit Range (Lowest to Highest in California)
Surgical		
Breast		
19120	Removal of breast lesion	10.85 – 13.19
19200	Removal of breast	25.27 - 29.64
Fractures		
25565	Reduction of arm fracture	19.44 – 23.20
27232	Reduction of thigh fracture	19.44 – 23.20
Heart		
33400	Repair of aortic valve	47.95 – 56.42
33420	Revision aortic valve	34.13 – 39.66
Digestive		
44950	Appendectomy	15.51 – 17.94
47600	Gallbladder removal	21.34 – 24.77
Maternity		
59400	Normal delivery	43.15 – 51.03
59510	Cesarean delivery	48.90 – 57.79
Thyroid		
60200	Thyroid lesion removal	16.58 – 19.78
60240	Thyroid removal	25.41 – 29.65
Medicine		
99201	New patient office/outpatient visit	0.99 – 1.23
99212	Est. patient office/outpatient visit	1.08 – 1.37
99217	Observation care discharge services	1.89 – 2.20
99241	Office/outpatient consultation	1.35 – 1.67
97110	Therapeutic procedure	0.75 – 0.90
Radiology		
71020	Chest x-ray	0.98 – 1.30
74241	Upper GI x-ray exam	2.57 – 3.39
Pathology		
81000	Routine urinalysis	0.12 – 0.12
85031	Complete manual hematology	0.22 –0.22
86580	Tuberculosis intradermal test	0.31 – 0.31
87081	Microbiology – culture, bacterial screening	0.24 – 0.24

Example:

Conversion Factor: $37.90 (Example of Medicare's RBRVS dollar conversion factor)

How to calculate Covered Expenses: Covered Expenses is 75% of the product of the relative value unit for the service or supply times the dollar amount conversion factor.

Example of a Covered Expense Calculation:

For a first time visit to a Physician's office, the Covered Expense is between $28.14 (75% of 0.99 x $37.90), and $34.96 (75% of 1.23 x $37.90), depending on the geographic location in which the service or supply is provided.

For Physician's services received during a normal delivery, the Covered Expense is between $1,226.54 (75% of 43.15 x $37.90) and $1,450.53 (75% of 51.03 x $37.90), depending on the geographic location in which the service or supply is provided.

NOTE: HNL has the right to adjust, without notice, the Limited Fee Schedule. Claims payment will be determined according to the schedule in effect at the time the charges are incurred. Claims payment will also never exceed the amount the Physician or other health care provider charges for the service or supply. **You should contact the Customer Contact Center if You wish to confirm the Covered Expenses for any treatment or procedure You are considering.**

GENERAL LIMITATIONS AND EXCLUSIONS

No payment will be made under this *Certificate* for expenses incurred for any of the items below, regardless as to whether You utilized the services of a Preferred Provider or an Out-of-Network Provider. Also, services or supplies that are excluded from coverage in the *Certificate*, exceed *Certificate* limitations, or are follow-up care (or related to follow-up care) to *Certificate* exclusions or limitations will not be covered.

MEDICAL SERVICES AND SUPPLIES

Not Medically Necessary

Services or supplies that are not Medically Necessary, as defined in the "Definitions" section. This includes any services, supplies or expenses received or incurred beyond the scope of Certification given, as described under the "Certification Requirement" portion of the "Plan Benefits" section of this *Certificate*. However, the *Certificate* does cover Preventive Care Services, voluntary family planning services and Medically Necessary services for medical conditions directly related to non-covered services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery).

Excess Charges

Amounts charged by Out-of-Network Providers for covered medical services and treatment that are in excess of the Schedule Amount, as defined in the "Definitions" section.

Clinical Trials

Although clinical trials are covered, as described in the "Medical Benefits" portion of the "Plan Benefits" section of this *Certificate*, coverage for clinical trials does not include the following items:

- Drugs or devices that are not approved by the FDA;
- Services other than health care services, including but not limited to cost of travel, or costs of other non-clinical expenses;
- Services provided to satisfy data collection and analysis needs which are not used for clinical management;
- Health care services that are specifically excluded from coverage under this *Certificate*; and
- Items and services provided free of charge by the research sponsors to Covered Persons in the trial.

Cosmetic Services and Supplies

Cosmetic surgery or services and supplies performed to alter or reshape normal structures of the body solely to improve the physical appearance of a Covered Person are not covered. However, the *Certificate* does cover Medically Necessary services and supplies for complications which exceed routine follow-up care that is directly related to cosmetic surgery (such as life-threatening complications). In addition, hair transplantation, hair analysis, hairpieces and wigs, cranial/hair prostheses, chemical face peels, abrasive procedures of the skin, liposuction or epilation are not covered.

However, when reconstructive surgery is performed to correct or repair abnormal structures of the body caused by, congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, and such surgery does either of the following:

- Improve function, or
- Create a normal appearance to the extent possible,

Then reconstructive surgery is covered:

In addition, when a Medically Necessary mastectomy (including lumpectomy) has been performed, the following are covered:

- Breast reconstructive surgery; and
- Surgery performed on either breast to achieve or restore symmetry (balanced proportions) in the breasts.

Breast reconstruction surgery and dental or orthodontic services for cleft palate procedures are subject to the Certification requirements described in the "Certification Requirement" portion of the "Plan Benefits" section of this

Certificate. However, Hospital stays related to mastectomies and lymph node dissections will be determined solely by the Physician and Certification for determining the length of stay will not be required.

The coverage described above in relation to a Medically Necessary mastectomy complies with requirements under the ***Women's Health and Cancer Rights Act of 1998****.*

Dental Services

Dental services are limited to the services stated in "Dental Injury" under the "Plan Benefits" section of this *Certificate* and in the following situations:

- General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the Covered Person requires that an ordinarily non-covered dental service which would normally be treated in a dentist's office and without general anesthesia must instead be treated in a Hospital or Outpatient Surgical Center. The general anesthesia and associated facility services, must be Medically Necessary, are subject to the other limitations and exclusions of this *Certificate* and will only be covered under the following circumstances (a) Covered Persons who are under 7 years of age, (b) Covered Persons who are developmentally disabled or (c) Covered Persons whose health is compromised and general anesthesia is Medically Necessary.
- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare Your jaw for radiation therapy of cancer in Your head or neck.

The following services are not covered under any circumstances for Covered Persons, except as described above for Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

- Care or treatment of teeth and supporting structures; extraction of teeth; treatment of dental abscess or granuloma; dental examinations and treatment of gingival tissues other than tumors are not covered, except as stated above.
- Spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, active splints or Orthotics (whether custom fit or not), dental implants (materials implanted into or on bone or soft tissue), or other dental appliances, and related surgeries to treat dental conditions, including conditions related to temporomandibular (jaw) joint (TMD/TMJ) disorders, are not covered. However, custom made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct TMD/TMJ disorders are covered if they are Medically Necessary, as described in the "Temporomandibular (Jaw) Joint Disorders" provision of this section.

Temporomandibular (Jaw) Joint Disorders

Temporomandibular Joint Disorder (also known as TMD or TMJ disorder) is a condition of the jaw joint which commonly caused headaches, tenderness of the jaw muscles, tinnitus or dull aching facial Pain. These symptoms often result when chewing muscles and jaw joints do not work together correctly. Custom-made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct a TMD/TMJ disorder are covered when Medically Necessary. However, spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints, dental implants and other dental appliances to treat dental conditions related to TMD/TMJ disorders are not covered for Covered Persons, as stated in the "Dental Services" provision of this section.

Surgery And Related Services For Disorders of the Jaw (often referred to as "Orthognathic Surgery" or "Maxillary and Mandibular Osteotomy")

Used for the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw or associated bone joints, except when such procedures are Medically Necessary. However, spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints (whether custom fit or not), dental implants and other dental appliances are not covered for Covered Persons under any circumstances.

Dietary or Nutritional Supplements
Dietary, nutritional supplements and specialized formulas are not covered except when prescribed for the treatment of Phenylketonuria (PKU) (see the "Phenylketonuria (PKU)" provision in the “Plan Benefits” section). However, amino acid-modified products, elemental dietary enteral formula and parenteral nutrition solutions are covered.

Refractive Eye Surgery
For Covered Persons age 19 and over, any eye surgery for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), and astigmatism, unless Medically Necessary, recommended by the Covered Person’s treating Physician and authorized by Us.

Gender/Sex Reassignment Surgery
Gender/sex reassignment surgery is not covered unless the health care services involved are otherwise available under this *Certificate*. This exclusion does not permit the denial of coverage if the health care services involved are otherwise available under this *Certificate*, including but not limited to hormone therapy, hysterectomy, mastectomy, and vocal training. Also, this exclusion does not permit the denial of coverage for health care services available to a covered person of one sex due only to the fact that the covered person is enrolled as belonging to the other sex or has undergone, or is in the process of undergoing, a gender transition.

Reconstruction of Prior Surgical Sterilization Procedures
Services to reverse voluntary surgically induced Infertility.

Conception by Medical Procedures
Services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include but are not limited to:

- In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), or any other process that involves the harvesting, transplanting, or manipulating of a human ovum. Also not covered are services or supplies, (including injections and injectable medications) which prepare the Covered Person to receive these services.
- Collection, storage, or purchase of sperm or ova.

Fertility Preservation
Fertility preservation treatments are covered as shown under “Family Planning” in the “Plan Benefits” section. However, the following services and supplies are not covered:

- Gamete or embryo storage
- Use of frozen gametes or embryos to achieve future conception
- Pre-implantation genetic diagnosis
- Donor eggs, sperm or embryos
- Gestational carriers (surrogates)

Prenatal Genetic Testing and Diagnostic Procedures
Prenatal genetic testing is covered for specific genetic disorders for which genetic counseling is available when Medically Necessary. The prescribing Physician must request Prior Authorization for coverage. Genetic testing will not be covered for non-medical reasons or when a Covered Person has no medical indication or family history of a genetic abnormality.

Experimental Or Investigational Procedures
Experimental or Investigational drugs, devices, procedures or other therapies are only covered when:

- Independent review deems them appropriate as described in the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "General Provisions" section of this *Certificate*; or
- Clinical trials for patients with cancer or other life-threatening diseases or conditions are deemed appropriate according to the "Clinical Trials" provision of the "Plan Benefits" section.

In addition, benefits will also be provided for services and supplies to treat medical complications caused by Experimental or Investigational services or supplies.

Routine Physical Examinations
Routine physical examinations taken to obtain or maintain employment, or participate in employee programs; for insurance or licensing or on a court order or as required by parole or probation. However, routine physical examinations that are Preventive Care Services are covered.

Immunizations Or Inoculations
Except for Preventive Care Services, this plan does not cover immunizations and injections for foreign travel or occupational purposes.

Custodial Or Domiciliary Care
This plan does not cover assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine). This exclusion does not apply to assistance with activities of daily living that is provided as part of covered Hospice, Skilled Nursing Facility, Home Health Care Services or inpatient Hospital care.

Noneligible Hospital Confinements
Inpatient room and board charges in conjunction with a Hospital, Hospice or Skilled Nursing Facility stay not meeting Medical Necessity and/or primarily for environmental change, personal convenience or custodial in nature are not covered. However, Hospice respite care is covered.

Noneligible Institutions
Any services or supplies furnished by a noneligible institution, which is an institution other than a legally operated Hospital, Hospice or Medicare-approved Skilled Nursing Facility, or which is primarily a place for the aged, a nursing home, or any similar institution, regardless of how designated. This exclusion does not apply to services required for Severe Mental Illness, Serious Emotional Disturbances of a Child, autism or pervasive developmental disorder.

Private Rooms
Except where Medically Necessary, expenses in excess of a Hospital's (or other inpatient facility's) most common semi-private room rate.

Private Duty Nursing
Inpatient and outpatient services (including incremental nursing) provided by a private duty nurse, except as Medically Necessary and not in excess of the visit maximum for Home Health Care Services. Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a Hospital or Skilled Nursing Facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of six hours in any 24-hour period. Private Duty Nursing may be provided in an Inpatient or outpatient setting, or in a non-institutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care" and includes any portion of shift care services. Private Duty Nursing provided as Home Health Care Services may not exceed a maximum of 3 visits per day, up to 2 hours per visit.

Noncovered Items
Any expenses related to the following items, whether authorized by a Physician or not:

- Alteration of Your residence to accommodate Your physical or medical condition, including the installation of elevators.
- Disposable supplies for home use, however, ostomy and urological supplies, items for Home Health Care, Hospice Care items including incontinence supplies, and equipment for the management of diabetes are covered. In addition, disposable devices that are Medically Necessary for the administration of a covered outpatient Prescription Drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs, and syringes for self-injectable outpatient Prescription Drugs that are not dispensed in pre-filled syringes are covered.
- Exercise equipment, including treadmills, and charges for activities or facilities normally intended or used for physical fitness.

- Hygienic equipment, Jacuzzis and spas.
- Surgical dressings are limited to primary dressings, i.e., a therapeutic and protective covering applied directly to lesions either on the skin or opening to the skin required as a result of a surgical procedure performed by a Physician. In addition, Medically Necessary non-primary surgical dressings are covered.
- Orthodontic appliances to treat dental conditions related to the treatment of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders).
- Support appliances such as stockings, over the counter support devices or Orthotics, and devices or Orthotics for improving athletic performance or sports-related activities. However, Medically Necessary compression burn garments and lymphedema wraps, light compression bandages, manual compression bandages and moderate compression bandages are covered
- Orthotics and Corrective Footwear, except as described in the "Durable Medical Equipment" and "Diabetic Equipment" provisions of the "Plan Benefits" section.
- Other Orthotics, including Corrective Footwear, not mentioned above, that are not Medically Necessary and custom made for the Covered Person. Corrective Footwear must also be permanently attached to an Orthotic device meeting coverage requirements under this *Certificate*.
- Equipment received and/or obtained from an Out-of-Network Provider or noncontracting vendor.
- Equipment not prescribed by a Physician.
- Personal or comfort items.
- Air purifiers, air conditioners and humidifiers.
- Hearing aids, except for implanted hearing aids.
- Food supplements (except as specifically stated in the "Outpatient Infusion Therapy" provision of the "Plan Benefits" section of this *Certificate*).
- Educational services or nutritional counseling, except as specifically provided in the "Patient Education," "Mental Health, Behavioral Health or Substance Abuse Needs" or "Outpatient Infusion Therapy" provisions of the "Plan Benefits" section of this *Certificate.*

Treatment of Obesity

Treatment or surgery for obesity, weight reduction or weight control, except when provided for morbid obesity or as a Preventive Care Service.

Transplants

Experimental or Investigational organ, stem cell and tissue transplants are only covered when independent review deems them appropriate as described in the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "General Provisions" section of this *Certificate*.

Duplicate Coverage

If You are covered by more than one plan, benefits will be determined by applying provisions of the "Coordination of Benefits" portion of the "General Provisions" section of this *Certificate*.

Medicare

All benefits provided under this *Certificate* shall be reduced by any amount to which You are entitled under the program commonly referred to as Medicare when federal law permits Medicare to pay before a group health plan.

Workers' Compensation

If You require services for which benefits are in whole or in part either payable or required to be provided under any Workers' Compensation or Occupational Disease Law, HNL will provide covered benefits to which You are entitled and will pursue recovery from the Workers' Compensation carrier liable for the cost of medical treatment related to Your illness or injury.

Expenses Before Coverage Begins
Services received before the Covered Person's Effective Date.

Expenses After Termination of Coverage
Services received after midnight on the effective date of cancellation of coverage under this *Certificate* ends, regardless of when the illness, disease, injury or course of treatment began, except as specifically stated under the "Extension of Benefits" portion of the "Eligibility, Enrollment and Termination" section of this *Certificate*.

Services For Which You Are Not Legally Obligated To Pay
Services for which no charge is made to You in the absence of insurance coverage, except services received at a charitable research Hospital which is not operated by a governmental agency.

Physician Self-Treatment
Self-treatment rendered in a non-emergency (including, but not limited to, prescribed services, supplies and drugs). Physician self-treatment occurs when Physicians provide their own medical services, including prescribing their own medication, ordering their own laboratory test and self-referring for their own services. Claims for emergency self-treatment are subject to review by HNL.

Services Provided by Immediate Family Members
Professional services or provider referrals (including, but not limited to, prescribed services, supplies and drugs) received from a person who lives in Your home or who is related to You by blood, marriage or domestic partnership. Covered Persons who receive routine or ongoing care from a member of their immediate family may be reassigned to another Physician.

Crime
Conditions caused by Your commission (or attempted commission) of a felony unless the condition was an injury resulting from an act of domestic violence or an injury resulting from a medical condition.

Nuclear Energy
Conditions caused by release of nuclear energy, when government coverage is in effect.

Governmental Agencies
Any services provided by or for which payment is made by a local, state or federal government agency. This exclusion does not apply to Medi-Cal, Medicaid or Medicare.

Totally Disabled on Your Effective Date
Generally, under the federal Health Insurance Portability and Accountability Act, HNL cannot deny You benefits due to the fact that You are totally disabled on Your Effective Date. However, if on Your Effective Date, You are totally disabled and pursuant to state law You are entitled to an extension of benefits from the insurance carrier providing coverage to Your prior group health plan, benefits of this *Certificate* will be coordinated with benefits payable by the insurance carrier providing coverage to Your prior group health plan, so that not more than 100% of Covered Expenses are provided for services rendered to treat the disabling condition under both plans.

For the purposes of coordinating benefits under this *Certificate*, if You are entitled to an extension of benefits from the insurance carrier providing coverage to Your prior group health plan, and state law permits such arrangements, the insurance carrier providing coverage to Your prior group health plan shall be considered the primary plan (paying benefits first) and benefits payable under this *Certificate* shall be considered the secondary plan (paying any excess Covered Expenses), up to 100% of total Covered Expenses. No extension will be granted unless HNL receives written certification of such total disability from Your Physician within 90 days of the date on which coverage was terminated, and thereafter at reasonable intervals.

Routine Foot Care
This Plan does not cover services for treatment of corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes or if the routine foot care is Medically Necessary.

Surrogate Pregnancy
This *Certificate* covers services for a surrogate pregnancy only when the surrogate is an HNL Covered Person. When compensation is obtained for the surrogacy, HNL shall have a lien on such compensation to recover its medical expense. A surrogate pregnancy is one in which a woman has agreed to become pregnant with the intention of surrendering custody of the child to another person. The benefits that are payable under this provision are subject to HNL's right to recovery as described in "Recovery of Benefits Paid by HNL Under A Surrogate Parenting Agreement" in the "Specific Provisions" section of this *Certificate.*

Chiropractic Services
Expenses related to chiropractic adjustments, manipulations and therapy.

Foreign Travel Or Work Assignment
If You receive services or obtain supplies in a foreign country, benefits will be payable for Emergency Services only. Determination of Covered Expenses will be based on the Maximum Allowable Amount in the USA for the same or a comparable service. Please refer to "Maximum Allowable Amount" in the "Definitions" section.

Telephone Consultations
Consultations with a Physician or other provider which are conducted over the telephone.

Home Birth
A birth which takes place at home will be covered when the criteria for Emergency Care, as defined in this *Certificate*, have been met.

Educational and Employment Services
Except for Medically Necessary services related to behavioral health treatment are covered as shown in the "Plan Benefits" section, all other services related to educational and professional purposes are not covered. Examples of excluded services include education and training for non-medical purposes such as:

- Vocational rehabilitation.
- Employment counseling, training or educational therapy for learning disabilities.
- Investigations required for employment.
- Education for obtaining or maintaining employment, or for professional certification.
- Education for personal or professional growth, development or training.
- Academic education during residential treatment.
- Behavioral training

Noncovered Treatments
The following types of treatment are only covered when Medically Necessary or when provided in connection with covered treatment for a Mental Disorder or Chemical Dependency:

- Treatment for co-dependency.
- Treatment for psychological stress.
- Treatment of marital or family dysfunction.

In addition treatment by providers who are not within licensing categories that are recognized by HNL as providing Covered Services in accordance with applicable medical community standards is not covered.

Nonstandard Therapies
Services that do not meet national standards for professional medical or mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, sleep therapy, biofeedback (except for certain

physical disorders, such as incontinence and chronic Pain, and as otherwise preauthorized by the Plan), hypnotherapy and crystal healing therapy are not covered.

Psychological Testing
Psychological testing is only covered, when ordered by a licensed mental health professional and is Medically Necessary to diagnose a Mental Disorder for purposes of developing a mental health treatment plan or when Medically Necessary to treat a Mental Disorder or condition of Chemical Dependency.

Treatment Related to Judicial or Administrative Proceedings
Medical, mental health care or Chemical Dependency services as a condition of parole or probation, and court-ordered treatment and testing are limited to Medically Necessary covered services.

OUTPATIENT PRESCRIPTION DRUG BENEFITS

The exclusions and limitations in the "Medical Services and Supplies" portion of this section also apply to the coverage of Prescription Drugs.

Note: Services or supplies excluded under the Prescription Drug benefits may be covered under Your medical benefits portion of this *Certificate*. Please refer to the "Plan Benefits" section for more information.

Additional exclusions and limitations:

Drugs Covered by Another Section
Prescription Drugs which are covered by any other benefits provided by this *Certificate*, including any drugs provided for outpatient infusion therapy, delivered or administered to the patient by the attending Physician, or billed by a Hospital or Skilled Nursing Facility, are not covered.

Noncovered Services
Drugs prescribed for a condition or treatment that is not covered by this *Certificate* are not covered. However, the *Certificate* does cover Medically Necessary drugs for a medical condition directly related to noncovered services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery).

No-Charge Items
Services or supplies for which You are not legally required to pay or for which no charge is made.

Nonprescription (Over-the-Counter) Drugs, Equipment and Supplies
Medical equipment and supplies (including insulin), that are available without a prescription, are covered only when prescribed by a Physician for the management and treatment of diabetes, or for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations or for female contraception. In addition, disposable devices that are Medically Necessary for the administration of a covered outpatient Prescription Drug are covered.

Any other non-Prescription Drugs, equipment or supplies which can be purchased without a Prescription Drug Order are not covered even if a Physician writes a prescription for such drug, equipment or supply unless specifically listed in the Essential Rx Drug List. These are commonly called over-the-counter drugs. Insulin is an exception to this limitation. However, if a higher dosage form of a non-Prescription Drug or over-the-counter drug is only available by prescription, that higher dosage drug will be covered.

Nonparticipating Pharmacies
Facilities not authorized by HNL to be Participating Pharmacies are covered only for Emergency Care.

Diagnostic Drugs
Drugs used for diagnostic purposes are not covered. Diagnostic drugs are covered under the medical benefit when Medically Necessary.

Drugs Prescribed for Cosmetic or Enhancement Purposes
Drugs that are prescribed for the following non-medical conditions are not covered: hair loss, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes and mental performance. Examples of drugs that are excluded when prescribed for such conditions include, but are not limited to, Latisse, Renova, Vaniqua, Propecia or Lustra. This exclusion does not exclude coverage for drugs when pre-authorized as Medically

Necessary to treat a diagnosed medical condition affecting memory, including but not limited to, Alzheimer's dementia, Medically Necessary drugs to treat sexual dysfunction and Medically Necessary Drugs to treat morbid obesity.

Dietary or Nutritional Supplements
Drugs used as dietary or nutritional supplements, including vitamins and herbal remedies, including when in combination with a Prescription Drug product, are limited to drugs that are listed in the Essential Rx Drug List. Phenylketonuria (PKU) is covered under the medical benefit (see the "Phenylketonuria" provision of the "Plan Benefits" section).

Drugs Prescribed for Common Cold
Drugs when prescribed to shorten the duration of the common cold are not covered.

Allergy Serum
Allergy desensitization products are not covered as Prescription Drugs, whether administered by injection or drops placed in the nose or mouth (transmucosal absorption), to lessen or end the person's allergic reactions are not covered. These products are sometimes described as "allergy serum." Allergy serum is covered as a medical benefit. See the "Visits to a Health Care Provider's Office or Clinic" portion of the "Schedule of Benefits" section and the "Allergy Testing and Treatment" provision in the "Plan Benefits" section.

Nonapproved Uses, Investigational or Experimental Drugs
Medications limited by law to Investigational use, prescribed for Experimental purposes or prescribed for indications not approved by the Food and Drug Administration are excluded from coverage unless Independent review deems them appropriate as described in the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "General Provisions" section of this *Certificate*. However, Off-Label Drugs prescribed or administered by a licensed health care professional for the treatment of a life-threatening or chronic and seriously debilitating condition are covered as described in the "Outpatient Prescription Drug Benefits" portion of the "Plan Benefits" section.

Irrigation Solutions
Irrigation solutions and saline solutions are not covered.

Sexual Dysfunction Drugs
Drugs on the Essential Rx Drug List when Medically Necessary for treating sexual dysfunction are limited to a maximum of 8 doses in any 30 day period.

Food and Drug Administration (FDA)
Supply amounts for prescriptions that exceed the FDA's or HNL's indicated usage recommendation are not covered unless Medically Necessary and Prior Authorization is obtained from HNL.

Quantity Limitations
Some drugs are subject to specific quantity limitations per Copayment or Coinsurance, whichever is applicable, based on recommendations for use by the FDA or HNL's usage guidelines Medications taken on an "as-needed" basis may have a Copayment or Coinsurance based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If Medically Necessary, Your Physician may request a larger quantity from HNL.

Unit Dose or "Bubble" Packaging
Individual doses of medication dispensed in plastic, unit doses, or foil packages and dosage forms used for convenience are not covered, unless Medically Necessary or only available in that form.

Lost, Stolen or Damaged Drugs
Once You have taken possession of drugs, lost, stolen or damaged drugs are not covered. You will have to pay the retail price for replacing them

Schedule II Narcotic Drugs
Schedule II narcotic drugs are not covered through mail order. Schedule II drugs are drugs classified by the Federal Drug Enforcement Administration as having a high abuse risk but also safe and accepted medical uses in the United States.

Hypodermic Syringes and Needles
Specific brands of disposable insulin needles and syringes, and specific brands of pen devices are covered. In addition, disposable devices that are Medically Necessary for the administration of a covered outpatient Prescription Drug are covered. Needles and syringes required to administer self-injected medications (other than insulin) will be provided through Our Specialty Pharmacy Vendor. All other devices, syringes and needles are not covered.

PEDIATRIC VISION SERVICES

The exclusions and limitations in the "Medical Services and Supplies" portion of this section also apply to vision care benefits.

Note: Services or supplies excluded under the vision care benefits may be covered under Your medical benefits portion of this *Certificate*. Please refer to the "Plan Benefits" section for more information.

Additional exclusions and limitations:

No-Charge items
Services or supplies for which the Covered Person is not legally required to pay or for which no charge is made are not covered.

Medical Treatment
Medical or surgical treatment of the eye is not covered; however, this is covered under the medical benefit.

Optional Frames
Additional fitting and measurement charges or special consultation charges due to the purchase of optional Frames are not covered.

Nonprescription Eyewear
Nonprescription Eyewear or vision devices or sunglasses, whether or not prescribed by an ophthalmologist or optometrist, are not covered.

Additional Eyewear
Obtaining two pairs of glasses in lieu of bifocals is not covered.

Drugs
Prescription drugs or over-the-counter drugs are not covered.

Lost, Stolen or Broken Eyewear
Replacement of lost, stolen or broken Lenses/Frames are not covered, except as otherwise available.

Orthoptics
Orthoptics or vision training is not covered.

Vision Examinations
Any eye or vision examination, or any corrective eyewear required by an employer as a condition of employment is not covered.

GENERAL PROVISIONS

TERM OF CERTIFICATE

This *Certificate* shall remain in effect for the period of time specified in the Group Policy held by the Group, subject to the payment of premiums as required and subject to the right of HNL and the Group to terminate or modify it, including the right to change premiums, in accordance with the terms of the Group Policy. Notice of modification or termination will be sent to the holder of the Group Policy. HNL will not provide notice of such changes to Covered Persons of this plan unless it is required to do so by law. The Group may have obligations under state or federal law to provide notification of these changes to the Covered Persons under this plan. Modification shall not affect the right to benefits provided under this *Certificate* in connection with a Hospital confinement commencing prior to such date.

Covered Persons who are totally disabled on the date coverage under this *Certificate* ends may be eligible for continuation of coverage. See the "Extension of Benefits" portion of the "Eligibility, Enrollment and Termination" section of this *Certificate*.

CUSTOMER CONTACT CENTER INTERPRETER SERVICES

HNL's Customer Contact Center has bilingual staff and an interpreter services for additional languages to handle Covered Person language needs. Examples of interpretive services provided include explaining benefits, filing a grievance and answering questions related to Your health plan in the Covered Person's preferred language. Also, our Customer Contact Center staff can help You find a health care provider who speaks Your language. Call the Customer Contact Center number on Your HNL ID card for this free service. HNL discourages the use of family members and friends as interpreters and strongly discourages the use of minors as interpreters at all medical points of contact where a covered benefit or service is received. Language assistance is available at all medical points of contact where a covered benefit or service is accessed. You do not have to use family members or friends as interpreters. If You cannot locate a health care provider who meets Your language needs, You can request to have an interpreter available at no charge.

COVERED PERSONS' RIGHTS AND RESPONSIBILITIES STATEMENT

HNL is committed to treating Covered Persons in a manner that respects their rights, recognizes their specific needs and maintains a mutually respectful relationship. In order to communicate this commitment, HNL has adopted these Covered Persons' rights and responsibilities. These rights and responsibilities apply to Covered Persons' relationships with HNL, its contracting practitioners and providers, and all other health care professionals providing care to its Covered Persons.

Covered Persons have the right to:

- Receive information about HNL, its services, its practitioners and providers and Covered Persons' rights and responsibilities;
- Be treated with respect and recognition of their dignity and right to privacy;
- Participate with practitioners in making decisions about their health care;
- A candid discussion of appropriate or Medically Necessary treatment options for their conditions, regardless of cost or benefit coverage;
- Request an interpreter at no charge to You;
- Use interpreters who are not Your family members or friends;
- File a grievance in Your preferred language by using the interpreter service or by completing the translated grievance form that is available on www.healthnet.com;
- File a complaint if Your language needs are not met;
- Voice complaints or appeals about the organization or the care it provides; and
- Make recommendations regarding HNL's member rights and responsibilities policies.

Covered Persons have the responsibility to:

- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care;
- Follow plans and instructions for care that they have agreed-upon on with their practitioners; and
- Be aware of their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

COORDINATION OF BENEFITS

Explanation

Benefits provided under this *Certificate* are subject to coordination with benefits payable to You for eligible expenses by any other group coverage including any Hospital, surgical or medical benefit policy, service plan contract, group prepayment plan, coverage through any governmental program or provided by any state or federal statute, as permitted by applicable law.

Purpose

Coordination of Benefits (COB) determines responsibility for payment of eligible expenses among insurers providing group coverage to You, so that the total of all reasonable expenses for Covered Services and Supplies will be paid up to the stated limits of each coverage, but not to exceed total expenses incurred for those services and supplies.

Administration

If You are known to have group coverage through any other health plan or insurer, responsibility for payment of benefits is determined by following the Rules Establishing the Order of Benefits Determination, formulated by the Insurance Commissioner of the State of California and incorporated in this *Certificate*. Such rules determine the order of payment responsibilities between HNL and any other applicable group insurer, by establishing which is the **Primary Plan** and which is the **Secondary Plan**.

The Covered Person's coverage is subject to the same limitations, exclusions and other terms of this Certificate whether HNL is the Primary Plan or the Secondary Plan.

- **COVERED EMPLOYEE:** HNL is the **Primary Plan** with responsibility for first payment, <u>except</u> when (a) You are covered by another group health plan or insurer as the employee and that plan has covered You longer than the HNL plan or (b) the group plan or insurer does not contain a "COB" provision similar to this one.
- **SPOUSE OR DOMESTIC PARTNER:** HNL is the **Primary Plan** with responsibility for first payment, <u>except</u> when (a) the spouse or Domestic Partner is covered under another group health plan or insurer as the employee or (b) the other group plan or insurer does not contain a "COB" provision similar to this one.
- **CHILD:** Determination of the **Primary Plan** will be based on the following:
  1. The insurer, under whom the child is covered as a principal enrollee, employee or primary individual, shall be the **Primary Plan** for that child;
  2. If the child is not covered as specified above and is covered as a dependent under the insurers of both parents, then the insurer of the parent whose date of birth, but not year of birth, occurs earlier in a Calendar Year shall be the **Primary Plan** for dependent children covered under their group health plan. The insurer of the parent whose birthday occurs later in the Calendar Year shall be the **Secondary Plan** for dependent children covered under their group health plan;
  3. Group health plan as determined above is the **Primary Plan** with responsibility for first payment, <u>unless</u> the Rules Establishing the Order of Benefit Determination are affected because of a divorce and assignment of legal custody of the child. **If the Mother has legal custody**, her group plan or insurer pays first; the stepfather's (if any) group plan or insurer pays second; and the natural father's third. **If the Father has legal custody**, his group plan or insurer pays first; the stepmother's (if any) pays second and the natural mother's third; or
  4. However, if the child's parents are separated or divorced and there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses of that child, then the

group health plan of the parent with such court-ordered financial responsibility shall be the **Primary Plan**. The group health plan of the other parent shall be the **Secondary Plan**.

When the points above do not establish an order of benefit determination, the insurer or group health plan who has covered the person for the longer period of time shall be the **Primary Plan** and the other insurer shall be the **Secondary Plan**, provided that:

- The benefits of a group health plan or insurer covering the person as a laid off or retired employee or dependent of such person, shall be determined after the benefits of any other insurer or group health plan covering such person as an employee, other than a laid off or retired employee or dependent of such person; and
- If either group health plan does not have a provision regarding laid off or retired employees, which results in each insurer or group health plan determining its benefits after the other, then the provisions of statement above shall not apply.

Facility of Payment

If payments which should have been made under this *Certificate* are made by any other group health plan or insurer, HNL shall have the right to pay over to such health plan or insurer any amount HNL determines to be warranted in order to satisfy the intent of this provision. Any amounts so paid shall be deemed to be benefits under this *Certificate* and to the extent of such payments, HNL shall be fully discharged from liability under this *Certificate*.

Right to Receive and Release Necessary Information

HNL may obtain or release any information considered to be necessary for "COB" with respect to any person claiming benefits under this *Certificate* without consent of or notice to You or any other person or organization. However, HNL shall not be required to determine the existence of any other group plan or insurer, or the benefits payable under such plan or insurer, when computing benefits due to You covered under this *Certificate*.

Services Instead of Cash Payments

When another group health plan or insurer provides services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid. The reasonable cash value of any services provided to the covered individual by any service organization group plan shall be deemed an expense incurred by the individual and the liability of HNL under this *Certificate* will be reduced accordingly.

Right of Recovery

Whenever HNL's payment for covered services exceeds the maximum amount of payment necessary to satisfy the intent of this provision, HNL shall have the right to recover those excessive amounts from any group health plan, any organization or any persons.

Medicare Coordination of Benefits (COB)

When You reach age 65, You may become eligible for Medicare based on age. You may also become eligible for Medicare before reaching age 65 due to disability or end stage renal disease. We will solely determine whether we are the primary plan or the secondary plan with regard to services to a Covered Person enrolled in Medicare in accordance with the Medicare Secondary Payer rules established under the provisions of Title XVIII of the Social Security Act and its implementing regulations. Generally, those rules provide that:

If You are enrolled in Medicare Part A and Part B, and are not an active employee or Your employer group has less than twenty employees, then this plan will coordinate with Medicare and be the secondary plan. This Plan also coordinates with Medicare if You are an active employee participating in a Trust through a small employer, in accordance with Medicare Secondary Payer rules. (If You are not enrolled in Medicare Part A and Part B, HNL will provide coverage for Medically Necessary Covered Services without coordination with Medicare.)

For services and supplies covered under Medicare Part A and Part B, claims are first submitted by Your provider or by You to the Medicare administrative contractor for determination and payment of allowable amounts. The Medicare administrative contractor then sends Your medical care provider a Medicare Summary Notice (MSN), (formerly an Explanation of Medicare Benefits (EOMB)). In most cases, the MSN will indicate that the Medicare administrative contractor has forwarded the claim to HNL for secondary coverage consideration. HNL will process secondary claims received from the Medicare administrative contractor. Secondary claims not received from the Medicare administrative contractor must be submitted to HNL by You or the provider of service, and must include a copy of the MSN. HNL and/or Your medical provider is responsible for paying the difference between the

Medicare paid amount and the amount allowed under this plan for the covered services described in this *Certificate*, subject to any limits established by Medicare COB law. This Plan will cover benefits as a secondary payer only to the extent services are coordinated by Your Physician and authorized by HNL as required under this *Certificate*.

If either You or Your spouse or Domestic Partner is over the age of 65 and You are actively employed, neither You nor Your spouse or Domestic Partner is eligible for Medicare Coordination of benefits, unless You are employed by a small employer and pertinent Medicare requirements are met.

For answers to questions regarding Medicare, contact:

- Your local Social Security Administration office or call **1-800-772-1213**;
- The Medicare Program at **1-800-MEDICARE (1-800-633-4227)**;
- The official Medicare website at www.medicare.gov;
- The Health Insurance Counseling and Advocacy Program (HICAP) at **1-800-434-0222**, which offers health insurance counseling for California seniors; or
- Write to:

  Medicare Publications
  Department of Health and Human Services
  Centers for Medicare and Medicaid Services
  6325 Security Blvd.
  Baltimore, MD 21207

GRIEVANCE AND APPEALS PROCESS

Appeal, complaint or grievance means any dissatisfaction expressed by You or Your representative concerning a problem with HNL, a medical provider or Your coverage under this *Certificate*, including an adverse benefit determination as set forth under the Affordable Care Act (ACA). An adverse benefit determination means a decision by HNL to deny, reduce, terminate or fail to pay for all or part of a benefit including on the basis of:

- A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review; or
- Any reduction or termination of an approved ongoing course of treatment to be provided over a period of time or number of treatments before the end of such period of time or number of treatments. If there is an adverse benefit determination, the Covered Person will be notified sufficiently in advance of the reduction or termination to allow time to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
- Rescission of coverage, even if it does not have an adverse effect on a particular benefit at that time; or
- Determination of an individual's eligibility to participate in this HNL plan; or
- Determination that a benefit is not covered; or
- An exclusion or limitation of an otherwise covered benefit based on a source-of-injury exclusion; or
- Determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

If You are not satisfied with efforts to solve a problem with HNL or a medical provider, You may file a grievance or appeal against HNL by calling the Customer Contact Center at **1-800-361-3366** or by submitting a Member Grievance Form through HNL website at www.healthnet.com. You must file Your grievance or appeal with HNL within 365 calendar days following the date of the incident or action that caused Your grievance. You may also file a complaint in writing by sending information to:

Health Net Life Insurance Company
Appeals and Grievance Department
P.O. Box 10348
Van Nuys, CA 91410-0348

The grievance and appeal process as it pertains to a urgent care claim dispute that is based on a Medical Necessity determination, is a 72-hour process from the time of the initial request was received by HNL, until the close of the case with the Covered Person. If a claim-related dispute resolution determination cannot be issued within the initial 72-hour period, HNL will still provide the Covered Person with a complete response based on the facts as then known by HNL within the initial 72-hour period. However, for urgent care claims involving the extension of an ongoing course of treatment, the process will be 24 hours from the time of the initial request.

The grievance and appeal process as it pertains to a claim dispute that is based on a non-urgent pre-service Medical Necessity determination, is a 5-business day process from the date the initial request was received by HNL, until the close of the case with the Covered Person. If a claim-related dispute resolution determination cannot be issued within the initial 5-business day period, HNL will still provide the Covered Person with a complete response based on the facts as then known by HNL within the initial 5-business day period.

The grievance and appeal process as it pertains to a claim dispute that is not based on a Medical Necessity determination, is a 15-calendar day process from the date the initial request was received by HNL, until the close of the case with the Covered Person. If a claim-related dispute resolution determination cannot be issued within the initial 15-calendar day period, HNL will still provide the Covered Person with a complete response based on the facts as then known by HNL within the initial 15-calendar day period. All other non-claim disputes are processed within 30 calendar days. Receipt date is defined as the earliest HNL stamp date or practitioner receipt date noted on the document. If any case exceeds the 15-day or 30-day time limit, a letter is sent to the Covered Person by the 15th or 30th calendar day informing him or her of the reason for the pended status.

There is no requirement that You participate in HNL's grievance or appeals process before requesting Independent Medical Review (IMR) for denials. In such cases, You may contact the California Department of Insurance (CDI) to request an IMR of the denial.

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE

You may request an independent medical review (IMR) of Disputed Health Care Services from the Department of Insurance (Department) if You believe that health care services eligible for coverage and payment under Your HNL plan have been improperly denied, modified or delayed by HNL. A "Disputed Health Care Service" is any health care service eligible for coverage and payment under Your HNL plan that has been denied, modified or delayed by HNL or one of its contracting providers, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available. You will not pay any application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. HNL will provide You with an IMR application form and HNL's grievance response letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause You to forfeit any statutory right to pursue legal action against HNL regarding the Disputed Health Care Service.

Eligibility

Your application for IMR will be reviewed by the Department to confirm that it meets all the eligibility requirements of the law for IMR which are set out below:

- Your provider has recommended a health care service as Medically Necessary, You have received urgent or Emergency Care that a provider determined to have been Medically Necessary; or in the absence of provider recommendation You have been seen by a Physician for the diagnosis or treatment of the medical condition for which You seek IMR;
- The Disputed Health Care Service has been denied, modified or delayed by HNL, based in whole or in part on a decision that the health care service is not Medically Necessary; and
- You have filed a grievance with HNL and the disputed decision is upheld by HNL or the grievance remains unresolved after 30 days. Within the next six months, You may apply to the Department for IMR or later, if the Department agrees to extend the application deadline. If Your grievance requires expedited review You may bring it immediately to the Department's attention. The Department may waive the requirement that You must follow HNL's grievance process in extraordinary and compelling cases.

If Your case is eligible for IMR, the dispute will be submitted to a medical Specialist who will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made in Your case from the IMR. If the IMR determines the service is Medically Necessary, HNL will provide benefits for the Disputed Health Care Service in accordance with the terms and conditions of this *Certificate*. If the case is not eligible for IMR, the Department will advise You of Your alternatives.

For non-urgent cases, the IMR organization designated by the Department must provide its determination within 30 days of receipt of the application for review and the supporting documents.

If there is an imminent and serious threat to the health of the Covered Person, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the Covered Person's health, all necessary information and documents shall be delivered to an independent medical review organization within 24 hours of approval of the request for review. In reviewing a request for review, the Department of Insurance may waive the requirement that the Covered Person follow the insurer's grievance process in extraordinary and compelling cases, where the commissioner finds that the Covered Person has acted reasonably.

For more information regarding the IMR process or to request an application form, please call the Customer Contact Center at the telephone number on Your HNL ID card.

INDEPENDENT MEDICAL REVIEW OF INVESTIGATIONAL OR EXPERIMENTAL THERAPIES

HNL does not cover Experimental or Investigational drugs, devices, procedures or therapies. However, if HNL denies or delays coverage for requested treatment on the basis that it is Experimental or Investigational and You meet the eligibility criteria set out below, You may request an independent medical review (IMR) of HNL's decision from the Department of Insurance.

Eligibility

- You must have a life-threatening or seriously debilitating condition;
- Your Physician must certify to HNL that You have a life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving Your condition or are otherwise medically inappropriate and there is no more beneficial therapy covered by HNL;
- Either (a) Your contracting Physician has recommended a drug, device, procedure, or other therapy that the Physician certifies in writing is likely to be more beneficial to You than any available standard therapies, or (b) You, or the Your Physician who is a licensed, board-certified or board-eligible Physician qualified to practice in the area of practice appropriate to treat Your condition, has requested a therapy that, based on two documents from the medical and scientific evidence, as defined below, is likely to be more beneficial for You than any available standard therapy. The Physician certification shall include a statement of the evidence relied upon by the Physician in certifying his or her recommendation. Nothing in this provision shall be construed to require HNL to pay for the services of a noncontracting Physician that are not otherwise covered pursuant to the contract.
- You have been denied coverage by HNL for the recommended or requested therapy; and
- If not for HNL's determination that the recommended or requested treatment is Experimental or Investigational, it would be covered.

For purposes of this provision, "life-threatening" means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

For purposes of this provision, "seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

For purposes of this provision, "medical and scientific evidence" means the following sources:

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
2. Peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database of Health Services Technology Assessment Research (HSTAR).
3. Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act.
4. Either of the following reference compendia:
   a. The American Hospital Formulary Service's Drug Information.
   b. The American Dental Association Accepted Dental Therapeutics.
5. Any of the following reference compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
   a. The Elsevier Gold Standard's Clinical Pharmacology.
   b. The National Comprehensive Cancer Network Drug and Biologics Compendium.
   c. The Thomson Micromedex DrugDex.
6. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.
7. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

If there is an imminent and serious threat to the health of the Covered Person, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the Covered Person's health, all necessary information and documents shall be delivered to an independent medical review organization within 24 hours of approval of the request for review. In reviewing a request for review, the Department of Insurance may waive the requirement that the Covered Person follow the insurer's grievance process in extraordinary and compelling cases, where the commissioner finds that the Covered Person has acted reasonably.

If HNL denies coverage of the recommended or requested therapy and You meet the eligibility requirements, HNL will notify You within five business days of its decision and Your opportunity to request an external review of HNL's decision through IMR. HNL will provide You with an application form to request an IMR of HNL's decision. The IMR process is in addition to any other procedures or remedies that may be available. You will not pay any application or processing fees of any kind for IMR. You have the right to provide information in support of Your request for IMR. If Your Physician determines that the proposed therapy should begin promptly, he or she may request expedited review and the experts on the IMR panel will render a decision within seven days of the request. If the IMR panel recommends that HNL cover the recommended or requested therapy, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled. A decision not to participate in the IMR process may cause You to forfeit any statutory right to pursue legal action against HNL regarding the denial of the recommended or requested therapy. For more information, please call the Customer Contact Center at the telephone number on Your HNL ID card.

ARBITRATION

As a condition to becoming a HNL Covered Person, You agree to submit all disputes You may have with HNL, except those described below, to final and binding arbitration. Likewise, HNL agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both You and HNL are bound to use binding arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available

to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by HNL's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Sometimes disputes or disagreements may arise between You (including Your enrolled Dependents, heirs or personal representatives) and HNL regarding the construction, interpretation, performance or breach of this *Certificate*, or regarding other matters relating to or arising out of Your HNL membership. Typically such disputes are handled and resolved through the HNL Grievance, Appeal and Independent Medical Review process described above. However, in the event that a dispute is not resolved in that process, HNL uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with HNL involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

HNL's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is $200,000 or less ($50,000 or less with respect to disputes with HNL involving alleged professional liability or medical malpractice), the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $200,000 or $50,000, whichever is applicable. In the event that total amount of damages is over $200,000 or $50,000, whichever is applicable, the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then, in accordance with California Insurance Code 10123.19(b), either party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter. When a petition is made to the court to appoint a neutral arbitrator, the court shall nominate five persons from lists of persons supplied jointly by the parties to the arbitration or obtained from a governmental agency concerned with arbitration or private disinterested association concerned with arbitration. The parties to the agreement who seek arbitration and against whom arbitration is sought may within five days of receipt of notice of the nominees from the court jointly select the arbitrator whether or not the arbitrator is among the nominees. If the parties fail to select an arbitrator within the five-day period, the court shall appoint the arbitrator from the nominees.

Arbitration can be initiated by submitting a demand for arbitration to HNL at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Health Net Life Insurance Company
Attention: Litigation Administrator
P.O. Box 4504
Woodland Hills, CA 91356-4505

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this *Certificate*, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law, and that award will be final and binding on all parties except to the extent that state or federal law provide for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Covered Person, HNL may assume all or portion of a Covered Person's share of the fees and expenses of the arbitration. Upon written notice by the Covered Person requesting a hardship application, HNL will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the Litigation Administrator at the address provided above.

Covered Persons who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit

determinations" made by HNL to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by HNL to deny, reduce, terminate or not pay for all or a part of a benefit. However, You and HNL may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

MEDICAL MALPRACTICE DISPUTES

HNL and the health care providers that provide services to You through this plan are each responsible for their own acts or omissions and are ordinarily not liable for the acts or omissions or costs of defending others.

SPECIFIC PROVISIONS

RECOVERY OF BENEFITS PAID BY HNL

When You Are Injured

If You are ever injured through the actions of another person or yourself (responsible party), HNL will provide benefits for all Covered Services and Supplies that You receive through this plan. However, if You receive money or are entitled to receive money because of Your injuries, whether through a settlement, judgment or any other payment associated with Your injuries, HNL or the medical providers retain the right to recover the value of any services provided to You under this *Certificate*.

As used throughout this provision, the term responsible party means any party actually or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term responsible party includes the liability insurer of such party or any insurance coverage.

Some examples of how You could be injured through the actions of a responsible party are:

- You were in a car accident; or
- You slip and fall in a store.

HNL's rights of recovery apply to any and all recoveries made by You or on Your behalf from the following sources, including but not limited to:

- Payments made by a third party or any insurance company on behalf of a third party;
- Uninsured or underinsured motorist coverage;
- Personal injury protection, no fault or any other first party coverage;
- Workers Compensation or Disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' insurance coverage, umbrella coverage; and
- Any other payments from any other source received as compensation for the responsible party's actions.

By accepting benefits under this Plan, You acknowledge that HNL has a right of reimbursement that attaches when this Plan has paid for health care benefits for expenses incurred due to the actions of a responsible party and You or Your representative recovers or is entitled to recover any amounts from a responsible party.

Under California law, HNL's legal right to reimbursement creates a health care lien on any recovery.

By accepting benefits under this Plan, You also grant HNL an assignment of Your right to recover medical expenses from any medical payment coverage available to the extent of the full cost of all covered services provided by the Plan and You specifically direct such medical payments carriers to directly reimburse the plan on Your behalf.

Steps the Covered Person Must Take

If You are injured because of a responsible party, You must cooperate with HNL's and the medical providers' efforts to obtain reimbursement, including:

- Telling HNL and the medical providers the name and address of the responsible party, if You know it, the name and address of his or her lawyer, if he or she is using a lawyer, the name and address of any insurance company involved with Your injuries and describing how the injuries were caused;
- Completing any paperwork that HNL or the medical providers may reasonably require to assist in enforcing the lien;
- Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions;
- Notifying the lienholders immediately upon You or Your lawyer receiving any money from the responsible parties, any insurance companies, or any other source;

- Pay the health care lien from any recovery, settlement or judgment, or other source of compensation and all reimbursement due HNL for the full cost of benefits paid under the Plan that are associated with injuries through a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether You are made whole or fully compensated for Your loss;
- Do nothing to prejudice HNL's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery the full cost of all benefits paid by the plan; and;
- Hold any money that You or Your lawyer receive from the responsible parties or, from any other source, in trust and reimbursing HNL and the medical providers for the amount of the lien as soon as You are paid.

How the Amount of the Covered Person's Reimbursement is Determined

The following section is not applicable to Workers' Compensation liens and may not apply to certain ERISA plans, hospital liens, Medicare plans and certain other programs and may be modified by written agreement.*

Your reimbursement to HNL or the medical provider under this lien is based on the value of the services received and the costs of perfecting this lien. For the purposes of determining the lien amount, the value of the services depends on how the provider was paid, as summarized below, and will be calculated in accordance with California Civil Code Section 3040, or as otherwise permitted by law.

- The amount of the reimbursement owed to HNL or the medical provider will be reduced by the percentage that the recovery is reduced if a judge, jury or arbitrator determines that You were responsible for some portion of Your injuries;
- The amount of the reimbursement owed HNL or the medical provider will also be reduced by a pro rata share for any legal fees or costs paid from money You received; and
- The amount You will be required to reimburse HNL or the medical provider for services received under this plan will not exceed one-third of the money You receive if You engage a lawyer or one-half of the money received if a lawyer is not engaged.

** Reimbursement related to Workers' Compensation benefits, ERISA plans, hospital liens, Medicare and other programs not covered by California Civil Code, Section 3040 will be determined in accordance with the provisions of this Certificate and applicable law.*

SURROGACY ARRANGEMENTS

A Surrogacy Arrangement is an arrangement in which a woman agrees to become pregnant and to carry the child for another person or persons who intend to raise the child.

Your Responsibility for Payment to HNL

If You enter into a surrogacy arrangement, You must pay Us for Covered Services and Supplies You receive related to conception, pregnancy, or delivery in connection with that arrangement ("Surrogacy Health Services"), except that the amount You must pay will not exceed the payments You and/or any of Your family members are entitled to receive under the surrogacy arrangement. You also agree to pay Us for the Covered Services and Supplies that any child born pursuant to the surrogacy arrangement receives at the time of birth or in the initial Hospital stay, *except* that if You provide proof of valid insurance coverage for the child in advance of delivery or if the intended parents make payment arrangements acceptable to HNL in advance of delivery, You will not be responsible for the payment of the child's medical expenses.

Assignment of Your Surrogacy Payments

By accepting Surrogacy Health Services, You automatically assign to Us Your right to receive payments that are payable to You or Your chosen payee under the surrogacy arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and/or any escrow account or trust established to hold those payments. Those payments shall first be applied to satisfy our lien. The assignment and Our lien will not exceed the total amount of Your obligation to Us under the preceding paragraph.

Duty to Cooperate

Within 30 days after entering into a surrogacy arrangement, You must send written notice of the arrangement, including the names and addresses of the other parties to the arrangement to include any escrow agent or trustee, and a copy of any contracts or other documents explaining the arrangement as well as the account number for any escrow account or trust, to:

Surrogacy Third Party Liability –Product Support
The Rawlings Company
One Eden Parkway
LaGrange, KY 40031-8100

You must complete and send Us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for Us to determine the existence of any rights we may have under this "Surrogacy Arrangements" provision and/or to determine the existence of (or accounting for funds contained in) any escrow account or trust established pursuant to Your surrogacy arrangement and to satisfy HNL's rights.

You must do nothing to prejudice the health plan's recovery rights.

You must also provide Us the contact and insurance information for the persons who intend to raise the child and whose insurance will cover the child at birth.

You may not agree to waive, release, or reduce our rights under this provision without Our prior, written consent. If Your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, Your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to Our liens and other rights to the same extent as if You had asserted the claim against the third party. We may assign our rights to enforce Our liens and other rights.

REFUND TO HNL OF OVERPAYMENT OF BENEFITS

If We pay health benefits for expenses incurred on account of You or Your Dependent, You or any other person or organization that was paid must make a refund to Us if:

- All or some of the expenses were not paid by You or Your Dependent or did not legally have to be paid;
- All or some of the payment made by Us exceeded the benefits under the *Certificate*; or
- All or some of the expenses were recovered from or paid by a source other than this *Certificate*. This may include payments made as a result of claims against a third party of negligence, wrongful acts or omissions.

The refund equals the amount We paid in excess of the amount it should have paid under this *Certificate*. In the case of recovery from or payment by a source other than this *Certificate*, the refund equals the amount of the recovery or payment up to the amount We paid.

If the refund is due from another person or organization, You and Your Dependent agree to help Us get the refund when requested.

If You, or any other person or organization that was paid, do not promptly refund the full amount, We may reduce the amount of any future benefits that are payable under this *Certificate*. The reduction will equal the amount of the required refund.

OUT-OF-STATE PROVIDERS

Health Net PPO has created a program which allows Covered Persons access to participating providers outside their state of residence. If You are traveling outside Your state of residence, require medical care or treatment, and use a provider from the travel network, Your out-of-pocket expenses may be lower than those incurred when You use an Out-of-Network Provider.

When You obtain services outside Your state of residence through the travel network, You will be subject to the same Copayments, Coinsurances, Deductibles, maximums and limitations as You would be if You obtained services from a Preferred Provider in Your state of residence. There is the following exception: Covered Expenses will be calculated based on the lower of (i) the actual billed charges or (ii) the charge that the out-of-state provider network is allowed to charge, based on the contract between HNL and the network. In a small number of states, local statutes may dictate a different basis for calculating Your Covered Expenses.

For the purpose of coverage under this provision, the “travel network” means the following:

When traveling within California, Arizona and Oregon, the travel network consists of providers who participate in the Health Net PPO program in these states. When traveling outside of these three states, the travel network consists of providers who participate in a network (other than the Health Net PPO network), as shown on Your HNL ID card, that agrees to provide discounted health care services to HNL Covered Persons.

SECOND MEDICAL OPINION

When requested by a Covered Person or participating health professional who is treating a Covered Person, We will authorize a second opinion by an appropriately qualified health care professional. When a Covered Person requests a second opinion, he or she will be responsible for any applicable Copayments. Reasons for a second opinion include, but are not limited to, the following:

- If the Covered Person questions the reasonableness or necessity of recommended surgical procedures.
- If the Covered Person questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious Chronic condition.
- If clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and the Covered Person requests an additional diagnosis.
- If the treatment plan in progress is not improving the medical condition of the Covered Person within an appropriate period of time given the diagnosis and plan of care, and Covered Person requests a second opinion regarding the diagnosis or continuance of the treatment.
- If the Covered Person has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

As used above, an appropriately qualified health care professional is a Physician or a Specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, injury, condition or conditions associated with the request for a second opinion.

If the Covered Person or participating health professional who is treating the Covered Person requests a second opinion, an authorization or denial shall be provided in an expeditious manner. When the Covered Person's condition is such that he or she faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb or other major bodily function, or lack of timeliness that would be detrimental to the Covered Person's life or health or could jeopardize the insured’s ability to regain maximum function, then the second opinion shall be rendered in a timely fashion appropriate to the nature of the Covered Person's condition, not to exceed 72 hours after HNL's receipt of the request, whenever possible.

To request an authorization for a second opinion, contact the Customer Contact Center at the telephone number on the HNL ID card. We will review the request in accordance with HNL’s procedures and timelines as stated in the second opinion policy. For more information on the second opinion policy, please contact the Customer Contact Center.

If We deny a request by a Covered Person for a second opinion, We will notify the Covered Person in writing of the reasons for the denial and will inform the Covered Person of the right to dispute the denial, and the procedures for exercising that right.

MISCELLANEOUS PROVISIONS

Form or Content of the Certificate

No agent or employee of HNL is authorized to change the form or content of this *Certificate*. Any changes can be made only through an endorsement authorized and signed by an officer of HNL.

Benefits Not Transferable

No person other than You is entitled to receive benefits to be furnished by HNL under this *Certificate*. Such right to benefits is not transferable. **Fraudulent use of such benefits will result in cancellation of Your eligibility under this *Certificate* and appropriate legal action.**

Transfer of Medical Records

A health care provider may charge a reasonable fee for the preparation, copying, postage or delivery costs for the transfer of your medical records. Any fees associated with the transfer of medical records are the Covered Person's responsibility.

Notice of Claim

Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any covered loss, or as soon thereafter as reasonably possible. Notice may be given to Us at 21281 Burbank Blvd., Woodland Hills, CA 91367, or to any of Our authorized agents or mailed to Us at P.O. Box 9103, Van Nuys, CA 91409-9103. Notice should include information sufficient for Us to identify the Covered Person.

Claim Forms

When We receive notice of a claim, We will furnish You with Our usual forms for filing proof of loss. If We do not do so within 15 days, You can comply with the requirements for furnishing proof of loss by submitting written proof within the time fixed in this *Certificate* for filing such proofs of loss. Such written proof must cover the occurrence, the character and the extent of the loss.

Proofs of Loss

Written proof of loss must be furnished to Us at 21281 Burbank Blvd., Woodland Hills, CA 91367, in case of claim for loss for which this *Certificate* provides any periodic payment contingent upon continuing loss, within 90 days after the end of the period of time for which claim is made; in the case of claim for any other loss, written proof of loss must be furnished within 90 days after the date of the loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if proof is furnished as soon as reasonably possible. Except in the absence of legal capacity, however, We are not required to accept proofs more than one year from the time proof is otherwise required.

Expenses for Copying Medical Records

We will reimburse the Covered Person or provider for reasonable expenses incurred in copying medical records requested by Us.

Time of Payment of Claims

We will pay benefits promptly upon receipt of due written proof of loss. HNL will reimburse each complete claim, or portion thereof, whether in-state or out-of-state, as soon as practical, but no later than 30 working days after receipt of the complete claim by HML. HNL may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the complete claim by HNL.

Indemnities payable under this *Certificate* for any loss other than loss for which this *Certificate* provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this *Policy* provides periodic payment will be paid and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Life Claim

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Covered Person. Any other accrued indemnities unpaid at the Covered Person's death may, at the option of HNL, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Covered Person.

If any indemnity of this *Certificate* shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, HNL may pay such indemnity, up to an amount not exceeding $1,000 to any relative by blood or connection by marriage or domestic partnership of the insured or beneficiary who is deemed by HNL to be equitably entitled thereto. Any payment made by HNL in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the Covered Person in the application or otherwise all or a portion of any indemnities provided by this *Certificate* on account of Hospital, nursing, medical, or surgical services may, at the HNL's option and unless the Covered Person requests otherwise in writing not later than the time of filing proofs of that loss, be paid directly to the person or persons having paid for the hospitalization or medical or surgical aid, or to the Hospital or person rendering those services; but it is not required that the service be rendered by a particular Hospital or person.

Cash Benefits

In most instances, You will not need to file a claim when You receive Covered Services and Supplies from a Preferred Provider. If You use an Out-of-Network Provider and file a claim, HNL will reimburse You for the amount You paid for Covered Expenses, less any applicable Deductible, Copayment or Coinsurance. If You signed an assignment of benefits and the provider presents it to Us, We will send the payment directly to the provider. You must provide proof of any amounts that You have paid.

If a parent who has custody of a child submits a claim for cash benefits on behalf of the child who is subject to a Medical Child Support Order, HNL will send the payment to the custodial parent.

Payment to Providers or Covered Persons:

- **Direct Payment.** Benefit payment for Covered Expenses will be made directly to:
  1. **Contracting Hospitals**: Hospitals which have Provider Service Agreements with HNL to provide services to Covered Persons.
  2. **Providers of Ambulance transportation and certified nurse midwives**: As required by the California Insurance Code, this must occur, even if written assignment has not been made by You. However, if the submitted provider's statement or bill indicates that the charges have been paid in full, payment will be made to You.
  3. **Other providers of service not mentioned above, Hospital and professional**: when You assign benefits to them in writing.
- **Joint Payment.** Benefit payment for Covered Expenses will be made jointly to other providers and You:
  1. When a written assignment stipulates joint payment.
  2. When the benefit payment is $2,000 or greater and the submitted bill indicates that there is a balance due.
  3. Joint payment will not be made to contracting Hospitals and providers of Ambulance services. Payment to them will be direct as described in "Direct Payment" provision above.
- **Direct Payment to You.** In situations not described above, payment will made to You.

Payment When You Are Unable To Accept
If a claim is unpaid at the time of Your death or if You are not legally capable of accepting it, it will be paid to Your estate or any relative or person who may legally accept on Your behalf.

Physical Examination and Autopsy
HNL, at its expense, has the right and opportunity to examine or request an examination of any Covered Person whose injury or sickness is the basis of a claim as often as is reasonably required while the claim is pended and to make an autopsy in case of death where it is not forbidden by law.

Change of Beneficiary
Unless the Covered Person makes an irrevocable designation or beneficiary, the right to change of beneficiary is reserved to the Covered Person and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this *Certificate* or to any change of beneficiary or beneficiaries, or to any other changes in this *Certificate.*

Dependent Coverage Outside California
Dependents living outside California and away from the primary residence of the principal Covered Person can still obtain Preferred Provider coverage within the United States, as described in the "Out-of-State Providers" provision in the "Specific Provisions" section. Outside the United States, coverage is limited to Emergency Care, as described below under "Foreign Travel or Work Assignment" in this "Miscellaneous Provisions" section.

Foreign Travel or Work Assignment
Benefits will be provided for Emergency Care received in a foreign country. Determination of Covered Expenses will be based on the amount that is no greater than the Maximum Allowable Amount (as determined by HNL) in the USA for the same or a comparable service. The Maximum Allowable Amount is defined in the Definitions section.

Workers' Compensation Insurance
This *Certificate* is not in lieu of and does not affect any requirement for, or coverage by, Workers' Compensation Insurance.

Diethylstilbestrol
Coverage under this *Certificate* will not be reduced, limited or excluded solely due to conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol.

Notice
Any notice required of HNL shall be sufficient if mailed to the holder of the Group Policy at the address appearing on the records of HNL. This *Certificate*, however, will be posted electronically on HNL's website at www.healthnet.com. The Group can opt for the Covered Person to receive this *Certificate* online. By registering and logging on to HNL's website, Covered Persons can access, download and print this *Certificate*, or can choose to receive it by U.S. mail, in which case HNL will mail this *Certificate* to each Covered Person's address on record.

If notice is required of You or the Group, it will be sufficient if mailed to Covered California.

Interpretation of Certificate
The laws of the State of California shall be applied to interpretations of this *Certificate*.

Legal Actions
No action at law or in equity may be brought to recover benefits prior to the expiration of 60 days after written Proof of Loss has been furnished. No such action may be brought after a period of 3 years (or the period required by law, if longer) after the time limits stated in the Proofs of Loss section.

Misstatement of Age
If the age of any Covered Person covered under this *Certificate* has been misstated, there shall be an adjustment of the premium for this *Certificate* so that there shall be paid to the insurer the premium for the coverage of such Covered Person at his correct age, and the amount of the insurance coverage shall not be affected.

Clerical Error
No clerical error on the part of the Group applying for coverage shall affect the insurance, or amount thereof, of any Covered Person, provided proper premium adjustment is made upon discovery of such error.

Non-Regulation of Providers
This Health Net PPO plan does not regulate the amounts charged by providers of medical care, except to the extent that the rates for the Covered Services and Supplies are negotiated with Preferred Providers.

Free Choice of Provider
As a Covered Person in this Health Net PPO plan, you are not required to select a primary care provider. This Health Net PPO plan does not interfere with Your right to select any properly licensed Hospital, Physician (including Specialists and behavioral health care providers) or other health care professional or facility that provides services or supplies covered by this plan. However, Your choice of provider may affect the amount of benefits payable. To identify a Preferred Provider, visit the HNL website at www.healthnet.com or contact the Customer Contact Center at the telephone number on Your HNL ID Card to obtain a copy of the Preferred Provider Directory.

Providing of Care
HNL is not responsible for providing any type of Hospital, medical or similar care. HNL is also not responsible for the quality of any type of Hospital, medical or similar care.

Continuity of Care
At the request of the Covered Person, HNL shall arrange for the completion of covered services by a terminated provider if the Covered Person is undergoing a course of treatment for any of the following conditions: (1) An acute condition (a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition; (2) A serious chronic condition a medical donation due to disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.) Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by HNL in consultation with the Covered Person and the terminated provider and consistent with good professional practice, not to exceed 12 months from the contract termination date, or 12 months from the effective date of coverage for a new Covered Person; (3) A pregnancy (the three trimesters of pregnancy and the immediate postpartum period.) Completion of covered services shall be provided for the duration of the pregnancy; (4) A terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less.) Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new Covered Person; (5) The care of a newborn child between birth and age 36 months Completion of covered services under this provision shall not exceed 12 months from the contract termination date, or 12 months from the effective date of coverage for a new Covered Person; (6) Performance of a scheduled surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a new Covered Person.

For more information on how to request continued care, please contact the Customer Contact Center at the telephone number on the Health Net PPO ID Card.

Relationship of Parties
The relationship, if any, between HNL and any health care providers is that of an independent contractor relationship. Physicians, Hospitals, Skilled Nursing Facilities and other health care providers and community agencies are not agents or employees of HNL. HNL shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by You while receiving care from any health care provider. Neither the Group nor any Covered Person is the agent or representative of HNL. Neither shall be liable for any acts or omissions of HNL, its agents or employees.

HNL retains the right to designate or replace an administrator to perform certain functions for providing the Covered Services and Supplies of this *Certificate*. If HNL does designate or replace any administrator, HNL will inform You of all new procedures. Any administrator designated by HNL is an independent contractor and not an employee or agent of HNL.

Technology Assessment

New technologies are those procedures, drugs or devices that have recently been developed for the treatment of specific diseases or conditions or are new applications of existing procedures, drugs or devices. New technologies are considered investigational or experimental during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to be considered investigational or experimental if clinical study has not shown safety or effectiveness or if they are not considered standard care by the appropriate medical specialty. Approved technologies are integrated into HNL benefits.

HNL determines whether new technologies should be considered medically appropriate, or investigational or experimental, following extensive review of medical research by appropriately specialized physicians. HNL requests review of new technologies by an independent, expert medical reviewer in order to determine medical appropriateness or investigational or experimental status of a technology or procedure.

The expert medical reviewer also advises HNL when patients require quick determinations of coverage, when there is no guiding principle for certain technologies or when the complexity of a patient's medical condition requires expert evaluation. If HNL denies, modifies or delays coverage for Your requested treatment on the basis that it is Experimental or Investigational, You may request an independent medical review (IMR) of HNL's decision from the Department of Insurance. Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" in the "General Provisions" section for additional details.

Confidentiality of Medical Records

A STATEMENT DESCRIBING HNL'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Health Care Plan Fraud

Health care plan fraud is a felony that can be prosecuted. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Your Responsibility

As a Covered Person, You must:

- File accurate claims. If someone else, such as Your spouse or Domestic Partner or another Dependent who is a Covered Person, files claims on Your behalf, You should review the form before You sign it;
- Review the explanation of benefits (EOB) form when it is returned to You. Make certain that benefits have been paid correctly based on Your knowledge of the expenses incurred and the services rendered;
- Never allow another person to seek medical treatment under Your identity. If Your ID card is lost, You should report the loss to Us immediately; and
- Provide complete and accurate information on claims forms and any other information forms. Attempt to answer all questions to the best of Your knowledge.

To maintain the integrity of Your health plan, We encourage You to notify Us whenever a provider:

- bills You for services or treatments that You have never received;
- asks You to sign a blank claim form; or
- asks You to undergo tests that You feel are not needed.

If You are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if You know of or suspect any illegal activity, call Our toll-free hotline at the number shown on Your HNL ID card. All calls are strictly confidential.

Financial Information Privacy Notice

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About this Notice

If you have any questions about this notice, please **call the toll-free member phone number on the back of your health plan ID card** or contact HNL at **1-800-361-3366**.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells You about the ways in which Health Net Life* (referred to as "We" or "the Plan") may collect, use and disclose Your protected health information and Your rights concerning Your protected health information. "Protected health information" is information about You, including demographic information, that can reasonably be used to identify You and that relates to Your past, present or future physical or mental health or condition, the provision of health care to You or the payment for that care.

We are required by federal and state laws to provide You with this Notice about Your rights and Our legal duties and privacy practices with respect to Your protected health information and notify you in the event of a breach of your unsecured protected health information. We must follow the terms of this Notice while it is in effect. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your protected health information we already have as well as any of your protected health information we receive in the future. We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your rights, our legal duties, or other privacy practices stated in the Notice. This will include, but may not be limited to updating the Notice on our website. (Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.)

How We May Use And Disclose Your Protected Health Information

We may use and disclose Your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures We may make without Your authorization for payment, health care operations and treatment.

- **Payment**. We use and disclose Your protected health information in order to pay for Your covered health expenses. For example, We may use Your protected health information to process claims, to be reimbursed by another insurer that may be responsible for payment or for premium billing.
- **Health Care Operations**. We use and disclose Your protected health information in order to perform Our plan activities, such as quality assessment activities or administrative activities, including data management or customer service.
- **Treatment**. We may use and disclose Your protected health information to assist Your health care providers (doctors, pharmacies, Hospitals and others) in Your diagnosis and treatment. For example, We may disclose Your protected health information to providers to provide information about alternative treatments.
- **Plan Sponsor**. We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).
- **Person(s) Involved in Your Care or Payment for Your Care.** We may also disclose protected health information to a person, such as a family member, relative, or close personal friend, who is involved with your care or payment. We may disclose the relevant protected health information to these persons if you do not object or we can reasonably infer from the circumstances that you do not object to the disclosure; however, when you are not present or are incapacitated, we can make the disclosure if, in the exercise of professional judgment, we believe the disclosure is in your best interest.

Other Permitted Or Required Disclosures

- **As Required by Law.** We must disclose protected health information about You when required to do so by law.

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- **Public Health Activities.** We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose protected health information to government agencies about abuse, neglect or domestic violence.
- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g., California Department of Health Services) for activities authorized by law.
- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about You in certain cases in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Coroners, Funeral Directors, Organ Donation.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
- **Research.** Under certain circumstances, We may disclose protected health information about You for research purposes, provided certain measures have been taken to protect Your privacy.
- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about You, with some limitations, when necessary to prevent a serious threat to Your health and safety or the health and safety of the public or another person.
- **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.
- **Fundraising Activities.** We may use or disclose your protected health information for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If We do contact You for fundraising activities, We will give you the opportunity to opt-out, or stop, receiving such communications in the future.

Other Uses Or Disclosures that Require Your Written Authorization

We are required to obtain your written authorization to use or disclose your protected health information, with limited exceptions, for the following reasons:

- **Marketing.** We will request Your written authorization to use or disclose Your protected health information for marketing purposes with limited exceptions, such as when We have face-to-face marketing communications with You or when We provide promotional gifts of nominal value.
- **Sale of Protected Health Information.** We will request Your written authorization before We make any disclosure that is deemed a sale of Your protected health information, meaning that We are receiving compensation for disclosing the protected health information in this manner.
- **Psychotherapy Notes** – We will request Your written authorization to use or disclose any of Your psychotherapy notes that We may have on file with limited exception, such as for certain treatment, payment or health care operation functions.
- **Other Uses or Disclosures.** All other uses or disclosures of Your protected health information not described in this Notice will be made only with Your written authorization, unless otherwise permitted or required by law.

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- **Revocation of an Authorization.** You may revoke an authorization at any time in writing, except to the extent that We have already taken action on the information disclosed or if We are permitted by law to use the information to contest a claim or coverage under the Plan.

Your Rights Regarding Your Protected Health Information

You have certain rights regarding protected health information that the Plan maintains about You.

- **Right To Access Your Protected Health Information.** You have the right to review or obtain copies of Your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of Your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing Your requested information, but We will tell You the cost in advance. If we deny your request for access, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

- **Right To Amend Your Protected Health Information.** If You feel that protected health information maintained by the Plan is incorrect or incomplete, You may request that We amend, or change, the information. Your request must be made in writing and must include the reason You are seeking a change. We may deny Your request if, for example, You ask Us to amend information that was not created by the Plan, as is often the case for health information in Our records, or You ask to amend a record that is already accurate and complete.

  If We deny Your request to amend, We will notify You in writing. You then have the right to submit to Us a written statement of disagreement with Our decision and We have the right to rebut that statement.

- **Right to an Accounting of Disclosures by the Plan.** You have the right to request an accounting of certain disclosures We have made of Your protected health information. The list will not include Our disclosures related to Your treatment, Our payment or health care operations, or disclosures made to You or with Your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

  Your request for an accounting of disclosures must be made in writing and must state a time period for which You want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form You want the list (for example, on paper or electronically). The first accounting that You request within a 12-month period will be free. For additional lists within the same time period, We may charge for providing the accounting, but We will tell You the cost in advance.

- **Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that We restrict or limit how We use or disclose Your protected health information for treatment, payment or health care operations. ***We may not agree to Your request for restriction on use or disclosure of Protected Health Information unrelated to the requirements of California Insurance Code Sections 791.06(c); (d);(f)(1)(A); and (i).*** If We do agree, We will comply with Your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In Your request, You must tell Us (1) what information You want to limit; (2) whether You want to limit how We use or disclose Your information, or both; and (3) to whom You want the restrictions to apply.

- **Right To Receive Confidential Communications.** You have the right to request that We use a certain method to communicate with You about the Plan or that We send Plan information to a certain location if the communication could endanger You. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from Us could endanger You. We will accommodate all reasonable requests. Your request must specify how or where You wish to be contacted.

- **Right to a Notice in the Event of a Breach.** You have a right to receive a notice of a breach involving your protected health information (PHI) should one occur.

- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if You had previously agreed to receive an electronic copy.

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- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting Our Privacy Office. See the end of this Notice for the contact information.

Health Information Security

HNL requires its employees to follow the HNL security policies and procedures that limit access to health information about Covered Persons to those employees who need it to perform their job responsibilities. In addition, HNL maintains physical, administrative and technical security measures to safeguard Your protected health information.

Changes To This Notice

We reserve the right to change the terms of this Notice at any time, effective for protected health information that We already have about You as well as any information that We receive in the future. We will provide You with a copy of the new Notice whenever We make a material change to the privacy practices described in this Notice. We also post a copy of Our current Notice on Our website at www.healthnet.com. Any time We make a material change to this Notice, We will promptly revise and issue the new Notice with the new effective date.

Privacy Complaints

If You believe that Your privacy rights have been violated, You may file a complaint with Us and/or with the Secretary of the Department of Health and Human Services. All complaints to the Plan must be made in writing and sent to the Privacy Office listed at the end of this Notice.

We support Your right to protect the privacy of Your protected health information. ***We will not retaliate against You or penalize You for filing a complaint.***

Contact The Plan

If You have any questions about this Notice or You want to submit a written request to the Plan as required in any of the previous sections of this Notice, please contact:

Address: Health Net Life Privacy Office
Attention: Privacy Officer
P.O. Box 9103
Van Nuys, CA 91409

You may also contact Us at:

Telephone: **1-800-361-3366**
Fax: **1-818-676-8314**
Email: Privacy@healthnet.com

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DEFINITIONS

This section defines words that will help You understand Your Plan. These words appear throughout this *Certificate* with the initial letter of the word in capital letters.

Accidental Injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental Injury does not include illness, infection (except infection of a cut or nonsurgical wound) or damage to the teeth or dental prosthesis caused by chewing.

Ambulance means an automobile or airplane (fixed wing or helicopter), which is specifically designed and equipped for transporting the sick or injured. It must have patient care equipment, including at least a stretcher, clean linens, first aid supplies and oxygen equipment. It must be staffed by at least two persons who are responsible for the care and handling of patients. One of these persons must be trained in advanced first aid. The vehicle must be operated by a business or agency which holds a license issued by a local, state, or national governmental authority authorizing it to operate Ambulances.

Average Wholesale Price for any Prescription Drug is the amount for pharmaceutical products from one of the following: Medi-Span, First DataBank or Micro-medics.

Bariatric Surgery Performance Center is a provider in HNL's designated network of California bariatric surgical centers and surgeons that perform weight loss surgery. Preferred Providers that are not designated as part of HNL's network of Bariatric Surgery Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for weight loss surgery.

Blood Products are biopharmaceutical products derived from human blood, including but not limited to, blood clotting factors, blood plasma, immunoglobulins, granulocytes, platelets and red blood cells.

Brand Name Drug is a Prescription Drug or medicine that has been registered under a brand or trade name by its manufacturer and is advertised and sold under that name, and indicated as a brand in the Medi-Span or similar national Database.

Calendar Year is the twelve-month period that begins at 12:01 a.m. Pacific Time on January 1 of each year.

Calendar Year Deductible is the amount of medical Covered Expenses which must be incurred by You or Your family each Calendar Year and for which You or Your family have payment responsibility before benefits become payable by HNL.

Certification refers to the process for certain Covered Expenses that require review and approval, frequently prior to the expense being incurred. The "Schedule of Benefits" section of this *Certificate* shows the penalties applicable to those expenses which are authorized in accordance with the provisions of this *Certificate*, and those expenses which require review and approval, prior to the expenses being incurred which are not so certified. The requirements for Certification are described in the "Certification Requirement" portion of the "Plan Benefits" section of this *Certificate.*

Chemical Dependency is alcoholism, drug addiction or other Chemical Dependency problems.

Coinsurance is the percentage of the Covered Expenses for which You are responsible, as specified in the "Schedule of Benefits" section.

Compounded Drugs are prescription orders that have at least one ingredient that is Federal Legend in a therapeutic amount and are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form and require a prescription order for dispensing.

Contracted Rate is the rate that Preferred Providers are allowed to charge You, based on a contract between HNL and such provider. Covered Expenses for services provided by a Preferred Provider will be based on the Contracted Rate.

Copayment is a fixed dollar fee charged to You for Covered Services and Supplies when You receive them. The amount of each Copayment is indicated in the "Schedule of Benefits" section.

Corrective Footwear includes specialized shoes, arch supports and inserts and is custom made for Members who suffer from foot disfigurement. Foot disfigurement includes, but is not limited to, disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by accident or developmental disability.

Covered Expenses are the maximum charges for which HNL will pay benefits for each covered service or supply (including covered services related to Mental Disorders and Chemical Dependency). The amount of Covered Expenses varies by whether You obtain services from a Preferred Provider or an Out-of-Network Provider. Covered Expenses are the lesser of the billed charge or: (i) Contracted Rate for the services or supplies provided by a Preferred Provider; (ii) the Maximum Allowable Amount for the services or supplies from an inpatient Hospital, Skilled Nursing Facility, Home Health Care Agency, for Outpatient surgery or for Emergency Care received during Foreign Travel or Work Assignment, provided by an Out-of-Network Provider; or (iii) for the cost of services or supplies from any other Out-of-Network Provider, the Schedule Amount.

Covered Person is the enrolled employee (referred to as "You" or "Your" or the “principal Covered Person”) or his or her Dependent who is covered under this *Certificate.*

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

Custodial Care is care that is rendered to a patient to assist in support of the essentials of daily living such as help in walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets and supervision of medications which are ordinarily self-administered, and for which the patient:

- Is disabled mentally or physically and such disability is expected to continue and be prolonged;
- Requires a protected, monitored, or controlled environment whether in an institution or in the home; and
- Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

Deductible is a set amount You pay for specified Covered Cervices and Supplies before HNL pays any benefits for those Covered Services and Supplies.

Dependents are individuals who meet the eligibility requirements for coverage under this *Certificate* and have been enrolled by the principal Covered Person (employee).

Domestic Partner is, for the purposes of this *Certificate*, a person eligible for coverage as a Dependent provided that the partnership is with the principal Covered Person and who meets all of the requirements of Section 308(c) of the California Family Code, or is a registered domestic partner, or meets all domestic partnership requirements under specified by section 297 or 299.2 of the California Family Code. Your Group allows enrollment of same-sex and opposite-sex domestic partners who do not meet all of the requirements of Sections 297 or 299.2 of the California Family Code, so the term “Domestic Partner” also includes Your domestic partner who meets Your Group’s eligibility requirements.

Durable Medical Equipment

- Serves a medical purpose (its reason for existing is to fulfill a medical need or health condition, it is not for convenience and/or comfort and it is not useful to anyone in the absence of a health condition);
- Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities;
- Withstands repeated use; and
- Is appropriate for use in a home setting.

Effective Date is the date on which You become covered or entitled to benefits under this *Certificate*.

Emergency Care is any otherwise covered service for an acute illness, a new injury or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or, if a minor, to the minor's parent or guardian that a reasonable person with an average knowledge of health and medicine (a prudent layperson), would seek if he or she was having serious symptoms (including symptoms of Severe Mental Illness and Serious Emotional Disturbances of a Child), and believed that without immediate treatment, any of the following would occur:

- His or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger);
- His or her bodily functions, organs or parts would become seriously damaged; or
- His or her bodily organs or parts would seriously malfunction.

Emergency Care also includes treatment of severe Pain or active labor. Active labor means labor at the time that either of the following would occur:

- There is inadequate time to effect safe transfer to another Hospital prior to delivery; or
- A transfer poses a threat to the health and safety of the Covered Person or unborn child.

Emergency Care is available and accessible to all Covered Persons in the Service Area 24 hours a day, seven days a week. Emergency Care includes air and ground Ambulance transport services provided through the "911" emergency response system, if the request was made for Emergency Care. Ambulance services will transport the Covered Person to the nearest 24-hour emergency facility with Physician coverage.

Emergency Care will also include additional screening, examination and evaluation by a Physician (or other health care provider acting within the scope of his or her license) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate such condition, within the capability of the facility.

A "psychiatric emergency medical condition" means a Mental Disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the Mental Disorder.

See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" under "General Provisions" for the procedure to request an Independent Medical Review of a Plan denial of coverage for Emergency Care.

Essential Health Benefits are a set of health care service categories (as defined by the Affordable Care Act and section 10112.27 of the California Insurance Code) that must be covered by all health benefits plans starting in 2014. Categories include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including dental and vision care.

Experimental (or Investigational) means a drug, biological product, device, equipment, medical treatment, therapy, or procedure ("Service") that is not presently recognized as standard medical care for a medically diagnosed condition, illness, disease, or injury, but which Service is being actively investigated for use in the treatment of the diagnosed condition, illness, disease, or injury.

A service is Investigational or Experimental if it meets any of the following criteria:

- It is currently the subject of active and credible evaluation (e.g., clinical trials or research) to determine:
  - clinical efficacy,
  - therapeutic value or beneficial effects on health outcomes, or
  - benefits beyond any established medical based alternative.
- It is the subject of an active and credible evaluation and does not have final clearance from applicable governmental regulatory bodies (such as the US Food and Drug Administration "FDA") and unrestricted

market approval for use in the treatment of a specified medical condition or the condition for which authorization of the service is requested.

- The most recent peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals do not conclude, or are inconclusive in finding, that the service is safe and effective for the treatment of the condition for which authorization of the service is requested.

EyeMed Vision Care, LLC, a contracted vision services provider panel, provides and administers the vision services benefits through a network of dispensing opticians and optometric laboratories.

Generic Drug is the pharmaceutical equivalent of a Brand Name Drug whose patent has expired and is available from multiple manufacturers as set out in the Medi-Span or similar third party database as used by HNL. The Food and Drug Administration must approve the Generic Drug as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

Group is the business organization (usually and employer or trust) to which HNL has issued the Policy to provide the benefits of this Plan.

Health Net Essential Rx Drug List (also known as Essential Rx Drug List) is a list of the Prescription Drugs that are covered by this Plan. Drugs not on the Essential Rx Drug List that are Medically Necessary are also covered. It is prepared and updated by HNL and distributed to Covered Persons, Physicians and Participating Pharmacies and posted on the HNL website at www.healthnet.com under the pharmacy information. Some Drugs in the Essential Rx Drug List require Prior Authorization from HNL in order to be covered.

Health Net Life Insurance Company (HNL) is a life and disability insurance company regulated by the California Department of Insurance. The term "We," "Our" or "Us" when they appear in this *Certificate* refer to HNL.

Health Net PPO is the Preferred Provider Organization (PPO) plan described in this *Certificate*, which allows You to obtain medical benefits from either a network of Preferred Providers with whom HNL has contracted to provide services at the Contracted Rate; or else any Out-of-Network Provider. Health Net PPO is underwritten by HNL.

Health Net PPO Service Area is the United States.

Home Health Care Agency is an organization licensed by the state in which it is located and has an agreement in force for rendering Home Health Care Services under the terms and conditions of this *Certificate* and certified by Medicare.

Home Health Care Services are services, including skilled nursing services, provided by a licensed Home Health Care Agency to a Covered Person in his or her place of residence that is prescribed by the Covered Person's attending Physician as part of a written plan**.** Home Health Care Services are covered if the Covered Person is homebound, under the care of a contracting physician, and requires Medically Necessary skilled nursing services, physical, speech, occupational therapy, or respiratory therapy or medical social services. Only Intermittent Skilled Nursing Services are covered benefits under this plan. See also "Intermittent Skilled Nursing Services" and "Private Duty Nursing."

Hospice is a facility or program that provides a caring environment for meeting the physical and emotional needs of the terminally ill. The Hospice and its employees must be licensed according to applicable state and local laws and certified by Medicare.

Hospice Care is care that is designed to provide medical and supporting care to the terminally ill and their families. Hospice Care is designed to be provided primarily in Your home.

Hospital is a legally operated facility licensed by the state as an acute care Hospital and approved either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by Medicare.

Infertility means either (1) the presence of a demonstrated condition recognized by a licensed Physician and surgeon as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Intermittent Skilled Nursing Services are services requiring the skilled services of a registered nurse or LVN.

Investigational (or Experimental) means a drug, biological product, device, equipment, medical treatment, therapy, or procedure ("Service") that is not presently recognized as standard medical care for a medically diagnosed condition, illness, disease, or injury, but which Service is being actively investigated for use in the treatment of the diagnosed condition, illness, disease, or injury.

A service is Investigational or Experimental if it meets any of the following criteria:

- It is currently the subject of active and credible evaluation (e.g., clinical trials or research) to determine:
  - clinical efficacy,
  - therapeutic value or beneficial effects on health outcomes, or
  - benefits beyond any established medical based alternative.
- It is the subject of an active and credible evaluation and does not have final clearance from applicable governmental regulatory bodies (such as the US Food and Drug Administration "FDA") and unrestricted market approval for use in the treatment of a specified medical condition or the condition for which authorization of the service is requested.
- The most recent peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals do not conclude, or are inconclusive in finding, that the service is safe and effective for the treatment of the condition for which authorization of the service is requested.

Maintenance Drugs are Prescription Drugs (excluding Specialty Drugs) taken continuously to manage chronic or long term conditions where Covered Persons respond positively to a drug treatment plan with a specific medication at a constant dosage requirement.

Maximum Allowable Amount is the amount on which HNL bases its reimbursement for Covered Services and Supplies received from a Hospital, Skilled Nursing Facility or Home Health Care Agency; for Outpatient surgery; or for Emergency Care received during Foreign Travel or Work Assignment, provided by an Out-of-Network Provider, which may be less than the amount billed for those services and supplies. HNL calculates Maximum Allowable Amount as the lesser of the amount billed by the Out-of-Network Provider or the amount determined as set forth herein. Maximum Allowable Amount is not the amount that HNL pays for a Covered Service; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles and other applicable amounts set forth in this *Certificate*.

- The Maximum Allowable Amount for Out-of-Network Emergency Care will be the greatest of: (1) the amount negotiated with Preferred Providers for the emergency service provided, excluding any in-network Copayment or Coinsurance; (2) the amount calculated using the same method HNL generally uses to determine payments for Out-of-Network providers, excluding any in-network Copayment or Coinsurance; or (3) the amount paid under Medicare Part A or B, excluding any in-network Copayment or Coinsurance.
- For all services received from an inpatient Hospital, Skilled Nursing Facility, Home Health Care Agency, for Outpatient surgery or for Emergency Care received during Foreign Travel or Work Assignment, Maximum Allowable Amount is determined by applying a percentage of what Medicare would allow (known as the Medicare allowable amount). The Maximum Allowable Amount for such services is 190% of the Medicare allowable amount.
- In the event the applicable service or database does not include an amount for the service or supply provided, Maximum Allowable Amount shall be deemed to be 75% of the covered charges billed by the provider. The Maximum Allowable Amount determined under the databases described above may be more or less than 75% of the amount normally charged by the provider for the same services or supplies.
- The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses. See "Schedule of Benefits," "Plan Benefits" and "General Limitations and Exclusions" sections for specific benefit limitations, maximums, pre-certification requirements and payment policies that limit the amount HNL pays for certain Covered Services and Supplies. HNL uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement.

In addition to the above, from time to time, HNL also contracts with vendors that have contracted fee arrangements with providers ("Third Party Networks"). In the event HNL contracts with a Third Party Network that has a contract with the Out-of-Network Provider, HNL may, at its option, use the rate agreed to by the Third Party Network as the Maximum Allowable Amount, in which case You will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance at the Out-of-Network level.

In addition, HNL may, at its option, refer a claim for Out-of-Network Services to a fee negotiation service to negotiate the Maximum Allowable Amount for the service or supply provided directly with the Out-of-Network Provider. In that situation, if the Out-of-Network Provider agrees to a negotiated Maximum Allowable Amount, You will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance at the Out-of-Network level.

In the event that the billed charges for the Out-of-Network Provider are more than the Maximum Allowable Amount, You are responsible for any amounts charged in excess of the Maximum Allowable Amount, except where the Out-of-Network Provider's fee is determined by reference to a Third Party Network agreement or the Out-of-Network Provider agrees to a negotiated Maximum Allowable Amount.

Please note that whenever You obtain Covered Services and Supplies from an Out-of-Network Provider, you are responsible for applicable Deductibles, Copayments and Coinsurance.

For more information on the determination of Maximum Allowable Amount, or for information, services and tools to help you further understand your potential financial responsibilities for Covered Out-of-Network Services and Supplies please log on to www.healthnet.com or contact HNL Customer Service at the number on Your member identification card.

Maximum Allowable Cost for any Prescription Drug is the maximum charge HNL will allow for Generic Drugs, or for Brand Name Drugs which have a generic equivalent. A list of Maximum Allowable Costs is maintained, and may be revised periodically, by HNL.

Medical Child Support Order is a court judgment or order that, according to state or federal law, requires group health plans that are affected by that law to provide coverage to a child or children who is the subject of such an order. HNL will honor such orders.

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

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

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

Medicare is the name commonly used to describe Health Insurance Benefits for the Aged and Disabled provided under Public Law 89-97 as amended to date or as later amended.

Mental Disorders are a nervous or mental condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM) that results in clinically significant distress or impairment of mental, emotional or behavioral functioning.

Neuro-Musculoskeletal Disorder is a misalignment of the skeletal structure, muscular weakness, osteopathic imbalance, or any disorder related to the spinal cord, neck, or joints.

Nonparticipating Pharmacy is a facility not authorized by HNL to be a Participating Pharmacy.

Open Enrollment Period is a period of time each Calendar Year, during which individuals who are eligible for coverage in this Plan may enroll for the first time, or if You were enrolled previously, may add Your eligible Dependents.

The Group decides the exact dates for the Open Enrollment Period.

Changes requested during the Open Enrollment Period become effective on the first day of the calendar month following the date the request is submitted, or on any date approved by Us.

Orthotics (such as bracing, supports and casts) are rigid or semi-rigid devices that are externally affixed to the body and designed to be used as a support or brace to assist the Member with the following:

- To restore function; or
- To support, align, prevent, or correct a defect or function of a body part; or
- To improve natural function; or
- As part of habilitative services to keep, learn, or improve skills and functioning; or
- To restrict motion.

Out-of-Network Providers are Physicians, Hospitals, or other providers of health care who are not part of the Health Net PPO Preferred Provider Organization (PPO), except as noted under the definitions for "Bariatric Surgery Performance Center" and "Transplant Performance Center."

Out-of-Pocket Maximum is the maximum dollar amount of Deductibles, Copayments and Coinsurance for which You or Your family must pay for medical, outpatient Prescription Drug and pediatric vision Covered Expenses during a Calendar Year. After that maximum is reached, your payment responsibilities for Copayments and Coinsurance will no longer apply for Covered Expenses incurred during the remainder of that Calendar Year, as shown in the "Schedule of Benefits" section. Penalties paid for services which were not certified as required will not be applied to the Out-of-Pocket Maximum, and your responsibility for these penalties will continue to apply to these expenses after the Out-of-Pocket Maximum is reached. For a family plan, an individual is responsible only for meeting the individual Out-of-Pocket Maximum.

Outpatient Surgical Center is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services.

Pain means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder or condition.

Participating Pharmacy is a facility authorized by HNL to dispense Prescription Drugs to persons eligible for benefits under the terms of this *Certificate*. A list of Participating Pharmacies and a detailed explanation of how the program operates has been provided or will be provided by HNL.

Participating Vision Provider is an optometrist, ophthalmologist or optician licensed to provide Covered Services and who or which, at the time care is rendered to a Member, has a contract in effect with Health Net to furnish care to Members. The names of Participating Vision Providers are set forth in Health Net's Participating Vision Provider Directory. The names of Participating Vision Providers and their locations and hours of practice may also be obtained by contacting Health Net's Customer Contact Center.

Physician means:

- A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
- One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for whom benefits are specified in this *Certificate*, and when benefits would be payable if the services were provided by a Physician as defined above:

  Dentist (D.D.S.)
  Optometrist (O.D.)
  Dispensing optician
  Podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)

Psychologist
Chiropractor (D.C.)
Nurse midwife
Nurse Practitioner
Physician Assistant
Clinical social worker (M.S.W. or L.C.S.W.)
Marriage, family and child counselor (M.F.C.C.)
Physical therapist (P.T. or R.P.T.)
Speech pathologist
Audiologist
Occupational therapist (O.T.R.)
Psychiatric mental health nurse
Respiratory care practitioner
Acupuncturist (A.C.)

Preferred Provider Organization is a health care provider arrangement whereby HNL contracts with a group of Physicians or other medical care providers who have contracted to furnish services at the negotiated rate known as the Contracted Rate.

Preferred Providers are Physicians, Hospitals or other providers of health care who have a written agreement with HNL to participate in the Preferred Provider Organization (PPO) network and have agreed to provide You with Covered Services and Supplies at a contracted rate (the Contracted Rate), except as noted under the definitions for "Bariatric Surgery Performance Center" and "Transplant Performance Center." You must pay any Deductible(s), Copayment or Coinsurance required, but are not responsible for any amount charged in excess of the Contracted Rate. Preferred Providers are listed in the Preferred Provider Directory given to You upon enrollment and periodically updated. To insure the participation by a Preferred Provider, please contact the Customer Contact Center at the telephone number on Your HNL ID card before services are received.

Prescription Drug is a drug or medicine that can be obtained only by a Prescription Drug Order. All Prescription Drugs are required to be labeled "Caution, Federal Law Prohibits Dispensing Without a Prescription." An exception is insulin and other diabetic supplies, which are considered to be covered Prescription Drugs.

Prescription Drug Covered Expenses are the maximum charges HNL will allow for each Prescription Drug Order. The amount of Prescription Drug Covered Expenses varies by whether a Participating or Nonparticipating Pharmacy dispenses the order. It is not necessarily the amount the pharmacy will bill. Any expense incurred which exceeds the following amounts is not a Prescription Drug Covered Expense: (a) for Prescription Drug Orders dispensed from a Participating Pharmacy, or through the mail service program, the Prescription Drug Allowable Charge; or (b) for Prescription Drug Orders dispensed by a Nonparticipating Pharmacy in emergency or urgent situations, the lesser of the Maximum Allowable Cost or the Average Wholesale Price.

Prescription Drug Allowable Charge is the charge that Participating Pharmacies and the mail service program have agreed to charge Covered Persons, based on a contract between HNL and such provider.

Prescription Drug Order is a written or verbal order or refill notice for a specific drug strength and dosage form (such as a tablet, liquid, syrup or capsule) directly related to the treatment of an illness, injury or health condition and which is issued by the attending Physician within the scope of his or her professional license.

Preventive Care Services (including services for the detection of asymptomatic diseases) are services provided under a Physician's supervision and which include, but are not limited to, the following:

- Reasonable health appraisal examinations on a periodic basis
- A variety of family planning services
- Preventive prenatal care in accordance with the guidelines of the Health Resources and Services Administration (HRSA)
- Vision and hearing testing for Covered Persons
- Immunizations for children in accordance with the recommendations of the American Academy of Pediatrics and immunizations for adults as recommended by the U.S. Public Health Service

- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA
- For women, evidence-informed preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the HRSA
- Venereal disease tests
- Cytology examinations on a reasonable periodic basis
- Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided through HNL
- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF)

Prior Authorization is HNL's approval process for Specialty Drugs and certain Tier I, Tier II and Tier III Drugs that require pre-approval. Physicians must obtain HNL's Prior Authorization before Specialty Drugs and certain Tier I, Tier II and Tier III Drugs will be covered.

Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a Hospital or Skilled Nursing Facility. Except for home health nursing services, Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of six hours in any 24-hour period. Private Duty Nursing provided as Home Health Care Services may not exceed a maximum of 3 visits per day, up to 2 hours per visit. Private Duty Nursing may be provided in an inpatient or outpatient setting, or in a non-institutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care" and includes any portion of shift care services.

Professional Vision Services include examination, material selection, fitting of eyeglasses or contact lenses, related adjustments, instructions, etc.

Qualified Autism Service Provider means either of the following: (1) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified. (2) A person licensed as a Physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

Qualified Autism Service Providers employ and supervise qualified autism service professionals and paraprofessionals who provide behavioral health treatment and implement services for pervasive developmental disorder or autism pursuant to the treatment plan developed and approved by the Qualified Autism Service Provider.

- A qualified autism service professional is a behavioral service provider that has training and experience in providing services for pervasive developmental disorder or autism and is approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations.
- A qualified autism service paraprofessional is an unlicensed and uncertified individual who has adequate education, training, and experience as certified by the Qualified Autism Service Provider, and who meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code.

Residential Treatment Center is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and

distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. HNL requires that all contracted Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

Schedule Amount is the amount from HNL's Limited Fee Schedule which HNL will base payments for the covered services of Out-of-Network Providers. A representative sample of that schedule is set in the "HNL Limited Fee Schedule for Out-of-Network Providers" portion of "Plan Benefits" section. You may contact the Customer Contact Center at the telephone number on Your HNL ID Card for assistance in calculating the Schedule Amount for any covered service or to obtain additional information on HNL's Limited Fee Schedule. Any amount charged by an Out-of-Network provider which exceeds the Schedule Amount is not a Covered Expense.

Serious Emotional Disturbances Of A Child is when a child under the age of 18 has one or more Mental Disorders identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following:

- As a result of the Mental Disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either (i) the child is at risk of removal from home or already has been removed from the home or (ii) the Mental Disorder and impairment have been present for more than six months or are likely to continue for more than one year;
- The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a Mental Disorder; and/or
- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Severe Mental Illness is a category of Mental Disorder which includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition of the *Diagnostic and Statistical Manual for Mental Disorders*), autism, anorexia nervosa and bulimia nervosa.

Skilled Nursing Facility is an institution that is licensed by the appropriate state and local authorities to provide skilled nursing services. In addition, Medicare must approve the facility as a participating Skilled Nursing Facility.

Special Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for the care of inpatients with acute conditions that require constant treatment and monitoring including, but not limited to, an intensive care, cardiac intensive care, and cardiac surgery intensive care unit, and a neonatal intensive or intermediate care newborn nursery.

Specialist is a Physician who delivers specialized services and supplies to the Covered Person.

Specialty Pharmacy Vendor is a pharmacy contracted with HNL specifically to provide Specialty Drugs.

Transplant Performance Center is a provider in HNL's designated network in California for solid organ, tissue and stem cell transplants and transplant-related services, including evaluation and follow-up care. For purposes of determining coverage for transplants and transplant-related services, HNL's network of Transplant Performance Centers includes any providers in HNL's designated supplemental resource network. Preferred Providers that are not designated as part of HNL's network of Transplant Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for transplants and transplant-related services.

INFERTILITY SERVICES

Counseling, planning and other services for problems of fertility and Infertility (as defined in the "Definitions" section of this *Certificate*, when determined to be Medically Necessary by a Physician These benefits are subject to all provisions of this *Certificate*.

	Preferred Providers	Out-of-Network
Infertility services (all covered services that diagnose, evaluate or treat Infertility)	50%	Not Covered
Lifetime benefit maximum for Infertility services	*$2,000*	*Not Applicable*
Lifetime benefit maximum for Infertility drugs	*$2,000*	*Not Applicable*

Notes:

- Infertility services include Prescription Drugs, professional services, inpatient and outpatient care and treatment by injections. Services include diagnosis, diagnostic tests, medication, surgery, artificial insemination and gamete intrafallopian transfer (GIFT).
- Injectable Infertility drugs may be obtained through a retail pharmacy that is a Participating Pharmacy.
- All calculations of the lifetime benefit maximum for Infertility services for each Covered Person are based on the total aggregate amount of benefits paid under this plan and all other Health Net or HNL plans sponsored by the same employer.
- Self-injectable drugs that are prescribed for the treatment of Infertility are covered when Certification is obtained from HNL and the drugs are dispensed by HNL's contracted Specialty Pharmacy Vendor. Once HNL approves the Certification request, HNL will forward the prescription order to the Specialty Pharmacy Vendor. The Specialty Pharmacy Vendor may contact You directly to coordinate the delivery of Your medications. The Specialty Pharmacy Vendor will only charge You for the appropriate Deductible (if applicable) and Copayment or Coinsurance shown in the "Schedule of Benefits" section. HNL will reimburse the Specialty Pharmacy Vendor directly.

Exclusions:

Services or supplies excluded under this "Infertility Services" section may be covered under the "Plan Benefits" section of this Certificate. In addition to the exclusion and limitations listed below, Infertility Services are subject to the general exclusions and limitations, as shown in the "General Limitations and Exclusions" section.

Conception by Medical Procedures

Services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include but are not limited to:

- In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), or any other process that involves the harvesting, transplanting, or manipulating of a human ovum. Also not covered are services or supplies, (including injections and injectable medications) which prepare the Covered Person to receive these services.
- Collection, storage, or purchase of sperm or ova.

NOTICE OF LANGUAGE SERVICES

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 or please call:
Individual & Family Plans: 1-888-926-4988
Small Business: 1-888-926-5133
TDD/TYY: 1-888-926-5180

For more help: If you are enrolled in a PPO or EPO insurance policy underwritten by Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in a HMO or HSP plan provided by Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219. Your ID card indicates whether your plan was issued by Health Net Life Insurance Company or Health Net of California, Inc.

English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o llame al:
Planes Individuales y Familiares: 1-888-926-4988
Pequeñas Empresas: 1-888-926-5133
TDD/TYY: 1-888-926-5180

Para obtener más ayuda: Si está inscrito en una póliza de seguro PPO o EPO asegurada por Health Net Life Insurance Company, llame al Departamento de Seguros de CA al 1-800-927-4357. Si está inscrito en un plan HMO o HSP proporcionado por Health Net of California, Inc., llame a la Línea de Ayuda del Departamento de Cuidado Médico (por sus siglas en inglés, DMHC) al 1-888-HMO-2219. Su tarjeta de identificación indica si su plan fue emitido por Health Net Life Insurance Company o Health Net of California, Inc.

Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，也可以把部分翻譯成您語言的文件寄送給您。
如需協助，請撥您會員卡上所列的電話號碼與我們聯絡，或請撥：
Individual & Family Plans：1-888-926-4988
小型企業：1-888-926-5133
聽 / 語障專線：1-888-926-5180

如需其他協助：如果您投保的是由 Health Net Life Insurance Company 核保的 PPO 或 EPO 保險保單，請撥 California Department of Insurance 電話 1-800-927-4357。如果您投保的是由 Health Net of California, Inc. 提供的 HMO 或 HSP 計畫，請撥 DMHC 協助專線1-888-HMO-2219。您的會員卡會註明您的計畫是由 Health Net Life Insurance Company 或 Health Net of California, Inc. 核發。

Chinese

Dịch vụ ngôn ngữ miễn phí. Quý vị có thể được cấp thông dịch viên và người đọc giúp các tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, vui lòng gọi cho chúng tôi theo số điện thoại ghi trên thẻ hội viên của quý vị hoặc gọi:
Chương trình bảo hiểm dành cho cá nhân và gia đình: 1-888-926-4988
Chương trình bảo hiểm dành cho tiểu thương nghiệp: 1-888-926-5133
Số TDD/TYY: 1-888-926-5180

Để được trợ giúp bổ túc: Nếu quý vị ghi danh trong các hợp đồng bảo hiểm PPO hoặc EPO do Health Net Life Insurance Company cam kết tài trợ, vui lòng gọi Bộ Bảo hiểm của California theo số 1-800-927-4357. Nếu quý vị ghi danh trong chương trình bảo hiểm HMO hoặc HSP do Health Net of California, Inc. cung cấp, xin gọi Đường dây trợ giúp của DMHC theo số 1-888-HMO-2219. Trên thẻ hội viên của quý vị có ghi rõ chương trình bảo hiểm của quý vị là do Health Net Life Insurance Company hay Health Net of California, Inc. cung cấp.

Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다.
도움이 필요하신 분은 본인의 ID 카드상의 안내번호로 전화하시거나 다음 안내번호로 문의하십시오.
개인 및 가족 플랜: 1-888-926-4988
스몰 비즈니스: 1-888-926-5133
TDD/TTY: 1-888-926-5180

더 많은 도움이 필요하시면: 만일 귀하가 Health Net Life Insurance Company가 인수한 PPO 또는 EPO 보험 폴리시에 가입하신 경우, 캘리포니아 보험국 (CA Dept. of Insurance), 안내번호 1-800-927-4357번으로 문의해 주십시오. 만일 귀하가 Health Net of California, Inc.에서 제공하는 HMO 또는 HSP 플랜에 가입하신 경우, 보건관리부 (DMHC) 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오. 귀하의 ID상에 귀하의 플랜이 Health Net Life Insurance Company에서 제공되는지 또는 Health Net of California, Inc.에서 제공되는지 명시되어 있습니다.

Korean

Walang Gastusin na Mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter at basahin sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o mangyaring tumawag sa:
Individual & Family Plans: 1-888-926-4988
Small Business: 1-888-926-5133
TDD/TYY: 1-888-926-5180

Para sa karagdagang tulong: Kung naka-enroll ka sa isang insurance policy ng PPO o EPO na napapailalim sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung naka-enroll ka sa isang plano ng HMO o HSP na ipinagkakaloob ng Health Net of California, Inc., tumawag sa DMHC Helpline sa 1-888-HMO-2219. Isinasaad ng iyong ID card kung ang iyong plano ay ibinigay ng Health Net Life Insurance Company o Health Net of California, Inc.

Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք բանավոր թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ Ձեր լեզվով: Օգնության համար մեզ զանգահարեք Ձեր ինքնության (ID) տոմսի վրա նշված համարով, կամ խնդրում ենք զանգահարել՝
Անհատական և Ընտանեկան Ծրագրեր՝ 1-888-926-4988
Փոքր Ձեռնարկություններ՝ 1-888-926-5133
Խուլերի համար սարք (TDD/TTY)՝ 1-888-926-5180

Հավելյալ օգնության համար՝ եթե գրանցվել եք PPO կամ EPO ապահովագրական ծրագրում, որի մատակարարն է Health Net Life Insurance Company-ն, 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք (CA Dept. of Insurance): Եթե գրանցվել եք HMO կամ HSP ծրագրում, որի մատակարարն է Health Net of California, Inc.-ը, 1-888-HMO-2219 համարով զանգահարեք DMHC-ի Օգնության Գծին: Ձեր ինքնության տոմսը նշում է, թե ով է թողարկել Ձեր ծրագիրը՝ Health Net Life Insurance Company-ն, թե՞ Health Net of California, Inc.-ը:

Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочитать документы на вашем языке. Если вам требуется помощь, звоните нам по номеру телефона, указанному на вашей идентификационной карте.
Планы индивидуального и семейного страхования: 1-888-926-4988
Малый бизнес: 1-888-926-5133
Линия TDD/TTY: 1-888-926-5180

Для получения дополнительной помощи: если у вас страховой полис Организации с предпочтительными поставщиками услуг (Preferred Provider Organization, PPO) или Организации с обязательными поставщиками услуг (Exclusive Provider Organization, EPO), который предоставляется компанией Health Net Life Insurance Company, обращайтесь в Департамент страхования штата Калифорния (CA Dept. of Insurance) по номеру 1-800-927-4357. Если вы зарегистрированы в плане HMO или HSP, который предоставлен компанией Health Net of California, Inc., звоните на телефон Горячей линии Департамента организованного медицинского обслуживания (DMHC Helpline) по номеру 1-888-HMO-2219. На вашей идентификационной карте указано, был ли ваш план оформлен компанией Health Net Life Insurance Company или компанией Health Net of California, Inc.

Russian

無料の言語サービス。日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または以下の番号までご連絡ください。
個人および家族プラン：1-888-926-4988
中小企業：1-888-926-5133
TDD/TTY専用番号：1-888-926-5180

さらに援助が必要な場合、Health Net Life Insurance Companyが保険引受会社となるPPOまたはEPO保険ポリシーにご加入の方は、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Health Net of California, Inc.が提供するHMOまたはHSPプランにご加入の方は、DMHCヘルプライン、1-888-HMO-2219までご連絡ください。お客様のプランの発行者がHealth Net Life Insurance CompanyまたはHealth Net of California, Inc.のどちらであるかは、IDカードに記載されています。

Japanese

خدمات بی هزینه مربوط به زبان. می توانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید تا نوشته ها به زبان خودتان برایتان خوانده شوند. برای دریافت کردن کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است تماس گرفته و یا به شماره های زیر تلفن کنید:
طرح افراد و خانواده ها: 1-888-926-4988
کسب و کار کوچک: 1-888-926-5133
TDD/TTY: 1-888-926-5180

برای دریافت کمک بیشتر: اگر برای یک بیمه نامه PPO یا EPO که توسط Health Net Life Insurance Company تضمین شده است ثبت نام کرده اید، به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید. اگر در یک طرح HMO یا HSP که توسط Health Net of California, Inc. فراهم شده است ثبت نام میکنید، به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید. کارت شناسائی تان نشان میدهد که آیا طرح شما توسط Health Net Life Insurance Company صادر شده است یا Health Net of California, Inc.

Farsi

ਭਾਸ਼ਾ ਦੀਆਂ ਮੁਫਤ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ ਇਥੇ ਫੋਨ ਕਰੋ:
ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾਵਾਂ: 1-888-926-4988
ਛੋਟਾ ਕਾਰੋਬਾਰ: 1-888-926-5133
TDD/TYY: 1-888-926-5180

ਹੋਰ ਮਦਦ ਲਈ: ਜੇ ਤੁਸੀਂ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕਿਸੇ PPO ਜਾਂ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ ਕੈਲੀਫੋਰਨਿਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net of California, Inc. ਵਲੋਂ ਮੁਹੱਈਆ ਕੀਤੀ ਗਈ ਕਿਸੇ HMO ਜਾਂ HSP ਯੋਜਨਾ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ DMHC ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ ਤੇ ਇਹ ਦਿਖਾਇਆ ਗਿਆ ਹੈ ਕਿ ਤੁਹਾਡੀ ਯੋਜਨਾ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕੀਤੀ ਗਈ ਸੀ ਜਾਂ Health Net of California, Inc. ਵਲੋਂ।

Punjabi

សេវាបកប្រែភាសាឥតអស់ថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងឲ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខមានកត់នៅលើប័ណ្ណ ID របស់អ្នក ឬសូមទូរស័ព្ទទៅ :
គំរោងបុគ្គលម្នាក់ៗ និងគ្រួសារ : 1-888-926-4988
ពាណិជ្ជកម្មតូច : 1-888-926-5133
លេខ TDD/TTY : 1-888-926-5180

សំរាប់ជំនួយបន្ថែម : បើអ្នកបានចុះឈ្មោះក្នុងធ្យាប់សន្យាធានារ៉ាប់រង PPO ឬ EPO បានធានារ៉ាប់រងដោយ Health Net Life Insurance Company ទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357. បើអ្នកបានចុះឈ្មោះក្នុងគំរោង HMO ឬ HSP ដែលបានផ្តល់ដោយ Health Net of California, Inc. ទូរស័ព្ទទៅខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219។ ប័ណ្ណ ID របស់អ្នកបង្ហាញថាតើគំរោងរបស់អ្នកបានចេញដោយ Health Net Life Insurance Company ឬ Health Net of California, Inc.។

Khmer

Kev Pab Lus Tsis Muaj Nqi Them. Koj txais tau tus neeg txhais lus thiab muab tau cov ntawv los nyeem rau koj ua koj hom lus. Kom tau kev pab, hu tuaj rau peb ntawm tus xovtooj uas nyob ntawm koj daim npav ID lossis thov hu rau:
Kev Npaj Pab Tus Kheej thiab Tsev Neeg (Individual and Family Plan; IFP): 1-888-926-4988
Cov Lagluam Me: 1-888-926-5133
Tus Xovtooj TDD/TTY: 1-888-926-5180

Yog xav tau kev pab ntxiv: Yog koj muaj npe nkag nrog PPO lossis EPO cov kev tuav pov hwm los ntawm Health Net Life Insurance Company, hu rau CA Qhov Chaw Saib Xyuas Txog Kev Tuav Pov Hwm (Dept. of Insurance) ntawm 1-800-927-4357. Yog koj muaj npe nkag nrog ib qho kev npaj pab HMO lossis HSP uas los ntawm Health Net of California, Inc., hu rau DMHC Tus Xovtooj Muab Kev Pab ntawm 1-888-HMO-2219. Koj daim npav ID yuav qhia tau tias koj qhov kev npaj pab yog los ntawm Health Net Life Insurance Company lossis Health Net of California, Inc.

Hmong

Doo Bąąh 'Alínígóó Saad Bee 'áka'anída'awo'ígíí. 'Ata' halne'í dóó naaltsoos bee 'éédahozinígíí t'áá ni nizaad bee hadadilyaago nich'į' yídóoltah. 'Áka'a'eyeed biniiyégo, ninaaltsoos nitł'izí bee nééhozinígíí bine'dę́ę́' béésh bee haneí biká'ígíí bee nich'į' hodíilnih, doodago t'áá shǫǫdí kohjį' hodíilnih:
Łą' Jizíh dóó Hooghan Haz'ą́ą́gi Naaltsoos Hadadít'éhígíí (IFP): 1-888-926-4988
T'áá 'ałtsziísígo Naalyéhí Báhooghan Daayéełyeedígíí: 1-888-926-5133
TDD/TYY: 1-888-926-5180

T'áá náásgóó 'áka'a'eyeed biniiyégo: PPO doodago EPO béeso 'ách'ą́ą́h naa'nil bibee haz'áanii Health Net Life Insurance Company bich'į' haidiilaaígíí bił ha'dít'éhígíí bił ha'diléehgo, CA Dept. béeso 'áchą́ą́h naa'nil bił haz'ánígíí bich'į' kohjį' 1-800-927-4357 hodíilnih. Health Net of California, Inc. biyaadóó HMO doodago HSP bił ha'dít'éhígíí bił ha'diléehgo, DMHC 'Áka'aná'awo' Bił Haz'ánígíí kohjį'1-888-HMO-2219 hodíilnih. Health Net Life Insurance Company doodago Health Net of California, Inc. bił naaltsoos bił náha'dít'éhígíí ninaaltsoos nitł'izí bine'dę́ę́' bikáá'.

Navajo

الخدمات اللغوية المجانية: يمكنك الحصول على مترجم فوري للمساعدة في قراءة مستنداتك باللغة التي تتحدث بها. للحصول على مساعدة، يُرجى الاتصال بنا على الرقم الموضح على بطاقة التعريف الخاصة بك، أو الاتصال بـ:
خطط الفرد والأسرة: 1-888-926-4988
Small Business (الأعمال الصغيرة): 1-888-926-5133
رقم الهاتف النصي/خط ضعاف السمع: 1-888-926-5180

للحصول على المزيد من المساعدة: إذا كنت مسجلاً في سياسة التأمين بخطة PPO أو EPO التي تضمنها شركة التأمين على الحياة Health Net Life Insurance Company، يُرجى الاتصال بـ CA Dept. of Insurance (وزارة التأمين بولاية كاليفورنيا) على الرقم 1-800-927-4357. إذا كنت مسجلاً في خطة HMO أو HSP التي توفرها شركة Health Net of California, Inc.، يُرجى الاتصال بخط المساعدة لدى DMHC على الرقم 1-888-HMO-2219. توضح بطاقة التعريف الخاصة بك ما إذا كان تم إصدار خطتك عبر شركة التأمين على الحياة Health Net Life Insurance Company أو شركة Health Net of California, Inc.

Arabic

Contact us

Health Net PPO
Post Office Box 10196
Van Nuys, California 91410-0196

Customer Contact Center
Large Group:
1-800-676-6976
(for companies with 51 or
more employees)

Small Business Group:
1-800-361-3366
(for companies with 2-50 employees)

Individual & Family Plans:
1-800-839-2172

1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

Telecommunications Device for
the Hearing and Speech Impaired
1-800-995-0852

www.healthnet.com