

CERTIFICATE OF INSURANCE

A complete explanation of Your plan

PPO (Plan JBL) 661271

Important benefit information – please read



PPO847LRG(1/22)NG

Dear Health Net Covered Person:

Thank you for choosing Health Net to provide your health care benefits. We look forward to ensuring a positive experience and your continued satisfaction with the services we provide.

This is Your new Health Net PPO *Certificate of Insurance*.

If your Group has requested that we make it available, you can access this document online through Health Net's secure website at www.healthnet.com. You can also elect to have a hard copy of this *Certificate* mailed to you. Please call the telephone number on the back of your identification card to request a copy.

If you've got a web-enabled smartphone, you've got everything you need to track your health plan details. Take the time to download Health Net Mobile. You'll be able to carry your ID card with you, easily find details about your plan, store provider information for easy access, search for doctors and hospitals, or contact us at any time. It's everything you need to track your health plan details – no matter where you are as long as you have your smartphone handy.

We look forward to serving you. Contact us at www.healthnet.com 24 hours a day, seven days a week for information about our plans, your benefits and more. You can even submit questions to us through the website, or contact us at one of the numbers below. Our Customer Contact Center is available from 8:00 a.m. to 6:00 p.m., Monday through Friday, except holidays. You'll find the number to call on the back of your Member ID card.

This document is the most up-to-date version. To avoid confusion, please discard any versions You may have previously received.

Thank You for choosing Health Net.

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INTRODUCTION TO HEALTH NET PREFERRED PROVIDER ORGANIZATION (PPO)

Plan JBL

348W

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

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 AND URGENT CARE. OUTSIDE THE UNITED STATES, COVERAGE IS LIMITED TO EMERGENCY CARE AND URGENT CARE, AS DESCRIBED UNDER "FOREIGN TRAVEL OR WORK ASSIGNMENT" IN THE "MISCELLANEOUS PROVISIONS" SECTION.

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 benefits described under this *Certificate* do not discriminate on the basis of race, ethnicity, color, nationality, ancestry, national origin, sex, gender, gender identity, gender expression, PPO847LRG(1/22)NG 661271

marital status, Domestic Partner status, age, disability, sexual orientation, genetic information, 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.

The PPO Preferred Provider Network is subject to change. It is your obligation to be sure that the provider You choose is a Preferred Provider with an HNL PPO Agreement in effect. **IMPORTANT NOTE:** Please be aware that it is Your responsibility and in Your best financial interest to verify that the health care providers treating You are Preferred Providers, including:

- The Hospital or other facility where care will be given. After verifying that the Hospital or the facility is a PPO Preferred Provider, You should not assume all providers at that Hospital or facility are also Preferred Providers; if you receive services from an Out-of-Network Provider at that Hospital or other facility, refer to "When Out-of-Network Non-Emergent Services are received at an In-Network Health Facility" below for information on how those services are paid.
- The provider You select, or to whom You are referred, at the specific location at which You will receive care. Some providers participate at one location, but not at others.

Preferred Providers may refer Covered Persons to Out-of-Network Providers. If Certification is required but not obtained prior to incurring services, such services will be subject to the noncertification penalty shown in the "Schedule of Benefits" section.

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 the Maximum Allowable Amount; and (iii) You are financially responsible for any amounts these Out-of-Network Providers charge in excess of this amount. Please refer to the definition of Maximum Allowable Amount in the "Definitions" section for details.

When Services are not Available through a Preferred Provider: If HNL determines that the Medically Necessary care You require is not available because there is no provider or facility that can provide the care within the Preferred Provider network, HNL will authorize You to receive the care and will arrange for the required medically appropriate care from an available and accessible Out-of-Network Provider or facility. Covered Services and Supplies received from Out-of-Network Providers under these circumstances will be payable at the Preferred Provider level of coverage. Cost-sharing paid at the Preferred Provider level of coverage will apply toward the in-network Deductible and accrue to

the in-network Out-of-Pocket Maximum and You will not be responsible for any amounts in excess of the Maximum Allowable Amount. If You need access to medically appropriate care that is not available in the PPO Preferred Provider network, or are being billed for amounts in excess of the Maximum Allowable Amount for Covered Services received under these circumstances, please call the Customer Contact Center at the number shown on your Health Net ID card.

When Out-of-Network Non-Emergent Services are received at an In-Network Health Facility: In addition, if You receive covered non-emergent services at an in-network (PPO) health facility (including, but not limited to, a licensed Hospital, an ambulatory surgical center or other outpatient setting, a laboratory, or a radiology or imaging center), at which, or as a result of which, You receive non-emergent Covered Services by an Out-of-Network Provider, the non-emergent services provided by the Out-of-Network Provider will be payable at the Preferred Provider level of cost-sharing and Deductible, if applicable, and without balance billing (balance billing is the difference between a provider's billed charge and the Maximum Allowable Amount); the cost-sharing and Deductible will accrue to the Out-of-Pocket Maximum for Preferred Providers.

The Out-of-Network Provider may bill or collect from You the difference between a provider's billed charge and the Maximum Allowable Amount in addition to any applicable Out-of-Network Deductible(s), Copayments and/or Coinsurance, when You consent in writing at least 24 hours in advance of care. The Out-of-Network Provider must give You notice that Your consent is required within the following time frames:

- If the appointment is scheduled at least 72 hours in advance, notice and consent forms must be provided to You not later than 72 hours prior to the day when the service will be furnished.
- If the appointment is scheduled between 24 hours and 72 hours in advance, notice and consent forms must be provided to You on the day the appointment is scheduled, no later than 24 hours in advance of care.

Notice by the Out-of-Network Provider, and/or Your written consent, less than 24 hours in advance of care is not allowed.

In order to be valid, that consent must meet all of the following requirements: (1) it must be in a document that is separate from the document used to obtain the consent for any other part of the care or procedure, (2) the Out-of-Network Provider has given You a written estimate of the total out-of-pocket cost of care, (3) the consent has advised You that You may elect to seek care from a Preferred Provider or may contact HNL to arrange to receive care from a Preferred Provider, (4) that any costs that You incur as a result of Your use of the Out-of-Network benefit shall be in addition to Preferred Provider cost-sharing amounts and may not count toward the annual Out-of-Pocket Maximum on Preferred Provider benefits or a Deductible, if any, for in-network benefits, and (5) the consent and estimate shall be provided to You in languages other than English under certain circumstances.

The consent criteria in this provision do not apply, and an Out-of-Network Provider will always be subject to the limitations of this provision with respect to the following services:

- Ancillary services, meaning:
 - o Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner;
 - o Items and services provided by assistant surgeons, hospitalists, and intensivists;

- o Diagnostic services, including radiology and laboratory services; and
- o Items and services provided by an Out-of-Network Provider if there is no Preferred Provider who can furnish such item or service at such facility.
- Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network Provider satisfied the consent criteria in this provision.

For information regarding HNL's payment for Out-of-Network Non-Emergent Services, please refer to the Maximum Allowable Amount definition in the "Definitions" section of this *Certificate*.

When Emergency Services are provided by an Out-of-Network Provider

When Covered Services are received in connection with Emergency Care, You will pay the Preferred Provider level of cost-sharing, regardless of whether the provider is a Preferred Provider or an Out-of-Network Provider, and without balance billing. Balance billing is the difference between an Out-of-Network Provider's billed charge and the Maximum Allowable Amount. When You receive Emergency Care from an Out-of-Network Provider, Your payment of the cost-sharing will accrue toward the Deductible (if applicable) and the Out-of-Pocket Maximum for Preferred Providers.

For information regarding HNL's payment for Out-of-Network Emergency Care, please refer to the Maximum Allowable Amount definition in the "Definitions" section of this *Certificate*.

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 "Authorized Hospital and Skilled Nursing Facility Services" portion of the "Schedule of Benefits" section and the "Professional 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 1-800-861-7214.

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.

THIS PLAN IS AVAILABLE TO ANY LARGE GROUP EMPLOYER IN THE STATE OF CALIFORNIA.

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 9103
Van Nuys, CA 91409-9103
1-800-861-7214**

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**

SCHEDULE OF BENEFITS

Health Net PPO Plan JBL

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.

Covered Services for medical conditions and Mental Health and Substance Use Disorders provided appropriately as Telehealth Services are covered on the same basis and to the same extent as Covered Services delivered in-person. Telehealth Services will be covered only when performed by a Preferred Provider.

COVID-19: The following are covered without cost-sharing or balance billing as long as required pursuant to a state or federal requirement:

- Hospital, emergency department, Urgent Care, and provider office visits (which includes in-person and telehealth visits) where the purpose of the visit is to be screened and/or tested for COVID-19
- All Medically Necessary items or services for screening and testing for COVID-19
- Any qualifying preventive service, including immunization, that is intended to prevent or mitigate COVID-19 disease

Upon expiration of the state or federal requirements, the above services may be subject to cost-shares and/or balance billing. You will be notified by HNL prior to the expiration of this requirement.

For additional information, please visit www.healthnet.com and select “COVID-19 Updates.”

Exception(s):

- Preventive Care Services are not subject to the Individual and Family Calendar Year Deductibles, when services are provided by a Preferred Provider.

Medical Benefits

Certification of Covered Expenses is required in some instances or benefits may be reduced. Please see the "Certification Requirement" section of this *Certificate* for a list of services and supplies which require Certification.

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.

Calendar Year Deductibles

Calendar Year Deductible (for Out-of-Network services, per Covered Person).....	\$200
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Family Calendar Year Deductible (all enrolled members of a family, for Out-of-Network services, during a Calendar Year)..... \$600

Additional Deductibles

Unless otherwise noted, the following Deductibles apply to Covered Expenses for Covered Services and Supplies provided by both Preferred Providers and Out-of-Network Providers after the Calendar Year Deductible has been met:

Inpatient Deductible (applies to each admission to a Hospital or Skilled Nursing Facility) through a Preferred Provider..... \$250
 Inpatient Deductible (applies to each admission to a Hospital or Skilled Nursing Facility) through an Out-of-Network Provider..... \$250
 Chiropractic services Deductible (applies each Calendar Year through a Preferred Provider) \$200

Out-of-Pocket Maximum

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

For services or supplies provided by a Preferred Provider \$1500
 For services or supplies provided by an Out-of-Network Provider..... \$1500

In addition, 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 \$4500
 For services or supplies provided by an Out-of-Network Provider..... \$4500

Deductibles, Copayments or Coinsurance paid for Out-of-Network Emergency Care (including emergency medical transportation and emergency Hospital care) and Urgent Care outside the United States 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.

- Penalties paid for services for which Certification was required but not received

Copayments and Coinsurance

You may be required to pay out-of-pocket charges for specific services and supplies after all applicable 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 Calendar Year Deductible does not apply. Services for which no Copayment or Coinsurance amount applies (\$0) are subject to the Calendar Year Deductible. However, any Preventive Care Services for which no Copayment or Coinsurance amount applies (\$0) are not subject to the Calendar Year Deductible.*

You will be responsible for paying Copayments until the amount paid during a Calendar Year is equal to the Out-of-Pocket Maximum shown above.

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.

Note(s):

- You will also be required to pay any charges billed by an Out-of-Network Provider that exceed Covered Expenses (Maximum Allowable Amount). You will not be reimbursed for any amount in excess of Covered Expenses (Maximum Allowable Amount). Any Copayment or Coinsurance paid for the services of a Preferred Provider will apply toward the out-of-pocket Covered Expenses (as defined).
- Any Copayments or Coinsurance paid for the services of a Preferred Provider will apply toward both the Out-of-Pocket Maximum for Preferred Providers and the Out-of-Pocket Maximum for Out-of-Network Providers. In addition, Coinsurance paid for the services of an Out-of-Network Provider will apply toward both the Out-of-Pocket Maximum for Preferred Providers and the Out-of-Pocket Maximum for Out-of-Network Providers.
- **UNLESS OTHERWISE NOTED, ALL BENEFIT MAXIMUMS WILL BE COMBINED FOR COVERED SERVICES AND SUPPLIES PROVIDED BY PREFERRED PROVIDERS AND OUT-OF-NETWORK PROVIDERS.**

Noncertification Penalties

	Preferred Providers	Out-of-Network
Noncertified inpatient services penalty (for each noncertified service)	\$500	\$500
Noncertified outpatient services penalty (for each noncertified service)	\$50	\$50
For Medically Necessary services for which Certification was required but not obtained, Your Coinsurance will be reduced to	50%	50%

Note(s):

- **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. However, HNL will not rescind or modify Certification after a provider renders health care services in good faith and pursuant to the Certification, and will pay benefits under this *Certificate* for the services certified.**
- **The noncertification penalty (that is, the dollar amount) listed above will apply before the Coinsurance is reduced to the amount shown. The noncertification penalty will not exceed the cost of the benefit to HNL.**
- For a list of services which require Certification, please see the "Certification Requirement" section. The Coinsurance percentage applicable to the coverage of noncertified services is based on the amount determined to be a Covered Expense, not a percentage of the billed charges.

Services in an Emergency Room or Urgent Care Center (for Medical Care other than Mental Health and Substance Use Disorders)

	Preferred Providers (or Out-of-Network Emergency Care*)	Out-of-Network (Nonemergency Care Only)
Emergency room care professional services.....	20%	20% (Deductible waived)
Emergency room facility	20%	20% (Deductible waived)
Urgent Care professional services	20%	20% (Deductible waived)
Urgent Care facility	20%	20% (Deductible waived)

Note(s):

- The Copayment or Coinsurance amount shown for Out-of-Network Providers will only apply for services that do not meet the criteria of Emergency Care.
- The emergency room Deductible will not apply if the Covered Person is admitted to a Hospital directly from an emergency room. See "Authorized Hospital and Skilled Nursing Facility Services" below for applicable Coinsurance.

* Services which meet the criteria for Emergency Care are payable at the Preferred Provider level of coverage even if the services were provided by an Out-of-Network Provider. All Emergency Care services are subject to the Preferred Providers Copayment or Coinsurance shown above and any applicable Preferred Provider Calendar Year Deductible. Cost-sharing paid at the Preferred Provider level of coverage will apply toward the in-network Deductible and accrue to the in-network Out-of-Pocket Maximum. However, the Covered Person will remain responsible for amounts billed in excess of Covered Expenses (Maximum Allowable Amounts) when Emergency Care is received from an Out-of-Network Provider. For information regarding HNL’s payment for Out-of-Network Emergency Care, please refer to the Maximum Allowable Amount definition in the “Definitions” section of this *Certificate*.

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."

Services in an Emergency Room or Urgent Care Center (for Mental Health and Substance Use Disorders)

	Preferred Providers (or Out-of-Network Emergency Care*)	Out-of-Network (Nonemergency Care Only)
Emergency room care professional services.....	20%	20% (Deductible waived)
Emergency room facility	20%	20% (Deductible waived)
Urgent Care professional services	\$0	20% (Deductible waived)
Urgent Care facility	\$0	20% (Deductible waived)

Note(s):

- The Copayment or Coinsurance amount shown for Out-of-Network Providers will only apply for services that do not meet the criteria of Emergency Care.
- The emergency room Deductible will not apply if the Covered Person is admitted to a Hospital directly from an emergency room. See "Authorized Hospital and Skilled Nursing Facility Services" below for applicable Coinsurance.

* Services which meet the criteria for Emergency Care are payable at the Preferred Provider level of coverage even if the services were provided by an Out-of-Network Provider. All Emergency Care services are subject to the Preferred Providers Copayment or Coinsurance shown above and any applicable Preferred Provider Calendar Year Deductible. Cost-sharing paid at the Preferred Provider level of coverage will apply toward the in-network Deductible and accrue to the in-network Out-of-Pocket Maximum. However, the Covered Person will remain responsible for amounts billed in excess of Covered Expenses (Maximum Allowable Amounts) when Emergency Care is received from an Out-of-Network Provider. For information regarding HNL’s payment for Out-of-Network Emergency Care, please refer to the Maximum Allowable Amount definition in the “Definitions” section of this *Certificate*.

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."

Authorized Hospital and Skilled Nursing Facility Services

	Preferred Providers	Out-of-Network
Unlimited days of care in a semi-private room or Special Care Unit including ancillary (additional) services.....	20%	40%
Confinement in a Skilled Nursing Facility	20%	40%
Outpatient surgery (Hospital or Outpatient Surgical Center charges only, except for Infertility services).....	\$0	40%
Outpatient services (other than surgery, except for Infertility services).....	\$0	40%
Routine nursery care for newborns	20%	40%
Confinement for bariatric (weight loss) surgery	20%	40%

Note(s):

- Inpatient and outpatient care for Infertility is described below in the "Infertility Services" section.
- 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 the "Preventive Care Services" section below. Diagnostic endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an outpatient facility require the Copayment or Coinsurance applicable for outpatient facility services.
- 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 (Maximum Allowable Amounts) for the inpatient stay by an Out-of-Network Provider. You will not be reimbursed for any amounts in excess of Maximum Allowable Amounts 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. For an inpatient stay for the delivery of a newborn, the newborn will not be subject to a separate Deductible and Coinsurance for inpatient Hospital services unless the newborn patient requires admission to a Special Care Unit or requires a length of stay greater than 48 hours for vaginal delivery or 96 hours for caesarean section.

Mental Health and Substance Use Disorders

Mental Health and Substance Use Disorder benefits are administered by MHN Services, an affiliate behavioral health administrative services company, which contracts with HNL to administer these benefits.

Mental Health	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, drug therapy monitoring and, in connection with gender dysphoria, hormone therapy)	\$0	\$0 (Deductible waived)

Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care program, day treatment, partial hospitalization and other outpatient procedures including the treatment of gender dysphoria and behavioral health treatment for pervasive developmental disorder or autism as detailed in the "Plan Benefits" section)	\$0	\$0 (Deductible waived)
Physician visit to Hospital, Behavioral Health Facility or Residential Treatment Center.....	20%	20% (Deductible waived)
Inpatient facility	20%	20% (Deductible waived)

Substance Use Disorders	Preferred Providers	Out-of-Network
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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)	\$0	\$0 (Deductible waived)
Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care and program, day treatment, partial hospitalization, medical treatment for withdrawal symptoms, outpatient detoxification and other outpatient services).....	\$0	\$0 (Deductible waived)
Inpatient facility	20%	20% (Deductible waived)

Inpatient detoxification (acute care for Substance Use Disorders).....	20%	20%
		(Deductible waived)

Office Visits

	Preferred Providers	Out-of-Network
Visit to a Physician's office	\$20	40%
Specialist consultation	\$20	40%
Annual non-preventive physical examination.....	\$20	40%
<i>Calendar Year maximum payable by HNL</i>	<i>\$250</i>	<i>\$250</i>
Physician visit to Covered Person's home.....	20%	40%
Specialist visit to Covered Person's home.....	20%	40%
Vision (for diagnosis or treatment, including refractive eye examinations) (birth through age 16).....	\$20	40%
Hearing examination (for diagnosis or treatment) (birth through age 16).....	\$20	40%
Telehealth consultation through the Select Telehealth Services Provider*	\$0	Not Covered

Note(s):

- * The designated Select Telehealth Services Provider for this Plan is listed on your HNL ID card. To obtain services, contact the Select Telehealth Services Provider directly as shown on your ID card.

Preventive Care Services

	Preferred Providers	Out-of-Network
Preventive Care Services	\$0	40%

Note(s):

- Preventive Care Services are covered at no cost to You and are not subject to any Deductible when services are provided by a Preferred Provider.

- Covered Services and Supplies include, but are not limited to, annual preventive physical examinations, immunizations, 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 weight management intervention services, diabetes screening including intensive behavioral counseling intervention for individuals who test positive for abnormal levels of blood glucose, tobacco cessation intervention services and preventive vision and hearing screening examinations. Refer to the "Preventive Care List of Services" 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.

Allergy and Injection Services

	Preferred Providers	Out-of-Network
Allergy testing.....	\$20	40%
Allergy serum.....	20%	40%
Allergy injection services (serum not included)	\$20	40%
Injections (except for Infertility).....	\$20	40%

Note(s):

- Immunizations that are considered Preventive Care Services are covered under "Preventive Care Services" in this section.
- Injections for the treatment of Infertility are described below in the "Infertility Services" section.
- 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. If You need to have the provider administer the Specialty Drug, You will need to obtain the Specialty Drug through Our contracted Specialty Pharmacy Vendor and bring it with You to the provider office. Alternatively, You can coordinate delivery of the Specialty Drug directly to the provider office through Our contracted Specialty Pharmacy Vendor. Please refer to the "Specialty Pharmacy Vendor" portion of this "Schedule of Benefits" section for the applicable Copayment or Coinsurance.

Care for Conditions of Pregnancy

	Preferred Providers	Out-of-Network
Prenatal office visit	\$0	40%
Postnatal office visit.....	20%	40%
Normal delivery, cesarean section.....	20%	40%
Complications of pregnancy.....	See note below.....	See note below

California Prenatal Screening

Program administered by the
California State Department
of Public Health

.....\$0	\$0
Genetic testing of fetus	20% 40%
Circumcision of newborn (birth through 30 days)*	20% 40%

Note(s):

- 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" 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 Care Services. Refer to "Care for Conditions of Pregnancy" in the "Plan Benefits" section and the "Preventive Care List of Services" section for more details.
- The Calendar Year Deductible does not apply to the California Prenatal Screening Program services.

* Circumcisions for Covered Persons aged 31 days and older are covered when Medically Necessary under "Outpatient Surgery." Refer to the "Authorized Hospital and Skilled Nursing Facility Services" section for applicable Copayments and Coinsurance.

Family Planning

	Preferred Providers	Out-of-Network
Sterilization of males	20%	40%
Sterilization of females*	\$0	40%

Note(s):

- The diagnosis, evaluation and treatment of Infertility are described below in the "Infertility Services" section.
- The above Copayments apply to professional services only. Services that are rendered in a Hospital are also subject to the Hospital services Copayment. Look under the "Authorized Hospital and Skilled Nursing Facility Services" heading to determine any additional Copayments that may apply.

* Sterilization of females and women’s contraception methods and counseling, as supported by HRSA guidelines, are covered under "Preventive Care Services" in this section.

Infertility Services

	Preferred Providers	Out-of-Network
Infertility services (all covered services that diagnose, evaluate or treat Infertility)	Not Covered.....	Not Covered

Medical Supplies

	Preferred Providers	Out-of-Network
Durable Medical Equipment*	20%	40%
Orthotics (such as bracing, supports and casts).....	20%	40%
Corrective Footwear	20%	40%
Diabetic equipment.....	20%	40%
Diabetic footwear.....	20%	40%
Prostheses	20%	40%
Hearing aids.....	Not Covered.....	Not Covered
Blood or Blood Products (except for Drugs used to treat hemophilia, including blood factors)**	20%	40%

Note(s):

- 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 this section. For additional information, please refer to the "Preventive Care List of Services" 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. Certification may be required. Please refer to the "Certification Requirement" 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.

** Drugs used to treat hemophilia, including blood factors, are covered 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 will need to obtain the Specialty Drug through Our contracted Specialty Pharmacy Vendor and bring it with You to the provider's office. Alternatively, You may be able to coordinate delivery of the Specialty Drug directly to the provider's office through Our contracted Specialty Pharmacy Vendor. Please refer to the "Specialty Pharmacy Vendor" portion of this "Schedule of Benefits" section for the applicable Copayment or Coinsurance.

Home Health Care Services

	Preferred Providers	Out-of-Network
Home Health Care Services	20%	40%

Hospice Care

	Preferred Providers	Out-of-Network
Hospice Care	20%	40%

Acupuncture and Chiropractic Services

	Preferred Providers	Out-of-Network
Acupuncture	Not Covered.....	Not Covered
Chiropractic services.....	20%	40%
<i>Number of visits covered during a Calendar Year.....</i>	<i>15</i>	<i>15</i>
<i>Calendar Year deductible*</i>	<i>\$200</i>	<i>Not applicable</i>

Note(s):

- * Once the \$200 deductible is satisfied, only the 20% coinsurance applies.
- Certification may be required. Please refer to the "Certification Requirement" section for details. Payment of benefits will be reduced as set forth herein if Certification is required but not obtained.

Ambulance (for Medical Care other than Mental Health and Substance Use Disorders)

	Preferred Providers	Out-of-Network
Air Ambulance	20%	40%
Ground Ambulance.....	20%	40%

Note(s):

- 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."

Ambulance (for Mental Health and Substance Use Disorders)

	Preferred Providers	Out-of-Network
Air Ambulance	20%	40%
Ground Ambulance.....	20%	40%

Note(s):

- 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."

Other Professional Services

	Preferred Providers	Out-of-Network
Physician visit to Hospital or Skilled Nursing Facility (excluding care for mental disorders).....	20%	40%
Surgery		
Performed in an office	20%	40%
Performed in an outpatient or Hospital facility.....	20%	40%
Administration of anesthetics		
Performed in an office	20%	40%
Performed in an outpatient or Hospital facility.....	20%	40%
Diagnostic imaging (including x-ray) and laboratory procedures		
Performed in an office	20%	40%
Performed in an outpatient or Hospital facility.....	20%	40%
Complex radiology (CT, SPECT, MRI, MUGA and PET)	20%	40%
Chemotherapy	20%	40%
Radiation therapy	20%	40%
Nuclear medicine	20%	40%
Organ, stem cell or tissue transplants (not Experimental or Investigational).....	20%	Not Covered
Renal dialysis	20%	40%
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy*	20%	40%

<i>Maximum visits per Calendar</i>		
<i>Year</i>	20.....	20
Medical social services.....	20%.....	40%
Diabetes education.....	\$0.....	40%
Outpatient infusion therapy.....	20%.....	40%
<i>Number of days for each supply of injectable Prescription Drugs and other substances, for each delivery</i>		
	14.....	14

Note(s):

- Benefits for up to 12 additional visits for physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy may be covered if precertified as Medically Necessary for rehabilitation services following neurological and orthopedic surgery, cerebral/cardiovascular accident, third degree burns, head trauma and spinal cord injury. All visit maximums will be combined for Covered Services and Supplies provided by Preferred Providers and Out-of-Network Providers. Medically Necessary rehabilitative services following post-mastectomy lymphedema syndrome are not subject to such visit limitations**. In addition, Medically Necessary rehabilitative or habilitative services for autism or pervasive developmental disorder are not subject to such visit limitations.
- * Certification may be required. Please refer to the "Certification Requirement" section for details. Payment of benefits will be reduced as set forth herein if Certification is required but not obtained.
- ** The coverage described above in relation to Medically Necessary rehabilitative services for post-mastectomy lymphedema syndrome 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.

Outpatient Prescription Drugs

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.

Out-of-Pocket Maximum

Except as noted below in "Exceptions to the Out-of-Pocket Maximum," after an individual Covered Person has paid Copayments and Coinsurance equal to the Out-of-Pocket Maximum shown below, such Covered Person will have satisfied the Out-of-Pocket requirement and will not be required to pay further Copayments or Coinsurance for Prescription Drugs incurred during the remainder of the Calendar Year.

For Prescription Drugs through a Participating Pharmacy.....	\$2000
For Prescription Drugs through a Nonparticipating Pharmacy.....	\$2000

In addition, if enrolled Covered Persons of the same family have paid 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 Copayment or Coinsurance for Prescription Drugs shall be required from any enrolled Covered Person in that family for the remainder of that Calendar Year.

For Prescription Drugs through a Participating Pharmacy..... \$4000
 For Prescription Drugs through a Nonparticipating Pharmacy..... \$4000

The total Out-of-Pocket Maximum for both medical benefits through a Preferred Provider and Prescription Drug benefits through a Participating Pharmacy will not exceed \$8,700 for an individual or \$17,400 for a family.

Exceptions to the Out-of-Pocket Maximum: Only expenses for covered Prescription Drugs will be applied to the Out-of-Pocket Maximum.

- Covered Expenses used by the Covered Person to meet the medical Calendar Year Deductible;
- Expenses paid by the Covered Person for medical benefits.

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 from Our contracted Specialty Pharmacy Vendor	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

Note(s):

- 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.
- 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. A partial prescription fill, which is of a quantity less than the entire prescription, can be requested by you or your Physician. Partial prescription fills are subject to a prorated Copayment or Coinsurance based on the amount of the prescription that is filled by the pharmacy.
- All benefits limited during a Covered Person's lifetime is the total amount of benefits offered under this plan, and shall apply to all Health Net or HNL plans sponsored by the same Group.

Copayments and Coinsurance

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

Retail Pharmacy

	Participating Pharmacy	Nonparticipating Pharmacy
Tier 1 Drugs include most Generic Drugs and some low-cost preferred Brand Name Drugs when listed in the Formulary	\$10	\$10 (see "Notes")
Tier 2 Drugs include non-preferred Generic Drugs, preferred Brand Name Drugs, insulin and diabetic supplies and certain Brand Name Drugs with a generic equivalent when listed in the Formulary	\$25	\$25 (see "Notes")
Tier 3 Drugs include non-preferred Brand Name Drugs, Brand Name Drugs with a generic equivalent (when Medically Necessary), Drugs listed as Tier 3 Drugs in the Formulary, Drugs indicated as "NF", if approved, or Drugs not listed in the Formulary	\$35	\$35 (see "Notes")
Preventive Drugs and women's contraceptives	\$0	Not Covered

Specialty Pharmacy Vendor

Specialty Pharmacy

Except as listed below, all Specialty Drugs are subject to the applicable Tier 1, 2 or 3 Drug Copayment shown above under "Retail Pharmacy."

Self-injectable drugs and drugs for the treatment of hemophilia, including blood factors, per prescription, maximum of 30 days per prescription..... \$20

Maintenance Drugs through the Mail Order Program

Mail Order Program

Tier 1 Drugs include most Generic Drugs and some low-cost preferred
Brand Name Drugs when listed in the Formulary \$20

Tier 2 Drugs include non-preferred Generic Drugs, preferred Brand Name Drugs, insulin and diabetic supplies and certain Brand Name Drugs with a generic equivalent when listed in the Formulary	\$50
Tier 3 Drugs include non-preferred Brand Name Drugs, Brand Name Drugs with a generic equivalent (when Medically Necessary), Drugs listed as Tier 3 Drugs in the Formulary, Drugs indicated as "NF", if approved, or Drugs not listed in the Formulary	\$70
Preventive Drugs and women's contraceptives	\$0

Note(s):

- **In addition to the Copayments listed above for Nonparticipating Pharmacies, You must also pay 50% of the Prescription Drug Covered Expense.**
- **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.**
- **Prescription 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. What you actually pay will accrue to the Deductible and Out-of-Pocket Maximum.
- If there is generic equivalent available and you request a Brand Name Drug, You will be required to pay the difference in cost between the Generic Drug and Brand Name Drug in addition to the Copayment shown above, unless the Physician has indicated on the Prescription Drug Order "Dispense As Written" or "Do Not Substitute" or words of similar meaning.
- Preventive Drugs and all 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 a Brand Name Drug is dispensed, and there is a generic equivalent commercially available, You will be required to pay the difference in cost between the Generic and Brand Name Drug. However, if a Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from HNL, then the Brand Name Drug will be dispensed at no charge.

Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order.

- Some Drugs may require Prior Authorization from HNL to be covered.
- In addition to the Copayments and Coinsurance shown above, You are responsible for charges billed in excess of the Prescription Drug Covered Expenses for all Drugs dispensed by a Nonparticipating Pharmacy.
- Generic or Brand Name Drugs not listed in the Formulary which are prescribed by Your Physician and not excluded or limited from coverage are subject to the Tier 3 Drug Copayment.
- Maintenance Drugs may also be obtained at a CVS retail pharmacy under the mail order program benefits.

- 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.
- "Split-fill" Program: For certain high cost orally-administered drugs, including anti-cancer drugs, HNL provides a free 14-day trial. Drugs under the Split-fill program are indicated in the Formulary with "SF" in the comment section. Health Net will approve the initial fill for a 14-day supply at no cost to You. If, after the initial fill, You are free of adverse effects and wish to continue on the Drug, the subsequent fills will be dispensed for the full quantity as written by your Physician. You will be charged the applicable Copayment or Coinsurance for each subsequent fill up to the Copayment and Coinsurance maximum for orally-administered anti-cancer Drugs described above.

ELIGIBILITY, ENROLLMENT AND TERMINATION

Who is Eligible for Coverage

The University establishes plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations.

ELIGIBILITY

Employees

Information pertaining to your eligibility, enrollment, cancellation or termination of coverage and conversion options can be found in the “Group Insurance Eligibility Fact Sheet for Postdocs and Eligible Family Members ” A copy of this fact sheet is available at the Garnett Powers website (www.garnett-powers.com/postdoc/index.htm). Additional resources are also available in the Garnett Powers website to help you with your health and welfare plan decisions.

ENROLLMENT

Employees

Information pertaining to enrollment can be found in the “Group Insurance Eligibility Fact Sheet for Postdocs and Eligible Family Members ” A copy of this fact sheet is available at the Garnett Powers website (www.garnett-powers.com/postdoc/index.htm)

The Covered Services and Supplies of this plan are available to *eligible employees* (principal Covered Persons) as long as they live in the continental United States; either work or live in the Health Net PPO Service Area; are full-time, paid on a salary or hourly basis (not 1099, commissioned, or substitute), nonseasonal, and working the minimum number of hours per week, as specified by the Group Application; and meet any eligibility requirements of the Group, or as mutually agreed upon with HNL.

Covered Services and Supplies of this plan are also available to the following Dependents of the principal Covered Person who meet any eligibility requirements of the Group or as mutually agreed upon with HNL:

- 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.

Please contact your Group administrator to discuss additional eligibility requirements.

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.

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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 60 days of the date You receive a request for such information about the dependent child from HNL. The child must have been covered as a dependent of the principal Covered Person or spouse or Domestic Partner under a previous group health plan at the time the child reached the age limit.

HNL must provide You notice at least 90 days prior to the date Your enrolled child reaches the age limit that coverage will terminate. You must provide HNL with proof of Your child's incapacity and dependency within 60 days of the date You receive such notice from HNL in order to continue coverage for a disabled child past the age limit.

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 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.

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 30 days of the date of marriage. Coverage begins on the first day of the month following the date the application for coverage is received.

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 30 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 30 days of the formation of the domestic partnership according to Your Group's eligibility rules. Coverage begins on the first day of the month following the date the application for coverage is received.

Newborn Child: Newborn children will be automatically covered for 31 days (including the date of birth). If You do not enroll the newborn within 31 days (including the date of birth), he or she is covered for only the 31 days starting on and including the date of birth.

Adopted Child: A newly adopted child or a child who is being adopted, becomes eligible on the date You or Your spouse or Domestic Partner receive physical custody of the child.

Coverage begins automatically and will continue for 30 days from the date of eligibility. You must enroll the child before the 30th day for coverage to continue beyond the first 30 days. HNL will require written proof of the right to control the child's health care when such child is enrolled.

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 30 days of the effective date of the guardianship. Coverage will begin on the first day of the month after HNL receives the enrollment request.

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

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. This does not include foster children.

Coverage begins automatically and will continue for 30 days from the date of eligibility. You must enroll the child before the 30th day for coverage to continue beyond the first 30 days.

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 HNL, become effective on the first day of the calendar month for which the change is submitted, unless otherwise approved by HNL.

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 for 12 months or until the next Open Enrollment Period.

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, HNL 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 or Your Dependents Did Not Enroll Because of Other Coverage and Later the Other Coverage is Lost**

If You or Your Dependents declined coverage in this plan, and You stated on the form the reason You or Your Dependents 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 or Your Dependents. The reasons for 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 intentional misrepresentation of material 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); or
- The other coverage was federal COBRA or California COBRA, and the period of coverage ends.

3. **You or Your Dependents Lose Eligibility from a Medi-Cal Plan**

If You or Your Dependents become ineligible and lose coverage under 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.

If the exceptions in 2 or 4 apply, 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.

Special Enrollment Rule for Newly Acquired Dependents

If an employee gains new Dependents due to childbirth, adoption or marriage or domestic partnership 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 30 days after childbirth, marriage, domestic partnership or adoption. 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, domestic partnership, adoption or placement for adoption, You can enroll yourself and the dependent within 30 days of childbirth, marriage, domestic partnership, 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 members 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 30 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 30 days of childbirth, marriage, domestic partnership, 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;
- For marriage or domestic partnership, the Effective Date will be the first of the month following the date application for coverage is received;
- Regarding adoption, the Effective Date will be the date of adoption or placement for adoption; and
- 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 30 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 for nonpayment of premiums by the Group, fraud or intentional misrepresentation of material fact, violation of participation or contribution rules, HNL's withdrawal of this type of health insurance policy from the market, or HNL ceases to issue group health insurance policies in California, as described in the Group Policy.

Principal Covered Person and All Dependents

The principal Covered Person and all his or her Dependents will become ineligible for coverage at the same time if the principal Covered Person loses eligibility for this plan.

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 HNL. 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 United States;
- The Covered Person becomes eligible for Medicare and assigns Medicare benefits to another health maintenance organization or competitive medical plan; 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 or domestic partnership, 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 have no obligation to provide notification of ineligibility or termination of coverage to individual Covered Persons.

Coverage Options Following Termination

Please examine Your options carefully before declining coverage.

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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:

- 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
- 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:

- You have been covered for 36 months from Your original COBRA effective date (under this or any other plan).*
- The Covered Person becomes entitled to Medicare, that is, enrolls in the Medicare program.
- The Covered Person moves outside the United States.
- 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."
- Your Group's Policy with HNL terminates. (See "Employer Replaces this Plan.")
- 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.

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

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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 in 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.

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. HNL 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, HNL must receive proof that Your total disability is continuing. It shall be Your responsibility to ensure that HNL 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.

CERTIFICATION REQUIREMENT

Some of the Covered Expenses under this plan are subject to a requirement of Certification in order for full benefits to be available. 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. However, HNL will not rescind or modify Certification after a provider renders health care services in good faith and pursuant to the Certification, and will pay benefits under this *Certificate* for the services certified.

Services Requiring Certification

Services requiring Certification include:

Inpatient facility admissions

Any type of facility, including but not limited to:

- Acute rehabilitation center
- Hospice
- Hospital, except in an emergency
- Mental health facility, except in an emergency
- Skilled Nursing Facility
- Substance Use Disorder facility, except in an emergency

Outpatient procedures, services or equipment

- Ambulance: non-emergency air or ground Ambulance services
- Bronchial thermoplasty
- Capsule endoscopy
- Cardiac procedures
- Clinical trials
- Dermatology such as chemical exfoliation and electrolysis, dermabrasions and chemical peels, laser treatment or skin injections and implants
- Diagnostic procedures:
 1. Advanced imaging
 - o Computerized Tomography (CT)
 - o Computed Tomography Angiography (CTA)
 - o Magnetic Resonance Angiography (MRA)
 - o Magnetic Resonance Imaging (MRI)

- o Positron Emission Tomography (PET)
- 2. Cardiac imaging
 - o Coronary Computed Tomography Angiography (CCTA)
 - o Echocardiography
 - o Myocardial Perfusion Imaging (MPI)
 - o Multigated Acquisition (MUGA) scan
- Durable Medical Equipment
 - 1. Bilevel Positive Airway Pressure (BiPAP)
 - 2. Bone growth stimulator
 - 3. Continuous glucose monitoring
 - 4. Continuous Positive Airway Pressure (CPAP)
 - 5. Custom-made items, including custom wheelchairs
 - 6. Hospital beds and mattresses
 - 7. Power wheelchairs and accessories
 - 8. Scooters
 - 9. Ventilators
- Ear, Nose and Throat (ENT) procedures
- Enhanced External Counterpulsation (EECP)
- Experimental/Investigational services
- Genetic testing
- Implantable Pain pumps including insertion or removal
- Injections for intended use of steroid and/or Pain management including epidural, nerve, nerve root, facet joint, trigger point and Sacroiliac (SI) joint injections
- Occupational therapy (includes home setting), subject to any benefit maximums stated in the "Schedule of Benefits" section except when therapy is used to treat autism.
- Organ, tissue and stem cell transplant services, including pre-evaluation and pre-treatment services and the transplant procedure. Transplants must be performed through Health Net's designated transplantation specialty network.
- Orthotics (custom-made items)
- Pharmaceuticals
 - 1. Outpatient Prescription Drugs

- o Most Specialty Drugs, including self-injectable drugs and hemophilia factors, must have Prior Authorization through the Outpatient Prescription Drug benefit and may need to be dispensed through the Specialty Pharmacy Vendor. Please refer to the Formulary to identify which Drugs require Prior Authorization. Urgent or emergent Drugs that are Medically Necessary to begin immediately may be obtained at a retail pharmacy.
- o Other prescription Drugs, as indicated in the Formulary may require Prior Authorization. Refer to the Formulary to identify which Drugs require Prior Authorization.
- 2. Certain Physician-administered drugs, including newly approved drugs, whether administered in a Physician office, free-standing infusion center, home infusion, Outpatient Surgical Center, outpatient dialysis center or outpatient Hospital. Refer to the Health Net website, www.healthnet.com, for a list of Physician-administered drugs that require Certification. Biosimilars are required in lieu of branded Drugs, unless Medically Necessary.
- Outpatient surgical procedures:
 1. Ablative techniques for treating Barrett's esophagus and for treatment of primary and metastatic liver malignancies
 2. Balloon sinuplasty
 3. Bariatric procedures
 4. Cochlear implants
 5. Joint surgeries
 6. Neuro or spinal cord stimulator
 7. Orthognathic procedures (includes TMJ treatment)
 8. Spinal surgery including, but not limited to, laminotomy, fusion, discectomy, vertebroplasty, nucleoplasty, stabilization and X-Stop
 9. Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
 10. Vestibuloplasty
- Physical therapy, (includes home setting), subject to any benefit maximums stated in the "Schedule of Benefits" section except when therapy is used to treat autism.
- Prosthesis and corrective appliances
- Radiation therapy
- Reconstructive and cosmetic surgery, service and supplies or procedures, including but not limited to:
 1. Bone alteration or reshaping such as osteoplasty
 2. Breast reductions and augmentations except when following a mastectomy (includes gynecomastia and macromastia)
 3. 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.

4. Excision, excessive skin and subcutaneous tissue (including lipectomy and panniculectomy) of the abdomen, thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad, and other areas
 5. Eye or brow procedures such as blepharoplasty, brow ptosis or canthoplasty
 6. Gynecologic or urology procedures such as clitoroplasty, labiaplasty, vaginal rejuvenation, scrotoplasty, testicular prosthesis, vulvectomy
 7. Hair electrolysis, transplantation or laser removal
 8. Lift such as arm, body, face, neck, thigh
 9. Liposuction
 10. Nasal surgery such as rhinoplasty or septoplasty
 11. Otoplasty
 12. Treatment of varicose veins
 13. Vermilionectomy with mucosal advancement
- Speech therapy, (includes home setting), subject to any benefit maximums stated in the "Schedule of Benefits" section except when therapy is used to treat autism or gender dysphoria.

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, a concurrent review will be performed. Confinement in excess of the number of days initially approved must be authorized by HNL.

Exceptions

- Certification will not apply to outpatient procedures/services for the treatment, diagnosis and prevention of a Mental Health or Substance Use Disorder diagnosis.
- 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; no penalty will apply if notification is not received. 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 mastectomies, lymph node dissections and for reconstructive surgery incident to a mastectomy (including lumpectomy).

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;
- 72 hours or sooner, taking into account the medical exigencies, for proposed services needed urgently.

- In the event of being admitted into a Hospital following outpatient emergency room or Urgent Care center services for Emergency Care; please notify HNL of the inpatient admission within 48 hours or as soon as reasonably possible;
- 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, Your benefits may be reduced by a percentage stated in the "Schedule of Benefits" section of this Certificate and an additional Deductible may apply.

Notice of the determination of a Certification request will be provided within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request by HNL. Notice of the determination for Urgent Care Certification requests must be provided within 72 hours of receipt of the request. Additionally, if the Covered Person requests to extend a course of treatment beyond time/number of treatments, the Certification request must be made at least 24 hours prior to the expiration of the prescribed period of time/number of treatments and notification of determination is required within 24 hours of the request.

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

For Urgent Care requests, HNL will notify the Covered Person of Our decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours from the receipt of the request. If additional information is necessary to make Our determination, HNL will notify the Covered Person (within 24 hours of the receipt of the request) of the specific information necessary to make the determination and a reasonable time frame (that is not less than 48 hours) to provide the information to HNL. HNL will notify the Covered Person of Our decision no later than 48 hours after the earlier of the receipt of the requested information, or the end of the time period to provide the requested information.

For all other requests in which the decisions are based in whole or in part on Medical Necessity, HNL will notify the Covered Person of Our decision not later than five (5) business days from the receipt of the request and information that is reasonably necessary to make the determination. For time frames of initial benefit determinations that are not based on Medical Necessity, refer to "Timing of Notice" under the "Notification of HNL's Initial Benefit Determination" provision in the "Coverage Decisions and Disputes Resolution" section of this *Certificate*.

Concurrent Review

Concurrent review is a type of treatment review that takes place during an inpatient stay or as part of an ongoing course of treatment to be provided over a period of time or number of treatments. HNL performs utilization management services for Covered Persons using approved clinical criteria in order to facilitate medical appropriateness, promote quality and continuity of care, and to coordinate discharge planning. Therefore, in the event of an admission a concurrent review of the admission is performed.

For treatment involving Urgent Care, the request by the Covered Person or the Covered Person's Physician to extend the course of treatment beyond the period of time or number of treatments shall be decided as soon as possible, taking in to account the medical exigencies. The Covered Person will be notified of Our decision within 24 hours of the receipt of the review request, provided that such a

request is made to HNL at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

If concurrent review results in 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. Refer to the "Resolution of Disputes" provision in this section if you disagree with Our decision.

Retrospective Review

Retrospective review is a type of treatment review that occurs when the initial review of a Certification request takes place after services have been rendered. Such delayed review follows the same general process as Certification prior to treatment and concurrent review, including evaluation of the reasons Certification was not obtained and application of the Certification penalty when appropriate, and evaluation of medical records for demonstration of Medical Necessity.

Covered Persons and providers will be notified of relevant decisions that are based in whole or in part on Medical Necessity, within 30 calendar days following the receipt of the claim and information that is reasonably necessary to make the determination. For time frames of initial benefit determinations that are not based on Medical Necessity, refer to "Timing of Notice" under the "Notification of HNL's Initial Benefit Determination" provision in the "Coverage Decisions and Disputes Resolution" section of this *Certificate*.

Notification of Adverse Benefit Determination

If Certification, concurrent review, or retrospective review results in denial, delay, or modification of a covered service, HNL will send a written or electronic notice to the patient and to the provider of the service. HNL's decision will include a clear and concise explanation of the reasons for Our decision, a description of the criteria or guidelines used and the clinical reasons for the decisions regarding Medical Necessity. The explanation will also include the specific plan provisions on which determination is based. The Medical Necessity decisions communicated to the medical providers will include the name and telephone number of the health care professional responsible for the denial, delay or modification.

In the case of an adverse benefit determination involving Urgent Care, HNL may provide the decision verbally as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request. The written or electronic notice will be provided to the Covered Person not later than 3 days after the verbal notice. The notice of Our decision related to Urgent Care will also include a description of the expedited review process.

Except for the benefit determination in relation to concurrent review and Urgent Care, if HNL is unable to make a decision to approve, modify or deny the request within the timeframes described under "Certification Procedure," and "Retrospective Review" provisions because we are not in receipt of all of the information reasonably necessary and requested, or because HNL requires consultation by an expert reviewer, or because HNL has asked that an additional examination or test be performed upon the Covered Person, provided that the examination or test is reasonable and consistent with good medical practice, HNL will provide a complete response based on the facts as then known by HNL within the specified timeframe. This response will specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. HNL shall also notify the provider and Covered Person of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by HNL, HNL shall approve, modify, or deny the request for authorization within the timeframes specified above.

In the case of denial, HNL will provide the following upon request:

- The criteria, guidelines, protocols, or other similar criterion used by HNL, or an entity with which HNL contracts for utilization review or utilization management functions, to determine whether to authorize, modify, delay, or deny health care services.
- If the adverse determination is based on Medical Necessity or Experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination.

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 the "Medical Benefits" subsection of the "Plan Benefits" of this *Certificate*.

If Certification is not obtained or services, supplies or expenses are received or incurred beyond the scope of Certification given, the payable percentage will be the reduced percentage as shown in the "Schedule of Benefits" section of this *Certificate*. Also, an additional penalty will be applied to Covered Expenses as shown in the "Schedule of Benefits" section.

Resolution of Disputes

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

- Either You or Your Physician may contact HNL to request an appeal of Our decision. Refer to the "Grievance and Appeals Process" provision in the "Coverage Decisions and Disputes Resolution" section for more details. Additional information may be requested or the treating Physician may be consulted in any reconsideration. A written reconsideration decision will be provided; and
- You may request an Independent Medical Review as set forth in the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" and "Arbitration" provisions of the "Coverage Decisions and Disputes Resolution" section of this *Certificate*. You must participate in HNL's grievance or appeals process before requesting Independent Medical Review (IMR) for Medical Necessity denials unless there is an imminent and serious threat to the Covered Person's health. However, You will not be required to participate in the HNL's grievance or appeals process for more than 30 days. In the case of a grievance that requires expedited review, You will not be required to participate in HNL's grievance process for more than three days.
- The final step to resolve disputes, except disputes concerning adverse benefit determinations as defined in 45 CFR 147.136, is binding arbitration as set forth in the "Arbitration" provision of the "Coverage Decisions and Disputes Resolution" section of this *Certificate*.

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 subject to the noncertification penalty shown in the "Schedule of Benefits" section. Please refer to the "Certification Requirement" section 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.

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.

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.

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 Maximum Allowable Amount as defined in the "Definitions" section.

Since the Out-of-Network Provider has not agreed to accept the Maximum Allowable Amount as payment in full, the amount billed by the Out-of-Network Provider may exceed the Maximum Allowable 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. Once the Maximum Allowable Amount is determined, the amount that HNL pays an Out-of-Network Provider and the amount which will be Your responsibility are determined as follows:

- HNL pays an Out-of-Network Provider an amount equal to the Maximum Allowable Amount, less any Deductible(s), Copayments and/or Coinsurance applicable to the Covered Expense for the service or supply that You receive.
- The portion of the Maximum Allowable Amount that will be Your responsibility is any Deductible(s), Copayments and/or Coinsurance applicable to the Covered Expense for the service or supply that You receive.
- Unless the Out-of-Network Provider has agreed to accept the Maximum Allowable Amount as payment in full, as described in the definition of Maximum Allowable Amount, the amount billed by the Out-of-Network Provider may exceed the Maximum Allowable Amount. You will be responsible for that excess amount, in addition to any applicable Deductible(s), Copayments and/or Coinsurance payment required. In addition, You are always responsible for services or supplies not covered by this plan.

When Services are not Available through a Preferred Provider: If HNL determines that the Medically Necessary care you require is not available because there is no provider or facility that can provide the care within the PPO Preferred Provider network, HNL will authorize You to receive the care and will arrange for the required medically appropriate care from an available and accessible Out-of-Network Provider or facility. Covered Services and Supplies received from Out-of-Network Providers under these circumstances will be payable at the Preferred Provider level of coverage. Cost-sharing paid at the Preferred Provider level of coverage will apply toward the in-network Deductible and accrue to the in-network Out-of-Pocket Maximum and You will not be responsible for any amounts in excess of the Maximum Allowable Amount. If you need access to medically appropriate care that is not available in the PPO Preferred Provider network, or are being billed for amounts in excess of the Maximum Allowable Amount for Covered Services received under these circumstances, please call the Customer Contact Center at the number shown on your Health Net ID card.

When Out-of-Network Non-Emergent Services are received at an In-Network Health Facility: In addition, if You receive covered non-emergent services at an in-network (PPO) health facility (including, but not limited to, a licensed Hospital, an ambulatory surgical center or other outpatient setting, a laboratory, or a radiology or imaging center) at which, or as a result of which, You receive non-emergent Covered Services by an Out-of-Network Provider, the non-emergent services provided by the Out-of-Network Provider will be payable at the Preferred Provider level of coverage, with the same cost-sharing and Deductible, if applicable, and without balance billing (balance billing is the difference

between a provider's billed charge and the Maximum Allowable Amount); the cost-sharing and Deductible will accrue to the Out-of-Pocket Maximum for Preferred Providers.

The Out-of-Network Provider may bill or collect from You the difference between a provider's billed charge and the Maximum Allowable Amount in addition to any applicable Out-of-Network Deductible(s), Copayments and/or Coinsurance, when You consent in writing at least 24 hours in advance of care. The Out-of-Network Provider must give You notice that Your consent is required within the following time frames:

- If the appointment is scheduled at least 72 hours in advance, notice and consent forms must be provided to You not later than 72 hours prior to the day when the service will be furnished.
- If the appointment is scheduled between 24 hours and 72 hours in advance, notice and consent forms must be provided to You on the day the appointment is scheduled, no later than 24 hours in advance of care.

Notice by the Out-of-Network Provider, and/or Your written consent, less than 24 hours in advance of care is not allowed.

In order to be valid, that consent must meet all of the following requirements: (1) it must be in a document that is separate from the document used to obtain the consent for any other part of the care or procedure, (2) the Out-of-Network Provider has given You a written estimate of the total out-of-pocket cost of care, (3) the consent has advised You that You may elect to seek care from a Preferred Provider or may contact HNL to arrange to receive care from a Preferred Provider, (4) that any costs that You incur as a result of Your use of the Out-of-Network benefit shall be in addition to Preferred Provider cost-sharing amounts and may not count toward the annual Out-of-Pocket Maximum on Preferred Provider benefits or a Deductible, if any, for in-network benefits, and (5) the consent and estimate shall be provided to You in languages other than English under certain circumstances.

The consent criteria in this provision do not apply, and an Out-of-Network Provider will always be subject to the limitations of this provision with respect to the following services:

- Ancillary services, meaning:
 - o Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner;
 - o Items and services provided by assistant surgeons, hospitalists, and intensivists;
 - o Diagnostic services, including radiology and laboratory services; and
 - o Items and services provided by an Out-of-Network Provider if there is no Preferred Provider who can furnish such item or service at such facility.
- Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network Provider satisfied the consent criteria in this provision.

For information regarding HNL's payment for Out-of-Network Non-Emergent Services, please refer to the Maximum Allowable Amount definition in the "Definitions" section of this *Certificate*.

When Emergency Services are provided by an Out-of-Network Provider: When Covered Services are received in connection with Emergency Care, You will pay the Preferred Provider level of cost-sharing, regardless of whether the provider is a Preferred Provider or an Out-of-Network Provider, and

without balance billing. Balance billing is the difference between an Out-of-Network Provider's billed charge and the Maximum Allowable Amount. When You receive Emergency Care from an Out-of-Network Provider, Your payment of the cost-sharing will accrue toward the Deductible (if applicable) and the Out-of-Pocket Maximum for Preferred Providers.

For information regarding HNL's payment for Out-of-Network Emergency Care, please refer to the Maximum Allowable Amount definition in the "Definitions" section of this *Certificate*.

Important Note: Even if a Hospital is a Preferred Provider, You should not assume that all Physicians at the Hospital and other individual providers of health care at the Hospital are Preferred Providers. If you receive services from an Out-of-Network Provider at that Hospital or other facility, refer to "When Out-of-Network Non-Emergent Services are received at an In-Network Health Facility" above for information on how those services are paid.

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*.
- There may also be Deductibles in addition to the Calendar Year Deductible for Out-of-Network services that You may need to pay, depending on the services or supplies received. Please check the "Deductibles" portion of the "Schedule of Benefits" section for details. Each Deductible is separate and distinct from the other, and Covered Expenses applied to one Deductible will not be applied to any other Deductible of this plan, except that a Calendar Year Deductible will be applied toward the satisfaction of the family Deductible, as set forth below unless otherwise noted.
- Covered Expenses incurred under this plan in the last three months of a Calendar Year that are used to satisfy this plan's Calendar Year Deductible for that year, may also be used to satisfy the Calendar Year Deductible for the following Calendar Year.
- 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*.
- Expenses incurred under the Prescription Drug Benefit are not applied to the Calendar Year or additional Deductible(s).

Out-of-Pocket Maximum

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

Except for exceptions noted in the "Schedule of Benefits" section, Copayments or Coinsurance paid for the services of a Preferred Provider will apply toward the Out-of-Pocket Maximum for Out-of-Network Providers. Similarly, Coinsurance paid for the services of an Out-of-Network Provider will apply toward the Out-of-Pocket Maximum for Preferred Providers.

Medical Benefits

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.

Hospital

Inpatient Services

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;
- Services in Special Care Units;
- Operating, delivery and special treatment rooms;
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services;
- Physical therapy;
- Radiation therapy, chemotherapy and renal dialysis treatment;
- Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Hospital for use during Your stay; and
- 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. This *Certificate* covers treatments which use umbilical cord blood, cord blood stem cells and adult stem cells (nor their collection, preservation and storage) only when deemed appropriate by an Independent Medical Review, as such treatments are considered to be Experimental or Investigational in nature. (Please refer to "Independent Medical Review of Investigational or Experimental Therapies" in the "Coverage Decisions and Disputes Resolution" section for additional information.)

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

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" 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. HNL shall make the final determination as to whether use of a Hospital setting was necessary.

Telehealth Services

Medically Necessary services, including consultation, diagnosis and treatment, for medical conditions and Mental Health and Substance Use Disorder provided appropriately as Telehealth Services are covered on the same basis and to the same extent as Covered Services delivered in-person. Telehealth Services will be covered only when performed by a Preferred Provider. For supplemental services that may provide telehealth coverage for certain services at a lower cost, see the "Telehealth Consultations through the Select Telehealth Services Provider" provision below. Please refer to the "Telehealth Services" definitions in the "Definitions" section for more information.

Telehealth Services are not covered if provided by an Out-of-Network Provider.

Telehealth Consultations through the Select Telehealth Services Provider

HNL contracts with certain Select Telehealth Services Providers to provide Telehealth Services for medical conditions and Mental Health and Substance Use Disorders. The Select Telehealth Services Provider for this plan is listed on your HNL ID card. To obtain services, contact the Select Telehealth Services Provider directly as shown on your ID card. Select Telehealth Services Provider services are not intended to replace services from Your Physician, but are a supplemental service that may provide telehealth coverage for certain services at a lower cost to the Covered Person. You are not required to use the HNL Select Telehealth Services Provider for your Telehealth Services.

Telehealth consultations through the Select Telehealth Services Provider are confidential consultations by telephone or secure online video. The Select Telehealth Services Provider provides primary care services and may be used when Your Physician's office is closed or You need quick access to a

Physician. You do not need to contact Your Primary Care Physician prior to using telehealth consultation services through the Select Telehealth Services Provider.

Prescription Drug orders received from the Select Telehealth Services Provider are subject to the applicable Deductible, Copayment or Coinsurance shown in the "Outpatient Prescription Drugs" portion of the "Schedule of Benefits" section and the coverage and Prior Authorization requirements, exclusions and limitations shown in the "Outpatient Prescription Drug Benefits" portion of the "Plan Benefits" and "General Limitations and Exclusions" sections.

Telehealth consultation services through the Select Telehealth Services Provider do not cover:

- Specialist services; and
- Prescriptions for substances controlled by the DEA, non-therapeutic drugs or certain other drugs which may be harmful because of potential for abuse.

Please refer to the definitions of "Select Telehealth Services Provider" and "Telehealth Services" in the "Definitions" section for more information.

Outpatient Surgical Center

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

Certification may be required for outpatient surgery, including Outpatient Surgical Center and professional surgical services. Please refer to the "Certification Requirement" section of this *Certificate* for details. Payment of benefits for Outpatient Surgical Center will be subject to the noncertification penalty set forth in the "Schedule of Benefits" if Certification is required but not obtained.

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:

- 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;
- Special treatment rooms;
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services;
- Physical, occupational 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; and

- 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. This *Certificate* covers treatments which use umbilical cord blood, cord blood stem cells and adult stem cells (nor their collection, preservation and storage) only when deemed appropriate by an Independent Medical Review, as such treatments are considered to be Experimental or Investigational in nature. (Please refer to "Independent Medical Review of Investigational or Experimental Therapies" in the "Coverage Decisions and Disputes Resolution" section for additional information.)

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

Custodial Care is not covered.

Professional Services

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

All covered surgical procedures, including the services of the surgeon or Specialist, assistant surgeon, and 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 Maximum Allowable Amount (as applicable) for the first (or major) procedure and one-half the Contracted Rate or Maximum Allowable 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 available 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.

Certification may be required for outpatient surgery, including Outpatient Surgical Center and professional surgical services. Please refer to the "Certification Requirement" section of this *Certificate* for details.

Non-preventive Physical Examinations

One non-preventive physical examination, requested by You without medical condition indications, is covered during a Calendar Year up to the maximum amount shown in the "Schedule of Benefits" section under the heading "Annual non-preventive Physical Examination."

A non-preventive physical examination is one that is not otherwise medically indicated or Physician-directed and is obtained for the purposes of checking Your general health in the absence of symptoms or other nonpreventive purpose. Examples include exams taken to obtain employment, or exams administered at the request of a third party, such as a school, camp or sports organization.

Please refer to "Annual non-preventive physical examination" in the "Schedule of Benefits" section for the applicable Copayment or Coinsurance required. See the "Preventive Care List of Services" section for information about coverage of exams that are for preventive health purposes.

Diagnostic Imaging (Including X-Ray) and Laboratory Procedures

All prescribed diagnostic imaging (including x-ray) and laboratory procedures, services and materials, including cancer screening tests and screening for blood lead levels in children as determined by a health care provider in accordance with standards adopted by the California Department of Public Health.

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 must be ordered by Your Physician and provided under a treatment plan describing the length, type and frequency of the visits to be provided. 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 because of illness or injury (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);
- The Home Health Care Services are part-time and intermittent in nature; a visit lasts up to 4 hours in duration in every 24 hours; and
- The services are in place of a continued hospitalization, confinement in a Skilled Nursing Facility, or outpatient services provided outside of the Covered Person home.

Custodial Care services and Private Duty Nursing, as described in the "Definitions" section and any other types of services primarily for the comfort or convenience of the Covered Person, are not covered

even if they are available through a Home Health Care Agency. Home Health Care Services do not include Private Duty Nursing or shift care. Private Duty Nursing (or shift care, including any portion of shift care services) is not a covered benefit under this plan even if it is available through a Home Health Care Agency or is Medically Necessary. See the "Definitions" section.

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

In addition, in accordance with an approved treatment plan, coverage will be provided for therapies in the home, when 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 below, and are not payable under this Home Health Care Services benefit.

Payment of benefits will be subject to the noncertification penalty shown in the "Schedule of Benefits" section if Certification is not obtained for home-based physical, speech or occupational therapy.

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. When available and indicated, infused medications will be administered in the home or a non-Hospital infusion suite setting.

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.

All services must be billed and performed by a provider licensed by the state. Only a 14-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 unless deemed appropriate by an Independent Medical Review, as such treatments are considered to be Experimental or Investigational in nature. (Please refer to "Independent Medical Review of Investigational or Experimental Therapies" in the "Coverage Decisions and Disputes Resolution" section for additional information.);
- Drugs or other substances obtained outside of the United States;

- Homeopathic or other herbal medications not approved by the FDA;
- FDA approved Drugs or medications prescribed for indications that are not approved by the FDA, or which do not meet medical community standards (except for non-Investigational FDA approved Drugs used for off-label indications when the conditions of state law have been met);
- Growth hormone treatment; 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.

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 the criteria for Emergency Care, as defined in this *Certificate*, have been met.

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

Covered Services provided by an Out-of-Network air Ambulance provider will be payable at the Preferred Provider level of cost-sharing and Deductible, if applicable, and without balance billing (balance billing is the difference between a provider's billed charge and the Maximum Allowable Amount).

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

Diabetes Education

HNL will pay for a diabetes instruction program supervised by a Physician. A diabetes instruction program is a program designed to teach You (the diabetic) and Your covered Dependents about the disease process, the daily management of diabetic therapy and medical nutrition therapy.

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.

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;
- 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; and
- All of these services and supplies will be provided or arranged by the Hospice. Payment by HNL for Hospice Care benefits shall not exceed the amount per day set forth in the "Schedule of Benefits" section.

Payment of benefits will be subject to the noncertification penalty shown in the "Schedule of Benefits" section if Certification is not obtained for the care.

Radiation Therapy, Chemotherapy and Renal Dialysis Treatment

Radiation therapy and nuclear medicine, chemotherapy and renal dialysis treatment are covered when Medically Necessary.

Please notify HNL upon initiation of renal dialysis treatment.

Bariatric (Weight Loss) Surgery

Bariatric surgery provided for the treatment of morbid obesity is covered when Medically Necessary and authorized by HNL.

When bariatric surgery is obtained through a Preferred Provider, You will be directed to a bariatric surgical center at the time authorization is obtained. All clinical work-up, diagnostic testing and preparatory procedures must be acquired through a Preferred Provider.

If You live 50 miles or more from the 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 Member and for the Certified bariatric weight loss surgery. All requests for travel expense reimbursement must be Certified by HNL, refer to the "Certification Requirement" section.

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 two three (3) (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

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

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) are covered; and
- Prostheses for restoring a method of speaking (but not including electronic voice boxes) following a laryngectomy are covered.

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 may be required. Please refer to the "Certification Requirement" section for details. Payment of benefits will be subject to the noncertification penalty shown in the "Schedule of Benefits" section if Certification is required but not obtained.

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 above.

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.

Corrective Footwear (including specialized shoes, arch supports and inserts) is covered when Medically Necessary and custom made for the Covered Person or is a podiatric device to prevent or treat diabetes-related complications.

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.

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

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 may be required. Please refer to the "Certification Requirement" section for details. Payment of benefits will be subject to the noncertification penalty shown in the "Schedule of Benefits" section if Certification is required but not obtained.

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, as supported by HRSA guidelines, are covered as Preventive Care Services. For additional information, please refer to the "Preventive Care List of Services" section.

Implanted Lens(es) Which Replace the Organic Eye Lens

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

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.

Payment of benefits for rehabilitative services will be subject to the noncertification penalty as set forth in the "Schedule of Benefits" if Certification is not obtained.

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.

Allergy Testing and Treatment

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

Reconstructive Surgery

Reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or diseases, or in connection with the treatment for gender dysphoria to either improve function or create a normal appearance to the extent possible. 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.

Surgery is not reconstructive if the surgery only offers a minimal improvement in the appearance of the Covered Person, as determined in accordance with the standard of care practiced by Physicians specializing in reconstructive surgery.

*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.*

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).
- Diabetic daycare, self-management training, education and medical nutrition therapy will be covered, only when provided by licensed health care professionals with expertise in the management or treatment of diabetes. Please refer to the "Diabetes Education" provision of this section for more information.

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.

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, and in accordance with the following:

- Those 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) <https://uspreventiveservicestaskforce.org/uspstf/>.
- Those 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 (CDC) <https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>.
- With respect to women, those evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) <https://www.hrsa.gov/womens-guidelines-2019>.
- With respect to infants, children and adolescents, such evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the HRSA <https://brightfutures.aap.org/Pages/default.aspx>.

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.

Additional information regarding Preventive Care Services may be accessed through

[\(https://www.healthcare.gov/coverage/preventive-care-benefits/\)](https://www.healthcare.gov/coverage/preventive-care-benefits/).

Preventive Care Services are covered as shown in the "Schedule of Benefits" section. Please consult with Your Physician to determine whether a specific service is preventive or diagnostic (cost sharing may differ, depending on whether a benefit is considered preventive care or not).

For a detailed list of Covered Services, see the "Preventive Care List of Services" section of this Certificate.

Breast Cancer

Services related to the diagnosis and treatment of breast cancer is covered.

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.

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.

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.

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, except as excluded under the "Dental Services" provision of the "General Limitations and Exclusions" 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 are covered, except as excluded under the "Dental Services" provision of the "General Limitations and Exclusions" section.

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. Prenatal testing administered by the State Department of Health Services through the California Prenatal Screening Program (formerly Expanded Alpha Feto Protein (AFP) program) is also covered.

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.

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 sections must be certified. If Certification is not obtained, payment of benefits subject to the noncertification penalty shown in the "Schedule of Benefits" section.

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.

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).

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. Please refer to the "Certification Requirement" 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. Providers that are not designated as part of HNL's network of Transplant Performance Centers are considered Out-of-Network Providers, even if they have a contract with HNL, 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.

For more information on organ donation coverage, please contact the Customer Contact Center at the telephone number on Your HNL ID card.

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 donation, including how to elect to be an organ donor, please 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 "Coverage Decisions and Disputes Resolution" section of this *Certificate*. You may also call HNL at the telephone number on Your ID card.

Organ, tissue and stem cell transplants are not covered if provided by an Out-of-Network Provider.

Family Planning

Counseling, planning and other services for problems of fertility, when Medically Necessary are covered in accordance with the "Schedule of Benefits" section. Sterilization of females and women's contraception methods and counseling on contraceptive methods, as supported by the HRSA guidelines, PPO847LRG(1/22)NG

are covered as Preventive Care Services. Contraceptive counseling includes, but is not limited to, follow-up and management of side effects of contraceptives, counseling for continued adherence and contraceptive device placement and removal.

As part of Preventive Care Services, HNL provides coverage of all FDA-approved contraceptive Drugs, devices, and other products for women, including all FDA-approved contraceptive Drugs, devices, and products available over the counter, as prescribed by Your provider; voluntary sterilization procedures; patient education and counseling on contraception; and follow-up services related to the Drugs, devices, products and procedures, including, but not limited to, management of side effects of contraceptives, counseling for continued adherence and contraceptive device placement and removal. Contraceptives that are covered under the medical benefit include intrauterine devices (IUDs), injectable contraceptives and implantable contraceptives. Prescribed contraceptives for women are covered as described in the "Outpatient Prescription Drug Benefits" portion of this "Plan Benefits" section of this *Certificate*.

Covered Expenses also include services under the California Prenatal Screening Program administered by the California State Department of Public Health.

Fertility Preservation

This *Certificate* covers Medically Necessary services and supplies for established fertility preservation treatments in connection with iatrogenic Infertility. Iatrogenic Infertility is Infertility that is caused by a medical intervention, including reactions from prescribed Drugs or from medical or surgical procedures for conditions such as cancer or gender dysphoria. This benefit is subject to the applicable Copayments and Coinsurance shown in the "Schedule of Benefits" section as would be required for covered services to treat any illness or condition under this *Certificate*.

Clinical Trials

Routine patient care costs for patients diagnosed with cancer or other life-threatening disease or condition who are accepted into phase I, II, III or IV clinical trials are covered when Medically Necessary, authorized by HNL, and either the Covered Person's treating Physician has recommended participation in the trial or the Covered Person has provided medical and scientific information establishing eligibility for the clinical trial. Clinical trial services performed by Out-of-Network Providers are covered only when the protocol for the trial is not available through Preferred Providers within California. 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.

"Routine patient care costs" are the costs associated with the requirements of HNL, including Drugs, items, devices and services that would normally be covered under this *Certificate*, if they were not provided in connection with a clinical trials program.

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 "Coverage Decisions and Disputes

Resolution" section of this *Certificate*. You may also call HNL at the telephone number on Your ID card.

Chiropractic Services

Chiropractic services are covered in accordance with the "Schedule of Benefits" section.

An initial examination is covered to determine the nature of Your problem.

Subsequent visits are covered up to the maximum number of visits stated in the "Schedule of Benefits" section, when Medically Necessary for the treatment of a Musculoskeletal and Related Disorder, as described in the proposed Chiropractic Treatment Plan.

Covered services received during a subsequent visit may include manipulations, adjustments, therapy, x-ray procedures and laboratory tests in various combinations.

X-ray services are also covered under this benefit when prescribed by a chiropractor and performed by another party.

X-ray second opinions, however, will be a covered benefit only when performed by a licensed radiologist for verification of suspected tumors or fractures, not for routine care.

The following services or supplies are not covered under this chiropractic benefit, but may be covered as stated elsewhere in this *Certificate*:

- Examinations or treatments for conditions other than those related to Musculoskeletal and Related Disorders, and physical medicine services (therapy) not associated with spinal, muscle or joint manipulation
- Services, lab tests, x-rays and other treatments not documented as Medically Necessary, or classified as Experimental or Investigational or as being in the research stage. Denial of Experimental procedures or Investigational services is subject to Independent Medical Review (please refer to the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "Coverage Decisions and Disputes Resolution" section of this *Certificate* for more information).
- Surgical procedures
- Durable Medical Equipment, Drugs or medications (prescription or non-prescription)
- Hypnotherapy, behavior training, sleep therapy and weight programs
- Massage therapy
- Thermography
- Magnetic Resonance Imaging and any types of diagnostic radiology, other than x-rays
- Transportation costs including local Ambulance charges
- Education programs, non-medical self-care, self-help training or any related diagnostic testing
- Vitamins, minerals, nutritional supplements or other similar products

Mental Health and Substance Use Disorders

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.

Services for Mental Health and Substance Use Disorder benefits are administered by MHN Services, an affiliate behavioral health administrative services company which contracts with HNL to administer these benefits.

Telehealth services for Mental Health and Substance Use Disorders are covered. See the "Telehealth Services" and "Telehealth Consultations through the Select Telehealth Services Provider" provisions in this "Plan Benefits" section for more details.

Emergency care services, regardless of whether the Covered Person is admitted, do not require Certification.

The following benefits are provided:

The diagnosis of and all Medically Necessary treatment of Mental Health and Substance Use Disorders are covered by this *Certificate*.

Gender Affirming Procedures – Medically Necessary gender affirming procedures, including, but not limited to, mental health evaluation and treatment, pre-surgical and postsurgical hormone therapy, fertility preservation, speech therapy, and surgical services (such as hysterectomy, ovariectomy, and orchiectomy, genital surgery, breast surgery, mastectomy, and other reconstructive surgery Medically Necessary to create a normal appearance for the gender with which the person identifies, including facial reconstruction, body contouring, and tracheal shaving), for the treatment of gender dysphoria or gender identity disorder are covered. Services not Medically Necessary for the treatment of gender dysphoria or gender identity disorder are not covered.

Reasonable travel, lodging and meal costs for a Covered Person to undergo an authorized transgender surgery are covered, limited to a lifetime maximum of \$75,000. Travel and lodging are only available for the patient (companion not covered).

Outpatient Services - Outpatient services are covered as shown in the "Schedule of Benefits" section under "Mental Health and Substance Use Disorders."

Covered services include:

- Outpatient office visits for the treatment of Mental Health and Substance Use Disorders, including gender dysphoria, by Physicians and other licensed providers, as described in this *Certificate*. Services include:
 - o outpatient crisis intervention,
 - o assessment and treatment services,
 - o specialized therapy including individual and group mental health evaluation and treatment,
 - o psychological testing when necessary to evaluate Mental Health and Substance Use Disorders,
 - o outpatient services for the purpose of monitoring medication management and drug therapy monitoring; and
 - o in connection with gender dysphoria, Physician office visits for hormone therapy (including hormone injections) and Physician surgical consultations.

- Outpatient services other than office visits for the treatment of Mental Health and Substance Use Disorders, including gender dysphoria as ordered by a Physician (or other licensed provider described in this *Certificate*). Services include:
 - o psychological and neuropsychological testing when necessary to evaluate Mental Health and Substance Use Disorders,
 - o neurofeedback (biofeedback),
 - o intensive outpatient care program,
 - o day treatment programs,
 - o partial hospitalization programs,
 - o medical treatment for withdrawal symptoms,
 - o electroconvulsive therapy, transcranial magnetic stimulation,
 - o other outpatient procedures; and
 - o in connection with gender dysphoria: fertility preservation, speech therapy, and surgical services (such as hysterectomy, ovariectomy and orchiectomy, breast surgery, genital surgery, mastectomy, and other reconstructive surgery Medically Necessary to create a normal appearance for the gender with which the person identifies, including facial reconstruction body contouring, and tracheal shaving).
- 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.
- 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 pervasive developmental disorder or autism are covered as shown in the "Schedule of Benefits" section under "Mental Health and Substance Use Disorders."
 - o A licensed Physician or licensed psychologist must establish the diagnosis of pervasive developmental disorder or autism.
 - o 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, by qualified autism service professionals who are supervised by the treating Qualified Autism Service Provider or by qualified autism service paraprofessionals who are supervised by the treating Qualified Autism Service Provider or a qualified autism service professional.

- o 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.
- o HNL may deny coverage for continued treatment if the ongoing Medical Necessity is not demonstrated. HNL will not deny or delay coverage for Medically Necessary BHT for lack of cognitive, developmental, or IQ testing; because services are available from a California Regional Center; or on the grounds that behavioral health treatment is Experimental, Investigational, or educational; or on the grounds that behavioral health treatment is not being, will not be, or was not, provided or supervised by a licensed person, entity or group when the provider or supervisor in question is certified by a national entity that is accredited by the National Commission for Certifying Agencies.

Inpatient Services - Inpatient services are covered as shown in the "Schedule of Benefits" section under "Mental Health and Substance Use Disorders."

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 Physician 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 Limitations and Exclusions" section.

Detoxification - Inpatient services for acute detoxification and treatment of acute medical conditions relating to Mental Health and Substance Use Disorders are covered.

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. In addition, coverage is subject to exclusions and limitations as shown under the "Outpatient Prescription Drug Benefits" section in the "General Limitations and Exclusions" section.

Covered Drugs and Supplies

Medically Necessary Prescription Drugs are covered. 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 Copayment or Coinsurance, as shown in the "Schedule of Benefits" section of this *Certificate*.

Cost-sharing and any accrual of amounts from all Drug Coupons paid on Your behalf for any Prescription Drugs obtained by You through the use of a Drug Discount, Coupon, or Copay Card provided by a Prescription Drug manufacturer will not apply toward Your plan Deductible or Out-of-Pocket Maximum.

Prescription Drugs must be dispensed for a condition, illness or injury that is covered by this Plan. Refer to the "General Limitations and Exclusions" section of this *Certificate* to find out if a particular condition is not covered.

Tier 1 Drugs (Primarily Generic) and Tier 2 Drugs (Primarily Brand) Tier 1 and Tier 2 Drugs listed in the Health Net Formulary are covered, when prescribed by a Physician, an authorized referral Specialist or an emergent or Urgent Care Physician. Some Tier 1 Drugs and Tier 2 Drugs require Prior Authorization from HNL to be covered. The fact that a drug is listed in the Formulary does not guarantee that Your Physician will prescribe it for You for a particular medical condition.

Tier 3 Drugs

Tier 3 Drugs are Prescription Drugs that may be Generic Drugs or Brand Name Drugs, and are either:

- Specifically listed as Tier 3 on the Formulary; or
- Not listed in the Health Net Formulary that are not excluded or limited from coverage.

Some Tier 3 Drugs require Prior Authorization from HNL to be covered.

Please refer to the "Formulary" portion of this subsection for more details.

Specialty Drugs

Specialty Drugs listed in the Health Net Formulary are covered when Prior Authorization is obtained from HNL and the Drugs are dispensed through HNL's contracted Specialty Pharmacy Vendor. These include Drugs that are made using biotechnology; Drugs that require special training for self-administration; Drugs that require regular monitoring of care by a pharmacy; and Drugs that cost more than six hundred dollars for a one-month supply.

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 Formulary; and
- Shown on the Formulary as requiring Prior Authorization.
- Drugs used to treat hemophilia, including blood factors, are covered as Specialty Drugs under this pharmacy benefit.

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 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

You are financially responsible for the applicable Deductible, Copayment or Coinsurance for the Brand Name Drug plus an additional amount, as shown in the "Schedule of Benefits" section of this *Certificate*, if a Generic Drug equivalent is commercially available, but You:

- Receive a Brand Name Drug at a Participating Pharmacy or through the Mail Order Program; or
- Submit a claim for a Brand Name Drug from a Nonparticipating Pharmacy or due to Emergency Care.

However, if the Prescription Drug Order indicates "do not substitute" or "dispense as written" or words of similar meaning, You are only responsible for the applicable Copayment.

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 Formulary 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.

Diabetic Drugs and Supplies

Prescription Drugs for the treatment of diabetes (including insulin) are covered as stated in the Formulary. 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 brands only); Ketone test strips; specific brands of lancet puncture devices and specific brands of lancets when used in monitoring blood glucose levels. Additional supplies are covered under the medical benefit; please refer to the "Diabetic Equipment" provision of the "Medical Benefits" portion of 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 FDA-approved contraceptives for women that are either available over-the-counter or are only available with a Prescription Drug Order. 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 Formulary.

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 "Medical Services and Supplies" portion of this section, under the heading "Family Planning" and the "Preventive Care List of Services" section for information regarding contraceptives covered under the medical benefit.

You may use the Prior Authorization process to obtain coverage at no cost for a prescription contraceptive that is not on the Formulary or the brand name equivalent of a covered generic

contraceptive that is unavailable. HNL will cover the contraceptive if Your Physician submits a Prior Authorization request when Medically Necessary. This request is not subject to denial by HNL.

HNL covers up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives when dispensed or furnished at one time by a contracted health care provider or pharmacist.

Smoking Cessation Coverage

Drugs that require a prescription in order to be dispensed for the relief of nicotine withdrawal symptoms are covered. In addition, all FDA-approved smoking cessation medications, including prescription and over the counter medications, are covered without Prior Authorization when prescribed by a Physician. 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. For all FDA-approved tobacco cessation medications, no limits will be imposed on the number of days that are covered, regardless of whether the medications are taken alone or in combination.

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. Coverage for Compounded Drugs is subject to Prior Authorization by HNL and Medical Necessity. Refer to the "Off-Label Drugs" provision in the "Outpatient Prescription Drugs Benefits" portion of the "Plan Benefits" section for information about FDA approved Drugs for off-label use. Coverage for Compounded Drugs requires the Tier 3 Drug Copayment and is subject to Prior Authorization by HNL and Medical Necessity. HNL covers compounded medication(s) when:

- The compounded medication(s) include at least one Drug, as defined;
- There are no FDA-approved, commercially available, medically appropriate alternative(s);
- The drug is not on the FDA's "Do Not Compound" list;
- The compounded medication is self-administered; and
- Medical literature supports its use for the requested diagnosis.

Schedule II Narcotic Drugs

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. A partial prescription fill, which is of a quantity less than the entire prescription, can be requested by you or your Physician. Partial prescription fills are subject to a prorated Copayment or Coinsurance based on the amount of the prescription that is filled by the pharmacy. Schedule II narcotic Drugs are not covered through mail order.

“Split-fill” Program

For certain high cost orally-administered Drugs, including anti-cancer Drugs, HNL provides a free 14-day trial. Drugs under the Split-fill program are indicated in the Formulary with “SF” in the comment section. Health Net will approve the initial fill for a 14-day supply at no cost to You. If, after the initial fill, You are free of adverse effects and wish to continue on the Drug, the subsequent fills will be dispensed for the full quantity as written by Your Physician. You will be charged the applicable Copayment or Coinsurance (up to the maximum limit as shown in the “Schedule of Benefits”) for each subsequent fill.

The Formulary

What is the Health Net Formulary?

HNL developed the Formulary to identify the safest and most effective medications for Health Net Life Covered Persons while attempting to maintain affordable pharmacy benefits. We specifically suggest to all Preferred Providers that they refer to this Formulary when choosing Drugs for patients who are Health Net Life Covered Persons. When Your Physician prescribes medications listed in the Formulary, it is ensured that You are receiving a high quality and high value prescription medication. In addition, the Formulary 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.

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 Formulary. You may also request a copy of the current Formulary, and it will be mailed to You. The current Formulary is also available on the HNL website at www.healthnet.com under the pharmacy information.

How are Drugs Chosen for the Health Net Formulary?

The Formulary is created and maintained by the Health Net Pharmacy and Therapeutics Committee. Before deciding whether to include a drug on the Formulary, 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 Formulary. The Formulary 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 Pharmacy and Therapeutics Committee ("Committee") develops, maintains, and oversees the Formulary. The Committee meets each quarter, and maintains written documentation of its decisions and the rationale informing its decisions.

Committee membership includes actively practicing Physicians of various medical specialties from Health Net contracting Physician groups and clinical pharmacists. HNL recruits voting members from contracting Physician groups throughout California based on their experience, knowledge and expertise. Frequently, the Committee consults external Physician experts for additional medical input. Neither voting members of the Committee nor the external medical professionals with whom the Committee consults are HNL employees, and this ensures decisions are unbiased and without conflicts of interest.

Additions to the Formulary are subject to a vote by the Committee, which may be based on the medical input from external Physician experts. Moreover, in developing or modifying the Formulary, the Committee's responsibilities include the following:

- a. Developing and documenting procedures to ensure appropriate drug review and inclusion;
- b. Basing clinical decisions on the strength of the scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and other related information;
- c. Considering the therapeutic advantages of Drugs in terms of safety and efficacy when selecting Formulary Drugs;
- d. Reviewing policies that guide exceptions and other utilization management processes, including drug utilization review, quantity limits, and therapeutic interchange;
- e. Evaluating and analyzing treatment protocols and procedures related to the insurer's Formulary at least annually;
- f. Reviewing and approving all clinical Prior Authorization criteria, step therapy protocols, and quantity limit restrictions applied to each covered drug;
- g. Reviewing new United States Food and Drug Administration-approved Drugs and new uses for existing Drugs;
- h. Ensuring HNL's Formulary cover a range of Drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all disease states, and do not discourage enrollment by any group of insureds; and
- i. Ensuring HNL's Formulary provides appropriate access to Drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time.

Prior Authorization Process

Prior Authorization status is included in the Formulary. The Formulary 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. Step therapy exceptions are also subject to the Prior Authorization process. You may obtain a list of Drugs requiring Prior Authorization by visiting Our website at www.healthnet.com. If a drug is not on the Formulary, Your Physician should call HNL to determine if the drug requires Prior Authorization.

Requests for Prior Authorization, including step therapy exceptions, may be submitted electronically or by telephone (at the phone number shown on your HNL ID card) or facsimile (1-800-314-6223). Urgent requests from Physicians for authorization are processed, and prescribing providers notified of HNL's determination as soon as possible, not to exceed 24 hours after HNL's receipt of the request. A Prior Authorization request is urgent when a Covered Person is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function. Routine requests from Physicians are processed, and prescribing providers notified of HNL's determination in a timely fashion, not to exceed 72 hours after HNL's receipt of the request. For both urgent and routine requests, HNL must also notify the insured or his or her designee of its decision. If HNL fails to respond within the required time limit, the Prior Authorization request is deemed granted.

If a drug is not on the Formulary, 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 Formulary, the non-preferred Brand Name Drug tier (Tier 3) 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 Formulary, then You, Your designee or Your Physician can request an expedited review. Expedited requests for an exception will be processed, and You, Your designee and the prescribing providers will be notified, within 24 hours after HNL's receipt of the request. Standard requests for an exception will be processed, and You, Your designee and the prescribing provider will be notified within 72 hours after HNL's receipt of the request. Exceptions based on your medical condition will be for the duration of your medical condition.

If you are denied a request for a drug not on the Formulary, you, your designee or your prescribing Physician may request that the original exception request and subsequent denial of such request be reviewed by an independent review organization. HNL will make its determination on the external exception request and notify you, your designee or your prescribing Physician of its coverage determination no later than 72 hours following receipt of a standard request and no later than 24 hours following receipt of an expedited exception request.

If a drug is eliminated from the Formulary, 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.

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.

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 "Coverage Decisions and Disputes Resolution" section of this *Certificate*.

Step Therapy

Step therapy is a process in which You may need to use one type of Prescription Drug before HNL will cover another one. We check certain Prescription Drugs to make sure that proper prescribing guidelines

are followed. These guidelines help you get high quality and cost effective Prescription Drugs. Exceptions to the step therapy process are subject to Prior Authorization. However, if You were taking a Prescription Drug for a medical condition under a previous plan before enrolling in this Health Net PPO plan, You will not be required to use the step therapy process to continue using the Prescription Drug.

Retail Pharmacies and the Mail Order Program

Prescription Drugs Dispensed by a Participating Pharmacy

You must purchase covered Drugs at a Participating Pharmacy to receive the highest available benefits for Prescription Drugs under this Plan.

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 card. 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.

(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 Formulary.

Specialty Drugs Dispensed by HNL's Contracted Specialty Pharmacy Vendor

Specialty Drugs must be obtained through HNL's contracted Specialty Pharmacy Vendor. 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.

Prescription 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, You will be required to:

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

To receive the highest available benefits for Prescription Drugs under this *Certificate*, You must have the Prescription Drug Order dispensed by a Participating Pharmacy, and request that Generic Drugs be substituted for Brand Name Drugs.

Claim forms will be provided by HNL upon request.

Prescription 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.

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 contact the Customer Contact Center at the telephone number on Your HNL ID card.

Maintenance Drugs may also be obtained at a CVS retail pharmacy under the mail order program benefit.

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 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.

GENERAL LIMITATIONS AND EXCLUSIONS

No payment will be made under this *Certificate* for expenses incurred for or in connection with 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. However, the *Certificate* does cover 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 Maximum Allowable Amount, as defined in the "Definitions" section. However, if medically appropriate care cannot be provided within the network, HNL shall arrange for the required care with available and accessible providers outside the network, with the patient responsible for paying only cost-sharing in an amount equal to the cost-sharing they would have paid for provision of that or a similar service in-network. In addition to in-network Copayments and Coinsurance, in-network cost sharing includes applicability of the in-network Deductible and accrual of cost sharing to the in-network Out-of-Pocket Maximum.

Ambulance Services

Paramedic and air or ground Ambulance services that are not Emergency Care will not be covered unless Certification is obtained and services are Medically Necessary. Non-emergency paramedic and air or ground Ambulance services which do not result in a patient's transportation will not be covered.

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:

- The Investigational drug, item, device or service itself;
- 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 analysis, hairpieces and wigs, cranial/hair prostheses, chemical face peels, abrasive procedures of the skin or epilation are not covered.

When cosmetic or reconstructive surgery is performed to correct or repair abnormal structures of the body caused by, congenital defects, developmental abnormalities, trauma, infection, tumors, or diseases, or in connection with the treatment for gender dysphoria and such surgery does either of the following:

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

Then the surgery or service will be covered when Medical Necessity is established.

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

- Breast reconstruction surgery; and
- Surgery performed on either breast to restore or achieve 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" 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

Unless otherwise covered as Preventive Care 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 eight 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.

The following services are not covered under any circumstances, 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.

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).

Refractive Eye Surgery

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.

Optometrics, Vision Therapy and Orthoptics

Any optometric services, vision therapy, eye exercises including orthoptics, routine eye exams and routine eye refractions. Contact or corrective lenses (except an implanted lens which replaces the organic eye lens), and eyeglasses unless specifically provided elsewhere in this *Certificate*.

Reconstruction of Prior Surgical Sterilization Procedures

Services to reverse voluntary surgically induced Infertility.

Fertility Preservation

Fertility preservation treatments are covered as shown under "Fertility Preservation" in the "Plan Benefits" section. However, coverage for fertility preservation does not include the following:

- 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 obtain Certification 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.

Infertility Services

This *Certificate* does not cover services or supplies to diagnose, evaluate or treat Infertility. Excluded procedures include, but are not limited to:

- Conception by medical procedures, such as artificial insemination, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or any process that involves harvesting, transplanting or manipulating 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.

For Medically Necessary fertility preservation services in connection with iatrogenic Infertility, refer to the "Fertility Preservation" section of the "Plan Benefits" section for more details.

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 "Coverage Decisions and Disputes Resolution" section of this *Certificate*; or
- Clinical trials for patients with cancer or life-threatening diseases or conditions are deemed appropriate according to the "Medical Benefits" portion 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.

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 *Certificate* 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) for which facilities or services of a general acute Hospital are not medically required. Furthermore, custodial or domiciliary care in Residential Treatment Centers is not covered. 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.

Inpatient Diagnostic Tests

Inpatient room and board charges incurred in connection with an admission to a Hospital or other inpatient treatment facility primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Noneligible Hospital Confinements

Inpatient room and board charges in conjunction with a Hospital, Hospice or Skilled Nursing Facility stay primarily for environmental change, personal convenience or custodial in nature are not covered.

Noneligible Institutions

Any services or supplies furnished by a noneligible institution, which is an institution other than a legally operated Hospital, Hospice, Medicare-approved Skilled Nursing Facility or Residential Treatment Center, 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 Mental Health and Substance Use Disorders.

Nonlicensed Provider

Treatments or services rendered by health care providers who are required to be, but who are not, licensed by the state where they practice to provide the treatments or services. Treatment or services for which the provider of services is not required to be licensed are also excluded from coverage. This includes treatment or services from a non-licensed provider under the supervision of a licensed Physician, except as specifically provided or arranged by HNL. This exclusion does not apply to the Medically Necessary treatment of pervasive developmental disorder or autism, to the extent stated in this *Certificate*.

Sober Living Facilities

Expenses related to a stay at a sober living facility. This exclusion does not apply to licensed Residential Treatment Centers.

Private Rooms

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 healthcare 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 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, except for disposable supplies for diabetes.
- Exercise equipment, including treadmills and charges for activities or facilities normally intended or used for physical fitness.

- Hygienic equipment, Jacuzzis and spas.
- 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.
- 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*.
- Durable Medical Equipment received and/or obtained from an Out-of-Network Provider or noncontracting vendor, except when provided, used or administered during a Medically Necessary inpatient or outpatient visit.
- Durable Medical 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 "Diabetes Education" "Phenylketonuria (PKU)," "Mental Health and Substance Use Disorders" 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 as specifically stated in the "Plan Benefits" section and when provided for morbid obesity or as a Preventive Care Service.

Transplants

Experimental or Investigational organ, stem cell and tissue transplants unless deemed appropriate by an Independent Medical Review. (Please refer to "Independent Medical Review of Investigational or Experimental Therapies" in the "Coverage Decisions and Disputes Resolution" section for additional information.)

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.

Acupuncture

Any expenses related to the puncture of the skin for diagnostic or therapeutic (counter-irritation) purposes either manually through the use of needles or electrically through the use of needles or the Transcutaneous Electrical Nerve Stimulation (TENS) device.

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.

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 "Surrogacy Arrangements" in the "Specific Provisions" section of this *Certificate*.

Outpatient Drugs and Medications

Any outpatient Drugs, medications or other substances dispensed or administered in any outpatient setting, except as specifically stated in the "Plan Benefits" section of this *Certificate*. Except for over-the-counter preventive Drugs and women's contraceptives, nonprescription (over-the-counter) Drugs that can be purchased without a prescription (including a drug requiring a prescription but for which there is a non-prescription equivalent), even if a Physician writes a Prescription for a non-Prescription Drug are not covered.

Sexual Dysfunction Drugs

Drugs (including injectable medications) prescribed for the treatment of sexual dysfunction are not covered.

Rehabilitative Services

Rehabilitative services, in excess of the number of visits stated in the "Schedule of Benefits" section, whether rendered in an inpatient or outpatient facility, are not covered. Medically Necessary rehabilitative services following post-mastectomy lymphedema syndrome are not subject to such visit limitations*.

* *The coverage described above in relation to Medically Necessary rehabilitative services for post-mastectomy lymphedema syndrome 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.*

Foreign Travel or Work Assignment

If You receive services or obtain supplies in a foreign country, benefits will be payable for Emergency Care and Urgent Care 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.

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.

Self-Injectable Drugs

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 it is administered in a Physician's office. If You need to have a provider administer the Specialty Drug, You will need to obtain the Specialty Drug through HNL's contracted Specialty Pharmacy Vendor and bring it with You to the provider office. Alternatively, You can coordinate delivery of the Specialty Drug directly to the provider's office through the contracted Specialty Pharmacy Vendor.

Aversion Therapy

Therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus is not covered.

Educational and Employment Services

Except for Medically Necessary services related to behavioral health treatment covered as shown in the "Medical Benefits" portion of "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

However, services related to behavioral health treatment for pervasive development disorder or autism are covered as shown in the "Medical Benefits" portion of "Plan Benefits" section.

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 Mental Health and Substance Use Disorders, and as otherwise specified in the "Plan Benefits" section), hypnotherapy, crystal healing therapy, yoga, hiking, rock climbing and any other type of sports activity are not covered.

State Hospital Treatment

Services in a state Hospital are limited to treatment or confinement as the result of an emergency or Urgently Needed Care as defined in the "Definitions" section.

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 "Medical Benefits" portion of 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
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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.

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 Formulary. 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.

Devices

Coverage is limited to vaginal contraceptive devices and those devices listed under the "Diabetic Supplies" provision of the "Outpatient Prescription Drug Benefits" portion of "Plan Benefits." No other devices are covered even if prescribed by a Physician.

Diagnostic Drugs

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

Appetite Suppressants or Drugs for Body Weight Reduction

Drugs for the treatment of obesity are not covered, unless Medically Necessary.

Drugs Prescribed for Cosmetic or Enhancement Purposes

Drugs that are prescribed for the following non-medical conditions are not covered: hair loss, sexual performance, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes and cognitive performance. Examples of Drugs that are excluded when prescribed for such conditions include, but are not limited to, Latisse, Renova, Vaniqa, Propecia or Lustra. This exclusion does not exclude coverage for Medically Necessary Drugs when Prior Authorization is received as shown in the "Prior Authorization Process" provision in the "Outpatient Prescription Drug Benefits" portion of "Plan Benefits" to treat a diagnosed medical condition affecting memory, including but not limited to, Alzheimer's dementia.

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 Formulary. Phenylketonuria (PKU) is covered under the medical benefit (see the "Phenylketonuria" provision of the "Plan Benefits" section).

Allergy Serum

Allergy desensitization products, 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 "Allergy and Injection Services" 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 deemed appropriate by an Independent Medical Review. (Please refer to "Independent Medical Review of Investigational or Experimental Therapies" in the "Coverage Decisions and Disputes Resolution" section for additional information.) 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.

Injectable Drugs

Self-administered injectable Drugs as described in the Formulary are covered. All other injectable Drugs are not covered under the Prescription Drug benefit. Surgically implanted Drugs are covered under the medical benefit (see the "Surgically Implanted Drugs" provision in the "Plan Benefits" section).

Irrigation Solutions

Irrigation solutions and saline solutions are not covered.

Sexual Dysfunction Drugs

Drugs prescribed for sexual dysfunction are not covered. This includes Drugs that establish, maintain or enhance sexual function, libido or satisfaction.

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. In addition, Drugs that are not approved by the FDA may be covered when Medically Necessary. If a Covered Person has a life-threatening or seriously debilitating condition and requests coverage of a non-FDA approved drug for an Experimental or Investigational purpose, he or she is entitled to IMR if Health Net delays, denies, or modifies the coverage. For more information, please refer to the "Independent Medical Review of Investigational or Experimental Therapies" provision in the "Coverage Decisions and Disputes Resolution" section in this *Certificate*.

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.

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 for medical uses in the United States.

Lost, Stolen or Damaged Drugs

Once You have taken possession of Drugs, replacement of lost, stolen or damaged Drugs is not covered. You will have to pay the retail price for replacing them. However, if a state of emergency is declared by the Governor and You are displaced by the disaster, this exclusion will not apply.

Hypodermic Syringes and Needles

Specific brands of disposable insulin needles and syringes, and specific brands of pen devices are covered. Needles and syringes required to administer self-injected medications (other than insulin) will be provided through Our contracted Specialty Pharmacy Vendor under the medical benefit. All other devices, syringes and needles are not covered.

Drugs Prescribed by a Dentist

Drugs prescribed for routine dental treatment are not covered.

GENERAL PROVISIONS

Term of Certificate

This *Certificate* shall remain in effect for the period of time specified in the 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 provide notice of such changes to Covered Persons of this plan when 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*.

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. (For Medicare coordination of benefits, please refer to the "Medicare Coordination of Benefits (COB)" portion of this section.)

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, *except* 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, *except* 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 Covered Person, 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, unless the Rules Establishing the Order of Benefit Determination are affected because of a divorce and assignment of legal custody of the child. The group plan or insurer of the **parent that has legal custody** pays first; the group plan or insurer of the stepparent (if any) pays second; and the group plan or insurer of the parent **that does not have legal custody** pays 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

COVERAGE DECISIONS AND DISPUTES RESOLUTION

Notification of HNL's Initial Benefit Determination

Timing of notice:

HNL shall notify the Covered Person of the initial benefit determination within the timeframes described below.

For Urgent Care claim: HNL will notify the Covered Person of Our decision as soon as possible, taking into account the medical exigencies, but not later than 72 hours from the receipt of the request. If additional information is necessary to make Our determination, HNL will notify the Covered Person (within 24 hours of the receipt of the request) of the specific information necessary to make the determination and a reasonable time frame (that is not less than 48 hours) to provide the information to HNL. HNL will notify the Covered Person of Our decision no later than 48 hours after the earlier of the receipt of the requested information, or the end of the time period to provide the requested information.

For concurrent care decisions: If the treatment involves Urgent Care, the request by the Covered Person or the Covered Person's Physician to extend the course of treatment beyond the period of time or number of treatments shall be decided as soon as possible, taking in to account the medical exigencies. The Covered Person will be notified of Our decision within 24 hours of the receipt of the review request, provided that such a request is made to HNL at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

If concurrent review results in 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.

For all other claims: The time frames that are described under the "Certification Procedure" and "Retrospective Review" provisions in the "Certification Requirement" section apply to pre-service and post-service claims in which the benefit determinations are based on Medical Necessity. Benefit determinations that are not based on Medical Necessity are subject to the time frames that are described herein.

In the case of a pre-service claim, HNL shall notify the Covered Person of Our decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the receipt of the request. HNL may extend this time period for up to 15 additional days if an extension is necessary due to matters beyond HNL's control. HNL will notify the Covered Person, prior to the end of the initial 15-day period, of the circumstances requiring the extension of time and the date by which HNL expects to render a decision. In the case in which HNL requires additional information that is necessary to make Our determination, the notice of extension shall describe the required information and the time frame (that is at least 45 days from the Covered Person's receipt of the notice) to provide the specified information.

In the case of a post-service claim, the Covered Person shall be notified of relevant decisions within a reasonable period of time, but no later than 30 calendar days following the receipt of the claim by HNL. HNL may extend this time period for up to 15 additional days if an extension is necessary due to matters beyond HNL's control. HNL will notify the Covered Person, prior to the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which HNL expects to render a

decision. In the case in which HNL requires additional information that is necessary to make Our determination, the notice of extension shall describe the required information and the time frame (that is at least 45 days from the Covered Person's receipt of the notice) to provide the specified information.

Manner and content of notice of an adverse benefit determination:

If Our determination results in an adverse benefit determination, HNL shall send a written or electronic notice to the Covered Person and to the provider of the service that shall include a clear and concise explanation of the reasons for Our decision, a description of the criteria or guidelines used and the clinical reasons for the decisions regarding Medical Necessity, and a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary. The explanation will also include the specific plan provisions on which determination is based. The Medical Necessity decisions communicated to the medical providers will include the name and telephone number of the health care professional responsible for the denial, delay or modification.

In the case of an adverse benefit determination involving Urgent Care, HNL may provide the decision verbally as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request. The written or electronic notice shall be provided to the Covered Person not later than 3 days after the verbal notice. The notice of Our decision related to Urgent Care will also include a description of the expedited review process.

HNL will provide the following upon request:

- The criteria, guidelines, protocols, or other similar criterion used by HNL, or an entity with which HNL contracts for utilization review or utilization management functions, to determine whether to authorize, modify, delay, or deny health care services.
- If the adverse determination is based on Medical Necessity or Experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination.

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 that is based on:

- 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 provider before filing an arbitration proceeding, You must file a grievance or appeal against HNL by calling the Customer Contact Center at the telephone number on Your HNL ID card or by submitting a Member Grievance Form through the 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

You must participate in HNL's grievance or appeals process before requesting Independent Medical Review (IMR) for Medical Necessity denials unless there is an imminent and serious threat to the Covered Person's health. However, You will not be required to participate in the HNL's grievance or appeals process for more than 30 days. In the case of a grievance that requires expedited review, You will not be required to participate in HNL's grievance process for more than three days. In such cases, You may contact the California Department of Insurance (CDI) to request an IMR of the denial.

For a grievance or appeal of HNL's benefit determination, HNL shall notify the Covered Person of Our decision in writing or electronically within the following time frames:

Urgent Care claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours from the time the initial request was received by HNL, until the close of the case with the Covered Person.

Non-Urgent Care services that have not been rendered (pre-service claims): Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days from the time the initial request was received by HNL, until the close of the case with the Covered Person.

Non-Urgent Care services that have already been rendered (post-service claims): Within a reasonable period of time, but not later than 60 days from the time the initial request was received by HNL, until the close of the case with the Covered Person.

If Our decision is to uphold the adverse benefit determination, the notice of Our decision shall include the specific reason or reasons for the adverse determination and reference to the specific plan provisions on which the determination is based. HNL will provide the following upon request:

- Copies of, all documents, records, and other information relevant to the claim;
- An internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination;

- If the adverse benefit determination is based on a Medical Necessity or Experimental treatment or similar exclusion or limitation, an explanation of the scientific or clinical judgment used for the determination.

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. For urgent cases involving an imminent and serious threat to Your health, including, but not limited to, serious Pain, the potential loss of life, limb, or major bodily function or the immediate and serious deterioration of Your health, the IMR organization must provide its determination within three days.

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 contact 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;
- Your Physician must certify that the proposed Experimental or Investigational therapy is likely to be more beneficial than available standard therapies, or as an alternative, You may submit a request for a therapy that, based on documentation presented from medical and scientific evidence, is likely to be more beneficial than available standard therapies;
- 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 contact 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 RELATING TO OR ARISING OUT OF YOUR HNL MEMBERSHIP TO INDIVIDUAL FINAL AND BINDING ARBITRATION, EXCEPT DISPUTES CONCERNING ADVERSE BENEFIT DETERMINATIONS AS DEFINED IN 45 CFR 147.136, AND YOU AGREE NOT TO PURSUE CLASS 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 bilateral 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 and you must attempt to resolve your dispute by utilizing that process before instituting arbitration. In the event that a dispute is not resolved in that process, HNL uses binding bilateral 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. However, you are not required to participate in final, binding arbitration to resolve disputes concerning adverse benefit determinations and are entitled to pursue any remedies available under the law. 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 \$500,000 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 \$500,000 or \$50,000, whichever is applicable. In the event that total amount of damages is over \$500,000 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.

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: Legal Department
P.O. Box 4504
Woodland Hills, CA 91365-4504

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. The 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 Legal Department at the address provided above.

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 HNL 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 HNL and You specifically direct such medical payments carriers to directly reimburse HNL 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 HNL 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 HNL; 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.*

- The Covered Person's 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 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 the Covered Person was responsible for some portion of his or her 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 the Covered Person received
- The amount the Covered Person will be required to reimburse HNL or the medical provider for services received under this plan will not exceed one-third of the money the Covered Person received if he or she engages a lawyer or one-half of the money received if a lawyer is not engaged.

- For health care services not provided on a capitated basis, the amount actually paid by the licensee, medical group, or independent practice association pursuant to that contract or policy to any treating medical provider.
- For health care services provided on a capitated basis, the amount equal to 80 percent of the usual and customary charge for the same services by medical providers that provide health care services on a noncapitated basis in the geographic region in which the services were rendered.
- * *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.

Out-of-State Providers

Health Net PPO 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.

When traveling outside Your state of residence, 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

The second opinion consultation is a consultation by an appropriately qualified healthcare professional, and may include recommendations for additional x-ray, laboratory services or treatment. You may seek a second opinion consultation from a provider without first receiving authorization from HNL. However, services recommended by the second opinion consultation may be subject to Certification. Please refer to the "Certification Requirement" section to determine which services are subject to Certification. When a Covered Person receives a second opinion, he or she will be responsible for any

applicable Deductible, Copayments or Coinsurance. 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.

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 9040, Farmington, MO 63640-9040. Notice should include information sufficient for Us to identify the Covered Person.

If you need to file a claim for covered Mental Health and Substance Use Disorder services provided upon referral by MHN Services, you must file the claim with MHN Claims within one year after receiving those services. Any claim filed more than one year from the date the expense was incurred will not be paid unless it was shown that it was not reasonably possible to file the claim within one year, and that it was filed as soon as reasonably possible. You must use the Member claim form found at <https://members.mhn.com/mbh/homepage> and you should send the claim to MHN Claims at the address below:

MHN Claims
P.O. Box 14621
Lexington, KY 40512-4621

MHN Claims will give you claim forms on request. For more information regarding claims for covered Mental Health and Substance Use Disorders, you may call MHN Claims at 1-800-444-4281 or you may write MHN Claims at the address given immediately above.

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 of time must be furnished to Us at P.O. Box 9040, Farmington, MO 63640-9040, in case of claim for loss for which this *Certificate* provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which HNL is liable; 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 HNL. Within 30 working days after receipt of the complete claim by HNL, HNL may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied. The notice will identify the contested or denied portion(s) of the claim, and the specific reasons for such contention or denial, as supported by the factual and legal bases known to HNL at that time.

In the event HNL requires additional time to affirm or deny the claim, HNL shall notify the claimant in writing. This written notice shall specify any additional information HNL requires in order to make a determination and shall state any continuing reasons for HNL's inability to make a determination. This notice shall be given within thirty calendar days of the notice that the claim is being contested and every thirty calendar days thereafter until a determination is made or legal action is served. If the determination cannot be made until some future event occurs, HNL shall comply with this continuing notice requirement by advising the claimant of the situation and providing an estimate as to when the determination can be made.

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 *Certificate* 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.

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.

Claims Denial

1. **DENIAL:** If the Covered Person submits a fully completed claim to HNL, and it is partially or totally denied, he or she will be notified in writing of the denial within 30 working days from the date the claim was submitted. The Covered Person will be given the specific reasons and sections of the *Certificate* on which the denial is based. If the claim might be paid with more information, the Covered Person will be told what additional information is necessary and why.
2. **APPEAL:** The Covered Person or his or her authorized representative has the right to appeal the denial or partial denial of any claim made under the *Certificate* by requesting a review of the claim. The request must be made in writing to HNL within 365 days of the date that appears on the claims denial.

If the request is not made within the 365 day period, the Covered Person waives the right to a review.

This request must include the Covered Person's name, address, date of denial and the reasons upon which the request for review is based. Any facts that support these reasons and any issues or comment the Covered Person or the representative deems relevant should be included. In addition, the Covered Person or the representative may examine pertinent documents that relate to the denial of the claim.

3. **REVIEW AND DECISION:** Upon receipt of the request for review, HNL will make full and fair review of the claim and its denial.

HNL has a period of 60 days (after the receipt of the request for review of an adverse benefit determination) in which to make a decision and notify the Covered Person.

The decision on the request for review will be in writing and will include the specific reasons supporting it and specific references to the pertinent *Certificate* provisions on which the decision is based. If HNL upholds the denial, the Covered Person may request an independent medical review or initiate binding arbitration. A Covered Person must participate in HNL's grievance or appeals process before requesting independent medical review for denials unless there is an imminent and serious threat to the Covered Person's health. However, You will not be required to participate in the HNL's grievance or appeals process for more than 30 days. In the case of a grievance that requires expedited review, You will not be required to participate in HNL's grievance process for more than three days. See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" and "Arbitration" under "Coverage Decisions and Disputes Resolution" for the procedure to request an Independent Medical Review or arbitration of a Plan denial of coverage.

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, nurse practitioners, midwives for perinatal care and certified nurse midwives:** As required by the California Insurance Code, this must occur. 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 required by law or at HNL's election if you agree, in writing.
- **Joint Payment.** Benefit payment for Covered Expenses may be made jointly to other providers and You, at HNL's election, when a written agreement stipulates joint payment.
- **Direct Payment to You.** In situations not described above, payment will made to You. HNL reserves the right to recover an overpayment if all or some of the payment made by Us exceeded the benefits under the *Certificate*. If an overpayment is discovered, we will notify You within 6 months of the date of the error. In the case of an error prompted by representations or nondisclosure of claimants or third parties, We will notify You within fifteen (15) calendar days after the date of discovery of such error. The notice will include the cause of the error and the amount of the overpayment. You will have 30 days to dispute the overpayment, and if We are notified within the time allotted of Your disagreement that an overpayment occurred, the overpayment will not be deducted from future benefits.

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 and Urgent 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 and Urgent 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 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, other than a notice required by law, 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 the HNL office at the address listed on the back cover of this *Certificate*.

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), laboratory or other health care professional or facility that provides services or supplies covered by this plan. However,

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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.

Timely Access to Care:

The California Department of Insurance (CDI) has issued regulations (California Code of Regulations Title 10 sections 2240.15 and 2240.16) with requirements for timely access to non-emergency health care services through Preferred Providers. HNL is required to provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the Covered Person's condition consistent with good professional practice. Please contact HNL at the number shown on Your HNL ID card, 7 days per week, 24 hours per day to access triage or screening services.

When You need to see a Preferred Provider, call his or her office for an appointment. Please call ahead as soon as possible. When You make an appointment, identify yourself as an HNL Member, and tell the receptionist when You would like to see Your doctor. The receptionist will make every effort to schedule an appointment at a time convenient for You. If You need to cancel an appointment, notify Your Physician as soon as possible.

Language assistance is available at all medical points of contact where a covered benefit or service is accessed including, but not limited to, at the time of Your appointment. HNL's Customer Contact Center has bilingual staff and interpreter services for additional languages to handle Your language needs. Call the Customer Contact Center number on Your HNL ID card for this free interpretive service. The use of the interpretive services will not cause a delay of Your scheduled appointment. Please see the "Language Assistance Services" provision in the "Important Notices" section for more details regarding the availability of interpreter services.

Please see the list of maximum waiting times as listed below. (A business day is every official working day of the week. Typically, a business day is Monday through Friday, and does not include weekends or holidays.) Wait times depend on Your condition and the type of care You need. You should get an appointment to see Your Physician:

- **Physician appointments for primary care:** within 10 business days of request for an appointment.
- **Physician appointments for Specialist care:** within 15 business days of request for an appointment.
- **Urgent Care appointment with Physician:** within 48 hours of request for an appointment.
- **Urgent Care appointments for services that require Certification:** within 96 hours of the request for an appointment.
- **Routine Check-up/Physical Exam:** within 30 business days of request for an appointment.
- **Non-urgent appointments with a non-physician mental health care or substance use disorder provider:** within 10 business days of request for an appointment.
- **Non-urgent appointments for ancillary services:** within 15 business days of request for an appointment.
- **Urgent appointments for pediatric oral and vision services:** within 72 hours of request for an appointment.

- **Non-urgent appointments for pediatric oral and vision services:** within 36 business days of request for an appointment.
- **Preventive appointments for pediatric oral and vision services:** within 40 business days of request for an appointment.

Continuity of Care

A Covered Person may request HNL to arrange for the Covered Person's continuing care from an Out-of-Network Provider at the in-network benefit level, in the circumstances shown below.

Termination of Provider or Facility Contract:

At the request of the Covered Person, HNL shall arrange for continuing care, at the in-network benefit level, from a provider or facility that has been terminated from the PPO network by HNL while the Covered Person is undergoing a course of treatment, including outpatient, institutional or inpatient care, with that terminated provider or facility for any of the conditions described below. In addition, if a provider contract is terminated, continuity of care is also required if benefits with respect to a contracted provider or facility are terminated because of a change in the terms of the participation of such provider or facility. The provider or facility must agree to accept the same contract terms that were in place prior to the time of contract termination. If the provider or facility does not accept such terms, HNL is not obligated to provide continuing care coverage at the in-network benefit level. HNL will notify each Covered Person who is a continuing care patient with respect to a provider or facility at the time of a termination affecting such provider or facility on a timely basis of such termination and the Covered Person's right to elect continuity of care.

Covered Persons new to HNL due to termination of prior coverage:

At the Covered Person's request, HNL shall arrange for continuing care from an Out-of-Network Provider at the in-network benefit level, if at the time his or her coverage with HNL becomes effective, the Covered Person meets both of the following criteria:

- The Covered Person's immediately prior health coverage was terminated due to either the health plan or health insurer no longer offering the Covered Person's plan, or the health plan or health insurer ceases offering new health coverage in all or a portion of the state.
- The Covered Person is undergoing a course of treatment for any of the specified conditions (as described below) with the provider, the treatment was covered at the in-network benefit level under the Covered Person's prior health coverage, and the provider is not in the HNL PPO network.

The provider must agree to accept the same contract terms applicable to providers currently contracted with HNL, and who practice in the same or similar geographic region. If the provider does not accept such terms, HNL is not obligated to provide continuing care coverage at the in-network benefit level.

Conditions Eligible for Continuity of Care:

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 condition 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 (including the duration of the pregnancy and immediate postpartum care); completion of Covered Services shall be provided for the duration of the pregnancy;
4. Maternal mental health (completion of covered services shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later);
5. 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;
6. 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 new Covered Person);
7. 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.

To request continued care, you will need to complete a Continuity of Care Request Form. For more information on how to request continued care, or request a copy of the Continuity of Care Request Form or of our continuity of care policy, please contact the Customer Contact Center at the telephone number on the Health Net PPO ID card.

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.

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 "Coverage Decisions and Disputes Resolution" 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.

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 listed in a national pharmaceutical pricing publication, and accepted as the standard price for that drug by HNL.

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 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 of obtaining approval from Us in advance of receiving certain services and supplies covered under this *Certificate*. 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" section of this *Certificate*.

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 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.

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 Covered Persons 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 Health and Substance Use Disorders). 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) the Contracted Rate for the services or supplies provided by a Preferred Provider; (ii) the Maximum Allowable Amount for the services or supplies provided by an Out-of-Network Provider.

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 Services 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*, the principal Covered Person's same-sex spouse if the principal Covered Person and spouse are a couple who is registered as domestic partners and meets all domestic partnership requirements specified by section 297 or 299.2 of the California Family Code.

Drug Discount or Coupon or Copay Card means cards or Coupons typically provided by a drug manufacturer to discount the Copayment and/or Coinsurance or Your other out-of-pocket costs (e.g., Deductible or Out-of-Pocket Maximum).

Drugs are: (1) FDA-approved medications that require a prescription either by California or Federal law; (2) insulin, and disposable hypodermic insulin needles and syringes; (3) pen delivery systems for the administration of insulin, as Medically Necessary; (4) diabetic testing supplies (including lancets, lancet puncture devices, blood and urine testing strips, and test tablets); (5) over-the-counter (OTC)

Drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B; (6) contraceptive Drugs and devices, including oral contraceptives, contraceptive rings, patches, diaphragms, cervical caps, female OTC contraceptive products when ordered by a Physician or health care provider, and emergency contraceptives; or (7) inhalers and inhaler spacers for the management and treatment of asthma.

Durable Medical Equipment

- Serves a medical purpose (its reason for existing is to fulfill a medical need, it is not for convenience and/or comfort and it is not useful to anyone in the absence of illness or injury);
- 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*. Enrolled Dependents may have a different Effective Date than the principal Covered Person if they are added later to the plan.

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, 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 includes, in conjunction with an emergency medical condition as described above, an appropriate medical screening examination as well as Covered Services and Supplies after the Covered Person is stabilized and as part of the outpatient observation or an inpatient or outpatient stay.

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 Health or Substance Use 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 Health or Substance Use Disorder.

See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" under "Coverage Decisions and Disputes Resolution" for the procedure to request an Independent Medical Review of a Plan denial of coverage for Emergency 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:
 - o clinical efficacy,
 - o therapeutic value or beneficial effects on health outcomes, or
 - o 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.

Formulary (also known as the Drug List) is a list of the Prescription Drugs that are covered by this Plan. It is prepared and updated by Health Net and distributed to Covered Persons, Member Physicians and Participating Pharmacies and posted on the HNL website at www.healthnet.com. The Formulary is also referred to as "3-Tier with Specialty Formulary." Some Drugs in the Formulary require Prior Authorization from HNL in order to be covered.

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 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 an employer or trust) to which HNL has issued the Policy to provide the benefits of this Plan.

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 to provide Home Health Care Services, certified by Medicare or accredited by Joint Commission on the Accreditation of Healthcare Organizations.

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 (not to exceed 4 hours a day) are covered benefits under this plan. Private Duty Nursing or shift care (including any portion of shift care services) is not covered 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 place that maintains and operates organized facilities licensed by the state in which they are located for the diagnosis, care, and treatment of human illnesses to which persons may be admitted for overnight stay, but which does not include Skilled Nursing Facility or Hospice, and which is accredited or certified 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, which do not exceed 4 hours in every 24 hours provided either continuously or intermittently, in a 24-hour period. Home health aide services are covered under the Home Health Care benefit if the Covered Person's condition requires the services of a nurse, physical therapist, occupational therapist, or speech therapist.

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:
 - o clinical efficacy,
 - o therapeutic value or beneficial effects on health outcomes, or
 - o 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 (MAA) is the amount on which HNL bases its reimbursement for Covered Services and Supplies 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 below. 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*.

- **Maximum Allowable Amount for Covered Services and Supplies, excluding Emergency Care and outpatient pharmaceuticals**, received from an Out-of-Network Provider is a percentage of what Medicare would pay, known as the Medicare Allowable Amount, as defined in this *Certificate*.

For illustration purposes only, Out-of-Network Provider: 70% HNL Payment / 30% Covered Person Coinsurance:

Out-of-Network Provider’s billed charge for extended office visit	\$128.00
MAA allowable for extended office visit (example only; does not mean that MAA always equals this amount)	\$102.40
Your Coinsurance is 30% of MAA: 30% x \$102.40 (assumes Deductible has already been satisfied)	\$30.72
You also are responsible for the difference between the billed charge (\$128.00) and the MAA amount (\$102.40)	\$25.60
Total amount of \$128.00 charge that is your responsibility	\$56.32

The Maximum Allowable Amount for facility services, including but not limited to Hospital, Skilled Nursing Facility, and Outpatient Surgery, is determined by applying 150% of the Medicare Allowable Amount.

Maximum Allowable Amount for Physician and all other types of services and supplies is the lesser of the billed charge or 100% of the Medicare Allowable Amount.

In the event there is no Medicare Allowable Amount for a billed service or supply code:

- a. Maximum Allowable Amount for professional and ancillary services shall be 100% of FAIR Health's Medicare gapfilling methodology. Services or supplies not priced by gapfilling methodology shall be the lesser of: (1) the average amount negotiated with Preferred Providers within the geographic region for the same Covered Services or Supplies provided; (2) the 50th percentile of FAIR Health database of professional and ancillary services not included in FAIR Health Medicare gapfilling methodology (3) 100% of the Medicare Allowable Amount for the same Covered Services or Supplies under alternative billing codes published by Medicare; or (4) 50% of the Out-of-Network Provider's billed charges for Covered Services. A similar type of database or valuation service will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination.
 - b. Maximum Allowable Amount for facility services shall be the lesser of: (1) the average amount negotiated with Preferred Providers within the geographic region for the same Covered Services or Supplies provided; (2) 100% of the derived amount using a method developed by Data iSight for facility services (a data service that applies a profit margin factor to the estimated costs of the services rendered), or a similar type of database or valuation service, which will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination; (3) 150% of the Medicare Allowable Amount for the same Covered Services or Supplies under alternative billing codes published by Medicare; or (4) 50% of the Out-of-Network Provider's billed charges for Covered Services.
- ***The Maximum Allowable Amount for Out-of-Network Emergency Care*** will be the greatest of: (1) the median of the amounts 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. Emergency Care provided by an Out-of-Network Provider is subject to the Preferred Provider level of cost-sharing (and Deductible, if applicable) based on this MAA amount. You are not responsible for any charges in excess of the amount other than the Preferred Provider level of cost-sharing (and Deductible, if applicable).
 - ***Maximum Allowable Amount for non-emergent services at an in-network health facility, at which, or as a result of which, You receive non-emergent Covered Services by an Out-of-Network Provider***, the non-emergent services provided by an Out-of-Network Provider will be payable at the greater of the average Contracted Rate or 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered unless otherwise agreed to by the noncontracting individual health professional and HNL.
 - ***Maximum Allowable Amount for covered outpatient pharmaceuticals*** (including but not limited to injectable medications) dispensed and administered to the patient, in an outpatient setting, including, but not limited to, Physician office, outpatient Hospital facilities, and services in the patient's home, will be the lesser of billed charges or the Average Wholesale Price for the drug or medication.

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. Alternatively, We may, at Our 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 either of these two circumstances, You will not be responsible for the difference between billed charges and the Maximum Allowable Amount. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance at the Out-of-Network level.

Note: When the Centers for Medicare and Medicaid Services (CMS) adjusts the Medicare Allowable Amount, HNL will adjust, without notice, the Maximum Allowable Amount based on the CMS schedule currently in effect. 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 Out-of-Network 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.

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 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 on Our pharmacy claims processor's website. The Maximum Allowable Cost refers to the upper limit or maximum amount that HNL will pay the pharmacy for Generic Drugs and Brand Name Drugs that have generic versions available ("multi-source brands").

Medicaid (identified as "Medi-Cal" in California) is the program of medical coverage provided by the states under Title XIX of the Social Security Act, as amended by Public Law 89-97, including any amendments which may be enacted in the future.

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)

For services other than Mental Health or Substance Use Disorders: 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, 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.

For Treatment of Mental Health or Substance Use Disorders: Medically Necessary (or Medical Necessity) means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of Mental Health and Substance Use Disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

For these purposes:

- "Generally accepted standards of Mental Health and Substance Use Disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of Mental Health and Substance Use Disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.
- "Health care provider" means any of the following:
 - o A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
 - o An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.
 - o A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 10144.51 of the Insurance Code and Section 1374.73.
 - o An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.
 - o An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.
 - o A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.

- o A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.
- o A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

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.

Medicare Allowable Amount: HNL uses available guidelines of Medicare to assist in its determination as to which services and procedures are eligible for reimbursement. HNL will, to the extent applicable, apply Medicare claim processing rules to claims submitted. HNL will use these rules to evaluate the claim information and determine accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying Medicare rules may affect the Maximum Allowable Amount if it is determined the procedure and/or diagnosis codes used were inconsistent with Medicare procedure coding rules or reimbursement policies.

Medicare pays 100% of the Medicare Allowable Amount. The Medicare Allowable Amount is subject to automatic adjustment by the Centers for Medicare and Medicaid Services (CMS), an agency of the federal government which regulates Medicare.

Mental Health and Substance Use Disorders means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this definition as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

Musculoskeletal and Related Disorders are conditions with associated signs and symptoms related to the nervous, muscular and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction of the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related neurological manifestations or conditions.

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 Covered Person with the following:

- To restore function; or
- To support, align, prevent, or correct a defect or function of an injured or diseased body part; or
- To improve natural function; or
- To restrict motion.

Out-of-Pocket Maximum is the maximum dollar amount of Deductibles, Copayments and Coinsurance for which You or Your family must pay Covered Expenses during a Calendar Year. After that maximum is reached, a different Coinsurance applies to further Covered Expenses incurred during the remainder of that Calendar Year, as shown in the "Schedule of Benefits" section. Certain expenses, as described in the "Schedule of Benefits" section, will not be applied to the Out-of-Pocket Maximum, nor will the different Coinsurance apply to these expenses after the Out-of-Pocket Maximum is reached.

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.

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:
 - o Dentist (D.D.S.)
 - o Optometrist (O.D.)
 - o Dispensing optician
 - o Podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
 - o Psychologist
 - o Chiropractor (D.C.)
 - o Nurse midwife
 - o Nurse Practitioner
 - o Physician Assistant

- o Clinical social worker (M.S.W. or L.C.S.W.)
- o Marriage, family and child counselor (M.F.C.C.)
- o Physical therapist (P.T. or R.P.T.)
- o Speech pathologist
- o Audiologist
- o Occupational therapist (O.T.R.)
- o Psychiatric mental health nurse
- o Respiratory care practitioner
- o Other Mental Health and Substance Use Disorder providers, including, but not limited to the following: Chemical Dependency Counselor (L.C.D.C.), Licensed Professional Counselor (L.P.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 rate known as the Contracted Rate.

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; (b) for Prescription Drug Orders dispensed by a Nonparticipating Pharmacy, 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 or injury 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 the following:

- Reasonable health appraisal examinations on a periodic basis
- A variety of family planning services
- Preventive prenatal and postnatal 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
- 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.

Prior Authorization is HNL's approval process for Specialty Drugs and certain Tier 1, Tier 2 and Tier 3 Drugs that require pre-approval. Physicians must obtain HNL's Prior Authorization before Specialty Drugs and certain Tier 1, Tier 2 and Tier 3 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. 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 four 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.

Qualified Autism Service Provider means either of the following: (1) A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification 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 who 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 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: (1) provides behavioral health treatment which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider; (2) is supervised by a Qualified Autism Service Provider; (3) provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (4) is a behavioral service provider that has training and experience in providing services for pervasive developmental disorder or autism and who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program; (5) has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code; and (6) is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.
- A qualified autism service paraprofessional is an unlicensed and uncertified individual who: (1) is supervised by a Qualified Autism Service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice; (2) provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (3) meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations; (4) has adequate education, training, and experience as certified by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers, and (5) is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

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 Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

Select Telehealth Services Provider means a telehealth service provider that is contracted with HNL to provide Telehealth Services that are covered under the “Telehealth Consultations through the Select Telehealth Services Provider” heading as shown in the “Schedule of Benefits” and “Plan Benefits” sections. The designated Select Telehealth Services Provider for this plan is listed on your HNL ID card. To obtain services, contact the Select Telehealth Services Provider directly as shown on your ID card.

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 Drugs are specific Prescription Drugs used to treat complex or chronic conditions and usually require close monitoring. These Drugs may require special handling, special manufacturing processes, and may have limited pharmacy availability or distribution. Specialty Drugs include Drugs that have a significantly higher cost than traditional pharmacy benefit Drugs and may be self-administered orally, topically, by inhalation, or by injection (either subcutaneously or intramuscularly). A list of Specialty Drugs can be found in the Health Net Formulary. Specialty Drugs require Prior Authorization from HNL and must be dispensed through the contracted Specialty Pharmacy Vendor to be covered.

Specialty Pharmacy Vendor is a pharmacy contracted with HNL specifically to provide Specialty Drugs and injectable medications (including needles and syringes, when appropriate, to administer such Drugs).

Telehealth Services means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the provider for telehealth is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers. For the purposes of this definition the following apply:

- “Asynchronous store and forward” means the transmission of a patient's medical information from an originating site to the health care provider for telehealth at a distant site without the presence of the patient.
- “Distant site” means a site where a health care provider for telehealth who provides health care services is located while providing these services via a telecommunications system.
- “Originating site” means a site where a patient is located at the time health care services are provided via telecommunications system or where the asynchronous store and forward service originates.
- “Synchronous interaction” means a real-time interaction between a patient and a health care provider for telehealth located at a distant site.

Tier 1 Drugs include most Generic Drugs and some low-cost preferred Brand Name Drugs when listed in the Formulary.

Tier 2 Drugs include non-preferred Generic Drugs, preferred Brand Name Drugs, insulin and diabetic supplies and certain Brand Name Drugs with a generic equivalent when listed in the Formulary.

Tier 3 Drugs include non-preferred Brand Name Drugs, Brand Name Drugs with a generic equivalent (when Medically Necessary), Drugs listed as Tier 3 in the Formulary, Drugs indicated as "NF", if approved, or Drugs not listed in the Formulary.

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. Providers that are not designated as part of HNL's network of Transplant Performance Centers are considered Out-of-Network Providers, even if they have a contract with HNL, for purposes of determining coverage and benefits for transplants and transplant-related services.

Urgent Care is any otherwise Covered Service for medical care or treatment with respect to which the application of the time periods for making non-Urgent Care determinations (by a person applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine) could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function; or, in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe Pain that cannot be adequately managed without the care or treatment in question.

PREVENTIVE CARE LIST OF SERVICES

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

Preventive Care Services are covered as shown in the "Schedule of Benefits" section. Please consult with Your Physician to determine whether a specific service is preventive or diagnostic. When Preventive Care Services, as described in this section, are received from a Participating Provider, they are covered at no cost share to You. If the primary purpose of the office visit is unrelated to a Preventive Care Service or if other non-Preventive Care Services are received during the same office visit, the non-Preventive Care Services are payable at benefit levels indicated in the "Schedule of Benefits" section. If You receive services from an Out-of-Network Provider, benefits are subject to Your Out-of-Network cost share amount, including Deductibles (if any) as indicated in the "Schedule of Benefits" section.

Preventive Care Services are covered for children and adults, as directed by Your Physician, and in accordance with the following:

- Those 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) <https://uspreventiveservicestaskforce.org/uspstf/>.
- Those 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 (CDC) <https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>.
- With respect to women, those evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) <https://www.hrsa.gov/womens-guidelines-2019>.
- With respect to infants, children and adolescents, such evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the HRSA https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

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. HNL will not make its own determinations as to risk and will defer to the Physician’s decision. Additional information regarding Preventive Care Services may be accessed through <https://www.healthcare.gov/coverage/preventive-care-benefits/>.

Preventive Care Services for children include:

- For the screening of alcohol, tobacco, and drug use for school-aged children and adolescents: Services include a physician interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents. Limited to one (1) screening per year.
- Autism Spectrum Disorder Screening for children: Limited to one (1) screening at the age of 18 month and one (1) at the age of 24 months, as recommended by the American Academy of Pediatrics.

- Psychosocial/Behavioral Assessments for children ages 0 to 17 years: This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. Please refer to the Bright Futures Periodicity Schedule for frequency information.
- Bilirubin Concentration Screening for the detection of genetic disorders in newborns: Please refer to the Bright Futures Periodicity Schedule for frequency information as recommended by the American Academy of Pediatrics.
- Blood Pressure Screening for children ages 0 to 17 years: Screening should occur per general clinical practice guidelines for screening and management of high blood pressure in children and adolescents. Limited to one (1) at every medical visit.
- Blood screening for newborns: Preventive coverage includes screening pursuant to the Recommended Uniform Screening Panel (RUSP) for newborns, verifying results, and follow up, as appropriate.
- Depression Screening for adolescents beginning routinely at age 7-18 years: For the detection of Major Depressive Disorder (MDD) in children and adolescents. Limited to one (1) screening per year.
- Developmental Screening for children under age 3 to diagnose and assess potential developmental delays: Using a surveillance algorithm as a strategy to support health care professionals in developing a pattern and practice for addressing developmental concerns in children from birth through 3 years of age. Limited to one (1) surveillance per year.
- Dyslipidemia Screening for all children. Please refer to the Bright Futures Periodicity Schedule for frequency information.
- Fluoride chemoprevention rinse or supplements for children ages 6 months to 17 years of age with a fluoride deficiency in their water source.
- Fluoride varnish for all infants at age 6 months, as soon as teeth are present, to children up to 5 years of age. A topical application administered in a pediatrician or dentist office. Limited to every 3-6 months for treatment.
- Gonorrhea preventive medication for the eyes of all newborns. Erythromycin ophthalmic ointment application to the eyes: Limited to one (1) treatment within 24 hours of birth.
- Hearing screening for all newborns and for children. Please refer to the Bright Futures Periodicity Schedule for frequency information.
- Height, weight and body mass index (BMI) measurements for children and adolescents ages: 0– 17 years. Limited to one (1) screening at the time of birth before discharge of hospital stay and at yearly wellness visit, as recommended by the American Academy of Pediatrics.
- Hepatitis B screening for adolescents at high risk for infection. Testing for antibodies to HBsAg (anti-HBs) and Hepatitis B core antigen (anti-HBc) is also done as part of a screening panel to help distinguish between infection and immunity. Periodic screening may be useful in patients with ongoing risk for HBV transmission who do not receive a vaccination. Screenings provided at the discretion of your Physician.

- HIV screening test for children and adolescents. Services include counseling and screening test for HIV. preventive coverage for at least a one-time screening between the ages of 15 and 18 regardless of risk, and additional screening based on risk for children and adolescents, including those under the age of 15, up to every 3 to 6 months in high-risk cases. Please refer to the Bright Futures Periodicity Schedule for frequency information.
- Immunization vaccines for children from birth to age 18. (Note: doses, recommended ages and recommended populations vary). Coverage will be pursuant to the Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, United States, 2018 (available at <https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html>).
 - Diphtheria, Tetanus, Pertussis (Whooping Cough) vaccination
 - Haemophilus influenza type b vaccination
 - Hepatitis A vaccination
 - Hepatitis B vaccination
 - Human Papillomavirus (HPV) vaccination
 - Inactivated Poliovirus vaccination
 - Influenza (flu shot) vaccination
 - Measles vaccination
 - Meningococcal meningitis vaccination
 - Pneumococcal vaccination
 - Rotavirus vaccination:
 - RotaTeq® (RV5)
 - Rotarix® (RV1)
 - Varicella (Chickenpox) Vaccination
- Iron screening for children. Anemia is a condition in which the amount of red blood cells in the body is decreased below normal for your child's age. Please refer to the Bright Futures Periodicity Schedule for frequency information.
- Lead screening (screening for blood lead levels) for children at risk of lead poisoning as determined by a health care provider in accordance with standards adopted by the California Department of Public Health. Screenings provided at the discretion of your Physician.
- Medical history for all children throughout development. Growth and development includes not only the physical changes that will occur from infancy to adolescence, but also some of the changes in emotions, personality, behavior, thinking and speech that children develop as they begin to understand and interact with the world around them. Please refer to the Bright Futures Periodicity Schedule for frequency information.
- Obesity screening and counseling in children and adolescents (when necessary, clinicians should offer or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status). Please refer to the Bright Futures Periodicity Schedule for frequency information.

- Oral health risk assessment for young children. When an oral examination by a dentist is not possible, an infant should receive an oral health risk assessment by age 6 months by a pediatrician or other qualified oral health professional (e.g., dental hygienist) or other health professional. Infants within one of the following risk groups should be referred to a dentist as soon as possible: mother or other primary caregiver has active caries, parent or other caregiver has low socioeconomic status, child receives more than three between meal foods or beverages containing sugar per day, child is put to bed with a bottle or a sippy cup with beverage containing sugar, child has special health care needs, child is a recent immigrant, child has white spot lesions or enamel defects, child has visible cavities or fillings, child has plaque on teeth. Please refer to the Bright Futures Periodicity Schedule for frequency information.
- Regular well-baby and well-child visits. Please refer to the Bright Futures Periodicity Schedule for frequency information.
- Sexually transmitted infection prevention counseling, screening, and behavioral counseling for all sexually active adolescents, as well as adults who are at increased risk for Sexually Transmitted Infections (STIs). Screenings provided at the discretion of your Physician for Sexually Transmitted Diseases (STD) for sexually active patients. Screenings for sexually transmitted diseases include, Chlamydia, Gonorrhea, HIV, Genital Herpes, Syphilis, Trichomoniasis, HPV, genital warts and cervical cancer.
- Skin cancer. Behavioral counseling intervention to help minimize exposure to ultraviolet (UV) radiation. Behavioral counseling interventions target sun-protection behaviors to reduce UV radiation exposure, including use of broad-spectrum sunscreen with a sun-protection factor of 15 or greater; wearing hats, sunglasses, or sun-protective clothing; avoiding sun exposure; seeking shade during midday hours (10 am to 4 pm); and avoiding indoor tanning bed use to reduce the risk of skin cancer for persons aged 6 months to 24 years. Limited to one (1) counseling intervention per year.
- Tuberculin testing for children at higher risk of tuberculosis ages: 0 months – 17 years. The Tuberculin skin test is performed by injecting a small amount of fluid (called tuberculin) into the skin on the lower part of the arm. Please refer to the Bright Futures Periodicity Schedule for frequency information.
- Vision screening for all newborns, children and adolescents (0-21). Vision screening can be performed by primary care providers, trained laypersons (e.g., school-based screenings), and eye care providers. Vision screening techniques are either provider-based (e.g., traditional acuity testing, inspection, red reflex testing) or instrument-based. Instrument-based screening can often be performed at an earlier age than provider-based acuity testing and allows earlier screening for risk factors that are likely to lead to amblyopia and poor vision. Please refer to the Bright Futures Periodicity Schedule for frequency information.

Preventive Care Services for women include:

- Anemia screening on a routine basis for pregnant women or women who may become pregnant. Several factors have been identified that may increase a pregnant woman's risk for iron deficiency anemia, including a diet lacking in iron-rich foods, gastrointestinal disease and/or medications that can decrease iron absorption, and a short interval between pregnancies. Limited to one (1) screening for anemia during the first prenatal visit. Limited to one (1) screening in high-risk pregnant women during each trimester and at 4 to 6 weeks postpartum.

- Anxiety screening for adolescent and adult women, including those who are pregnant or postpartum. Adolescent and adult women, including those who are pregnant and postpartum, should be assessed for anxiety as a routine preventive health service. Screenings provided at the discretion of your Physician.
- Breast cancer chemoprevention counseling and medications for women at higher risk. Women at high risk of breast cancer may be able to improve the odds of staying cancer-free by taking certain medicines, an approach known as chemoprevention or preventive therapy. Taking medicines to help lower the risk of getting a disease is called chemoprevention. The most commonly used medicine options to lower breast cancer risk are tamoxifen and raloxifene. Counseling and medication treatments at the discretion of your Physician.
- Breast cancer genetic counseling and testing (BRCA) for women at high risk. Genetic testing gives people the chance to learn if their breast cancer or family history of breast cancer is due to an [inherited gene mutation](#). Genetic testing for hereditary breast and ovarian cancer looks for mutations in the BRCA1 and BRCA2 genes. Your Physician might suggest testing using a multigene panel, which looks for mutations in several genes at the same time, including BRCA1 and BRCA2. Counseling and testing are provided at the discretion of your Physician.
- Breast cancer mammography screenings (once annually for average risk women beginning at the age of 40). A mammogram is an x-ray picture of the breast. Doctors use a mammogram to look for early signs of breast cancer. Regular mammograms are the best tests doctors have to find breast cancer early, sometimes up to three years before it can be felt. A monthly self-exam should be performed. Limited to one (1) mammogram screening every year if not considered high risk. Limited to two (2) mammogram screenings for high risk Covered Persons.
- Breastfeeding comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and the postpartum period to ensure the successful initiation and maintenance of breastfeeding for pregnant and nursing women as prescribed by Your Physician. We will determine the type of equipment, whether to rent or purchase the equipment, and the vendor. You can find out how to obtain a breast pump by calling the Customer Contact Center at the phone number on Your Health Net Life ID card.
- Cervical dysplasia screening for females at ages 21 - 65: For the early detection of abnormal changes in cells. Limited to one (1) screening per year or every 5 years screening with high-risk Human Papillomavirus (hrHPV) testing alone or every 5 years with hrHPV testing in combination with Pap (cotesting).
- Cervical cancer screening. These tests can help find cervical cells that are infected with HPV or other abnormal cells before they turn into cervical cancer. Limited to one (1) screening per year as part of annual well visit.
 - o Pap test (also referred to as a Pap smear) for women 21 – 65 and
 - o Human Papillomavirus (HPV) DNA test with the combination of a Pap smear every year for women 30 – 65 who don't want a more frequent Pap smear.
- Chlamydia infection screening for women age 24 and younger, and older women at increased risk. Generally performed as a urinalysis or a swab test. Limited to one (1) screening per year as part or annual well visit.

- Contraception all FDA-approved contraceptive Drugs, devices, sterilization, and other products for women. Preventative contraception includes all FDA-approved contraceptive Drugs and devices, (including, but not limited to, IUDs, injectable and implantable contraceptives). Coverage also includes contraceptive counseling, contraceptive education, (including, but not limited to, follow-up and management of side effects of contraceptives, counseling for continued adherence) and contraceptive device placement and removal.
- Depression screening for pregnant and postpartum women. Screening for the presence of prenatal mood and anxiety disorders, using an evidence-based tool such as the Edinburgh Postnatal Depression Screen (EPDS) or Patient Health Questionnaire (PHQ-9). Screenings are provided at the discretion of your Physician.
- Depression interventions for pregnant and postpartum women. Pregnant and postpartum individuals who are at increased risk of perinatal depression will be provided with or referred to counseling interventions. Preventive intervention in this case applies to a pregnant woman and up to 1 year postpartum.
- Diabetes screening for women with a history of gestational diabetes who are not currently pregnant and who have not been diagnosed with type 2 diabetes before. Physicians may use blood tests to diagnose gestational diabetes. Patients may have the glucose challenge test, the oral glucose tolerance test, or both. Limited to one (1) screening per year as part of annual well visit.
- Domestic and interpersonal violence screening and counseling for all women (screening women of reproductive age for interpersonal and domestic violence is recommended, at least annually, and, when needed, providing or referring to ongoing support services). Limited to one (1) screening and counseling per year as part of annual well visit. However, additional treatment will be provided as needed, at the discretion of your Physician.
- Folic acid supplement counseling and testing (daily supplement containing 0.4 to 0.8 mg of folic acid) for women who may become pregnant. A folic acid test measures the amount of folic acid in the blood. Folic acid is one of many B vitamins. The body needs folic acid to make Red Blood Cells (RBC), White Blood Cells (WBC) and platelets, and for normal growth. Folic acid also is important for the normal development of a baby (fetus). Limited to one (1) testing and counseling per year as part of annual well visit.
- Gestational diabetes screening for women 24 to 28 weeks pregnant, as well as those at high risk of developing gestational diabetes. Testing can be performed one of two ways. There is formal systematic testing with a 75g, 2-hour OGTT for GDM between 24 and 28 weeks of gestation. There is also the one step approach, in the 1-step approach, a 75-g glucose load is administered after fasting and plasma glucose levels are evaluated after 1 and 2 hours. GDM is diagnosed if 1 glucose value fails at or one above the specified glucose threshold. Screenings are provided at the discretion of your Physician.
- Gonorrhea screening for all sexually active women. All pregnant women aged 25 years and older women at increased risk for gonorrhea (e.g., those with a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection) should be screened for gonorrhea at the first prenatal visit. Screenings are provided at the discretion of your Physician.

- Healthy weight gain counseling for pregnant women. Behavioral health counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.
- Hepatitis B screening for pregnant women at their first prenatal visit, as well as additional screening will be covered under preventive care at the time of admission for delivery if:
 - The patient's HBsAg status is unknown (e.g., the woman did not obtain prenatal care or if she is admitted to a hospital other than the one that performed the screening at the first prenatal visit) or
 - She has new or continuing risk factors for Hepatitis B virus (HBV) infection.

Screenings are provided at the discretion of your Physician.

- HIV screening and counseling for women. Services include counseling and screening for HIV. Screenings limited to every 3 or 6 months, depending on risk factors.
- Human Papillomavirus (HPV) screening test. The HPV test is primarily used to screen for cervical cancer and/or determine whether you may be at increased risk of cervical cancer if you are a woman between the ages of 30 and 65. The test determines whether your cervical cells are infected with a high-risk type of Human Papillomavirus (hrHPV). Limited to one (1) screening per year.
- Osteoporosis screening for postmenopausal women to prevent osteoporotic fractures is recommended with bone measurement testing, as follows:
 - For postmenopausal women younger than 65 years at increased risk (as determined by a formal clinical risk assessment tool) and
 - For postmenopausal women 65 years and older.

Limited to one (1) screening and counseling per year as part of annual well visit.

- Preeclampsia prevention. Low-dose aspirin is recommended as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia. Counseling is provided at the discretion of your Physician.
- Preeclampsia (PE) screening for pregnant women. All pregnant women should be screened for preterm PE. Biomarkers offer a potential for early diagnosis and effective treatments. Screenings are provided at each prenatal care visit and repeated as needed at the discretion of your Physician.
- Rh incompatibility screening follow-up testing for women. This test often is done at the first prenatal visit. The results from this test also can suggest how severe the baby's hemolytic anemia has become. Screenings are at the discretion of your Physician. Rh (D) immunoglobulin is a medication used to prevent RhD isoimmunization in mothers who are RhD negative and to treat idiopathic thrombocytopenic purpura in people who are Rh positive. It is often given both during and following pregnancy. It may also be used when RhD negative people are given RhD positive blood. If an Rh(D)-positive or weakly Rh(D)-positive (e.g., Du-positive) infant is delivered, a dose of Rh(D) immunoglobulin should be repeated postpartum, preferably within 72 hours after delivery or at the discretion of your Physician.
- Sexually transmitted infections counseling and screenings for women. Screenings and counseling for sexually transmitted diseases include: Chlamydia, Gonorrhea, HIV, Genital Herpes, Syphilis, Trichomoniasis, HPV, genital warts and cervical cancer, as recommended at the discretion of your Physician.

- Syphilis screening for all pregnant women (pregnant women should be screened as early as possible in the pregnancy) or women who may become pregnant, as well as for any woman at increased risk. All women should be screened serologically for syphilis early in pregnancy. A Rapid Plasma Reagin (RPR) test screening and treatment (if the RPR test is reactive) should be performed at the time pregnancy is confirmed. Screenings are at the discretion of your Physician. Urinary incontinence screening for women yearly. Screening should ideally assess whether women experience urinary incontinence and whether it impacts their activities and quality of life. Screenings are at the discretion of your Physician.
- Tobacco use screening, counseling and cessation advice is recommended for all pregnant individuals. Physicians should ask all pregnant individuals about tobacco use, advise cessation and provide behavioral interventions for cessation.
- Urinary tract or other infection screening, antibiotic therapy and monitoring for pregnant women or women who may become pregnant. Urinary tract infections are diagnosed by performing a urinalysis, which looks for evidence of infection, such as bacteria and white blood cells in a sample of urine. Screenings, therapy and monitoring are at the discretion of your Physician.
- Weight gain counseling for pregnant women. Behavioral health counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.
- Well-woman visits. Well-woman visits include a full checkup, separate from any other visit for sickness or injury. These visits focus on preventive care for women, which may include services, like shots, that improve your health by preventing diseases and other health problems. Preventive coverage for as many well-woman visits as are determined by your Physician to be necessary

Preventive Care Services for adults include:

- Abdominal aortic aneurysm one-time screening for men of specified ages (65 to 75 years) who have ever smoked or who have smoked at least 100 cigarettes in their lifetime. Limited to one (1) screening and counseling per year as part of annual well visit.
- Alcohol misuse screening, interventions, and counseling is recommended for adults 18 years or older, including pregnant women (persons engaged in risky or hazardous drinking will be provided behavioral counseling interventions to reduce unhealthy alcohol use). Screenings, interventions, and counseling will be at the discretion of your Physician.
- Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk. The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10 year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years. Aspirin interferes with your blood's clotting action. When you bleed, your blood's clotting cells, called platelets, build up at the site of your wound. The platelets help form a plug that seals the opening in your blood vessel to stop bleeding. Medication treatment is at the discretion of your Physician.
- Blood pressure screening. Screening should occur per general clinical practice guidelines for screening and management of high blood pressure. Limited to one (1) screening and counseling per year as part of annual well visit.

- Cholesterol screening for adults of certain ages or at higher risk. Adults age 20 or older should have their cholesterol and other traditional risk factors checked every four to six years. After age 40, your health care provider will also want to use an equation to calculate your 10-year risk of experiencing cardiovascular disease or stroke. Limited to one (1) screening and counseling per year as part of annual well visit.
- Colorectal Cancer: Screening for men and women age 45-75 for colorectal cancer. Fecal occult blood test/fecal immunochemical test annually; or fecal DNA testing (Cologuard) every 3 years; or flexible sigmoidoscopy every 5 years; or CT colonography every 5 years; or colonoscopy every 10 years. All surgical procedures such as polyp removal, anesthesia, consultations, readings/results of polyp biopsy as well as preparation associated with screening will be included as part of the screening in conjunction with frequency recommendations by the United States Preventive Services Task Force.
- Depression screening: For the detection of Major Depressive Disorder (MDD) in adults. When initial screening is positive, preventive coverage also includes additional assessment that considers severity of depression and comorbid psychological problems (e.g. anxiety, panic attacks, or substance abuse), alternate diagnoses, and medical conditions. Screenings, interventions, medications, and counseling will be at the discretion of your Physician.
- Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese. Coverage includes intensive behavioral counseling interventions for patients with abnormal blood glucose to promote a healthful diet and physical activity. Screenings are at the discretion of your Physician.
- Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting and at increased risk for falls. This screening consists of asking patients whether they have fallen 2 or more times in the past year or sought medical attention for a fall, or, if they have not fallen, whether they feel unsteady when walking. Effective exercise interventions include supervised individual and group classes and physical therapy, although most studies reviewed by the USPSTF included group exercise. The most common frequency and duration for exercise interventions was 3 sessions per week for 12 months, although duration of exercise interventions ranged from 2 to 42 months.
- Healthy diet and physical activity counseling to prevent Cardiovascular Disease (CVD): adults 18 years or older with known hypertension or elevated blood pressure, those with dyslipidemia, or those who have mixed or multiple risk factors, such as metabolic syndrome or an estimated 10-year CVD risk of 7.5% or greater will be offered/referred to behavioral counseling interventions to promote a healthy diet and physical activity. HNL will cover any intervention prescribed by a Physician as Preventive Care Services. Counseling frequencies and interventions are at the discretion of your Physician.
- Hearing screening: Hearing screening is a test to tell if people might have hearing loss. Limited to one (1) screening per year.
- Hepatitis B screening for people at high risk of infection. Testing for antibodies to HBsAg (anti-HBs) and Hepatitis B core antigen (anti-HBc) is also done as part of a screening panel to help distinguish between infection and immunity. Periodic screening may be useful in patients with ongoing risk for HBV transmission who do not receive vaccination. Screenings are at the discretion of your Physician.

- Hepatitis C screening for adults at increased risk, as well as offering a one-time screening for adults aged 18 to 79 years without known liver disease, with periodic rescreening for those with continued risk for HCV infection. Screening for hepatitis C is performed by measuring antibody to HCV (anti-HCV) in a person's serum. A positive test (detection of the antibody) is not a diagnosis of the disease; it only indicates that a person was previously exposed to hepatitis C. Screenings are at the discretion of your Physician.
- HIV preexposure prophylaxis for the prevention of HIV infection (clinicians should offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition). Pre-Exposure Prophylaxis (or PrEP) is a way for people who do not have HIV but who are at very high risk of getting HIV to prevent HIV infection by taking a pill every day. Screenings are at the discretion of your Physician. Preventive coverage without cost sharing for all of the following:
 - HIV and other testing to initiate PrEP
 - PrEP medication:
 - Truvada (or TE);
 - Descovy; and
 - tenofovir disoproxil fumarate
 - Follow-up and monitoring, including but not limited to:
 - HIV testing every 3 months
 - Office visits to a primary care provider or Specialist
 - Additional lab tests to monitor the effects of the PrEP medication
 - STI screening
- HIV screening for everyone ages 15 to 65, as well as other ages if at increased risk. An antibody-antigen blood test checks for levels of both HIV antibodies and the p24 antigen. Limited to one (1) screening every 3 or 6 months in high risk cases. Screenings are at the discretion of your Physician.
- Immunization vaccines for adults ages 18 and up. (note: doses, recommended ages and recommended populations vary): <https://www.cdc.gov/vaccines/schedules/hcp/adult.html>
 - Diphtheria
 - Hepatitis A
 - Hepatitis B
 - Herpes Zoster
 - Human Papillomavirus (HPV)
 - Influenza (flu shot) vaccination
 - Measles
 - Meningococcal
 - Mumps

- o Pertussis
- o Pneumococcal
- o Rubella
- o Tetanus
- o Varicella (Chickenpox)
- Lung cancer screening with low-dose computed tomography for adults aged 50 – 80 at high risk for lung cancer (they are heavy smokers or have quit in the past 15 years). During an LDCT scan, you lie on a table and an X-ray machine uses a low dose (amount) of radiation to make detailed images of your lungs. Screenings are at the discretion of your Physician.
- Nutritional counseling for adults at higher risk for chronic disease. A healthy diet helps properly manage and reduce their risks of chronic diseases, including obesity. Adults who eat a healthy diet live longer and have a lower risk of obesity, heart disease, type 2 diabetes, and certain cancers. Limited to one (1) counseling session per year.
- Obesity screening and counseling (those with a body mass index of 30 or higher should be offered or referred to intensive, multicomponent behavioral interventions). Screening are at the discretion of your Physician for BMI and behavioral therapy sessions that include a dietary assessment and counseling to help you lose weight by focusing on diet and exercise.
- Periodic health evaluations. A periodic health examination is an evaluation of your overall health status during which your doctor will evaluate your body, organs, and their functioning. Limited to one (1) annual screening.
- Screening and diagnosis of prostate cancer (including prostate-specific antigen testing and digital rectal examinations). One test is the digital rectal exam (DRE). The doctor or nurse inserts a lubricated, gloved finger into your rectum to feel the prostate for lumps or anything unusual. Another test is the prostate-specific antigen (PSA) blood test. Your PSA level may be high if you have prostate cancer. Limited to one (1) annual screening.
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
- Skin cancer. Behavioral counseling intervention to help minimize exposure to ultraviolet (UV) radiation and reduce the risk of skin cancer for persons aged 6 months to 24 years. The screening checks the skin for moles, birthmarks, or other marks that are unusual in color, size, shape, or texture. Certain unusual marks may be signs of skin cancer. Behavioral counseling interventions target sun-protection behaviors to reduce UV radiation exposure, including use of broad-spectrum sunscreen with a sun-protection factor of 15 or greater; wearing hats, sunglasses, or sun-protective clothing; avoiding sun exposure; seeking shade during midday hours (10 am to 4 pm); and avoiding indoor tanning bed use and reduce the risk of skin cancer. Limited to one (1) annual screening.
- Smoking cessation intervention services, including behavioral management activities, tailored self-help materials, and tobacco cessation counseling sessions. We provide coverage for 4 in-person, 10-minute long individual or group counseling sessions, as well as 3 telephone counseling sessions. Services related to pharmacotherapy and behavioral interventions, and all combinations thereof, are covered as preventive care. Screenings are at the discretion of your Physician.

- Statin preventive medication for adults ages 40 to 75 years with no history of Cardiovascular Disease (CVD), 1 or more CVD risk factors, and a calculated 10 year CVD event risk of 10% or greater. Statins are a group of medicines that can help lower the level of Low-Density Lipoprotein (LDL) cholesterol in the blood. LDL cholesterol is often referred to as "bad cholesterol," and statins reduce the production of it inside the liver. Medication treatment coverage is for daily use of low-to moderate-dose statin without limit on duration. Screenings and medication treatments are at the discretion of your Physician.
- Syphilis screening for adults at higher risk. Screenings are at the discretion of your Physician.
- Tobacco use screening, counseling and cessation advice is recommended for all adults. Physicians should ask about tobacco use, advise cessation and provide behavioral interventions and US Food and Drug Administration (FDA)-approved pharmacotherapy for cessation.
- Tuberculosis screening for adults without symptoms at high risk. The Tuberculin skin test is performed by injecting a small amount of fluid (called tuberculin) into the skin on the lower part of the arm. Limited to one (1) screening during annual well visit.
- Unhealthy drug use screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)

IMPORTANT NOTICES

Covered Persons' Rights, Responsibilities and Obligations 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 Covered Person rights and responsibilities policies.

Covered Persons have the responsibility and obligation to:

- Supply information (to the extent possible) that health care practitioners and providers need in order to provide care;
- Follow plans and instructions for care that they have agreed-upon with their practitioners;
- Be aware of their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible; and
- Refrain from intentionally submitting materially false or fraudulent claims or information to HNL.

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.

Covered Entities Duties:

Health Net Life* (referred to as "We" or "the Plan") is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Health Net Life is required by law to maintain the privacy of Your protected health information (PHI), provide You with this Notice of Our legal duties and privacy practices related to Your PHI, abide by the terms of the Notice that is currently in affect and notify You in the event of a breach of Your unsecured PHI. PHI 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.

This Notice describes how We may use and disclose Your PHI. It also describes Your rights to access, amend and manage Your PHI and how to exercise those rights. All other uses and disclosures of Your PHI not described in this Notice will be made only with Your written authorization.

Health Net Life reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for Your PHI We already have as well as any of Your PHI We receive in the future. Health Net Life will promptly revise and distribute this Notice whenever there is a material change to:

- the uses or disclosures
- Your rights
- Our legal duties
- other privacy practices stated in the notice.

We will make any revised Notices available on our website and in our Member Handbook.

Internal Protections of Oral, Written and Electronic PHI:

Health Net protects your PHI. We have privacy and security processes to help.

These are some of the ways we protect your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.

* This Notice of Privacy Practices also applies to enrollees in any of the following: Health Net entities Health Net of California, Inc., Health Net Life Insurance Company, Health Net Health Plan of Oregon, Inc., Managed Health Network. LLC, and Health Net Community Solutions, Inc.

- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how We may use or disclose Your PHI without Your permission or authorization:

- **Treatment** - We may use or disclose Your PHI to a Physician or other health care provider providing treatment to You, to coordinate Your treatment among providers, or to assist us in making prior authorization decisions related to Your benefits.
- **Payment** - We may use and disclose Your PHI to make benefit payments for the health care services provided to You. We may disclose Your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:
 - o processing claims
 - o determining eligibility or coverage for claims
 - o issuing premium billings
 - o reviewing services for Medical Necessity
 - o performing utilization review of claims
- **Health Care Operations** - We may use and disclose Your PHI to perform Our health care operations. These activities may include
 - o providing customer services
 - o responding to complaints and appeals
 - o providing case management and care coordination
 - o conducting medical review of claims and other quality assessment
 - o improvement activities

In Our health care operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of Your PHI with these associates. We may disclose Your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with You for its health care operations. This includes the following:

 - o quality assessment and improvement activities
 - o reviewing the competence or qualifications of health care professionals
 - o case management and care coordination
 - o detecting or preventing health care fraud and abuse
- **Group Health Plan/Plan Sponsor Disclosures** – 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).

Other Permitted or Required Disclosures of Your PHI:

- ***Fundraising Activities*** – We may use or disclose Your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their 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.
- ***Underwriting Purposes*** – We may use or disclosure Your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If We do use or disclose Your PHI for underwriting purposes, We are prohibited from using or disclosing Your PHI that is genetic information in the underwriting process.
- ***Appointment Reminders/Treatment Alternatives*** – We may use and disclose Your PHI to remind You of an appointment for treatment and medical care with us or to provide You with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.
- ***As Required by Law*** – If federal, state, and/or local law requires a use or disclosure of Your PHI, We may use or disclose Your PHI to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, We will comply with the more restrictive laws or regulations.
- ***Public Health Activities*** – We may disclose Your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclosure Your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness of products or services under the jurisdiction of the FDA.
- ***Victims of Abuse and Neglect*** – We may disclose Your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law authorized by law to receive such reports if We have a reasonable belief of abuse, neglect or domestic violence.
- ***Judicial and Administrative Proceedings*** - We may disclose Your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:
 - o an order of a court
 - o administrative tribunal
 - o subpoena
 - o summons
 - o warrant
 - o discovery request
 - o similar legal request
- ***Law Enforcement*** - We may disclose Your relevant PHI to law enforcement when required to do so. For example, in response to a:
 - o court order
 - o court-ordered warrant
 - o subpoena

- o summons issued by a judicial officer
- o grand jury subpoena

We may also disclose Your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.

- **Coroners, Medical Examiners and Funeral Directors** - We may disclose Your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose Your PHI to funeral directors, as necessary, to carry out their duties.
- **Organ, Eye and Tissue Donation** - We may disclose Your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:
 - o cadaveric organs
 - o eyes
 - o tissues
- **Threats to Health and Safety** - We may use or disclose Your PHI if We believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
- **Specialized Government Functions** - If You are a member of U.S. Armed Forces, We may disclose Your PHI as required by military command authorities. We may also disclose Your PHI:
 - o to authorized federal officials for national security and intelligence activities
 - o the Department of State for medical suitability determinations
 - o for protective services of the President or other authorized persons
- **Workers' Compensation** - We may disclose Your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- **Emergency Situations** – We may disclose Your PHI in an emergency situation, or if You are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by You. We will use professional judgment and experience to determine if the disclosure is in Your best interests. If the disclosure is in Your best interest, We will only disclose the PHI that is directly relevant to the person's involvement in Your care.
- **Inmates** - If You are an inmate of a correctional institution or under the custody of a law enforcement official, We may release Your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide You with health care, to protect Your health or safety or the health or safety of others, or for the safety and security of the correctional institution.
- **Research** - Under certain circumstances, We may disclose Your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of Your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

We are required to obtain Your written authorization to use or disclose Your PHI, with limited exceptions, for the following reasons:

- **Sale of PHI** – We will request Your written authorization before We make any disclosure that is deemed a sale of Your PHI, meaning that We are receiving compensation for disclosing the PHI in this manner.
- **Marketing** – We will request Your written authorization to use or disclose Your PHI 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.
- **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.

Individuals Rights

The following are Your rights concerning Your PHI. If You would like to use any of the following rights, please contact us using the information at the end of this Notice.

- **Right to Revoke an Authorization** - You may revoke Your authorization at any time, the revocation of Your authorization must be in writing. The revocation will be effective immediately, except to the extent that We have already taken actions in reliance of the authorization and before We received Your written revocation.
- **Right to Request Restrictions** - You have the right to request restrictions on the use and disclosure of Your PHI for treatment, payment or health care operations, as well as disclosures to persons involved in Your care or payment of Your care, such as family members or close friends. Your request should state the restrictions You are requesting and state to whom the restriction applies. We are not required to agree to this request. If We agree, We will comply with Your restriction request unless the information is needed to provide You with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when You have paid for the service or item out of pocket in full.
- **Right to Request Confidential Communications** - You have the right to request that We communicate with You about Your PHI by alternative means or to alternative locations. This right only applies in the following circumstances: (1) the communication discloses PHI including all or part of the medical information or provider name and address relating to receipt of sensitive services, or (2) disclosure of PHI including all or part of the medical information or provider name and address could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason for your request, but your request must clearly state that either the communication discloses PHI including all or part of the medical information or provider name and address relating to receipt of sensitive services or that disclosure of PHI including all or part of the medical information or provider name and address could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where Your PHI should be delivered.

- **Right to Access and Received Copy of Your PHI** - You have the right, with limited exceptions, to look at or get copies of Your PHI contained in a designated record set. You may request that We provide copies in a format other than photocopies. We will use the format You request unless We cannot practicably do so. You must make a request in writing to obtain access to Your PHI. If We deny Your request, 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 PHI** - You have the right to request that We amend, or change, Your PHI if You believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny Your request for certain reasons, for example if We did not create the information You want amended and the creator of the PHI is able to perform the amendment. If We deny Your request, We will provide You a written explanation. You may respond with a statement that You disagree with Our decision and We will attach Your statement to the PHI You request that We amend. If We accept Your request to amend the information, We will make reasonable efforts to inform others, including people You name, of the amendment and to include the changes in any future disclosures of that information.
- **Right to Receive an Accounting of Disclosures** - You have the right to receive a list of instances within the last 6 years period in which We or Our business associates disclosed Your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures You authorized and certain other activities. If You request this accounting more than once in a 12-month period, We may charge You a reasonable, cost-based fee for responding to these additional requests. We will provide You with more information on Our fees at the time of Your request.
- **Right to File a Complaint** - If You feel Your privacy rights have been violated or that We have violated Our own privacy practices, You can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-800-368-1019, (TTY: 1-866-788-4989) or visiting <http://www.hhs.gov/ocr/privacy/hipaa/complaints/>.

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

- **Right to Receive a Copy of this Notice** - You may request a copy of Our Notice at any time by using the contact information list at the end of the Notice. If You receive this Notice on Our web site or by electronic mail (e-mail), You are also entitled to request a paper copy of the Notice.

Contact Information

If You have any questions about this Notice, Our privacy practices related to Your PHI or how to exercise Your rights You can contact us in writing or by phone using the contact information listed below.

Health Net Life Privacy Office
Attn: Privacy Official
P.O. Box 9103
Van Nuys, CA 91409

Telephone: 1-800-522-0088
Fax: 1-818-676-8314
Email: Privacy@healthnet.com

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 such as other insurers;
- 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 phone number on the back of Your ID card or contact Health Net Life at 1-800-522-0088.

Nondiscrimination Notice

Health Net Life Insurance Company (Health Net) complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

HEALTH NET:

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

If you need these services, contact Health Net's Customer Contact Center at:

Group Plans through Health Net 1-800-522-0088 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Health Net's Customer Contact Center at the number above and telling them you need help filing a grievance. Health Net's Customer Contact Center is available to help you file a grievance.

You can also file a grievance by mail, fax or email at:

Health Net Life Insurance Company Appeals & Grievances

P.O. Box 10348

Van Nuys, CA 91410-0348

Fax: 1-877-831-6019

Email: Member.Discrimination.Complaints@healthnet.com (Covered Person)

Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

You may submit a complaint by calling the California Department of Insurance at 1-800-927-4357 or online at <https://www.insurance.ca.gov/01-consumers/101-help/index.cfm>.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

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

Language Assistance Services

HNL provides free language assistance services, such as oral interpretation, sign language interpretation, translated written materials and appropriate auxiliary aids for individuals with disabilities. HNL's Customer Contact Center has bilingual staff and interpreter services for additional languages to support the Covered Person's language needs. Oral interpretation services in Your language can be used for, but not limited to, explaining benefits, filing a grievance and answering questions related to Your health plan. 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 and to schedule an interpreter. Providers may not request that a Covered Person bring his or her own interpreter to an appointment. There are limitations on the use of family and friends as interpreters. Minors can only be used as interpreters if there is an imminent threat to the patient's safety and no qualified interpreter is available. Language assistance is available 24 hours a day, 7 days a week at all points of contact where a covered benefit or service is accessed. If You cannot locate a health care provider who meets Your language needs, You can request to have an interpreter available at no charge. Interpreter services shall be coordinated with scheduled appointments for health care services in such a manner that ensures the provision of interpreter services at the time of the appointment.

Notice of Language Services

English

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call the Customer Contact Center at the number on your ID card or call Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). For California marketplace, call IFP On Exchange 1-888-926-4988 (TTY: 711) or Small Business 1-888-926-5133 (TTY: 711). For Group Plans through Health Net, call 1-800-522-0088 (TTY: 711).

Arabic

خدمات لغوية مجانية. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة اللازمة، يرجى التواصل مع مركز خدمة العملاء عبر الرقم المبين على بطاقتك أو الاتصال بالرقم الفرعي لخطة الأفراد والعائلة: (TTY: 711) 1-800-839-2172. للتواصل في كاليفورنيا، يرجى الاتصال بالرقم الفرعي لخطة الأفراد والعائلة عبر الرقم: (TTY: 711) 1-888-926-4988 أو المشروعات الصغيرة (TTY: 711) 1-888-926-5133. لخطط المجموعة عبر Health Net، يرجى الاتصال بالرقم (TTY: 711) 1-800-522-0088.

Armenian

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Օգնության համար զանգահարեք Հաճախորդների սպասարկման կենտրոն ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք Individual & Family Plan (IFP) Off Exchange՝ 1-800-839-2172 հեռախոսահամարով (TTY՝ 711): Կալիֆորնիայի համար զանգահարեք IFP On Exchange՝ 1-888-926-4988 հեռախոսահամարով (TTY՝ 711) կամ Փոքր բիզնեսի համար՝ 1-888-926-5133 հեռախոսահամարով (TTY՝ 711): Health Net-ի Խմբային ծրագրերի համար զանգահարեք 1-800-522-0088 հեռախոսահամարով (TTY՝ 711):

Chinese

免費語言服務。您可使用口譯員服務。您可請人將文件唸給您聽並請我們將某些文件翻譯成您的語言寄給您。如需協助，請撥打您會員卡上的電話號碼與客戶聯絡中心聯絡或者撥打健康保險交易市場外的 Individual & Family Plan (IFP) 專線：1-800-839-2172（聽障專線：711）。如為加州保險交易市場，請撥打健康保險交易市場的 IFP 專線 1-888-926-4988（聽障專線：711），小型企業則請撥打 1-888-926-5133（聽障專線：711）。如為透過 Health Net 取得的團保計畫，請撥打 1-800-522-0088（聽障專線：711）。

Hindi

बिना शुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, अपने आईडी कार्ड में दिए गए नंबर पर ग्राहक सेवा केंद्र को कॉल करें या व्यक्तिगत और फैमिली प्लान (आईएफपी) ऑफ एक्सचेंज: 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफोर्निया बाजारों के लिए, आईएफपी ऑन एक्सचेंज 1-888-926-4988 (TTY: 711) या स्मॉल बिजनेस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के माध्यम से ग्रुप प्लान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong

Tsis Muaj Tus Nqi Pab Txhais Lus. Koj tuaj yeem tau txais ib tus kws pab txhais lus. Koj tuaj yeem muaj ib tus neeg nyeem cov ntaub ntawv rau koj ua koj hom lus hais. Txhawm rau pab, hu xovtooj rau Neeg Qhua Lub Chaw Tiv Toj ntawm tus npawb nyob ntawm koj daim npav ID lossis hu rau Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) Ntawm Kev Sib Hloov Pauv: 1-800-839-2172 (TTY: 711). Rau California qhov chaw kiab khw, hu rau IFP Ntawm Qhov Sib Hloov Pauv 1-888-926-4988 (TTY: 711) lossis Lag Luam Me 1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hu rau 1-800-522-0088 (TTY: 711).

Japanese

無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプが必要な場合は、IDカードに記載されている番号で顧客連絡センターまでお問い合わせいただくか、Individual & Family Plan (IFP) (個人・家族向けプラン) Off Exchange: 1-800-839-2172 (TTY: 711) までお電話ください。カリフォルニア州のマーケットプレイスについては、IFP On Exchange 1-888-926-4988 (TTY: 711) または Small Business 1-888-926-5133 (TTY: 711) までお電話ください。Health Netによるグループプランについては、1-800-522-0088 (TTY: 711) までお電話ください。

Khmer

សេវាកម្មភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជនតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក ឬហៅទូរស័ព្ទទៅកាន់កម្មវិធី Off Exchange របស់គម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) តាមរយៈលេខ៖ 1-800-839-2172 (TTY: 711)។ សម្រាប់ទីផ្សាររដ្ឋ California សូមហៅទូរស័ព្ទទៅកាន់កម្មវិធី On Exchange របស់គម្រោង IFP តាមរយៈលេខ 1-888-926-4988 (TTY: 711) ឬក្រុមហ៊ុនអាជីវកម្មខ្នាតតូចតាមរយៈលេខ 1-888-926-5133 (TTY: 711)។ សម្រាប់គម្រោងជាក្រុមតាមរយៈ Health Net សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-522-0088 (TTY: 711)។

Korean

무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 고객센터 센터에 연락하시거나 개인 및 가족 플랜(IFP)의 경우 Off Exchange: 1-800-839-2172(TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스의 경우 IFP On Exchange 1-888-926-4988(TTY: 711), 소규모 비즈니스의 경우 1-888-926-5133(TTY: 711)번으로 전화해 주십시오. Health Net을 통한 그룹 플랜의 경우 1-800-522-0088(TTY: 711)번으로 전화해 주십시오.

Navajo

Doo bą́ą́h ílínígóó saad bee háká ada'íiyeed. Ata' halne'ígíí da ła' ná hádídóot'íí. Naaltsos da t'áá shí shizaad k'ehjí shichí' yídooltah nínízingo t'áá ná ákódoolníí. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíjí' hodíílnih ninaaltsos nanítingo bee néého'dolzinígíí hodoonihjí' bikáá' éí doodago kojí' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojí' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí kojí' hólne' 1-888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí kojí' hólne' 1-800-522-0088 (TTY: 711).

Persian (Farsi)

خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای دریافت کمک، با مرکز تماس مشتریان به شماره روی کارت شناسایی یا طرح فردی و خانوادگی (IFP) Off Exchange) 1-800-839-2172 (TTY:711) تماس بگیرید. برای بازار کالیفرنیا، با IFP On Exchange شماره 1-888-926-4988 (TTY:711) یا کسب و کار کوچک 1-888-926-5133 (TTY:711) تماس بگیرید. برای طرح های گروهی از طریق Health Net، با 1-800-522-0088 (TTY:711) تماس بگیرید.

Panjabi (Punjabi)

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਐੱਫ ਐਕਸਚੇਂਜ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਐੱਓ ਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੇਲ ਬਿਜ਼ਨੇਸ ਨੂੰ 1-888-926-5133 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਹੈਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਹਿਕ ਪਲੈਨਾਂ ਲਈ, 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian

Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь, звоните по телефону Центра помощи клиентам, указанному на вашей карте участника плана. Вы также можете позвонить в отдел помощи участникам не представленных на федеральном рынке планов для частных лиц и семей (IFP) Off Exchange 1-800-839-2172 (TTY: 711). Участники планов от California marketplace: звоните в отдел помощи участникам представленных на федеральном рынке планов IFP (On Exchange) по телефону 1-888-926-4988 (TTY: 711) или в отдел планов для малого бизнеса (Small Business) по телефону 1-888-926-5133 (TTY: 711). Участники коллективных планов, предоставляемых через Health Net: звоните по телефону 1-800-522-0088 (TTY: 711).

Spanish

Servicios de idiomas sin costo. Puede solicitar un intérprete, obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, comuníquese con el Centro de Comunicación con el Cliente al número que figura en su tarjeta de identificación o llame al plan individual y familiar que no pertenece al Mercado de Seguros de Salud al 1-800-839-2172 (TTY: 711). Para planes del mercado de seguros de salud de California, llame al plan individual y familiar que pertenece al Mercado de Seguros de Salud al 1-888-926-4988 (TTY: 711); para los planes de pequeñas empresas, llame al 1-888-926-5133 (TTY: 711). Para planes grupales a través de Health Net, llame al 1-800-522-0088 (TTY: 711).

Tagalog

Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, tumawag sa Customer Contact Center sa numerong nasa ID card ninyo o tumawag sa Off Exchange ng Planong Pang-individwal at Pampamilya (Individual & Family Plan, IFP): 1-800-839-2172 (TTY: 711). Para sa California marketplace, tumawag sa IFP On Exchange 1-888-926-4988 (TTY: 711) o Maliliit na Negosyo 1-888-926-5133 (TTY: 711). Para sa mga Planong Pang-grupo sa pamamagitan ng Health Net, tumawag sa 1-800-522-0088 (TTY: 711).

Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้สามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โทรหาศูนย์ลูกค้าสัมพันธ์ได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือโทรหาฝ่ายแผนบุคคลและครอบครัวของเอกชน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โทรมด TTY: 711) สำหรับเขตแคลิฟอร์เนีย โทรหาฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โทรมด TTY: 711) หรือ ฝ่ายธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โทรมด TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โทรมด TTY: 711)

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi Trung Tâm Liên Lạc Khách Hàng theo số điện thoại ghi trên thẻ ID của quý vị hoặc gọi Chương Trình Bảo Hiểm Cá Nhân & Gia Đình (IFP) Phi Tập Trung: 1-800-839-2172 (TTY: 711). Đối với thị trường California, vui lòng gọi IFP Tập Trung 1-888-926-4988 (TTY: 711) hoặc Doanh Nghiệp Nhỏ 1-888-926-5133 (TTY: 711). Đối với các Chương Trình Bảo Hiểm Nhóm qua Health Net, vui lòng gọi 1-800-522-0088 (TTY: 711).

CA Commercial On and Off-Exchange Member Notice of Language Assistance

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Contact us

Health Net PPO
Post Office Box 9103
Van Nuys, California 91409-9103

Customer Contact Center
1-800-861-7214

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)

www.healthnet.com

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