POLICY

A complete explanation of Your plan

Individual and Family Silver Plan Policy PPO (Plan 9LQ)

PPO Silver $45/$2000

Important benefit information – please read

Health Net®
LIFE INSURANCE COMPANY

P30601(CA 1/14)OE

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

● Persons Covered

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

● Amounts of Coverage

The basic coverage protections provided by the Association are as follows.

● Life Insurance, Annuities and Structured Settlement Annuities

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

● Health Insurance

The maximum amount of protection provided by the Association to an individual, as of April 1, 2011, is $470,125. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract

- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society

- If the person is provided coverage by the guaranty association of another state.

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual

- Employer and association plans, to the extent they are self-funded or uninsured

- A policy or contract providing any health care benefits under Medicare Part C or Part D

- An annuity issued by an organization that is only licensed to issue charitable gift annuities

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract

- Any policy of reinsurance unless an assumption certificate was issued

- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance Guarantee Association
P.O Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

Health Net
Life Insurance Company

HEALTH NET PPO INSURANCE POLICY
(the *Policy*)

ISSUED BY

HEALTH NET LIFE INSURANCE COMPANY
(HNL)

LOS ANGELES, CALIFORNIA

Upon payment of Premium charges in the amount and manner provided in this *Policy*. Health Net Life Insurance Company

HEREBY AGREES

to provide benefits as defined in this *Policy* to the Policyholder and their eligible Dependents according to the terms and conditions of this *Policy*. Payment of Premium by the Policyholder in the amount and manner provided for in the *Policy* shall constitute the Policyholder's acceptance of the terms and conditions of the *Policy*. This Health Net Life Insurance Company Policy, the Application for Individual and Family Policy and the enrollment forms of Policyholder's Dependents, inclusively shall constitute the entire agreement between the parties.

HEALTH NET LIFE INSURANCE COMPANY

Steven Sickle
Secretary

Steven Sell
President

Notice of Right to Examination: If You are not satisfied with Your coverage under this *Policy,* You may return it within 10 days of receipt. The *Policy* must be mailed or delivered to HNL. If the *Policy* is returned to HNL within 10 days of receipt, HNL will refund any Premium paid and the *Policy* will be considered void from the beginning as if it had never been issued.

INSURANCE PLAN 9LQ

2CSS

HEALTH NET PPO POLICY

ISSUED BY

HEALTH NET LIFE INSURANCE COMPANY

Los Angeles, California

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

HEALTH NET LIFE INSURANCE COMPANY (herein called HNL) agrees to provide benefits as described in this *Policy* to the Policyholder (herein called "You" or "Your") and Your eligible Dependents.

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

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

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

HNL will provide 60 days advance notice to Policyholders before the effective date of any material modification to this *Policy*, including changes in Preventive Care Services.

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 the Covered Persons under this *Policy* with Covered Services and Supplies as explained in this *Policy* and accept a special contracted rate, called the "Contracted Rate" as payment in full. The Covered Person's share of costs is based on that contracted rate. Preferred Providers are listed on the HNL website at www.healthnet.com or one can contact the Customer Contact Center at the telephone number on the HNL ID Card to obtain a copy of the Preferred Provider Directory.

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 OUT-OF-NETWORK PROVIDERS, BENEFITS ARE SUBSTANTIALLY REDUCED. WHEN YOU USE OUT-OF-NETWORK PROVIDERS WILL INCUR SIGNIFICANTLY HIGHER OUT-OF-POCKET EXPENSE.** The Covered Person's out-of-pocket expense is greater because: (1) the Covered Person is responsible for a higher percentage of the benefits than for the services of Preferred Providers; (2) HNL's benefit for Out-of-Network Providers is based on a percentage of the Maximum Allowable Amount; and (3) the Covered Person is financially responsible for any amounts 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. Covered Services and Supplies received from Out-of-Network Providers will be payable at the Preferred Provider level of coverage, if HNL does not meet adequacy

and accessibility standards for Preferred Providers, as required by California Code of Regulations, Title 10, section 2240 et seq., based upon the workplace or residence address of the Policyholder.

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.

To maximize the benefits received under this Health Net PPO insurance plan, Covered Persons must use Preferred Providers.

HNL applies certain payment policies and rules to determine appropriate reimbursement that may affect Your responsibility (including, but not limited to, rules affecting reductions in reimbursement for charges for multiple procedures, services of an assistant surgeon, unbundled or duplicate items, and services covered by a global charge for the primary procedure). See the "Outpatient Surgery and Services" and "Hospital Stay" portions of the "Schedule of Benefits" section and the "Professional Surgical Services" portion of the "Medical 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 *Policy* and that the Covered Person might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. The Covered Person should obtain more information before enrollment by calling his or her prospective doctor, Preferred Provider, or clinic, or call HNL's Customer Contact Center at the telephone number on his or her HNL ID Card, to ensure that the health care services needed can be obtained.

Notice of Right to Examination: If You are not satisfied with Your coverage under this *Policy,* You may return it within 10 days of receipt. The *Policy* must be mailed or delivered to HNL. If the *Policy* is returned to HNL within 10 days of receipt, HNL will refund any Premium paid and the *Policy* will be considered void from the beginning as if it had never been issued.

PLEASE CONTACT OUR MEMBER SERVICE DEPARTMENT BEFORE SERVICES ARE RECEIVED WITH QUESTIONS ABOUT THE COVERAGE.

THE TERMS "YOU" OR "YOUR," WHEN THEY APPEAR IN THIS *POLICY*, REFER TO THE POLICYHOLDER. THE TERMS "WE," "OUR" OR "US," WHEN THEY APPEAR IN THIS *POLICY*, REFER TO HNL. PLEASE REFER TO "POLICYHOLDER" AND "HNL" IN THE "DEFINITIONS" SECTION FOR MORE INFORMATION.

Important Notice To California Policyholders

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

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

1-888-926-4988

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
www.insurance.ca.gov

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DEFINITIONS

This section defines words that will help You understand Your plan. These words appear throughout the *Policy* with the initial letter of the word in capital letters. Definitions do not imply coverage and are subject to eligibility rules, coverage limitations and exclusions specified elsewhere in this *Policy*.

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.

BARIATRIC SURGERY PERFORMANCE CENTER is a provider in HNL's designated network of California bariatric surgical centers and surgeons that perform weight loss surgery. Preferred Providers that are not designated as part of HNL's network of Bariatric Surgery Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for weight loss surgery.

BLOOD PRODUCTS are biopharmaceutical products derived from human blood, including but not limited to, blood clotting factors, blood plasma, immunoglobulins, granulocytes, platelets and red blood cells.

CALENDAR YEAR is the continuous, twelve-month period commencing January 1 of each year at 12:01 a.m., Pacific Time.

CALENDAR YEAR DEDUCTIBLE is the amount of medical Covered Expenses which must be incurred by You or Your family each Calendar Year and for which You or Your family has payment responsibility before benefits become payable by HNL.

CERTIFICATION refers to the requirement that certain Covered Expenses require review and approval, frequently prior to the expenses being incurred. The "Schedule of Benefits" shows the penalties applicable to those expenses which are authorized in accordance with the provisions of this *Policy*, and those expenses which are not so certified. The requirements for Certification are described in the "Certification Requirement" section.

CHEMICAL DEPENDENCY is alcoholism, drug addiction or other chemical dependency problems.

COINSURANCE is the percentage of the Covered Expenses, for which the Covered Person is responsible, as specified in the "Schedule of Benefits."

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 a Covered Person for Covered Services and Supplies. The amount of each Copayment is indicated in "Schedule of Benefits" and is due and payable by the Covered Person to the provider of care at the time services are rendered.

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, spinabifida, diabetes, and foot disfigurement caused by accident or developmental disability.

COVERED DENTAL SERVICE is a Dental Service or Dental Procedure for which benefits are provided under this *Policy*.

COVERED EXPENSES are the maximum charges for which HNL will pay benefits for each Covered Service or Supply. The amount of Covered Expenses varies by whether the Covered Person obtains 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 cost of services or supplies provided by a Preferred Provider; or (ii) Maximum Allowable Amount for the cost of services or supplies provided by an Out-of-Network Provider.

COVERED PERSON means You and Your Dependents who are covered under this *Policy.*

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 *Policy*.

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.

DENTAL PROVIDER is any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

DENTAL SERVICE or DENTAL PROCEDURES is dental care or treatment provided by a Dental Provider to a Covered Person while the *Policy* is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

DENTAL SERVICES DEDUCTIBLE is the amount a Covered Person must pay for Covered Dental Services in a Calendar Year before we will begin paying for Network or Non-Network Benefits in that year.

DEPENDENT includes:

1. a Policyholder's legally married spouse or Domestic Partner as defined by California law;
2. a Policyholder's child who is:
   (a) under the age of 26; or
   (b) over the age of 26 and incapable of self-sustaining employment by reason of physical disability incurred prior to attainment of age 26 and who is chiefly dependent upon the Policyholder or Policyholder's spouse or Domestic Partner for support;

The term "child" includes a stepchild, a legally adopted child from the moment of placement in Your home, and any other child for whom You or Your spouse or Domestic Partner has assumed a parent-child relationship, as indicated by intentional assumption of parental duties, as certified by You or Your Domestic Partner at the time of enrollment of the child, and annually thereafter up to age 26.

In order for a child to remain insured after age 26, You must provide proof of the child's incapacity and dependency to Us within 60 days of the child becoming 26 years of age.

DOMESTIC PARTNER is a person eligible for coverage as a Dependent provided that the partnership with the Policyholder and who meets all of the requirements of Section 308(c) of the California Family Code, or are registered domestic partners, or meets all domestic partnership requirements under specified by section 297 or 299.2 of the California Family Code.

DURABLE MEDICAL EQUIPMENT:

- Serves a medical purpose (its reason for existing is to fulfill a medical need, and it is not useful to anyone in the absence of illness or injury);
- Withstands repeated use; and
- Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities.

EFFECTIVE DATE is the date on which the Policyholder becomes covered by the benefits under this *Policy*. The precise Effective Date can be found on the Notice of Acceptance.

ELIGIBLE DENTAL EXPENSES for Covered Dental Services, incurred while the *Policy* is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Eligible Dental Expenses are our contracted fee(s) for Covered Dental Services with that provider.
- For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dental Providers, Eligible Dental Expenses are the Usual and Customary fees, as defined below.

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 danger)
- His or her bodily functions, organs, or parts would become seriously damaged
- His or her bodily organs or parts would seriously malfunction

Emergency Care also includes treatment of severe pain or active labor. Active labor means labor at the time that either of the following would occur:

- There is inadequate time to effect safe transfer to another Hospital prior to delivery; or
- A transfer poses a threat to the health and safety of the Covered Person or unborn child.

Emergency Care is available and accessible to all Covered Persons in the Service Area 24 hours a day, seven days a week. Emergency Care includes air and ground Ambulance transport services provided through the **911** emergency response system. Ambulance services will transport the Covered Person to the nearest 24-hour emergency facility with Physician coverage.

See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" under "Specific Provisions" for the procedure to request an Independent Medical Review of a Plan denial of coverage for Emergency Care.

ESSENTIAL HEALTH BENEFITS are a set of health care service categories (as defined by the Affordable Care Act and section 10112.27 of the California Insurance Code) that must be covered by all health benefits plans starting in 2014. Categories include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including dental and vision care.

EXPERIMENTAL (or INVESTIGATIONAL) means a drug, biological product, device, equipment, medical treatment, therapy, or procedure ("Service") that is not presently recognized as standard medical care for a medically diagnosed condition, illness, disease, or injury, but which Service is being actively investigated for use in the treatment of the diagnosed condition, illness, disease, or injury.

A service is considered Investigational or Experimental if it meets any of the following criteria:

- It is currently the subject of active and credible evaluation (e.g., clinical trials or research) to determine:
  - clinical efficacy,
  - therapeutic value or beneficial effects on health outcomes, or
  - benefits beyond any established medical based alternative.
- It is the subject of an active and credible evaluation and does not have final clearance from applicable governmental regulatory bodies (such as the US Food and Drug Administration "FDA") and unrestricted market approval for use in the treatment of a specified medical condition or the condition for which authorization of the service is requested.

- The most recent peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals do not conclude, or are inconclusive in finding, that the service is safe and effective for the treatment of the condition for which authorization of the service is requested.

EYEMED VISION CARE, LLC, a contracted vision services provider panel, provides and administers the vision services benefits through a network of dispensing opticians and optometric laboratories.

GRACE PERIOD is the 30 day period which begins on the day following the due date of any Premium due, other than the first Premium.

HEALTH NET LIFE INSURANCE COMPANY or HNL (also referred to as "We," "Our" and "Us") is a life and disability insurance company regulated by the California Department of Insurance.

HEALTH NET PPO is the Preferred Provider Organization (PPO) insurance plan described in this *Policy*, which allows Covered Persons 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. HNL underwrites the benefits of Health Net PPO.

HOME HEALTH CARE AGENCY is an organization licensed by the state in which it is located and has an agreement in force for rendering Home Health Care Services under the terms and conditions of this *Policy* and certified by Medicare.

HOME HEALTH CARE SERVICES are services, including skilled nursing services, provided by a licensed Home Health Care Agency to a Covered Person in his or her place of residence that is prescribed by the Covered Person's attending Physician as part of a written plan**.** Home Health Care Services are covered if the Covered Person is homebound, under the care of a contracting Physician, and requires Medically Necessary skilled nursing services, physical, speech, occupational therapy, or respiratory therapy or medical social services. Only Intermittent Skilled Nursing Services are covered benefits under this plan. 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 program provided by a public agency or private organization, or a part of either, that is primarily engaged in providing certain services to terminally ill persons. The Hospice and its employees must be licensed in accordance with 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 the Covered Person's home.

HOSPITAL is a legally operated facility defined as a Hospital and an institution licensed by the state and approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by Medicare.

INTERMITTENT SKILLED NURSING SERVICES are services requiring the skilled services of a registered nurse or LVN.

INPATIENT means being confined as a bed patient in a Hospital, Hospice or Skilled Nursing Facility.

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 considered Investigational or Experimental if it meets any of the following criteria:

- It is currently the subject of active and credible evaluation (e.g., clinical trials or research) to determine:
  - clinical efficacy,
  - therapeutic value or beneficial effects on health outcomes, or
  - benefits beyond any established medical based alternative.
- It is the subject of an active and credible evaluation and does not have final clearance from applicable governmental regulatory bodies (such as the US Food and Drug Administration "FDA") and unrestricted market approval for use in the treatment of a specified medical condition or the condition for which authorization of the service is requested.

- The most recent peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals do not conclude, or are inconclusive in finding, that the service is safe and effective for the treatment of the condition for which authorization of the service is requested.

MAXIMUM ALLOWABLE AMOUNT is the amount on which HNL bases its reimbursement for Covered Services and Supplies received from an Out-of-Network Provider, which may be less than the amount billed for those services and supplies. HNL calculates Maximum Allowable Amount as the lesser of the amount billed by the Out-of-Network Provider or the amount determined as set forth herein. Maximum Allowable Amount is not the amount that HNL pays for a Covered Service; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles and other applicable amounts set forth in this *Policy*.

- Maximum Allowable Amount for Physician services is determined by applying a designated percentile from the database of Physician charges from the FAIR Health RV Benchmarks or a similar type of database of Physician charges.
- For all other types of services, Maximum Allowable Amount is determined by applying a percentage of what Medicare would allow (known as the Medicare allowable amount). The Maximum Allowable Amount for such services is 190% of the Medicare allowable amount.
- In the event the applicable service or database does not include an amount for the service or supply provided, Maximum Allowable Amount shall be deemed to be 75% of the covered charges billed by the provider. The Maximum Allowable Amount determined under the databases described above may be more or less than 75% of the amount normally charged by the provider for the same services or supplies.
- The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses. See "Schedule of Benefits," "Medical Benefits" and "General Exclusions and Limitations" sections for specific benefit limitations, maximums, pre-certification requirements and payment policies that limit the amount HNL pays for certain Covered Services and Supplies. HNL uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement.

In addition to the above, from time to time, HNL also contracts with vendors that have contracted fee arrangements with providers ("Third Party Networks"). In the event HNL contracts with a Third Party Network that has a contract with the Out-of-Network Provider, HNL may, at its option, use the rate agreed to by the Third Party Network as the Maximum Allowable Amount, in which case You will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance at the Out-of-Network level.

In addition, HNL may, at its option, refer a claim for Out-of-Network Services to a fee negotiation service to negotiate the Maximum Allowable Amount for the service or supply provided directly with the Out-of-Network Provider. In that situation, if the Out-of-Network Provider agrees to a negotiated Maximum Allowable Amount, You will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance at the Out-of-Network level.

In the event that the billed charges for the Out-of-Network Provider are more than the Maximum Allowable Amount, You are responsible for any amounts charged in excess of the Maximum Allowable Amount, except where the Out-of-Network Provider's fee is determined by reference to a Third Party Network agreement or the Out-of-Network Provider agrees to a negotiated Maximum Allowable Amount.

Please note that whenever You obtain Covered Services and Supplies from an Out-of-Network Provider, You are responsible for applicable Deductibles, Copayments and Coinsurance.

For more information on the determination of Maximum Allowable Amount, or for information, services and tools to help You further understand Your potential financial responsibilities for Covered Out-of-Network Services and Supplies please log on to www.healthnet.com or contact HNL Customer Service at the number on Your member identification card.

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 Pediatric Dental Services, Medically Necessary (or Necessary) means Dental Services and supplies under this *Policy* which are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
    - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
    - Safe with promising efficacy
        - For treating a life threatening dental disease or condition.
        - Provided in a clinically controlled research setting.
        - Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this *Policy*. The definition of Necessary used in this *Policy* relates only to Benefits under this *Policy* and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

MEDICARE is the name commonly used to describe Health Insurance Benefits for the Aged and Disabled provided under Public Law 89-97 as amended to date or as later amended.

MENTAL DISORDERS are a nervous or mental condition identified as a "mental disorder" in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM)* that results in clinically significant distress or impairment of mental, emotional or behavioral functioning.

NEURO-MUSCULOSKELETAL DISORDERS are misalignment of the skeletal structure and muscular weakness, osteopathic imbalances and disorders related to the spinal cord, neck and joints.

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-NETWORK PROVIDERS are Physicians, Hospitals, or other Providers of health care who are not part of the Health Net Preferred Provider Organization (PPO), except as noted under the definitions for "Bariatric Surgery Performance Center" and "Transplant Performance Center."

OUT-OF-POCKET MAXIMUM is the maximum dollar amount of Deductibles, Copayments and Coinsurance for which You or Your family must pay for medical, outpatient Prescription Drug, pediatric dental and pediatric vision 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." Certain expenses, as described in the "Schedule of Benefits," 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. For a family plan, an individual is responsible only for meeting the individual Out-of-Pocket Maximum.

OUTPATIENT SURGICAL CENTER is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services.

PARTICIPATING VISION PROVIDER Is an optometrist, ophthalmologist or optician licensed to provide Covered Services and who or which, at the time care is rendered to a Member, has a contract in effect with Health Net to furnish care to Members. The names of Participating Vision Providers are set forth in Health Net's Participating Vision Provider Directory. The names of Participating Vision Providers and their locations and hours of practice may also be obtained by contacting Health Net's Customer Contact Center.

PHYSICIAN means:

- A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided, or
- One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this *Policy*, and when benefits would be payable if the services were provided by a Physician as defined in 1., above:
  a. Dentist (D.D.S.)
  b. Optometrist (O.D.)
  c. Dispensing optician
  d. Podiatrist, or Chiropodist (D.P.M., D.S.P. or D.S.C.)
  e. Psychologist
  f. Chiropractor (D.C.)
  g. Nurse midwife
  h. Nurse practitioner
  i. Physician assistant
  j. Clinical social worker (M.S.W. or L.C.S.W.)
  k. Marriage, family and child counselor (M.F.C.C.)
  l. Physical therapist (P.T. or R.P.T.)
  m. Speech pathologist
  n. Audiologist
  o. Occupational therapist (O.T.R.)
  p. Psychiatric mental health nurse.
  q. Respiratory therapist

r. Acupuncturist (A.C.)

POLICYHOLDER is the person enrolled under this *Policy* who is responsible for payment of Premiums to HNL and whose status is the basis for Dependent eligibility under this *Policy*.

PREFERRED PROVIDER ORGANIZATION is a health care provider arrangement whereby HNL contracts with a group of Physicians or other medical care providers who agree to furnish Covered Services and Supplies at the rate known as the Contracted Rate, except as noted under the definitions for "Bariatric Surgery Performance Center" and "Transplant Performance Center."

PREFERRED PROVIDERS are Physicians, Hospitals or other Providers of health care who have a written agreement with HNL to participate in the Preferred Provider Organization (PPO) network and have agreed to provide Covered Persons with Covered Services and Supplies at the Contracted Rate, except as noted under the definitions for "Bariatric Surgery Performance Center" and "Transplant Performance Center." The Covered Person must pay any Deductible(s), Copayment or Coinsurance required, but is not responsible for any amount charged in excess of the Contracted Rate. Preferred Providers are listed in the Preferred Provider Directory given to each Covered Person upon enrollment. The Preferred Provider Directory is periodically updated. To insure the participation by any Preferred Provider, please contact Our Customer Contact Center at the telephone number on the HNL ID card before services are received.

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 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

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.

PREMIUM is the amount the Policyholder pays HNL for the insurance provided under this *Policy*.

PROFESSIONAL VISION SERVICES include examination, material selection, fitting of eyeglasses or contact lenses, related adjustments, instructions, etc.

QUALIFIED AUTISM SERVICE PROVIDER means either of the following: (1) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified. (2) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

Qualified Autism Service Providers employ and supervise qualified autism service professionals and paraprofessionals who provide behavioral health treatment and implement services for pervasive developmental disorder or autism pursuant to the treatment plan developed and approved by the Qualified Autism Service Provider.

- A qualified autism service professional is a behavioral service provider that has training and experience in providing services for pervasive developmental disorder or autism and is approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations.
- A qualified autism service paraprofessional is an unlicensed and uncertified individual who has adequate education, training, and experience as certified by the Qualified Autism Service Provider, and who meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code.

RESIDENTIAL TREATMENT CENTER is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. HNL requires that all contracted Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

SERIOUS EMOTIONAL DISTURBANCES OF A CHILD is when a child under the age of 18 has one or more Mental Disorders identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary chemical dependency disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following: (a) as a result of the Mental Disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either (i) the child is at risk of removal from home or already has been removed from the home or (ii) the Mental Disorder and impairment have been present for more than six months or are likely to continue for more than one year; (b) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a Mental Disorder and/or (c) the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

SEVERE MENTAL ILLNESS includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition of the *Diagnostic and Statistical Manual for Mental Disorders*), autism, anorexia nervosa and bulimia nervosa.

SERVICE AREA is the state of California.

SKILLED NURSING FACILITY is an institution which is licensed by the state in which it is situated to provide skilled nursing services. At the time of the Covered Person's admission, the facility must be approved as a Participating Skilled Nursing Facility under the Medicare program.

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 Essential Rx Drug List. Specialty Drugs require Prior Authorization from HNL and must be dispensed through the Specialty Pharmacy Vendor to be covered. You may refer to our website at www.healthnet.com to review the drugs that require a Prior Authorization as noted in the Essential Rx Drug List.

SPECIALTY PHARMACY VENDOR is a pharmacy contracted with HNL specifically to provide injectable medications, needles and syringes.

TRANSPLANT PERFORMANCE CENTER is a provider in HNL's designated network in California for solid organ, tissue and stem cell transplants and transplant-related services, including evaluation and follow-up care. For purposes of determining coverage for transplants and transplant-related services, HNL's network of Transplant Performance Centers includes any providers in HNL's designated supplemental resource network. Preferred Providers that are not designated as part of HNL's network of Transplant Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for transplants and transplant-related services.

USUAL AND CUSTOMARY fees are calculated by us based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the provider would charge any similarly situated payor for the same services.

Usual and Customary fees are determined solely in accordance with our reimbursement policy guidelines. Our reimbursement policy guidelines are developed by us, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology* (publication of the *American Dental Association*).
- As reported by generally recognized professionals or publications.
- As utilized for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination that we accept.

SCHEDULE OF BENEFITS

Health Net PPO
Plan 9LQ

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

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

COPAYMENTS AND COINSURANCE

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

Copayments: Copayments are fixed dollar amounts, shown below, for which the Covered Person is responsible. HNL will pay 100% of covered Expenses of the services listed below after the Copayment is made. The Covered Person 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 the Covered Person is responsible. After any applicable Deductible(s) have been satisfied, the Covered Person will be responsible for paying Coinsurance until the amount paid during a Calendar Year is equal to the Out-of-Pocket Maximum.

Notes:

- The Covered Person 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 Amounts). Any Copayment or Coinsurance paid for the services of a Preferred Provider will apply toward the out-of-pocket Covered Expenses (as defined).

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

- **UNLESS OTHERWISE NOTED, ALL BENEFIT MAXIMUMS WILL BE COMBINED FOR COVERED SERVICES AND SUPPLIES PROVIDED BY PREFERRED PROVIDERS AND OUT-OF-NETWORK PROVIDERS.**

OUT-OF-POCKET LIMITS ON EXPENSES

Out-of-Pocket Maximum:

For Covered Persons: After the Covered Person has paid Deductible, Copayments and Coinsurance equal to the Out-of-Pocket Maximum amount shown below, he or she will not be required to pay further Copayments and Coinsurance for Covered Expenses incurred during the remainder of the Calendar Year. Please see "**Exceptions to the Out-of-Pocket Maximum"** below for Deductible, Copayments and Coinsurance that do not apply toward the Out-of-Pocket Maximum.

After the Covered Person has met the Out-of-Pocket Maximum amount, HNL will pay 100% of Covered Expenses for any additional Covered Services and Supplies, except as stated below. 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 $6350

For services or supplies provided by an Out-of-Network Provider $12700

For Families: Each Covered Person is responsible only for meeting his or her individual Out-of Pocket Maximum. However, if enrolled Covered Persons of the same family have paid Covered Expenses equal to the amounts shown below, then the Out-of-Pocket Maximum will be considered to have been met for the entire family. No Copayments or Coinsurance shall be required from any enrolled Covered person in that family for the remainder of the Calendar Year. The Covered Person will continue to pay any charges billed in excess of Covered Expenses for the services of Out-of-Network Providers.

NOTE: In order for the Family Out-of-Pocket Maximum to apply, all Dependents must be enrolled under a single Policyholder as a Family Unit. Dependents enrolled as separate Policyholders are each subject to the per Covered Person Out-of-Pocket Maximum.

For services or supplies provided by a Preferred Provider $12700

For services or supplies provided by an Out-of-Network Provider.....$25400

Copayments or Coinsurance paid for the services of a Preferred Provider will not apply toward the Out-of-Pocket Maximum for Out-of-Network Providers and Coinsurance paid for the services of an Out-of-Network Provider will not apply toward the Out-of-Pocket Maximum for Preferred Providers. However, Copayments or Coinsurance paid for Out-of-Network Emergency Care will be applied to the Out-of-Pocket Maximum for Preferred Providers.

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

- Penalties paid for services which were not certified as required.

MEDICAL DEDUCTIBLE

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

Calendar Year Deductible, for Preferred Provider services per Covered Person.....$2000

Calendar Year Deductible, for Out-of-Network services per Covered Person.....$4000

Family Calendar Year Deductible (all enrolled members of a family, for Preferred Provider services, during a Calendar Year).....$4000

Family Calendar Year Deductible (all enrolled members of a family, for Out-of-Network services, during a Calendar Year).....$8000

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

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

Your payments under Outpatient Prescription Drug Benefits, Pediatric Vision and Pediatric Dental are not applied to the Medical Deductible.

NONCERTIFICATION PENALTIES

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

* Inpatient admissions will be subject to the $250 penalty each day until HNL is notified of the admission. Please refer to the “Certification Requirements” section for more information.

Note:

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

VISITS TO A HEALTH CARE PROVIDER'S OFFICE OR CLINIC

	Preferred Providers	Out-of-Network
Primary care visits to treat an injury or illness		
In a Physician's office	$45*	50%
At a Covered Person's home	$45*	50%
Postnatal office visits	$45*	50%
Specialist consultation		
In a Physician's office	$65*	50%
At a Covered Person's home	$65*	50%
Vision or hearing examination (for diagnosis or treatment, including refractive eye examinations)(age 19 and over; for birth to age 19, see "Child Needs Eye Care" below)	$65*	Not Covered
Allergy testing, serum and injections	$65*	50%
Other practitioner office visit (acupuncturist)	$45*	Not Covered
Medical social services	$45*	Not Covered
Patient education		
Diabetes education	$45*	50%
Asthma education	$45*	50%
Weight management education	$45*	50%
Stress management education	$45*	50%
Preventive Care Services	$0	Not Covered

Notes

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

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

*The Calendar Year Deductible does not apply.

TESTS

	Preferred Providers	Out-of-Network
Laboratory tests	$45*	50%
X-rays and diagnostic imaging	$65*	50%
Imaging (CT, PET, MRI)	20%	50%

*The Calendar Year Deductible does not apply.

OUTPATIENT SURGERY AND SERVICES

	Preferred Providers	Out-of-Network
Facility fee		
Outpatient surgery and services	20%*	50%
Physician/surgeon fees		
Surgery	20%*	50%
Anesthetics	20%*	50%
Sterilization of male	20%*	50%
Sterilization of females*	$0	Not Covered
Outpatient infusion therapy	$45*	50%
Blood or Blood Products (except for drugs used to treat hemophilia, including blood factors)**	20%*	50%
Drugs used to treat hemophilia, including blood factors**	20%*	Not Covered
Chemotherapy and radiation therapy	$45*	50%
Nuclear medicine	20%*	50%
Organ, stem cell or tissue transplant (not Experimental or Investigational)	20%*	Not Covered
Renal dialysis	$45*	50%

Note

*The Calendar Year Deductible does not apply.

- The Calendar Year Deductible does not apply for services through Preferred Providers.

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

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

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

NEED IMMEDIATE ATTENTION

Services in an Emergency Room or Urgent Care Center

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

Note

*The Calendar Year Deductible does not apply.

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

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

HOSPITAL STAY

	Preferred Providers	Out-of-Network
Facility fee	20%	50%
Confinement for bariatric (weight loss) surgery	20%	Not Covered
Physician/surgeon fees		
Surgery	20%*	50%
Anesthetics	20%*	50%
Physician visit to Hospital	20%*	50%
Blood or Blood Products (except for drugs used to treat hemophilia, including blood factors)**	20%*	50%
Drugs used to treat hemophilia, including blood factors**	20%*	Not Covered
Chemotherapy and radiation therapy	$45*	50%
Nuclear medicine	20%*	50%
Organ, stem cell or tissue transplant (not Experimental or Investigational)	20%*	Not Covered
Renal dialysis	$45*	50%

Notes:

- The Preferred Provider Coinsurance will apply if the Covered Person is admitted to a Hospital directly from an emergency room or urgent care center. The Covered Person will remain responsible for amounts billed in excess of Covered Expenses (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. If a newborn patient requires admission to a Special Care Unit, a separate Copayment for inpatient hospital services will apply.

*The Calendar Year Deductible does not apply.

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

MENTAL HEALTH, BEHAVIORAL HEALTH OR SUBSTANCE ABUSE NEEDS

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

Mental Disorders	***Preferred Providers***	***Out-of-Network***
Outpatient professional services (including psychological evaluation, therapeutic session in an office setting, intensive outpatient care and partial hospitalization/day treatment)	$45*	50%
Outpatient professional consultation (psychological evaluation or therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day)	$45*	50%
Inpatient services	20%	50%

Chemical Dependency	**Preferred Providers**	**Out-of-Network**
Outpatient professional services (including psychological evaluation, therapeutic session in an office setting, intensive outpatient care and partial hospitalization/day treatment)**	$45*	50%
Inpatient services	20%	50%
Detoxification	20%	50%

Notes:

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

*The Calendar Year Deductible does not apply.

**Includes methadone maintenance during pregnancy and two months after delivery. See "Methadone Treatment" in "General Exclusions and Limitations."

PREGNANCY

	Preferred Providers	**Out-of-Network**
Prenatal care and preconception visits	$0*	50%
Delivery and all inpatient services		
Hospital	20%	50%
Professional (including elective terminations of pregnancy, genetic testing of fetus and circumcision of newborn**)	20%*	50%

Notes:

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

- Prenatal, postnatal and newborn care Preventive Care Services are covered in full by Preferred Providers. See "Preventive Care Services" in the "Visit to a Health Care Provider's Office or Clinic" provision above. If other non-Preventive Care Services are received during the same office visit, the above Copayment or Coinsurance will apply for the non-preventive services. Refer to “Preventive Care Services” and “Pregnancy” in the “Medical Benefits” section for more details.

*The Calendar Year Deductible does not apply.

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

HELP RECOVERING OR OTHER SPECIAL HEALTH NEEDS

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

Notes:

- Diabetic equipment and Orthotics which are covered under the medical benefit include blood glucose monitors, insulin pumps and Corrective Footwear.

- Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under “Preventive Care Services” in "Visit to a Health Care Provider's Office or Clinic" in this section. For additional information, please refer to the "Preventive Care Services" provision in the "Medical Benefits" section.

- For confinement in a Skilled Nursing Facility, a benefit period begins on the date You are admitted to a Hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a Hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care Hospital is not required.

- Durable Medical Equipment is covered when Medically Necessary and acquired or supplied by an HNL designated contracted vendor for Durable Medical Equipment. Preferred Providers that are not designated by HNL as a contracted vendor for Durable Medical Equipment are considered Out-of-Network Providers for purposes of determining coverage and benefits. Durable Medical Equipment is not covered if provided by an Out-of-Network Provider. Certification may be required. Please refer to the "Certification Requirements" section for details. Payment of benefits will be reduced as set forth herein if Certification is required but not obtained. For information about HNL's designated contracted vendors for Durable Medical Equipment, please contact the Customer Contact Center at the telephone number on Your HNL ID Card.

  *The Calendar Year Deductible does not apply.

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

  Coverage for physical, occupational and speech rehabilitation therapy services is subject to certain limitations as described in the "General Exclusions and Limitations" section.

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

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

DRUGS TO TREAT ILLNESS OR CONDITION - OUTPATIENT PRESCRIPTION DRUGS

Subject to the provisions of the "Drugs to Treat Illness or Condition – Outpatient Prescription Drugs" section of this *Policy*, all Medically Necessary Prescription Drugs are covered.

The outpatient Prescription Drug benefits are subject to the Out-of-Pocket Maximums as described at the beginning of this section.

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 "Drugs to Treat Illness or Condition - Outpatient Prescription Drug Benefits" section for more information about what benefits are provided.

Brand Name Drugs Deductible

Prescription Drug Deductible required for Brand Name Drugs (per Covered Person, per Calendar Year).....$250

Prescription Drug Deductible required for Brand Name Drugs (per family, per Calendar Year).....$500

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

The Deductible applies to Brand Name Drugs, insulin, and diabetic supplies. Once Your payment of Prescription Drug Covered Expenses for Brand Name Drugs, insulin, and diabetic supplies equals the Calendar Year Deductible shown above, You are only responsible for the applicable retail pharmacy Coinsurance as described herein.

Benefit Maximums

	Maximum
Number of days per Prescription Drug Order for drugs from a retail Pharmacy	30

Number of days per Prescription Drug Order for Maintenance Drugs through the Mail Order Program 90

Number of days per Prescription Drug Order for drugs from a 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

Notes:

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

Copayments and Coinsurance

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

Retail Pharmacy

	Participating Pharmacy	Nonparticipating Pharmacy
Tier I Drugs (Generic Drugs when listed in the Essential Rx Drug List)	$19	Not Covered
Tier II Drugs (preferred Brand Name Drugs, insulin and diabetic supplies when listed in the Essential Rx Drug List)	$50	Not Covered
Tier III Drugs (non-preferred Brand Name Drugs, Brand Name Drugs with generic equivalent (when Medically Necessary), drugs listed as Tier III Drugs in the Essential Rx Drug List or drugs not listed in the Essential Rx Drug List)	$70	Not Covered
Smoking cessation drugs (including injectable drugs)	50%	Not Covered
Preventive drugs and women's contraceptives	$0	Not Covered

Specialty Pharmacy Vendor

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

Maintenance Drugs through the Mail Order Program

	Mail Order Program
Tier I Drugs (Generic Drugs when listed in the Essential Rx Drug List)	$38
Tier II Drugs (preferred Brand Name Drugs, insulin and diabetic supplies when listed in the Essential Rx Drug List)	$100
Tier III Drugs (non-preferred Brand Name Drugs, Brand Name Drugs with generic equivalent (when Medically Necessary), drugs listed as Tier III Drugs in the Essential Rx Drug List or drugs not listed in the Essential Rx Drug List)	$140
Smoking cessation Drugs	50%

Preventive drugs and women's contraceptives $0

Notes:

- If the pharmacy's retail price is less than the applicable Copayment or Coinsurance, You will pay the pharmacy's retail price.
- Generic Drugs will be dispensed when a Generic Drug equivalent is available. We will cover Brand Name Drugs that have a generic equivalent at the Copayment for Tier III Drugs, when Medically Necessary.
- Preventive drugs and women's contraceptives that are approved by the Food and Drug Administration are covered as shown above. Please see the "Preventive Drugs and Women's Contraceptives" provision in the "Drugs to Treat Illness or Condition - Outpatient Prescription Drug Benefits" section for additional details. If Your Physician determines that none of the methods designated by HNL are medically appropriate for You, We shall cover some other FDA-approved prescription contraceptive method.

  If a Medically Necessary Brand Name Drug is dispensed, and there is a generic equivalent commercially available, You will be required to pay the Tier III Drug Copayment.
- Some drugs may require Prior Authorization from HNL to be covered.
- Generic or Brand Name Drugs not listed in the Essential Rx Drug List which are prescribed by Your Physician and not excluded or limited from coverage are subject to the Tier III Copayment.
- Up to a 90-consecutive-calendar-day-supply of covered Maintenance Drugs will be dispensed at the applicable mail order Copayment or Coinsurance when ordered through HNL's contracted mail service vendor. Some Specialty Drugs listed in the Essential Rx Drug List are not available through mail order.

CHILD NEEDS DENTAL OR EYE CARE

Pediatric Dental Services

Refer to the "Pediatric Dental Services" portion of the "Medical Benefits" section of this *Policy* for the benefit information which includes the Dental Schedule.

Pediatric Vision Plan Benefits

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

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

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

Routine eye exam limit: 1 per Calendar Year Exam Options: Standard Contact Lens Fit and Follow-up Premium Contact Lens Fit and Follow-up	$0 Copayment
Lenses limit: 1 pair per Calendar Year, including • Single vision, bifocal, trifocal, lenticular • Glass, or Plastic	$0 Copayment
Provider selected frames limit: 1 per Calendar Year	$0 Copayment
Optional Lenses and Treatments including • UV Treatment	$0 Copayment

• Tint (Fashion & Gradient & Glass-Grey) • Standard Plastic Scratch Coating • Standard Polycarbonate – • Photocromatic / Transitions Plastic • Standard Anti-Reflective Coating • Polarized • Standard Progressive Lens • Hi-Index Lenses • Blended segment Lenses • Intermediate vision Lenses • Select or ultra progressive lenses	
• Premium Progressive Lens	$0 Copayment
Provider selected contact lenses, a one year supply is covered every Calendar Year (in lieu of eyeglass lenses): • Disposables • Conventional • Medically Necessary*	$0 Copayment

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

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

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

TERM OF *POLICY* AND PREMIUMS

A. TERM OF *POLICY* AND TERMINATION

Coverage for this *Policy* will commence on the date set forth in the Notice of Acceptance. This *Policy* shall remain in effect subject to the payment of Premiums as required, and subject to the right of HNL and the Policyholder to terminate it in accordance with the terms of the *Policy*.

The following describes the termination provisions of this *Policy*:

Coverage under this *Policy* will automatically terminate on the earliest to occur of the following dates:

- If any Premium as specified in the Notice of Acceptance is not paid before the end of the Grace Period, this Policy will terminate effective on midnight of the last day of the 30 day Grace Period The Policyholder is liable for all Premiums due for the period coverage is in force.

- If the Policyholder ceases to be eligible according to the eligibility provisions of this *Policy*, coverage will be terminated for the Policyholder and any enrolled Dependents effective on midnight of the last day of the month in which loss of eligibility occurred.

- If a Dependent ceases to be eligible according to the eligibility provisions of this *Policy*, coverage will be terminated only for that person effective on midnight of the last day of the month in which loss of eligibility occurred.

- On midnight of the last day of the month in which entry of the final decree of dissolution of marriage, annulment or termination of domestic partnership occurs, a spouse or Domestic Partner shall cease to be an eligible Dependent. Children of the spouse or Domestic Partner who are not also the natural or legally adopted children of the Policyholder shall cease to be eligible Dependents at the same time.

- If a Policyholder makes a fraudulent or intentional misrepresentation or omission of material facts in applying for this insurance plan, or obtains or attempts to obtain Covered Services by means of deception or false, misleading or fraudulent information, acts or omissions, HNL may cancel coverage immediately upon notice.

B. TERMINATION UPON NOTICE

The Policyholder may terminate this *Policy* by sending a written notice to Health Net Individual Products, P.O. Box 1150, Rancho Cordova, CA 95670. The *Policy* will end at 12:01 a.m. on the first day of the month following Our receipt of Your written notice to cancel.

If HNL discontinues offering health benefit plans in California, it will provide notice to the Commissioner of Insurance of California and to each affected Policyholder of its intention to discontinue offering health benefit plans to California Policyholders at least 180 days prior to termination of health benefit plan coverage.

If HNL decides to discontinue offering a particular health benefit plan in the market in California, it will:

a. provide notice to the Commissioner of Insurance of California and each affected Policyholder of its intention to discontinue offering the particular health benefit plan in California;

b. provide such notice at least 90 days prior to discontinuance of the particular health benefit plan; and

c. offer to each affected Policyholder whose coverage is being discontinued, the option of replacing the discontinued plan with any other individual plan currently being offered by HNL in California, for which the Policyholder is eligible.

The written notice given by HNL to notify the Policyholder that coverage has terminated will be delivered to or mailed to the Policyholder at his/her last address as shown on HNL's records.

C. RENEWAL PROVISIONS

Subject to the termination provisions described in this *Policy*, coverage will remain in effect for each month Premium fees are received and accepted by HNL. This Policy is guaranteed renewable and HNL may only non-renew or cancel coverage for nonpayment of premiums.

D. CHANGES IN PREMIUMS

Premiums may be changed by HNL on at least 60 days written notice to the Policyholder prior to the date of such change. Any change in Premium shall take effect on the first day of the next Calendar Year.

If a governmental authority (a) imposes a tax or fee that is computed on premiums or (b) requires a change in coverage or administrative practice that increases HNL's risk, HNL may amend this Policy and increase the premium sufficiently to cover the tax, fee or risk. The effective date shall be the date set forth in a written notice from HNL to the Policyholder. The effective date shall not be earlier than the date that the tax, fee or required change in coverage or administrative practice is imposed by the governmental authority.

Premium changes due to legislative or regulatory requirements will become effective on the effective date of such changes.

If this *Policy* is terminated for any reason, the Policyholder shall be liable for all Premiums for any time this *Policy* is in force.

At least once each year, HNL shall permit an individual who has been covered for at least 18 months under an individual health benefit plan to transfer, without medical underwriting, to any other individual health benefit plan offered by HNL that provides equal or lesser benefits as determined by HNL. HNL shall notify in writing all Policyholders of the right to transfer to another individual health benefit plan pursuant to this section, at a minimum, when HNL changes the Policyholder's premium rate.

E. GRACE PERIODS

A Grace Period of 30 days will be allowed for payment of any Premium due, except the first one. During this period the *Policy* will remain in force (subject to the right of the HNL to cancel in accordance with the termination provision above). If the Policyholder fails to pay the required Premium when due, coverage could be canceled after a 30-day grace period. On or before the Premium due date, HNL will provide notification of the 30-day grace period. During the 30-day grace period, HNL must continue your coverage under this plan. If HNL does not receive payment of the delinquent subscription charges within the 30-day grace period, coverage will be terminated at the end of the grace period. The Policyholder will be responsible for the full cost of any Medical Services rendered after the Covered Person's date of termination. The Policyholder shall not be permitted to unilaterally reinstate coverage through the submission of Premium payments after the date on which this Evidence of Coverage has been terminated pursuant to this provision. Refer to "Reinstatement" below for further information. Premium payments received by HNL following expiration of the Grace Period shall be returned to the Policyholder, and the Policyholder shall not be entitled to further coverage hereunder.

F. REINSTATEMENT

If any renewal premium be not paid within the time granted the Policyholder for payment, a subsequent acceptance of premium by HNL or by any agent duly authorized by HNL to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the *Policy*; provided, however, that if HNL or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the *Policy* will be reinstated upon approval of such application by HNL or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless HNL has previously notified the Policyholder in writing of its disapproval of such application. The reinstated *Policy* shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the Policyholder and HNL shall have the same rights thereunder as they had under the *Policy* immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

ELIGIBILITY AND ENROLLMENT

This *Policy* is subject to the Guaranteed Availability and Guaranteed Renewability rules of the Affordable Care Act (ACA).

HNL establishes the conditions of eligibility that must be met in order to be eligible for coverage and continuing coverage under this Policy. In order to receive coverage under this Policy, the Policyholder and each of the Policyholder's Dependents that apply for coverage must continually reside in Our Service Area. The Notice of Acceptance indicates the names of applicants who have been accepted for coverage, the Effective Date thereof and the Deductible selected.

Policyholders covered under this *Policy* may also enroll Dependents who satisfy the eligibility requirements for enrollment. The following types of Dependents describe those who may enroll in this *Policy*:

- Spouse: The legal spouse, as defined by California law. (The term "spouse" also includes the Policyholder's Domestic Partner as defined.)
- Children: The children of the Policyholder or the Policyholder's spouse (including legally adopted children, stepchildren and wards, as defined in the following provision), under 26 years of age.
- Wards: Children for whom the Policyholder or the Policyholder's spouse is a court-appointed 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.

Disabled children 26 years of age and older.

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 Policyholder for support and maintenance.

If the Policyholder is *enrolling* a disabled child for new coverage, he or she must provide HNL with proof of incapacity and dependency within 60 days of the date the Policyholder receives a request for such information about the dependent child from HNL.

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

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

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.

Application for Coverage (Enrollment) and Effective Date for Newly Eligible Dependents

You are entitled to add newly eligible Dependents (subject to the applicable Premium payment) to this Policy as shown below:

- An application to add coverage for a newly married spouse or Domestic Partner will only be considered if We receive a completed application within sixty (60) days of marriage or Declaration of Domestic Partnership. Evidence of Insurability will be required at the time of the new spouse or Domestic Partner's enrollment. Coverage shall begin on the date indicated on the Notice of Acceptance for the new enrollee.
- A newly adopted child, or a child who is being adopted, becomes eligible on the date the Policyholder or his or her spouse or Domestic Partner receives physical custody of the child.

Coverage begins automatically and will continue for 30 days from the date of eligibility. The Policyholder must enroll the child before the 60th day for coverage to continue beyond the first 30 days.

- Coverage for newborn children will be effective upon birth and during the first thirty (30) days following birth. However, coverage after thirty (30) days is contingent upon the Policyholder enrolling the newborn within sixty (60) days following birth.
- If a court has ordered the Policyholder to provide coverage for an eligible Dependent, coverage will be effective for the first thirty (30) days following the date of the court order. To continue coverage after thirty (30) days, the Policyholder must enroll the eligible Dependent within sixty (60) days of the date of the court order and pay any required Premiums.

MEDICAL 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 *Policy*.

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

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

An expense is incurred on the date the Covered Person receives 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 benefits maximum described in the "Schedule of Benefits" section or elsewhere in the *Policy*, 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.

HNL will not make benefit payments for any Covered Person that exceed any of the benefit limits shown in the "Schedule of Benefits" section.

This Plan provides benefits required by the Newborns' and Mothers' Health Protection Act of 1996 and the Women's Health and Cancer Rights Act of 1998.

NOTE: Please read this description of plan benefits carefully. Please, also read the "Schedule of Benefits" section regarding the Covered Person's out of pocket expenses and "General Limitations and Exclusions," for details of any restrictions placed on the benefits.

HOW COVERED EXPENSES ARE DETERMINED

HNL will pay for Covered Expenses a Covered Person incurs under this plan. Covered Expenses are based on the maximum charge HNL will accept for 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,” “Medical Benefits” and “General Exclusions and Limitations” 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 *Policy* as the Contracted Rate.

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

Out-Of-Network Providers

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. The Covered Person will need to pay that excess amount, in addition to any applicable Deductible(s), Copayments or Coinsurance payment required. The Covered Person is 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.

Important Note: Even if a Hospital is a Preferred Provider, the Covered Person should not assume that all Physicians and other individual providers of health care are Preferred Providers. Covered Persons should request that all provider services be performed by Preferred Providers whenever the Covered Person enters a Hospital.

OUT-OF-POCKET LIMITS ON EXPENSES

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

Copayments or Coinsurance paid for the services of a Preferred Provider will not apply toward the Out-of-Pocket Maximum for Out-of-Network Providers. In addition, Coinsurance paid for the services of an Out-of-Network Provider will not apply toward the Out-of-Pocket Maximum for Preferred Providers. However, Copayments or Coinsurance paid for Out-of-Network Emergency Care will be applied to the Out-of-Pocket Maximum for Preferred Providers.

MEDICAL DEDUCTIBLES

- After HNL determines the amount of Covered Expenses, HNL will subtract the applicable Deductible(s) and either the Copayment or the Coinsurance that applies to the covered service or supply. HNL will then pay up to the benefit limit shown in the "Schedule of Benefits" section.
- Only Covered Expenses will be applied to the satisfaction of the Deductible(s) shown in this *Policy*.
- Expenses incurred under the Prescription Drug Benefit will not be applied to the Calendar Year Deductible or any additional Deductible(s) or any benefit Deductible.

VISITS TO A HEALTH CARE PROVIDER'S OFFICE OR CLINIC

Professional Services

Necessary services of a Physician, including office visits and consultations, Hospital and Skilled Nursing Facility visits and visits to the Covered Person’s home.

Vision and Hearing Examinations

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

Allergy Testing and Treatment

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

Acupuncture

Medically Necessary (as defined) acupuncture services, subject to the benefit maximums shown in the "Schedule of Benefits" section.

Patient Education

HNL will pay for a diabetes instruction program supervised by a licensed or registered health care professional. A diabetes instruction program is a program designed to teach the Covered Person (the diabetic) and Covered Persons of the diabetic's family about the disease process and the daily management of diabetic therapy.

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

Preventive Care Services:

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

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

- U.S. Preventive Services Task Force Grade A & B recommendations (www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm)
- The Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Center for Disease Control and Prevention (www.cdc.gov/vaccines/recs/ACIP/)
- Guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA) (www.hrsa.gov/womensguidelines/)
- For infants, children and adolescents, please refer to the American of Pediatrics Bright Futures Recommendations for Pediatric Preventive Health Care, and the Uniform Screening Panel recommended by the U.S. Department of Health and Human Services Secretary's Discretionary Advisory Committee on Heritable Disorders in Newborn and Children

Your Physician will evaluate Your health status (including, but not limited to, Your risk factors, family history, gender and/or age) to determine the appropriate Preventive Care Services and frequency. The list of Preventive Care Services are available through www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html. Examples of Preventive Care Services include, but are not limited to:

- Periodic health evaluations
- Preventive vision and hearing screening
- Blood pressure, diabetes, and cholesterol tests
- USPSTF and HRSA recommended cancer screenings, including FDA-approved human papillomavirus (HPV) screening test, screening and diagnosis of prostate cancer (including prostate-specific antigen testing and digital rectal examinations), screening for breast, cervical and colorectal cancer, human immunodeficiency virus (HIV) screening, mammograms and colonoscopies
- Developmental screenings to diagnose and assess potential developmental delays
- Counseling on such topics as quitting smoking, lactation, losing weight, eating healthfully, treating depression, prevention of sexually-transmitted disease, and reducing alcohol use
- Routine immunizations against diseases such as measles, polio, or meningitis
- Flu and pneumonia shots
- Vaccination for acquired immune deficiency disorder (AIDS) that is approved for marketing by the FDA and that is recommended by the United States Public Health Service
- Counseling, screening, and immunizations to ensure healthy pregnancies
- Regular well-baby and well-child visits
- Well-woman visits

Preventive Care Services for women also include screening for gestational diabetes; sexually-transmitted infection counseling; human immunodeficiency virus (HIV) counseling; FDA-approved contraception methods for women and contraceptive counseling; breastfeeding support, supplies and counseling; and domestic violence screening and counseling.

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

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

TESTS

Diagnostic Imaging (Including X-Ray) and Laboratory Procedures

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

OUTPATIENT SURGERY AND SERVICES

Professional Surgical Services

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

HNL uses 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 available 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 available 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 billed by an Out-of-Network Provider are eligible for payment separately or as part of a bundled package, including but not limited to, which items are separate professional or technical components of services and procedures. HNL also uses proprietary guidelines to identify potential billing inaccuracies.

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

Outpatient Services

Covered Expenses include:

- Use of a Hospital emergency room or urgent care facility, supplies, ancillary services, laboratory and X-ray services, drugs and medicines administered by the Hospital emergency room or urgent care facility;
- Use of outpatient Hospital facility services. Examples are the use of Hospital centers in which ambulatory patients receive the following services: surgery, rehabilitation therapy (including physical, occupational and speech therapy), pulmonary rehabilitation therapy and cardiac rehabilitation therapy, laboratory tests, X-rays, radiation therapy; and chemotherapy
- 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 Requirements" section of this *Policy* 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 the Covered Person's health if the dental services are not performed and when use of the Hospital setting has been ordered by both a medical doctor and a dentist. Certification will be required.

Outpatient Surgical Center

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

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

Outpatient Infusion Therapy

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

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

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

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

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

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

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

- Non-Prescription Drugs or medications
- Any drug labeled "Caution, limited by Federal Law to Investigational use" or Investigational drugs not approved by the FDA
- Drugs or other substances obtained outside of the United States
- Homeopathic or other herbal medications not approved by the FDA

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

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

Radiation Therapy, Chemotherapy and Renal Dialysis Treatment

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

Please notify HNL upon initiation of renal dialysis treatment.

Organ, Tissue And Stem Cell Transplants

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

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

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

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

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

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

If a Covered Person receives services which are not Certified by HNL for an organ, tissue or stem cell transplant, he or she will incur the Non-Certification penalties described in the "Schedule of Benefits" section.

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

NEED IMMEDIATE ATTENTION

Emergency Care

HNL uses a prudent layperson standard to determine whether the criteria for Emergency Care have been met. HNL applies the prudent layperson standard to evaluate the necessity of medical services which a Covered Person accesses in connection with a condition that the Covered Person perceives to be an emergency situation.

Please refer to “Emergency Care” in the "Definitions" section to see how the prudent layperson standard applies to the definition of "Emergency Care."

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

Urgent Care

Through a Preferred Provider, urgent care is covered as long as services would have otherwise been covered under this *Policy*. Through an Out-of-Network Provider, urgent care is covered if (a) services are received while the Covered Person is temporarily outside the Service Area, and (b) the Covered Person reasonably believes that Covered Person or the Covered Person's unborn child’s health would seriously deteriorate if treatment was delayed until return. Urgent Care-related follow up care is not covered Out-of-Network.

Ambulance Services

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

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

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

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

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

HOSPITAL STAY

Covered Expenses include:

- Accommodations as an Inpatient in a room of two or more beds, at the Hospital's most common semi-private room rate with customary furnishings and equipment (including special diets as Medically Necessary);
- Services in Special Care Units;
- Private rooms, when Medically Necessary
- Physician services
- Specialized and critical care
- General nursing care
- Special duty nursing as Medically Necessary);
- Operating, delivery and special treatment rooms;
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services;
- Physical, speech, occupational and respiratory therapy;

- Radiation therapy, chemotherapy and renal dialysis treatment;
- Other diagnostic, therapeutic and rehabilitative services, as appropriate;
- Biologicals and radioactive materials;
- Anesthesia and oxygen services,
- Durable Medical Equipment and supplies;
- Medical social services
- Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Hospital for use during the Covered Person's stay;
- Blood transfusions, including blood processing, the cost of blood and unreplaced blood and Blood Products are covered. Self-donated (autologous) blood transfusions are covered only for a scheduled surgery that has been certified; and
- Coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

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

Bariatric (Weight Loss) Surgery

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

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

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

Covered travel-related expenses will be reimbursed as follows:

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

Radiation Therapy, Chemotherapy and Renal Dialysis Treatment

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

Please notify HNL upon initiation of renal dialysis treatment.

Organ, Tissue And Stem Cell Transplants

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

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

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

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

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

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

If a Covered Person receives services which are not Certified by HNL for an organ, tissue or stem cell transplant, he or she will incur the Non-Certification penalties described in the "Schedule of Benefits" section.

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

MENTAL HEALTH, BEHAVIORAL HEALTH OR SUBSTANCE ABUSE NEEDS

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

Payment of benefits for Inpatient services will be reduced as described in the "Schedule of Benefits" section if Certification is not obtained for the services.

The following benefits are provided:

Serious Emotional Disturbances of a Child (SED) - The treatment and diagnosis of Serious Emotional Disturbances of a Child under the age of 18 is covered as shown in the "Schedule of Benefits" section under “Mental Health, Behavioral Health or Substance Abuse Needs.”

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

Covered services include treatment of:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder (including Autistic Disorder, Rett’s Disorder, Child otherwise specified to include Atypical Autism, in accordance with the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders)
- Autism
- Anorexia nervosa
- Bulimia nervosa

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

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

Covered services include:

- Outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy, individual and group mental health evaluation and treatment, psychological testing when necessary to evaluate a Mental Disorder and outpatient services for the purpose of monitoring drug therapy.
- Chemical Dependency: individual Chemical Dependency evaluation and treatment, group Chemical Dependency treatment, day-treatment programs, intensive outpatient programs, individual and group Chemical Dependency counseling, transitional recovery services, medical treatment for withdrawal symptoms, methadone treatment during pregnancy and two months after delivery and any rehabilitative care that is related to Chemical Dependency.
- Medication management care, when appropriate.
- Intensive outpatient care program which 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 which is a treatment program that may be free-standing or Hospital-based and provides services at least four (4) hours per day and at least four (4) days per week.
- Intensive psychiatric treatment programs, including short-term Hospital-based intensive outpatient care (partial hospitalization), short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program, short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis, and psychiatric observation for an acute psychiatric crisis

- Behavioral Health Treatment for Pervasive Developmental Disorder or Autism: Outpatient professional services for behavioral health treatment are covered as shown in the "Schedule of Benefits" section under "Mental Health, Behavioral Health or Substance Abuse Needs."
    - Behavioral health treatment includes outpatient professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of a Covered Person diagnosed with the Severe Mental Illnesses of pervasive developmental disorder or autism.
    - 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. The treatment must be administered by the Qualified Autism Service Provider or by qualified autism service professionals and paraprofessionals who are supervised and employed by the treating Qualified Autism Service Provider.
    - A licensed Physician or licensed psychologist must establish the diagnosis of pervasive development disorder or autism. In addition, the Qualified Autism Service Provider must submit the initial treatment plan to HNL.
    - Prior Certification is not required for these outpatient services, however, prior notification is required. Notification must include documentation that a licensed physician or licensed psychologist has established the diagnosis of pervasive developmental disorder or autism. In addition, the Qualified Autism Service Provider must submit the initial treatment plan to HNL.
    - The treatment plan must have measurable goals over a specific timeline, and must be reviewed by the Qualified Autism Service Provider at least once every six months and modified whenever appropriate. The treatment plan must not be used for purposes of providing or for the reimbursement of respite, day care or educational services, or to reimburse a parent for participating in a treatment program.
    - The Qualified Autism Service Provider must submit updated treatment plans to HNL for continued behavioral health treatment beyond the initial six months and at ongoing intervals of no more than six-months thereafter. The updated treatment plan must include documented evidence that progress is being made toward the goals set forth in the initial treatment plan.
    - HNL may deny coverage for continued treatment if the requirements above are not met or if ongoing efficacy of the treatment is not demonstrated.

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

Covered services and supplies include:

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

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

PREGNANCY

*The coverage described below 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).

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.

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.

When a Covered Person gives birth to a child in a Hospital, the Covered Person is entitled to benefits for 48 hours of Inpatient care following a vaginal delivery or 96 hours following a cesarean section delivery. Longer stays in the Hospital and cesarean sections must be certified.

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

See "Chemical Dependency" under the "Mental Health, Behavioral Health or Substance Abuse Needs" portion of the "Schedule of Benefits" and the "Methadone Treatment" provision in the "General Exclusions and Limitations" section for information regarding coverage of methadone maintenance during pregnancy.

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

Additionally, this *Policy* covers terminations of pregnancy (Medically Necessary or elective).

Breastfeeding support, supplies and counseling, as supported by the Health Resources and Services Administration (HRSA) guidelines, are covered as preventive care.

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

HELP RECOVERING OR OTHER SPECIAL HEALTH NEEDS

Home Health Care Agency Services

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

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

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

- The skilled nursing care is appropriate for the medical treatment of a condition, illness, disease or injury;
- The Covered Person is homebound 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 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. 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 determined to be Medically Necessary. See the “Definitions” section. In addition, care that an unlicensed family member or layperson could provide safely and effectively or care in the home if the home is not a safe and effective treatment setting is excluded.

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

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

Payment of benefits for Home Health Care Agency Services will be reduced as set forth herein if Certification is not obtained for the services.

Rehabilitative Services

Rehabilitative services, including physical therapy, acupressure, occupational therapy, speech therapy, cardiac therapy and inhalation therapy, are covered, when Medically Necessary, in accordance with the "Schedule of Benefits," except as stated in the "General Exclusions and Limitations" section.

Habilitative Services

Coverage for habilitative services and/or therapy is limited to Medically Necessary services that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical, when provided by a Preferred Provider, licensed physical, speech or occupational therapist or other contracted provider, acting within the scope of his or her license, to treat physical and mental health conditions, subject to any required authorization from HNL. The services must be based on a treatment plan authorized, as required by HNL.

Examples of health care services that are not habilitative include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training.

Cardiac Rehabilitation Therapy

Cardiac rehabilitation therapy provided in connection with the treatment of heart disease is covered, when Medically Necessary, in accordance with the "Schedule of Benefits" section, except as stated in the "General Exclusions and Limitations" section.

Pulmonary Rehabilitation Therapy

Pulmonary Rehabilitation Therapy provided in connection with the treatment of chronic respiratory impairment is covered, when Medically Necessary, in accordance with the "Schedule of Benefits " section, except as stated in the "General Exclusions and Limitations" section.

Skilled Nursing Facility

The Covered Person must be referred to the Skilled Nursing Facility by a Physician and must remain under the active supervision of a Physician. The Covered Person’s condition must be such that skilled care is Medically Necessary; Covered Expenses include:

- Physician and nursing services.
- Accommodations in a room of two or more beds. Payment will be made based on the Skilled Nursing Facility's prevailing charge for two-bed room accommodations. If Medically Necessary, private rooms will be covered.
- Special treatment rooms.
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services.
- Physical, occupational, respiratory and speech therapy.

- Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Skilled Nursing Facility for use during the Covered Person's stay.
- Durable Medical Equipment if the Skilled Nursing Facility ordinarily furnishes the equipment.
- Medical social services.
- 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.

Benefits for Skilled Nursing Facility services are limited to a maximum number of days per Calendar Year as set forth in the "Schedule of Benefits" section.

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

Custodial care is not covered.

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 in infusion therapy, corrective shoes or shoe inserts, will be payable only as stated in the "Outpatient Infusion Therapy" provision of this section.

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

- Tracheostomy equipment: artificial larynx; replacement battery for artificial larynx; tracheo-esophageal voice prosthesis; tracheostomy supplies, including: adhesive disc, filter, inner cannula, tube, tube plug/stop, tube collar/holder, cleaning brush, mask, speaking valve, gauze, sterile water, waterproof tape, and tracheostomy care kits.
- Dry pressure pad for a mattress
- Cervical traction equipment (over door)
- Osteogenesis stimulation devices: non-invasive electrical osteogenesis stimulators, for spinal and non-spinal applications; non-invasive low density ultrasound osteogenesis stimulator.
- Respiratory drug delivery devices: large and small volume nebulizers; disposable and non-disposable administration sets; aerosol compressors; aerosol mask; disposable and non-disposable corrugated tubing for nebulizers; disposable and non-disposable filters for aerosol compressors; peak expiratory flow rate meter; distilled water for nebulizer; water collection device for nebulizer.
- IV Pole
- Phototherapy (bilirubin) light with photometer
- Lymphedema garments
- Pneumatic compressor

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

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

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

Covered Durable Medical Equipment will be repaired or replaced when necessary. However, repair or replacement for loss or misuse is not covered. HNL will decide whether to replace or repair an item.

HNL applies nationally recognized Durable Medical Equipment coverage guidelines as defined by the Medicare Durable Medical Equipment Regional Administrative Contracts (DME MAC), Healthcare Common Procedure Coding System (HCPCS) Level II and Medicare National Coverage Determinations (NCD) in assessing Medical Necessity for coverage. Some Durable Medical Equipment may have quantity limits or may not be covered as they are considered primarily for non-medical use.

Certification Payment of benefits for rental or purchase of Durable Medical Equipment will be reduced as set forth herein if Certification is required but not obtained.

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

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

Diabetic Equipment

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

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

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

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

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

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

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.
- Visual aids (excluding eyewear) to assist the visually impair with proper dosing of insulin.

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

- Affixed to the body externally, and
- Required to replace all or any part of any body organ or extremity, or

In the event that more than one type of prostheses 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), adhesive skin supports for external prostheses and brassieres to hold a breast prosthesis;
- Intraocular lenses, cochlear implants and osseointegrated hearing devices;
- Prostheses to replace all or part of an external facial body part that has been removed or impaired by disease, injury or congenital defect; Medically Necessary compression burn garments and lymphedema wraps;
- Prostheses for restoring a method of speaking following a laryngectomy; and
- Ostomy and urological supplies, including the following:
    - Adhesives -liquid, brush, tube, disc or pad
    - Adhesive removers
    - Belts - ostomy
    - Belts – hernia
    - Catheters
    - Catheter Insertion Trays
    - Cleaners
    - Drainage Bags/Bottles -bedside and leg
    - Dressing Supplies
    - Irrigation Supplies
    - Lubricants
    - Miscellaneous Supplies -urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; soma caps tape; colostomy plugs; ostomy inserts; irrigation syringes, bulbs and pistons; tubing; catheter clamps, leg straps and anchoring devices; penile or urethral clamps and compression devices
    - Pouches -urinary. drainable, ostomy
    - Rings - ostomy rings
    - Skin barriers
    - Tape -all sizes, waterproof and non-waterproof

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

DENTAL APPLIANCES ARE NOT A COVERED EXPENSE.

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

Hospice Care

Hospice Care is care that is reasonable and necessary to control or manage terminal illness or related conditions. Hospice Care benefits are designed to be provided primarily in the Covered Person's home. The Hospice entity must be licensed in accordance with California Hospice Licensure Act of 1990 or a licensed home health agency with federal I certification and must provide interdisciplinary team care with development and maintenance of an appropriate plan of care.

Covered Persons to receive Hospice Care benefits 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;
- Bereavement services;

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

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

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

Family Planning

Sterilization of females and women's contraception methods and counseling, as supported by the HRSA guidelines, are covered as Preventive Care Services.

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" section of this *Policy*.

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

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

Implanted Lens(es) Which Replace the Organic Eye Lens

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

Reconstructive Surgery

Reconstructive surgery to restore and achieve symmetry including surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or create normal appearance to the extent possible, unless the surgery offers only a minimal improvement in the appearance of the Covered Person. 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 Exclusions and Limitations" section.

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

mastectomy, including lymphedema. See also "Prostheses" in this "Medical Benefits" section for a description of coverage for prostheses.

Phenylketonuria (PKU)

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

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

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

Other specialized formulas and nutritional supplements are not covered.

Pediatric Asthma

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

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.

AIDS Vaccine

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

Osteoporosis

HNL shall provide coverage for services related to diagnosis, treatment, and appropriate management of osteoporosis including, but not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate.

Degenerative Illness

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

Dental Injury

Emergency Care of a Physician, while You are covered under this *Policy,* treating an accidental injury to the natural teeth. The Covered Person must be covered under this *Policy* 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.

Clinical Trials

- Routine patient care costs for items and services furnished in connection with participation in an approved clinical trial are covered when Medically Necessary, recommended by the Covered Person's treating Physician and authorized by HNL. The Physician must determine that participation has a meaningful potential to benefit the Covered Person and the trial has therapeutic intent. Clinical trial services performed by Out-of-Network Providers are covered only when the protocol for the trial is not available through Preferred Providers. Services rendered as part of a clinical trial are subject to the reimbursement guidelines as specified in the law.

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

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

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

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

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

Routine patient care costs include the following:

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

Routine patient care costs do not include:

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

Please refer to the "General Exclusions and Limitations" section for more information.

CHILD NEEDS DENTAL OR EYE CARE

Accessing Pediatric Dental Services

We provide toll-free access to our Customer Service Associates to assist you with benefit coverage questions, resolving problems or changing your dental office. Customer Service can be reached Monday through Friday at **(866) 249-2382** from 5:00 a.m. to 8:00 p.m. Pacific Standard Time. Automated service is also provided after hours for eligibility verification and dental office transfers.

Network and Non-Network Benefits

Network Benefits - these Benefits apply when you choose to obtain Covered Dental Services from a Network Dental Provider. You generally are required to pay less to the provider than you would pay for services from a

non-Network provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid as Network Benefits, you must obtain all Covered Dental Services directly from or through a Network Dental Provider.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call *Customer Service* to determine which providers participate in the Network. The telephone number for *Customer Service* is on your ID card.

Non-Network Benefits - these Benefits apply when you decide to obtain Covered Dental Services from non-Network Dental Providers. You generally are required to pay more to the provider than for Network Benefits. Non-Network Benefits are determined based on our contracted fee(s) for Covered Dental Services with a Network Dental Provider in the same geographic area for each Covered Dental Service. The actual charge made by a non-Network Dental Provider for a Covered Dental Service may exceed the contracted fee(s). As a result, you may be required to pay a non-Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee(s). In addition, when you obtain Covered Dental Services from non-Network Dental Providers, you must file a claim with us to be reimbursed for Eligible Dental Expenses.

Covered Dental Services

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a Covered Dental Service under this *Policy*.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the *Policy*. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Pre-Authorization

Pre-authorization is required for Medically Necessary orthodontia services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a Benefit based on the less costly procedure.

Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in this subsection when such services are:

A. Necessary.

B. Provided by or under the direction of a Dental Provider.

C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a Benefit based on the least costly procedure. If a less-costly dental procedure should have been performed instead of what was actually rendered by the dentist, we would pay up to the allowance of the least costly procedure. For example, if a crown was submitted for a Pre-Treatment estimate or performed and billed on the claim, but an amalgam would have been the appropriate course of treatment, then we would pay up to the allowance for the amalgam. We understand that the Healthy Families plan is the benchmark plan and said services are Essential Health Benefits, however, there may be instances where a less costly procedure would be the appropriate course of treatment.

D. Not excluded as described in "*Pediatric Dental Exclusions"* of this subsection below.

Benefits for Covered Dental Services are subject to satisfaction of the Dental Services Deductible.

Network Benefits:

Benefits for Eligible Dental Expenses are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network provider may charge you. However, these charges will not be considered Covered Dental Services and Benefits will not be payable.

Non-Network Benefits:

Benefits for Eligible Dental Expenses from non-Network providers are determined as a percentage of our contracted fee(s) for Covered Dental Services with a Network Dental Provider in the same geographic area. You must pay the amount by which the non-Network provider's billed charge exceeds the Eligible Dental Expense.

Dental Services Deductible

Benefits for pediatric Dental Services are subject to a separate Dental Services Deductible. For Network Benefits, the Dental Services Deductible per Calendar Year is $60 per Covered Person and $120 per family (two or more Covered Persons). For Non-Network Benefits, the Dental Services Deductible per Calendar Year is $60 per Covered Person and $120 per family. For any combination of Network and Non-Network Benefits, the Dental Services Deductible per Calendar Year is $60 per Covered Person and $120 per family.

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

Benefits

Dental Services Deductibles are calculated on a Calendar Year basis.

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Calendar Year basis unless otherwise specifically stated.

Benefit Description

Procedure Description	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic and Preventive Benefits		
Initial and periodic oral evaluation	$0	$0
Consultations, including specialist consultations	$0	$0
Topical fluoride treatment	$0	$0
Preventive dental education and oral hygiene instruction	$0	$0
Roentgenology (x-rays)	$0	$0
Prophylaxis services (cleanings)	$0	$0
Dental sealant treatments	$0	$0
Space maintainers, including removable acrylic and fixed band type, recementation of space maintainer[s],the removal of fixed space maintain-ers[s]	$0	$0
Restorative Benefits		
Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries	50%	50%
Micro filled resin restorations which are non-cosmetic	50%	50%
Replacement of restoration	50%	50%
Use of pins and pin build-up in conjunction with a restoration	50%	50%
Sedative base and sedative filings	50%	50%
Oral Surgery		
Extractions, including surgical extractions	50%	50%
Removal of impacted teeth	50%	50%
Biopsy of oral tissues	50%	50%
Alveolectomies	50%	50%
Excision of cysts and neoplasms	50%	50%
Treatment of palatal torus	50%	50%
Treatment of mandibular torus	50%	50%
Frenectomy	50%	50%
Incision and drainage of abscesses	50%	50%
Post-operative services, including exams, suture removal and treatment of complications	50%	50%
Root recovery (separate procedure)	50%	50%

Endodontics		
Direct pulp capping	50%	50%
Pulpotomy	50%	50%
Apexification filling with calcium hydroxide	50%	50%
Root amputation	50%	50%
Root canal therapy, including culture canal limited retreatment of previous root canal therapy as specified below	50%	50%
Apicoectomy	50%	50%
Vitality tests	50%	50%
Periodontics		
Emergency treatment, including treatment for periodental abscess and acute periodontitis	50%	50%
Periodontal scaling and root planing, and subgin-gival curettage	50%	50%
Gingivectomy	50%	50%
Osseous or muco-gingival surgery	50%	50%
Crown and Fixed Bridge		
Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown and stainless steel	50%	50%
Related dowel pins and pin build-up	50%	50%
Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold	50%	50%
Recementation of crowns, bridges, inlays and onlays	50%	50%
Cast post and core, including cast retention under crowns	50%	50%
Repair or replacement of crowns, abutments or pontics	50%	50%
Removable Prosthetics		
Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers	50%	50%
Office or laboratory relines or rebases	50%	50%
Denture repair	50%	50%
Denture adjustment	50%	50%
Tissue conditioning	50%	50%
Denture duplication	50%	50%
Space maintainer	50%	50%
Stayplate	50%	50%
Medically Necessary Orthodontics	50%	50%

Other benefits		
Local anesthetics	50%	50%
Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure	50%	50%
Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure	50%	50%
Emergency treatment, palliative treatment	50%	50%
Coordination of benefits with Covered Person's health plan in the event hospitalization or outpatient surgery setting in medically appropriate for dental services		

Limitations:

Diagnostic & Preventive Limitations:

·Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.

·Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months.

·Panoramic film x-rays are limited to once every 24 consecutive months.

·Prophylaxis services (cleanings) are limited to two in a 12-month period.

·Dental sealant treatments are limited to permanent first and second molars only.

Basic Restorative Limitations:

·For the treatment of caries, if the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations. Any other restoration such as a crown or jacket is considered optional.

·Composite resin or acrylic restorations in posterior teeth are optional. Amalgam is the Plan benefit. Plan will pay as amalgam.

·Replacement of a restoration is covered only when it is defective, as evidence by conditions such a recurrent caries or fracture, and replacement is dentally necessary.

Oral Surgery Limitation

·The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

Endodontics Limitations

·Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing systems.

·Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

Periodontics Limitation

·Periodontal scaling and root planing, and subgingival curettage are limited to five (5) quadrant treatments in any 12 consecutive months.

Crown Limitations

·Replacement of each unit is limited to once every 36 consecutive months, except when

the crown is no longer functional.

·Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an Optional Benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.

Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filing. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filing.

·Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

Denture Limitations

·Partial dentures will not be replaced within 36 months, unless 1) It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or 2) The denture is unsatisfactory and cannot be made satisfactory.

·The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.

·A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.

·Full upper and/or lower denture are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.

·The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. It a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.

·Office or laboratory relines or rebases are limited to one (1) per arch in any 12 consecutive months.

·Tissue conditioning is limited to two per denture.

·Implants are considered an Optional Benefit.

·Stayplates (interim partial dentures) are a benefit only when used as anterior space maintainers for children.

Bridge Work Limitations

·Fixed bridges will be used only when a partial cannot satisfactorily restore the case. ·A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person under the age of 16. If performed on a Member under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.

·Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.

·Fixed bridges are optional when provided in connection with a partial denture on the same arch.

·Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

·The benefit allows up to five units of crown or bridgework per arch. Upon the sixth unit,

the treatment is considered full mouth reconstruction, which is optional treatment.

Medically Necessary Orthodontic Limitations:

Orthodontic benefits are covered when Medically Necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.

All orthodontic treatment must be prior authorized.

Pediatric Dental Exclusions

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

IMPORTANT: If you opt to receive dental services that are not covered services under this Policy, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at (866) 249-2382 or your insurance broker. To fully understand your coverage, you may wish to carefully review this Policy.

1. Services which, in the opinion of the attending dentist, are not necessary to the Covered Person's dental health.
2. Procedures, appliances, or restoration to correct congenital or developmental malformations are not covered benefits unless specifically listed in the "Benefits" subsection above.
3. Cosmetic dental care.
4. General anesthesia or intravenous/conscious sedation unless specifically listed as a benefit or is a given by a dentist for covered oral surgery.
5. Experimental procedures or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or devices usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficiency have not been determined for use in the treatment for which the item in service in question is recommended or prescribed.
6. Services that were provided without cost to the Covered Person by State government or an agency thereof, or any municipality, county or other subdivisions.
7. Hospital charges of any kind.
8. Major surgery for fractures and dislocations.
9. Loss or theft of dentures or bridgework.
10. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Covered Person become eligible for such services.

11. Any service that is not specifically listed as a covered benefit.
12. Malignancies.
13. Dispensing of drugs not normally supplied in a dental office.
14. Additional treatment costs incurred because of dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the Covered Person.
15. The cost of precious metals used in any form of dental benefits.
16. The surgical removal of implants.
17. Services of a pedodontist/pediatric dentist, except when the Covered Person is unable to be treated by his or her panel provider, or treatment by a pedodontist/pediatric dentist is Medically Necessary, or his or her plan provider is a pedodontist/pediatric dentist.

Claims for Pediatric Dental Services

When obtaining Dental Services from a non-Network provider, you will be required to pay all billed charges directly to your Dental Provider. You may then seek reimbursement from us.

Providers who do not have an agreement with HNL may, or may not file your claim with HNL. If a Provider does not file a claim with HNL, send a copy of your paid itemized bill to HNL, along with a completed claim form which can be obtained by calling the Dental Customer Contact Center All claims, including the bill for services, must be submitted in English and in U.S. currency. Payment of the Eligible Expense amount for Covered Services or billed charges, whichever is less, will be paid to you, except as required by applicable state or federal law. You will be responsible for Copayments, Deductibles, coinsurance amounts, any non-covered or excluded charges, and amounts over specifically limited benefits. Even when a Provider does file a claim with HNL, HNL reserves the right, at HNL's sole discretion, to remit applicable payment to either You or the Provider. When payment for Covered Services is made to You, it is Your responsibility to pay the Provider.

Reimbursement for Dental Services

You are responsible for sending a request for reimbursement to our office, on a form provided by or satisfactory to us.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Covered Person's name and address.
- Covered Person's identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts or molds are required to pay claims for orthodontics or when requested by the health plan. .
- Itemized bill which includes the *CPT* or *ADA* codes or description of each charge.
- The date the dental disease began.
- A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, call us at the telephone number stated on your ID Card and a claim form will be sent to you. If you do not receive the claim form within 15 calendar days of your request, send in the proof of loss with the information stated above.

Written notice of a claim must be given to HNL within 90 days after the occurrence or commencement of any covered loss, or as soon thereafter as reasonably possible. Notice may be given to HNL of a dental claim at Health Net Dental Attn: Claims Unit P.O. Box 30567, Salt Lake City, UT 84130 0567.

Complaint Procedures

Complaint Resolution

If you have a concern or question regarding the provision of Dental Services or benefits under the *Policy*, you should contact the Company's customer service department at the telephone number shown on your ID card. Customer service representatives are available to take your call during regular business hours, Monday through Friday. At other times, you may leave a message on voicemail. A customer service representative will return your call. If you would rather send your concern to us in writing at this point, the Company's authorized representative can provide you with the appropriate address.

If the customer service representative cannot resolve the issue to your satisfaction over the phone, he or she can provide you with the appropriate address to submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

If you disagree with our decision after having submitted a written complaint, you can ask us in writing to formally reconsider your complaint. If your complaint relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card
- The date(s) of service(s)
- The provider's name
- The reason you believe the claim should be paid
- Any new information to support your request for claim payment

We will notify you of our decision regarding our reconsideration of your complaint within 60 days of receiving it. If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Complaint Hearing

If you request a hearing, we will appoint a committee to resolve or recommend the resolution of your complaint. If your complaint is related to clinical matters, the Company may consult with, or seek the participation of, medical and/or dental experts as part of the complaint resolution process.

The committee will advise you of the date and place of your complaint hearing. The hearing will be held within 60 days following receipt of your request by the Company, at which time the committee will review testimony, explanation or other information that it decides is necessary for a fair review of the complaint.

We will send you written notification of the committee's decision within 30 days of the conclusion of the hearing. If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Exceptions for Emergency Situations

Your complaint requires immediate actions when your Dentist judges that a delay in treatment would significantly increase the risk to your health. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Dentist should call us as soon as possible.

- We will notify you of the decision by the end of the next business day after your complaint is received, unless more information is needed.
- If we need more information from your Dentist to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The complaint process for urgent situations does not apply to prescheduled treatments or procedures that we do not consider urgent situations.

If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Pediatric Vision Services

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

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

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

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

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

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

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

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

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

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

Notice and Proof of Claim and Claim Forms
Written notice of a claim must be given to HNL within 90 days after the occurrence or commencement of any covered loss, or as soon thereafter as reasonably possible. Notice may be given to HNL of a vision claim at P.O. Box 8504, Mason, OH 45040-7111.

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

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

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

HNL may contract with a third party to negotiate discounts with Out-of-Network Providers. If HNL does, the discounted rate plus any administrative fees will be used to calculate your financial responsibility (usually Coinsurance). You may also be responsible for a portion of the fee related to the negotiation or administration of such a discount.

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

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

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

Payment of Claims
Benefits will be paid directly to the Covered Person, unless otherwise directed by the Covered Person, for Covered Services. HNL cannot require that services be rendered by a particular Provider.

GENERAL EXCLUSIONS AND LIMITATIONS

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

A. NOT MEDICALLY NECESSARY: Services or supplies that are not Medically Necessary, as defined in the "Definitions" section. This includes any services, supplies or expenses received or incurred beyond the scope of Certification given, as provided under the "Certification Requirements" section of this *Policy*, will be reduced. However, the *Policy* 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).

B. 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.

C. 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 *Policy* does cover Medically Necessary services and supplies for complications which exceed routine follow-up care that is directly related to cosmetic surgery (such as life-threatening complications). In addition, hair transplantation, hair analysis, hairpieces and wigs, cranial/hair prostheses, chemical face peels, abrasive procedures of the skin, liposuction, or epilation are not covered.

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

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

Then, reconstructive surgery is covered:

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

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

Breast reconstruction surgery and dental or orthodontic services for cleft palate procedures will be subject to the Certification requirements described in the "Certification Requirements" section. 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.

D. DENTAL SERVICES: Except as specifically stated elsewhere in this *Policy* dental services are limited to the services stated in "Dental Injury" under the "Medical Benefits" section of this *Policy* and in the following situations:

- General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the Covered Person requires that an ordinarily non-covered dental service which would normally be treated in a dentist's office and without general anesthesia must instead be treated in a Hospital or Outpatient Surgical Center. Such services, including general anesthesia and associated facility services, must be Medically Necessary and subject to the other limitations and exclusions of this *Policy* and will be covered for Covered Persons under any of the following circumstances (a) Covered Person s who are under seven years of age, (b) developmentally disabled or (c) whose health is compromised and general anesthesia is Medically Necessary.

- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck.

The following services are not covered under any circumstances for Covered Persons age 19 and over, except as described above for Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

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

E. TEMPOROMANDIBULAR (JAW) JOINT DISORDERS: Temporomandibular Joint Disorder (also known as TMD or TMJ disorder) is a condition of the jaw joint, tinnitus which commonly causes headaches, tenderness of the jaw muscles, or dull aching facial pain. These symptoms often result when chewing muscles and jaw joints do not work together correctly. Custom-made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct a TMD/TMJ disorder are covered when Medically Necessary and require Certification. However, spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints, dental implants and other dental appliances to treat dental conditions related to TMD/TMJ disorders are not covered for Covered Persons age 19 and over, as stated in the "Dental Services" provision of this section.

F. SURGERY AND RELATED SERVICES (OFTEN REFERRED TO AS "ORTHOGNATHIC SURGERY" OR "MAXILLARY AND MANDIBULAR OSTEOTOMY") for the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw or associated bone joints, except when such procedures are Medically Necessary. However, spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints (whether custom fit or not), dental implants and other dental appliances are not covered for Covered Persons age 19 and over under any circumstances.

G. 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 "Medical Benefits" section). However, amino acid-modified products and elemental dietary enteral formula are covered.

H. REFRACTIVE EYE SURGERY: For Covered Persons age 19 and over, any eye surgery for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism, unless Medically Necessary, recommended by the Covered Person's treating Physician and authorized by Us.

I. OPTOMETRICS AND ORTHOPTICS: For Covered Persons age 19 and over, optometric services, eye exercises including orthoptics, except as specifically stated elsewhere in this *Policy*. Contact or corrective lenses (except an implanted lens which replaces the organic eye lens), and eyeglasses unless specifically provided elsewhere in this *Policy*.

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

K. RECONSTRUCTION OF PRIOR SURGICAL STERILIZATION PROCEDURES: Services to reverse voluntary surgically induced infertility.

L. CONCEPTION BY MEDICAL PROCEDURE: Services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include, but are not limited to:

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

M. FERTILITY PRESERVATION: Fertility preservation treatments are covered. However, the following services and supplies are not covered:

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

N. PRENATAL GENETIC TESTING AND DIAGNOSTIC PROCEDURES: Prenatal genetic testing is covered for specific genetic disorders for which genetic counseling is available when Medically Necessary. The prescribing Physician must request prior authorization for coverage. Genetic testing will not be covered for non-medical reasons or when a Covered Person has no medical indication or family history of a genetic abnormality.

O. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES: Experimental or Investigational drugs, devices, procedures or other therapies are only covered when:

- Independent review deems them appropriate (please refer to the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "Specific Provisions" section for more information);
- Clinical trials for cancer patients are deemed appropriate according to the "Medical Benefits" section.

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

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

P. ROUTINE PHYSICAL EXAMINATIONS: Routine physical examinations taken to obtain or maintain employment or participate in employee programs; for insurance or licensing' or on a court order or as required by parole or probation.

Q. IMMUNIZATIONS OR INOCULATIONS: Except for Preventive Care Services, this plan does not cover immunizations and injections for foreign travel or occupational purposes.

R. SERVICES NOT RELATED TO COVERED ILLNESS OR INJURY: Except for Preventive Care Services and habilitative services, any services not related to the diagnosis or treatment of a covered illness or injury. However, treatment of complications arising from non-covered services, such as complications due to non-covered cosmetic surgery, are covered.

S. CUSTODIAL OR DOMICILIARY CARE OR REST CURES: This plan does not cover assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine). This exclusion does not apply to assistance with activities of daily living that is provided as part of covered Hospice, Skilled Nursing Facility, or inpatient Hospital care

T. NON-ELIGIBLE HOSPITAL CONFINEMENTS: Inpatient room and board charges in conjunction with a Hospital, Hospice or Skilled Nursing Facility stay not meeting Medical Necessity and/or primarily for environmental change, personal convenience or custodial in nature are not covered.

U. NON-ELIGIBLE INSTITUTIONS: Any services or supplies furnished by a non-eligible institution, which is other than a legally operated Hospital, Hospice or Medicare-approved Skilled Nursing Facility, or which is primarily a place for the aged, a nursing home or any similar institution, regardless of how designated.

V. PRIVATE ROOMS: Except where Medically Necessary, expenses in excess of a Hospital's (or other Inpatient facility's) most common semi-private room rate.

W. INFERTILITY: Services to diagnose, evaluate or treat infertility are not covered.

X. PRIVATE DUTY NURSING: Inpatient and outpatient services (including incremental nursing) provided by a private duty nurse, except as Medically Necessary. 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

Y. NONCOVERED ITEMS: Any expenses related to the following items, whether authorized by a Physician or not:

- Alteration of the Covered Person's residence, to accommodate the Covered Person’s physical or medical condition, including the installation of elevators.
- Disposable supplies for home use, however, ostomy and urological supplies, items for Home Health Care, Hospice Care items including incontinence supplies, and equipment for the management of diabetes are covered.
- Exercise equipment, including treadmills and charges for activities or facilities normally intended or used for physical fitness.
- Hygienic equipment, Jacuzzis and spas.
- Surgical dressings are limited to primary dressings, i.e., a therapeutic and protective covering applied directly to lesions either on the skin or opening to the skin required as a result of a surgical procedure performed by a Physician.
- For Covered Persons age 19 and over, 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 "Medical 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 *Policy*.
- Personal or comfort items.
- Air purifiers, air conditioners and humidifiers.
- Hearing aids except for implanted hearing aids.
- Educational services or nutritional counseling, except as specifically provided in the "Patient Education", “Mental Health, Behavioral Health or Substance Abuse Needs” or "Outpatient Infusion Therapy" provisions of the "Medical Benefits" section.

Z. TREATMENT OF OBESITY: Treatment or surgery for obesity, weight reduction or weight control, except as specifically stated in the "Medical Benefits" section and when provided for morbid obesity or as a Preventive Care Service.

AA. MEDICARE: All benefits provided under this *Policy* shall be reduced by any amounts to which a Covered Person is entitled under the program commonly referred to as Medicare when federal law permits Medicare to pay before an individual health plan.

BB. EXPENSES BEFORE COVERAGE BEGINS: Services received before the Covered Person's Effective Date.

CC. EXPENSES AFTER TERMINATION OF COVERAGE: Services received after midnight on the effective date of cancellation of coverage under this *Policy* ends, regardless of when the illness, disease, injury or course of treatment began.

DD. SERVICES FOR WHICH THE COVERED PERSON IS NOT LEGALLY OBLIGATED TO PAY: Services for which no charge is made to the Covered Person in the absence of insurance coverage, except services received at a charitable research Hospital which is not operated by a governmental agency.

EE. 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.

FF. 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 the Covered Person's home or who is related to the Covered Person by blood, marriage or domestic partnership. Covered Persons who receive routine or ongoing care from a Covered Person of their immediate family may be reassigned to another Physician.

GG. ROUTINE FOOT CARE: This *Policy* does not cover services for treatment of corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes.

HH. CRIME: Conditions caused by the Covered Person's 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.

II. NUCLEAR ENERGY: Conditions caused by release of nuclear energy, when government funds are available.

JJ. GOVERNMENTAL AGENCIES: Any services provided by or for which payment is made by, a local, state or federal government agency. This limitation does not apply to Medi-Cal, Medicaid or Medicare.

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

LL. CHIROPRACTIC SERVICES: Expenses related to chiropractic adjustments, manipulations and therapy.

MM. FOREIGN TRAVEL OR WORK ASSIGNMENT: If the Covered Person receives services or obtains supplies in a foreign country, benefits will be payable for Emergency 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.

NN. HOME BIRTH: A birth which takes place at home will be covered when the criteria for Emergency Care, as defined in this *Policy*, have been met.

OO. EDUCATIONAL AND EMPLOYMENT SERVICES: Except for Medically Necessary services related to behavioral health treatment are covered as shown in the "Medical 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” section.

PP. ELECTRO-CONVULSIVE THERAPY: Electro-Convulsive therapy is not covered except as Medically Necessary.

QQ. NONABSTINENCE-BASED TREATMENT: Methadone maintenance is only covered during pregnancy and two months after delivery; all other methadone maintenance for the purpose of long term opiate craving reduction is not covered. All other Chemical Dependency treatment not based on abstinence is not covered.

RR. NONCOVERED TREATMENTS: The following types of treatment are only covered when Medically Necessary or when provided in connection with covered treatment for a Mental Disorder or Chemical Dependency:

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

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

SS. NONSTANDARD THERAPIES: Services that do not meet national standards for professional medical or mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, sleep therapy, biofeedback (except for certain physical disorders, such as incontinence and chronic pain, and as otherwise preauthorized under this *Policy*), hypnotherapy and crystal healing therapy are not covered.

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

UU. RESIDENTIAL TREATMENT CENTER: Admissions that are not considered medically appropriate and are not covered include admissions for wilderness center training; for Custodial Care, for a situational or environmental change; or as an alternative to placement in a foster home or halfway house.

VV. 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.

WW. TREATMENT RELATED TO JUDICIAL OR ADMINISTRATIVE PROCEEDINGS: Medical, mental health care or Chemical Dependency services as a condition of parole or probation, and court-ordered treatment and testing are limited to Medically Necessary covered services.

XX. PEDIATRIC VISION SERVICES: The following items are excluded when obtained while receiving Pediatric Vision Services:

1. Orthoptic or vision training;
2. Medical and/or surgical treatment of the eye, eyes or supporting structures; however, this is covered under the medical benefit.;
3. Any eye or vision examination, or any corrective eyewear required as a condition of employment; safety eyewear
4. Services provided as a result of any Workers’ Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5. Plano (non-prescription) lenses and/or contact lenses;
6. Non-prescription sunglasses;
7. Two pair of glasses in lieu of bifocals;
8. Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered,
9. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

YY. PEDIATRIC DENTAL SERVICES: Refer to the “Pediatric Dental Services” portion of the "Medical Benefits" section of this *Policy* for the dental exclusions and limitiations.

CERTIFICATION REQUIREMENTS

Some of the Covered Expenses under this insurance plan are subject to a requirement of Certification, or treatment review, before services are received, in order for the noncertification penalty to not apply.

Certification and any further Certifications are performed by HNL or an authorized designee. The telephone number which the Covered Person can use to obtain Certification is listed on the Health Net PPO Identification Card issued by HNL.

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

A. SERVICES REQUIRING PRIOR CERTIFICATION

1. Inpatient admissions

   Any type of facility, including but not limited to:

   - Acute rehabilitation center
   - Chemical dependency facility
   - Hospice
   - Hospital
   - Mental health facility
   - Skilled Nursing Facility
2. Ambulance: non-emergency air or ground Ambulance services
3. Bariatric-related services: non-surgical bariatric-related consultations and services
4. Clinical trials
5. Custom orthotics
6. Durable Medical Equipment:
   - Bone growth stimulator
   - Continuous positive airway pressure (CPAP)
   - Custom-made items
   - Hospital beds
   - Power wheelchairs
   - Scooters
7. Experimental/Investigational services and new technologies.
8. Home Health Care Services including home uterine monitoring, Hospice, nursing, occupational therapy, physical therapy, speech therapy, and tocolytic services
9. Hospice Care
10. Intensity modulated radiation therapy (IMRT)
11. Medically Necessary orthodontic treatment (for Covered Persons under 19 years of age)
12. Neuro or spinal cord stimulator
13. Occupational and speech therapy.
14. Organ, tissue and stem cell transplant services including pre-evaluation and pre-treatment services, and the transplant procedure

15. Outpatient Diagnostic Imaging:
    - CT (Computerized Tomography)
    - MRA (Magnetic Resonance Imaging)
    - MRI (Magnetic Resonance Imaging)
    - PET (Positron Emission Tomography)
    - Nuclear cardiology procedures, including SPECT (Single Photon Emission Computed Tomography)
16. Outpatient pharmaceuticals
    - Self-injectables
    - Hemophilia factors and intravenous immunoglobulin (IVIG)
    - Certain Physician-administered drugs, whether administered in a Physician office, free-standing infusion center, ambulatory surgery center, outpatient dialysis center, or outpatient hospital. Refer to the Health Net Life website, www.healthnet.com, for a list of Physician-administered drugs that require Certification.
17. Outpatient physical, cardiac and pulmonary rehabilitation therapy and acupuncture (exceeding 12 visits).
18. Outpatient surgical procedures including:
    - Abdominal, ventral, umbilical, incisional hernia repair
    - Bariatric procedures
    - Blepharoplasty
    - Breast reductions and augmentations
    - Mastectomy for gynecomastia
    - Orthognathic procedures (includes TMJ treatment)
    - Rhinoplasty
    - Treatment of varicose veins
    - Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
    - 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.
19. Prosthesis over $2500 in billed charges
20. Stereotactic radiosurgery and stereotactic body radiotherapy (SBRT)
21. Tocolytic services (intravenous drugs used to decrease or stop uterine contractions in premature labor)

HNL will consider the Medical Necessity for the proposed treatment, the proposed level of care (Inpatient or Outpatient) and the duration of the proposed treatment, with the exception of reconstructive surgery incident to a mastectomy.

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

Additional services not indicated in the above list may require Certification. Please consult the "Schedule of Benefits" section of this *Policy* to see additional services that may require Certification.

Exceptions

HNL does not require Certification for maternity care. However, please notify HNL at the time of the first prenatal visit.

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, HNL should be notified within 24 hours fol-

lowing birth. Certification must be obtained for a scheduled cesarean section or if the Physician determines that a longer Hospital stay is Medically Necessary either prior to or following the birth.

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

Certification is not needed for renal dialysis. However, HNL should be notified if renal dialysis services are received within 24 hours of the service.

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

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

B. CERTIFICATION PROCEDURE

Certification must be requested, by You, within the following periods:

- Five (5) or more business days before the proposed admission date or the commencement of treatment, except when due to a medical emergency.
- In the event of being admitted into a Hospital or outpatient emergency room or urgent care center for non-Emergency Care; within forty-eight (48) hours or as soon as reasonably possible.
- Before admission to a Skilled Nursing Facility or Hospice Care program or before Home Health Care Services are scheduled to begin.

In order to obtain Certification, the Covered Person or the Covered Person’s Physician is responsible for contacting HNL as shown on the Health Net PPO Identification Card before receiving any service requiring Certification. If the Covered Person receives any such service and does not follow the procedures set forth in this "Certification Requirements" section, the Noncertification Penalties stated in the "Schedule of Benefits" will be applied.

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

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

C. 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" section of this *Policy*.

If Certification is not obtained, but the Covered Person receives the services anyway, the Noncertification Penalties shown in "Schedule of Benefits" will be applied. Failure to obtain Certification for an Essential Health Benefit, as defined under California Insurance Code section 10112.27, will not result in denial of coverage for that benefit.

D. RESOLUTION OF DISPUTES

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

- Either the Covered Person or the Covered Person’s Physician must contact HNL to request reconsideration of the decision. Additional information may be requested, or the treating Physician may be consulted in any reconsideration. A written reconsideration decision will be provided.
- If You still remain dissatisfied with the reconsideration decision following review by HNL, the Covered Person 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 "Specific Provisions" section of this *Policy*.

SPECIFIC PROVISIONS

Customer Contact Center Interpreter Services

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

Covered Persons' Rights and Responsibilities Statement

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

Covered Persons have the right to:

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

Covered Persons have the responsibility to:

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

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 *Policy,* including an adverse benefit determina-

tion 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:

- 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 pre-existing condition exclusion or a source-of-injury exclusion; or
- Determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

If You are not satisfied with efforts to solve a problem with HNL or a medical provider, the Covered Person may 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:

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

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

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

Independent Medical Review of Grievances Involving a Disputed Health Care Service

The Covered Person may request an independent medical review ("IMR") of disputed health care services from the Department of Insurance ("Department") if he or she believes that health care services eligible for coverage and payment under his or her 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 the Covered Person's HNL plan that has been denied, modified, or delayed by HNL, 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. The Covered Person pays no application or processing fees of any kind for IMR. The Covered Person has the right to provide information in support of the request for IMR. HNL will provide the Covered Person 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 the Covered Person to forfeit any statutory right to pursue legal action against HNL regarding the Disputed Health Care Service.

Eligibility

The Covered Person's 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:

1.(A) The Covered Person's provider has recommended a health care service as Medically Necessary, or

(B) The Covered Person has received urgent or Emergency Care that a provider determined to have been Medically Necessary

(C) In the absence of the provider recommendation described in 1.(A) above, or the receipt of urgent or Emergency Care described in 1.(B) above, the Covered Person has been seen by a Physician for the diagnosis or treatment of the medical condition for which he or she seeks IMR;

2. 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
3. The Covered Person has 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, the Covered Person may apply to the Department for IMR, or later, if the Department agrees to extend the application deadline. If the Covered Person's grievance requires expedited review he or she may bring it immediately to the Department's attention. The Department may waive the requirement that the Covered Person follow HNL's grievance process in extraordinary and compelling cases.

If the Covered Person's 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. The Covered Person will receive a copy of the assessment made in his or her 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 *Policy*. If the case is not eligible for IMR, the Department will advise the Covered Person of his or her 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 the Covered Person's 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 the Covered Person's health, the IMR organization must provide its determination within three business days.

For more information regarding the IMR process, or to request an application form, please call HNL's 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 the Covered Person meets the eligibility criteria set out below, the Covered Person may request an independent medical review ("IMR") of HNL's decision from the Department of Insurance.

Eligibility

- The Covered Person must have a life-threatening or seriously debilitating condition.
- The Covered Person's Physician must certify to HNL that he or she has a life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving the Covered Person's condition or are otherwise medically inappropriate, and there is no more beneficial therapy covered by HNL.
- The Covered Person's Physician must certify that the proposed Experimental or Investigational therapy is likely to be more beneficial than available standard therapies or as an alternative, the Covered Person 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.
- The Covered Person has been denied coverage by HNL for the recommended or requested therapy.
- If not for HNL's determination that the recommended or requested treatment is Experimental or Investigational, it would be covered.

If HNL denies coverage of the recommended or requested therapy and the Covered Person meets the eligibility requirements, HNL will notify the Covered Person within five business days of its decision and his or her opportunity to request an external review of HNL's decision through IMR. HNL will provide the Covered Person 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. The Covered Person pays no application or processing fees of any kind for IMR. The Covered Person has the right to provide information in support of his or her request for IMR. If the Covered Person's 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 the Covered Person to forfeit any statutory right to pursue legal action against HNL regarding the denial of the recommended or requested therapy. For more information, please call the Customer Contact Center at the telephone number on Your HNL ID Card.

A. ARBITRATION

As a condition to becoming a HNL Policyholder, You agree to submit all disputes You may have with HNL to final and binding arbitration. Likewise, HNL agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both You and HNL are bound to use binding arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by HNL's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

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

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

If the parties fail to reach an agreement during this time frame, then, in accordance with California Insurance Code 10123.19(a), 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.

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

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this *Policy*, 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 Litigation Administrator at the address provided above.

B. RECOVERY OF BENEFITS PAID BY HNL WHEN THE COVERED PERSON IS INJURED:

If the Covered Person is ever injured through the actions of another person or him or herself (responsible party), HNL will provide benefits for all Covered Services and Supplies the Covered Person receives through this *Policy*. However, if the Covered Person receives money or is entitled to receive money because of the Covered Person's injuries, whether through a settlement, judgment or any other payment associated with the Covered Person's injuries, HNL or the medical providers retain the right to recover the value of any services provided to the Covered Person under this *Policy*.

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 the Covered Person could be injured through the actions of a responsible party are:

- The Covered Person was in a car accident; or
- The Covered Person slips and falls in a store.

HNL's rights of recovery apply to any and all recoveries made by the Covered Person or on the Covered Person's 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, the Covered Person acknowledges that HNL has a right of reimbursement that attaches when this Plan has paid for health care benefits for expenses incurred due to the actions of a responsible party and the Covered Person or his or her 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, the Covered Person also grants HNL an assignment of his or her right to recover medical expenses from any medical payment coverage available to the extent of the full cost of all covered services provided by the Plan and the Covered Person specifically directs such medical payments carriers to directly reimburse the plan on his or her behalf.

Steps the Covered Person Must Take

If the Covered Person is injured because of a responsible party, he or she 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 the Covered Person knows 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 his or her 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 the Covered Person or his or her lawyer receiving any money from the responsible parties, any insurance companies, or any other source;
- Pay the health care lien from any recovery, settlement or judgment, or other source of compensation and all reimbursement due HNL for the full cost of benefits paid under the Plan that are associated with injuries through a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether the Covered Person is made whole or fully compensated for his or her loss;
- Do nothing to prejudice HNL's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery the full cost of all benefits paid by the plan; and;
- Hold any money that the Covered Person or his or her lawyer receives 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 he or she is paid.

How the Amount of the Covered Person 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 the purposes of determining the lien amount, the value of the services depends on how the provider was paid, as summarized below, and will be calculated in accordance with California Civil Code Section 3040, or as otherwise permitted by law. The amount of the reimbursement owed to HNL or the medical provider will be reduced by the percentage that the recovery is reduced if a judge, jury or arbitrator determines that 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 on 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.

  * *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 Policy and applicable law.*

C. RECOVERY OF BENEFITS PAID BY HNL UNDER A SURROGATE PARENTING AGREEMENT

This *Policy* covers services for a surrogate pregnancy only when the surrogate is an HNL Covered Person. When compensation is obtained for the surrogacy, We shall have a lien on such compensation to recover its medical expense.

HNL will provide benefits for all covered services that You receive through this *Policy*. However, if You receive money or are entitled to receive money for the surrogacy, HNL or the medical providers retains the right to recover the value of any services provided to You through this *Policy*. HNL's rights of recovery apply to any and all compensation received by You as part of the surrogate parenting agreement up to the full cost of benefits paid under the *Policy* that are associated with the surrogate pregnancy.

By accepting benefits under this *Policy*, You acknowledge that HNL has a right of reimbursement that attaches when We have paid for health care benefits associated with a surrogate pregnancy.

Under California law, HNL's legal right to reimbursement creates a health care lien on any recovery. You must cooperate with HNL's and the medical providers' efforts to obtain reimbursement, including:

- Informing HNL of any surrogacy compensation agreement and providing a copy when requested by HNL;
- 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;

- Notifying the lienholders immediately upon You or Your lawyer receiving the compensation; and
- Pay the health care lien from any recovery, settlement or judgment, or other source of compensation and all reimbursement due HNL You receive for the surrogate pregnancy up to the full cost of benefits paid under the *Policy* that are associated with the surrogate pregnancy.

Your reimbursement to HNL or the medical provider under this lien is based on the value of the services You receive 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 and will be calculated in accordance with California Civil Code, Section 3040, or as otherwise permitted by law.

D. OUT-OF-CALIFORNIA PROVIDERS

Health Net PPO has created a program which allows Covered Persons access to Participating Providers outside California. This program is through the out-of-California provider network shown on Your HNL ID Card and is limited to Covered Persons traveling outside California.

If a Covered Person traveling outside California, requires medical care or treatment and uses a provider from the out-of-California provider network, the Covered Person's out-of-pocket expenses may be lower than those incurred when the Covered Person uses an Out-of-Network Provider.

When a Covered Person obtains services outside California though the out-of-California provider network, the Covered Person will be subject to the same Copayments, Coinsurance, Deductibles, maximums and limitations as the Covered Person would be if the Covered Person obtained services from a Preferred Provider in California. 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 California 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 the Covered Persons Covered Expenses.

E. TERMINATION OF MEMBERSHIP FOR CAUSE:

HNL may terminate a Policyholder and/or any enrolled Dependent's coverage under this *Policy*:

- If any Premium as specified in the Notice of Acceptance is not paid before the end of the Grace Period, this *Policy* will terminate effective on midnight of the last day of the 30 day Grace Period The Policyholder is liable for all Premiums due for the period coverage is in force.

- If the Policyholder ceases to be eligible according to the eligibility provisions of this *Policy*, coverage will be terminated for the Policyholder and any enrolled Dependents effective on midnight of the last day of the month in which loss of eligibility occurred.

- If a Dependent ceases to be eligible according to the eligibility provisions of this *Policy*, coverage will be terminated only for that person effective on midnight of the last day of the month in which loss of eligibility occurred.

- On midnight of the last day of the month in which entry of the final decree of dissolution of marriage, annulment or termination of domestic partnership occurs, a spouse or Domestic Partner shall cease to be an eligible Dependent. Children of the spouse or Domestic Partner who are not also the natural or legally adopted children of the Policyholder shall cease to be eligible Dependents at the same time.

- If a Policyholder makes a fraudulent or intentional misrepresentation of material facts on the application within 24 months following issuance of the *Policy*, HNL may cancel coverage upon 30 days written notice.

F. 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.

Policyholder Responsibility

The Policyholder must:

- File accurate claims. If someone else, such as the Policyholder's spouse, Domestic Partner or another Dependent, 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.

G. 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 THE COVERED PERSON UPON REQUEST.

H. SECOND MEDICAL OPINION

When requested by a Covered Person or participating health professional who is treating a Covered Person, We will authorize a second opinion by an appropriately qualified health care professional. Reasons for a second opinion include, but are not limited to, the following:

- If the Covered Person questions the reasonableness or necessity of recommended surgical procedures.
- If the Covered Person questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious Chronic condition.
- If clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and the Covered Person requests an additional diagnosis.
- If the treatment plan in progress is not improving the medical condition of the Covered Person within an appropriate period of time given the diagnosis and plan of care, and Covered Person requests a second opinion regarding the diagnosis or continuance of the treatment.
- If the Covered Person has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

As used above, an appropriately qualified health care professional is a Physician or a Specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, injury, condition or conditions associated with the request for a second opinion.

If the Covered Person or participating health professional who is treating the Covered Person requests a second opinion, an authorization or denial shall be provided in an expeditious manner. When the Covered Person's condition is such that he or she faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb or other major bodily function, or lack of timeliness that would be detrimental to the Covered Person's life or health or could jeopardize the insured's ability to regain maximum

function, then the second opinion shall be rendered in a timely fashion appropriate to the nature of the Covered Person's condition, not to exceed 72 hours after HNL's receipt of the request, whenever possible.

To request an authorization for a second opinion, contact the Customer Contact Center at the telephone number on the HNL ID card. We will review the request in accordance with HNL's procedures and timelines as stated in the second opinion policy. For more information on the second opinion policy, please contact the Customer Contact Center.

If We deny a request by a Covered Person for a second opinion, We will notify the Covered Person in writing of the reasons for the denial and will inform the Covered Person of the right to dispute the denial, and the procedures for exercising that right.

GENERAL PROVISIONS

A. FORM OR CONTENT OF *POLICY*: No agent or employee of HNL is authorized to change the form or content of this *Policy*. Any changes can be made only through an endorsement authorized and signed by an officer of HNL.

B. ENTIRE CONTRACT: This *Policy*, the Policyholder's application for this *Policy* and any riders and endorsements to the *Policy* shall constitute the entire contract between the Company and the Policyholder. No change in this *Policy* shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this *Policy* or to waive any of its provisions

All statements made by the Policyholder or any of the insured persons will be considered except for fraud, to be representations and not warranties. No statement made by an insured person will be used to void his or her insurance or in defense of a claim unless it is in writing and a copy has been given to the insured person or his or her beneficiary.

C. GRACE PERIOD: A Grace Period of 30 days will be granted for the payment of each Premium falling due after the first Premium, during which Grace Period the policy shall continue in force (subject to the right of the insurer to cancel in accordance with the cancellation provision hereof).

D. CHARTER NOT PART OF *POLICY*: None of the terms or provisions of the charter, constitution or bylaws of HNL shall form a part of this *Policy* or be used in the defense of any suit hereunder, unless the same is set forth in full in this *Policy*.

E. DISTRIBUTION OF NOTICES: HNL will send required notices as specified in this Policy to the Policyholder's address on record.

F. NOTICE OF RIGHT OF EXAMINATION: If the Policyholder is not satisfied with his or her coverage under this *Policy,* he or she may return it within 10 days of receipt. The *Policy* must be mailed or delivered to HNL. If the *Policy* is returned to HNL within 10 days of receipt, HNL will refund any Premium paid and the *Policy* will be considered canceled.

G. BENEFITS NOT TRANSFERABLE: No person other than the Covered Person is entitled to receive benefits to be furnished by HNL under this *Policy*. Such right to benefits is not transferable. ***Fraudulent use of such benefits will result in cancellation of the Covered Person's eligibility under this Policy and appropriate legal action.***

H. BENEFIT CHANGES: HNL will provide the Policyholder at least 60 days' notice in advance of any changes in benefit or *Policy* provisions. There is no vested right to receive the benefits of this *Policy*.

I. TIME LIMIT ON CERTAIN DEFENSES: After two years from the date of issue of this *Policy*, no misstatements, except fraudulent misstatements, made by the applicant in the application for the *Policy* shall be used to void the *Policy* or to deny a claim for loss incurred or disability commencing after the expiration of the two-year period.

No claim for loss incurred or disability commencing after two years from the date of issue of this *Policy* shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this *Policy*.

J. **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.

K. 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 21281 Burbank Blvd., Woodland Hills, CA 91367. Notice should include information sufficient for Us to identify the Covered Person.

L. 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 *Policy* for filing such proofs of loss. Such written proof must cover the occurrence, the character and the extent of the loss. We will not pay legal fees or interest due on claims that the Covered Person fails to submit in a timely manner.

M. PROOFS OF LOSS: Written proof of loss must be furnished to Us at 21281 Burbank Blvd., Woodland Hills, CA 91367, in case of claim for loss for which this *Policy* provides any periodic payment contingent upon continuing loss, within 90 days after the end of the period of time for which claim is made; in the case of claim for any other loss, written proof of loss must be furnished within 90 days after the date of the loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if proof is furnished as soon as reasonably possible. Except in the absence of legal capacity, however, We are not required to accept proofs more than one year from the time proof is otherwise required**.**

N. EXPENSES FOR COPYING MEDICAL RECORDS: We will reimburse the Covered Person or provider for reasonable expenses incurred in copying medical records requested by Us.

O. TIME OF PAYMENT OF CLAIM: We will pay benefits promptly upon receipt of due written proof of loss. HNL will reimburse each complete claim, or portion thereof, whether in-state or out-of-state, as soon as practical, but no later than 30 working days after receipt of the complete claim by HML. HNL may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the complete claim by HNL.

Indemnities payable under this *Policy* for any loss other than loss for which this *Policy* provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this *Policy* provides periodic payment will be paid and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

P. 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 *Policy* 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 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 *Policy* 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.

Q. 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 should be notified in writing of the denial within 30 days from the date the claim was submitted. The Covered Person will be given the specific reasons and sections of the *Policy* 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.

   In some cases, more than 90 days will be needed to make a decision on the claim. The Covered Person will be notified in writing if more time is needed, but in no case will a decision take longer than 180 days from the date the fully completed claim is submitted. Although HNL is required to give the Covered Person this written notice if his or her claim is denied, if notice is not received within 30 days of the date of the claim, the Covered Person can assume the claim has been denied and he or she can begin the appeal process explained below.

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 *Policy* 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 and that HNL has authorized for release.

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 in which to make a decision, unless special circumstance requires an extension of time for processing. The Covered Person will be notified if an extension of time beyond 60 days is necessary. A decision will be made as soon as possible, but no later than 120 days after receipt of a request for review.

   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 *Policy* provisions on which the decision is based. This written notice shall be final and binding.

R. PAYMENT TO PROVIDERS OR POLICYHOLDER:

1. **DIRECT PAYMENT:** Benefit payment for Covered Expenses will be made directly to:

   a. **Contracting Hospitals:** Hospitals which have provider service agreements with HNL to provide services to Covered Persons.

   b. **Providers of Ambulance Transportation and Certified Nurse Midwives:** As required by the California Insurance Code, this must occur, even if written assignment has not been made by the Covered Person. But, if the submitted provider's statement or bill indicates that the charges have been paid in full by the Policyholder, payment will be made to the Policyholder.

   c. **Other Providers of Service** not mentioned in a. and b. above, Hospital and professional, when the Covered Person assigns benefits to them in writing.

2. **JOINT PAYMENT:** Benefit payment for Covered Expenses will be made jointly to other providers and the Policyholder:

   a. When a written assignment stipulates joint payment.

   b. When the benefit payment is $2,000 or greater and the submitted bill indicates that there is a balance due.

   c. Joint payment will not be made to contracting Hospitals and providers of Ambulance services. Payment to them will be direct as described in 1.a. and 1.b. above.

3. **DIRECT PAYMENT TO POLICYHOLDER:** In situations not described above, payment will be made to the Policyholder.

S. PAYMENT WHEN POLICYHOLDER IS UNABLE TO ACCEPT: If a claim is unpaid at the time of the Covered Person's death or if the Covered Person is not legally capable of accepting it, it will be paid to the Covered Person's estate or any relative or person who may legally accept on the Covered Person behalf.

T. PHYSICAL EXAMINATION: 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.

U. 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 *Policy* or to any change of beneficiary or beneficiaries, or to any other changes in this *Policy*.

V. DEPENDENT COVERAGE OUTSIDE SERVICE AREA: Dependents living outside the Service Area and away from the primary residence of the Policyholder can still obtain Preferred Provider coverage within the United States, as described in the "Out-of-California Providers" provision in the "Specific Provisions" section. Outside the United States, coverage is limited to Emergency Care, as described below under "Foreign Travel or Work Assignment" in this "General Provisions" section.

W. FOREIGN TRAVEL OR WORK ASSIGNMENT: Benefits will be provided for Emergency Care received in a foreign country. Determination of Covered Expenses will be based on the amount that is no greater than the Maximum Allowable Amount in the USA for the same or a comparable service. The Maximum Allowable Amount is defined in the Definitions section.

X. NOTICE OF CANCELLATION: If this *Policy* terminates for any reason, HNL will send the notice of cancellation to the Policyholder.

Y. MODIFICATIONS TO PLAN AND NOTICE OBLIGATIONS: If the plan is modified in accordance with the terms and provisions of this *Policy*, HNL will send notice of such modification to the Policyholder.

Z. WORKERS' COMPENSATION INSURANCE: This *Policy* is not in lieu of and does not affect any requirement for, or coverage by, Workers' Compensation Insurance.

AA. DIETHYLSTILBESTROL: Coverage under this *Policy* will not be reduced, limited or excluded solely due to conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol.

BB. NOTICE: Any notice required of HNL shall be sufficient if mailed to the Policyholder, at the address appearing on the records of HNL; and, if notice is required of the Policyholder, it will be sufficient if mailed to the HNL office at the address listed on the back cover of this *Policy*.

CC. REGULATION AND INTERPRETATION OF *POLICY*: This *Policy* is issued with and is governed by the state of California. The laws of the state of California shall be applied to interpretations of this *Policy*.

DD. NONDISCRIMINATION: HNL hereby agrees that no person who is otherwise eligible for coverage under this *Policy* shall be refused enrollment nor shall his or her coverage be canceled solely because of race, color, national origin, ancestry, religion, sex, gender identity, gender expression, marital status, sexual orientation, age, health status, or physical or mental handicap.

EE. 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**.**

FF. 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 Participating and Preferred Providers

GG. 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 the Covered Person's right to select any properly licensed Hospital, Physician (including Specialists and behavioral health care providers) or other health care professional or facility that provides services or supplies covered by this plan. However, the Covered Person's 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.

HH. PROVIDING OF CARE: HNL is not responsible for providing any type for Hospital, medical or similar care. HNL is also not responsible for the quality of any type of Hospital, medical or similar care.

If the Covered Person would like more information on how to request continued care please contact The Customer Contact Center at the telephone number on Your HNL ID Card.

II. CONTINUITY OF CARE: At the request of the Covered Person, HNL shall arrange for the completion of covered services by a terminated provider if the Covered Person is undergoing a course of treatment for any of the following conditions: (1) An acute condition (a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration); (2) A serious chronic condition (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, not to exceed 12 months from the contract termination date.); (3) A pregnancy; (4) A terminal illness (Comple-

tion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date); (5) 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.); (6) Performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date.

JJ. 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 the Covered Person while receiving care from any health care provider. No 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 *Policy*. If HNL does designate or replace any administrator, HNL will inform the Covered Persons of all new procedures. Any administrator designated by HNL is an independent contractor and not an employee or agent of HNL.

KK. 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 “Specific Provisions” section for additional details.

LL. PRIVACY STATEMENT: HNL wants You to understand how We protect Your privacy when We collect and use information about Covered Persons, and the measures that We take to safeguard that information. These provisions apply to both current and former Covered Person, unless We state otherwise.

- **Information Security**

  The only individuals who are authorized to have access to nonpublic personal information about Covered Persons ("Covered Person Information") are those individuals who need it to perform their job responsibilities or to provide products or services to Covered Persons. For example, We may access Covered Person Information to offer other compatible products or services We provide, to process requests We receive from a Covered Person and to administer Our products or services. Our employees are required to maintain the confidentiality of Covered Person Information and to follow the policies and procedures We establish to secure such information. In addition, We maintain physical, electronic and procedural security measures to safeguard Covered Person Information.

- **Information We Collect**

  As part of providing Covered Persons with Our services and products, We obtain and collect Covered Person Information about a Covered Person, including:

- Information We receive from the Covered Person on applications or other forms (such as the Covered Person's name, address, telephone number, social security number, account information, employment, health status and other personal information relevant to the Covered Person's coverage); and

- Information about the Covered Person's transactions with Us, Our affiliates or others (such as information about Premium payment history, Copayments, claims payments, Coinsurance and Deductibles).

Although We collect such information primarily from applications and forms, We may also collect information through other means, such as telephone conversations, web sites and through third parties, such as employers, Physicians, Hospitals and other medical providers. We may also collect such information from Internet "cookies" which may be used to track web site usage, remember passwords and provide the Covered Person with web site content specific to the Covered Person's needs and interests.**

- **Disclosures**

  We do not disclose any Covered Person Information about a Covered Person or Our former Covered Persons to anyone, except as permitted by law. We may disclose all of the information We collect, as described above in the "Information We Collect" section. For example, Covered Person Information will or may be disclosed for purposes such as to provide services to Covered Persons; to coordinate with reinsurance and excess or stop loss insurers; to enforce a Covered Person's rights; to protect against actual or potential fraud; to resolve Covered Person inquiries or disputes; to carry out Our business; to protect the confidentiality or security of Our records; to administer preventive health and case management programs; to perform underwriting, auditing and ratemaking functions; to enable Our service providers to perform marketing on Our behalf to inform Covered Persons about Our own products or services; to allow Our health insurance affiliate to provide Covered Persons with information about Medicare supplement products; and to comply with federal or state laws and other applicable legal requirements.

- **Additional Information about this Privacy Statement**
  The policies indicated in this privacy statement will remain effective, even if the Covered Person's coverage is terminated, to the extent We retain Covered Person Information about the Covered Person. We may change this privacy statement at any time and will inform the Covered Person of any changes as required by law or regulation.

  **Information We collect through Our Internet web site is subject to Our Web privacy statement, which is available on Our web site at www.healthnet.com.

MM. NOTICE OF PRIVACY PRACTICES: THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION **AND NONPUBLIC PERSONAL FINANCIAL INFORMATION*** ABOUT THE COVERED PERSON MAY BE USED AND DISCLOSED**. THIS NOTICE ALSO DESCRIBES** HOW THE COVERED PERSON CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells the Covered Person about the ways in which HNL (referred to as "We" or "the Plan") may collect, use and disclose You're a Covered Person's protected health information and the Covered Person rights concerning the Covered Person's protected health information. "Protected health information" is information about the Covered Person, including demographic information, that can reasonably be used to identify the Covered Person and that relates to the Covered Person's past, present or future physical or mental health or condition, the provision of health care to the Covered Person or the payment for that care.

We are required by federal and state laws to provide the Covered Person with this Notice about the Covered Person's rights and Our legal duties and privacy practices with respect to the Covered Person protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

- **How We May Use And Disclose Your Protected Health Information**

  We may use and disclose the Covered Person's protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures We may make without the Covered Person's authorization for payment, health care operations and treatment.

  1. **Payment**. We use and disclose the Covered Person's protected health information in order to pay for the Covered Person's covered health expenses. For example, We may use the Covered Person's protected health information to process claims or be reimbursed by another insurer that may be responsible for payment or for Premium billing.
  2. **Health Care Operations**. We use and disclose the Covered Person's protected health information in order to perform Our plan activities, such as quality assessment activities or administrative activities, including data management or customer service.
  3. **Treatment**. We may use and disclose he Covered Person's protected health information to assist the Covered Person's health care providers (doctors, pharmacies, Hospitals and others) in he Covered Person's diagnosis and treatment. For example, We may disclose the Covered Person's protected health information to providers to provide information about alternative treatments.

- **Other Permitted Or Required Disclosures**

  1. **As Required by Law**. We must disclose protected health information about the Covered Person when required to do so by law.
  2. **Public Health Activities.** We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
  3. **Victims of Abuse, Neglect or Domestic Violence.** We may disclose protected health information to government agencies about abuse, neglect or domestic violence.
  4. **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g., California Department of Health Services) for activities authorized by law.
  5. **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about the Covered Person in certain cases in response to a subpoena, discovery request or other lawful process.
  6. **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
  7. **Coroners, Funeral Directors, Organ Donation.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
  8. **Research.** Under certain circumstances, We may disclose protected health information about the Covered Person for research purposes, provided certain measures have been taken to protect the Covered Person's privacy.
  9. **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about the Covered Person, with some limitations, when necessary to prevent a serious threat to the Covered Person's health and safety or the health and safety of the public or another person.
  10. **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
  11. **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

- **Other Uses Or Disclosures With An Authorization**

  Other uses or disclosures of the Covered Person's protected health information will be made only with the Covered Person's written authorization, unless otherwise permitted or required by law. The Covered Person may revoke an authorization at any time in writing, except to the extent that We have already taken

action on the information disclosed or if We are permitted by law to use the information to contest a claim or coverage under the Plan.

- **A Covered Person's Rights Regarding Your Protected Health Information**

  The Covered Person have certain rights regarding protected health information that the Plan maintains about the Covered Person.

  1. **Right To Access A Covered Person's Protected Health Information.** the Covered Person have the right to review or obtain copies of the Covered Person's protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of the Covered Person's protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing the Covered Person's requested information, but We will tell the Covered Person the cost in advance.

  2. **Right To Amend A Covered Person's Protected Health Information.** If the Covered Person feel that protected health information maintained by the Plan is incorrect or incomplete, the Covered Person may request that We amend the information. Your request must be made in writing and must include the reason the Covered Person are seeking a change. We may deny the Covered Person's request if, for example, the Covered Person ask Us to amend information that was not created by the Plan, as is often the case for health information in Our records, or the Covered Person ask to amend a record that is already accurate and complete.

     If We deny the Covered Person's request to amend, We will notify the Covered Person in writing. the Covered Person then have the right to submit to Us a written statement of disagreement with Our decision and We have the right to rebut that statement.

  3. **Right to an Accounting of Disclosures by the Plan.** The Covered Person have the right to request an accounting of disclosures We have made of the Covered Person's protected health information. The list will not include Our disclosures related to the Covered Person's treatment, Our payment or health care operations, or disclosures made to the Covered Person or with the Covered Person's authorization. The list may also exclude certain other disclosures, such as for national security purposes.

     Your request for an accounting of disclosures must be made in writing and must state a time period for which the Covered Person want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form the Covered Person want the list (for example, on paper or electronically). The first accounting that the Covered Person request within a 12-month period will be free. For additional lists within the same time period, We may charge for providing the accounting, but We will tell the Covered Person the cost in advance.

  4. **Right To Request Restrictions on the Use and Disclosure of A Covered Person's Protected Health Information.** The Covered Person have the right to request that We restrict or limit how We use or disclose the Covered Person's protected health information for treatment, payment or health care operations. ***We may not agree to a Covered Person request.*** If We do agree, We will comply with the Covered Person's request unless the information is needed for an emergency. The Covered Person's request for a restriction must be made in writing. In the Covered Person's request, the Covered Person's must tell Us (1) what information the Covered Person want to limit; (2) whether the Covered Person want to limit how We use or disclose the Covered Person's information, or both; and (3) to whom the Covered Person want the restrictions to apply.

  5. **Right To Receive Confidential Communications.** The Covered Person has the right to request that We use a certain method to communicate with the Covered Person about the Plan or that We send Plan information to a certain location if the communication could endanger the Covered Person. The Covered Person's request to receive confidential communications must be made in writing. The Covered Person's request must clearly state that all or part of the communication from Us could endanger the Covered Person. We will accommodate all reasonable requests. The Covered Person's request must specify how or where the Covered Person wish to be contacted.

6. **Right to a Paper Copy of This Notice.** The Covered Person have a right at any time to request a paper copy of this Notice, even if the Covered Person had previously agreed to receive an electronic copy.

7. **Contact Information for Exercising The Covered Person's Rights.** The Covered Person's may exercise any of the rights described above by contacting Our privacy office. See the end of this Notice for the contact information.

- **Health Information Security**

  HNL requires its employees to follow the HNL security policies and procedures that limit access to health information about Covered Persons to those employees who need it to perform their job responsibilities. In addition, HNL maintains physical, administrative and technical security measures to safeguard the Covered Person's protected health information.

- **Changes To This Notice**

  We reserve the right to change the terms of this Notice at any time, effective for protected health information that We already have about the Covered Person as well as any information that We receive in the future. We will provide the Covered Person with a copy of the new Notice whenever We make a material change to the privacy practices described in this Notice. We also post a copy of Our current Notice on Our website at www.healthnet.com. Any time We make a material change to this Notice, We will promptly revise and issue the new Notice with the new effective date.

- **Complaints**

  If the Covered Person believe that Your privacy rights have been violated, the Covered Person may file a complaint with Us and/or with the Secretary of the Department of Health and Human Services. All complaints to the Plan must be made in writing and sent to the privacy office listed at the end of this Notice.

  We support the Covered Person's right to protect the privacy of the Covered Person's protected health information. ***We will not retaliate against the Covered Person or penalize the Covered Person for filing a complaint.***

- **Contact The Plan**

  If the Covered Person has any complaints or questions about this Notice or the Covered Person wants to submit a written request to the Plan as required in any of the previous sections of this Notice, the Covered Person may send it in writing to:

  Address: HNL Privacy Office
  Attention: Director, Information Privacy
  P.O. Box 9103
  Van Nuys, CA 91409

  the Covered Person may also contact Us at:

  Telephone: **1-800-676-6941**
  Fax: **1-818-676-8314**
  Email: Privacy@healthnet.com

* *Nonpublic personal financial information includes personally identifiable financial information that You provided to us to obtain health plan coverage or we obtained in providing benefits to You. Examples include Social Security numbers, account balances and payment history. We do not disclose any nonpublic personal information about You to anyone, except as permitted by law.*

DRUGS TO TREAT ILLNESS OR CONDITION - OUTPATIENT PRESCRIPTION DRUG BENEFITS

The preceding sections of this *Policy* provide for coverage for Prescription Drugs obtained while an Inpatient in a Hospital. The provisions which follow are in addition to, and do not replace, any other provision under this *Policy* which may apply to Prescription Drugs. **Subject to the following provisions, all Medically Necessary Prescription Drugs are covered.**

A. DEFINITIONS

The following definitions apply to the coverage provided under this "Outpatient Prescription Drug Benefits" section. Other "Definitions" appearing within this *Policy* also apply to the coverage provided under this "Outpatient Prescription Drug Benefits" section.

1. **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.
2. **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.
3. **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.
4. **COMPOUNDED DRUGS** are prescription orders that have at least one ingredient that is Federal Legend in a therapeutic amount and are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form and require a prescription order for dispensing.
5. **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 database 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.
6. **HEALTH NET ESSENTIAL RX DRUG LIST (also known as Essential Rx Drug List)** is list of the Prescription Drugs that are covered under this *Policy*. The Covered Person may call the Customer Contact Center at the telephone number on his or her Health Net PPO ID card to find out if a particular drug is listed in the Essential Rx Drug List. The Covered Person may also request a copy of the current Essential Rx Drug List, and it will be mailed by HNL. The current Essential Rx Drug List is also available on the internet at www.healthnet.com. It is prepared by HNL and given to all Preferred Providers and Participating Pharmacies. It may be revised periodically. Some drugs in the Essential Rx Drug List may require Prior Authorization in order to be covered.
7. **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.
8. **PARTICIPATING PHARMACY** is a facility authorized by HNL to dispense Prescription Drugs to persons eligible for benefits under the terms of this *Policy*. A list of Participating Pharmacies and a detailed explanation of how the program operates has been provided or will be provided by HNL.
9. **PRESCRIPTION DRUG** is a drug or medicine which, according to federal law, can be obtained only by a Prescription Drug Order and is required to bear a label which says, "Caution, Federal Law Prohibits Dispensing Without a Prescription," or is restricted to prescription dispensing by state law. Insulin is also included.
10. **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.
11. **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 Nonpartic-

ipating 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.

12. **PRESCRIPTION DRUG ORDER** is a written or oral 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.
13. **PRIOR AUTHORIZATION** is HNL's approval process for certain Prescription Drugs that require preapproval. Physicians must obtain HNL's Prior Authorization before certain drugs will be covered.
14. **NONPARTICIPATING PHARMACY** is a facility not authorized by HNL to be a Participating Pharmacy.
15. **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). Specialty Drugs can be found in the Health Net Essential Rx Drug List. Some Specialty Drugs require Prior Authorization from HNL and must be dispensed through the Specialty Pharmacy Vendor when indicated on the Essential Rx Drug List to be covered.
16. **SPECIALTY PHARMACY VENDOR** is a pharmacy contracted with HNL specifically to provide injectable medications.
17. **TIER I DRUGS** are Generic Drugs listed in the Health Net Essential Rx Drug List that are not Specialty Drugs and are not excluded or limited from coverage.
18. **TIER II DRUGS** are preferred Brand Name Drugs listed in the Health Net Essential Rx Drug List and are not excluded or limited from coverage.
19. **TIER III DRUGS** are Prescription Drugs that are not listed in the Health Net Essential Rx Drug List, nonpreferred Brand Name Drugs, Brand Name Drugs with a generic equivalent (when Medically Necessary), or drugs listed as Tier III Drugs in the Essential Rx Drug List which are not excluded or limited from coverage. Some Tier III Drugs require Prior Authorization from HNL in order to be covered.

    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.

B. BENEFITS

Each Covered Person must satisfy the Calendar Year Deductible for Brand Name Drugs before benefits for Prescription Drugs become payable by HNL. Refer to the "Schedule of Benefits" section for details.

Outpatient Prescription Drug Benefits shall be provided if a Covered Person, while covered under this *Policy*, incurs an expense for Prescription Drugs which were prescribed by any Physician who is either a Preferred Provider or Out-of-Network Provider. HNL will pay the Prescription Drug Covered Expense (less any applicable Deductible, Copayment or Coinsurance) up to the benefit maximums as stated in the "Schedule of Benefits" section.

When the Covered Person meets the Out-of-Pocket Maximum in a Calendar Year, no further Prescription Drug Copayment or Coinsurance will be required from that Covered Person for the remainder of the year. Refer to the "Schedule of Benefits" section under "Outpatient Prescription Drug Benefits," for more details.

Health Net Essential Rx Drug List (also known as Essential Rx Drug List)

HNL developed the Essential Rx Drug List to identify the safest and most effective medications for HNL Covered Persons while attempting to maintain affordable pharmacy benefits. We specifically suggest to all Preferred Providers that they refer to this Essential Rx Drug List when choosing drugs for patients who are HNL Covered Persons. When Your Physician prescribes medications listed in the Essential Rx Drug List, it is en-

sured that You are receiving a high quality and high value prescription medication. In addition, the Essential Rx Drug List identifies whether a Generic version of a Brand Name Drug exists, and whether the drug requires Prior Authorization.

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

Diabetic Drugs and Supplies on the Essential Rx Drug List

Prescription Drugs for the treatment of diabetes (including insulin) are covered as stated in the Essential Rx Drug List. Diabetic supplies are also covered, including, but not limited to, specific brands of pen delivery systems, specific brands of disposable insulin needles and syringes, disposable insulin pen needles, specific brands of blood glucose monitors and test strips (specific brand only), Ketone test strips, lancet puncture devices and lancets used in monitoring blood glucose levels. Refer to the "Schedule of Benefits" section for details about the supply amounts that are covered at the applicable Copayment, after satisfying the Calendar Year Deductible.

Preventive Drugs and Women's Contraceptives

Preventive drugs and women's contraceptives are covered as shown in the "Schedule of Benefits" section of this Policy. 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 Essential Rx Drug List.

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

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

For the purpose of coverage provided under this provision, "emergency contraceptives" means FDA-approved drugs taken after intercourse to prevent pregnancy.

Specialty Drugs

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

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

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

Certain specified *Specialty Drugs or drugs with limited distribution* must be obtained through a contracted specialty pharmacy. These specified Specialty Drugs that must be obtained through the specialty pharmacy program are limited up to a 30-day supply. The specialty pharmacy program will deliver Your medication to

You by mail or common carrier. These drugs are subject to the applicable Copayments or Coinsurances listed under "Drugs to Treat Illness or Condition – 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.

Smoking Cessation Coverage

Drugs that require a prescription in order to be dispensed for the relief of nicotine withdrawal symptoms are covered for the course of therapy stated in the "Exclusions" portion of this section. The Covered Person must be concurrently enrolled in a comprehensive smoking cessation behavioral modification support program. The prescribing Physician must request Prior Authorization for coverage.

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

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

Prescription Drugs listed in the Health Net Essential Rx Drug List are covered, when dispensed by Participating Pharmacies and prescribed by a Physician, an authorized referral specialist or an emergent or urgent care Physician. Some Prescription Drugs require Prior Authorization from HNL to be covered.

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

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

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.

Off-Label Drugs

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

1. The drug is approved by the Food and Drug Administration; AND
2. The drug meets one of the following conditions:
    A. The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition; OR
    B. The drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is Medically Necessary to treat such condition and the drug is either on the Essential Rx Drug List or Prior Authorization by HNL has been obtained; AND
3. The drug is recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following:
    A. The American Hospital Formulary Service Drug Information; OR
    B. One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer therapeutic regimen:
        i. The Elsevier Gold Standard’s Clinical Pharmacology.
        ii. The National Comprehensive Cancer Network Drug and Biologics Compendium.
        iii. The Thomson Micromedex DrugDex; OR

C. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

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

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

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

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

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

C. PRIOR AUTHORIZATION PROCESS:

Prior Authorization status is included in the Essential Rx Drug List. The Essential Rx Drug List identifies which drugs require Prior Authorization. A Physician must get approval from HNL before writing a Prescription Drug Order for a drug that is listed as requiring Prior Authorization, in order for the drug to be covered by HNL. You may refer to our website at www.healthnet.com to review the drugs that require a Prior Authorization as noted in the Essential Rx Drug List. If a drug is not on the Essential Rx Drug List, Your Physician should call HNL to determine if the drug requires Prior Authorization.

Requests for Prior Authorization may be submitted electronically or by telephone or facsimile. Urgent requests from Physicians (including pain medications for terminally ill Covered Persons) for authorization are processed as soon as possible, not to exceed 2 business days or 72 hours, whichever is less, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. Routine requests from Physicians are processed in a timely fashion, not to exceed 2 business days, as appropriate and Medically Necessary, for the nature of the Covered Person's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination.

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

Once a medication is approved, its authorization becomes effective immediately.

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

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

D. WHO IS ON THE HEALTH NET PHARMACY AND THERAPEUTICS COMMITTEE AND HOW ARE DECISIONS MADE?

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

E. 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 the HNL ID Cardhttp:///. The Covered Person, upon presentation of a valid Health Net PPO Identification Card which indicates coverage for Prescription Drugs, shall be entitled to have a Prescription Drug Order filled by a Participating Pharmacy for up to a 30 consecutive calendar day supply per prescription, subject to the following:

(If the Health Net PPO Identification Card has not been received or if it has been lost, refer to the subsection titled "When the Health Net PPO Identification Card is Not in the Covered Person's Possession" below.)

a. **IF A GENERIC DRUG IS DISPENSED** by a Participating Pharmacy, after satisfying the Calendar Year Deductible, the Covered Person must pay the Participating Pharmacy the Copayment specified in the "Schedule of Benefits" for each Generic Drug dispensed.

b. **IF A BRAND NAME DRUG IS DISPENSED** by a Participating Pharmacy and there is an equivalent Generic Drug available, after satisfying the Calendar Year Deductible, the Covered Person must pay the pharmacy the Deductible and Tier III Drug Copayment specified in the "Schedule of Benefits."

   A Covered Person may avoid paying this additional amount by requesting that the Tier I Generic Drug be substituted.

F. SPECIALTY DRUGS DISPENSED BY THE SPECIALTY PHARMACY VENDOR

Specialty Drugs must be obtained through the 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.

G. PRESCRIPTION DRUGS DISPENSED BY A NONPARTICIPATING PHARMACY

There are **no benefits** for Prescription Drugs which are dispensed by Nonparticipating Pharmacies. The only exception are those Prescription Drugs used in conjunction with Emergency Care.

H. PRESCRIPTION DRUGS DISPENSED THROUGH THE MAIL SERVICE PRESCRIPTION DRUG PROGRAM

If the Covered Person's prescription is for a Maintenance Drug, the Covered Person shall be entitled to have a Prescription Drug Order filled through a mail delivery program selected by HNL. Through this program a Covered Person can receive, through the mail, up to a 90-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. After satisfying the Calendar Year Deductible, the applicable mail order Copayments or the mail order pharmacy's retail charge, whichever is less, will be required.

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

When a Brand Name Drug is dispensed, but there is an equivalent Generic Drug available, the Covered Person will be billed the difference between the cost and the cost of the Brand Name Drug as well as the Deductible and any Copayment specified in the "Schedule of Benefits."

A Covered Person may avoid paying this additional amount by requesting that the Generic Drug be substituted.

Note:

Schedule II narcotic drugs and Specialty Drugs are not covered through the mail order program. Refer to the "Exclusions" section below for more information.

Specialty Drugs are only covered when dispensed through the Specialty Pharmacy Vendor, as described above, and are not covered through any other mail-order prescription drug program.

I. WHEN THE HEALTH NET PPO IDENTIFICATION CARD IS NOT IN THE COVERED PERSON'S POSSESSION

If the Covered Person needs to have a Prescription Drug Order filled by a Participating Pharmacy and has not received a Health Net PPO Identification Card, or it has been lost, the Covered Person must pay the cost of the drug(s). The Covered Person may then be entitled to reimbursement minus the applicable Copayment. After the Health Net PPO Identification Card has been received, the Covered Person must file a claim. Claim forms will be provided by HNL upon request.

J. GENERAL PROVISIONS

The following "General Provisions" apply to the coverage provided under this section. Other General Provisions appearing within this *Policy* also apply.

- Expense must be incurred on or after the Covered Person's Effective Date of coverage under this *Policy* and prior to termination of such coverage. An expense will be considered to have been incurred on the date that the Prescription Drug is dispensed.
- The amount of Prescription Drugs (including insulin) which may be dispensed per Prescription Drug Order or refill at a pharmacy will be in quantities normally prescribed by a Physician up to and including a thirty (30) consecutive calendar day supply, provided that a 30-consecutive calendar day supply is within the FDA's guidelines for indicated usage. This 30-consecutive calendar day maximum is applicable to all forms of the Prescription Drug, including pills, vials, ampoules, tubes, manufacturer's packages or inhalers.
- Up to a 90 consecutive calendar day supply of Maintenance Drugs (see the "Definitions" subsection above) may be dispensed through the Mail Service Prescription Drug Program. Prescription Drugs that are not Maintenance Drugs will also be dispensed by the mail order program, but the quantity dispensed may be less than a 90 day quantity. For information, the Covered Person should call the mail order program at **1-888-858-2951**.
- Compounded Drugs are prescription orders that have at least one ingredient that is Federal Legend or state restricted in a therapeutic amount as Medically Necessary and are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form and require a prescription order for dispensing. Compounded Drugs (that use FDA approved drugs for an FDA approved indication) are covered if at least one of the ingredients is on the Essential Rx Drug List. Refer to the "Off-Label Drugs" provision in this section for information about FDA approved drugs for off-label use. Coverage for Compounded Drugs requires the Tier III Drug Copayment and is subject to Prior Authorization by HNL and Medical Necessity.
- Any Participating Pharmacy furnishing benefits to the Covered Person does so as an independent contractor and 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 the Covered Person.
- HNL shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with the manufacturing, compounding, dispensing or use of any Prescription Drug covered under this *Policy*.
- HNL retains the right to replace any third-party contracting agency through which Covered Persons may be required to obtain Prescription Drugs. If HNL should replace any such third-party contracting agency, the Policyholder would be notified of all new procedures. HNL also retains the right to modify the program with due notice to Covered Persons.

K. EXCLUSIONS:

In addition to any applicable "General Exclusions and Limitations" contained elsewhere in this *Policy*, the following "Exclusions" shall apply to the coverage described under this "Drugs to Treat Illness or Condition - Outpatient Prescription Drugs" section.

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

- Prescription Drugs which are covered by any other benefits provided by this *Policy*, 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.
- Drugs prescribed for a condition or treatment that is not covered by this *Policy*. However, the *Policy* does cover Medically Necessary drugs for a medical condition directly related to noncovered services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery).
- Services or supplies for which the Covered Person is not legally required to pay.
- Services or supplies for which no charge is made.
- 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, 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, even if a Physician writes a Prescription for such drug, equipment or supply unless specifically listed on the Essential Rx Drug List. These are commonly called over-the-counter drugs. Insulin is an exception to this rule. 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.

  If a drug that is previously available by prescription becomes available in an over-the-counter (OTC) form in the same prescription strength, this drug and similar agents that have comparable clinical effect(s), will only be covered when Medically Necessary and Prior Authorization is obtained from HNL.
- Drugs prescribed for cosmetic or enhancement purposes, including and not limited to those intended to treat wrinkles, baldness or conditions of hair loss, sexual performance, athletic performance, anti-aging and mental performance are not covered. Examples of these drugs that are excluded when prescribed for such conditions include, but are not limited to, Latisse, Renova, Vaniqua, Propecia or Lustra. This exclusion does not exclude coverage for drugs when pre-authorized as Medically Necessary to treat a diagnosed medical condition affecting memory, including but not limited to, Alzheimer’s dementia.
- Cosmetics and health or beauty aids.
- Weight-loss aids, however drugs for the treatment of morbid obesity are covered.
- Drugs used as dietary or nutritional supplements (including vitamins and nutritional supplements), even when prescribed in combination with a prescription drug product, unless listed in the Essential Rx Drug List. Phenylketonuria (PKU) is covered under the medical benefit (see the "Phenylketonuria" provision of the "Medical Benefits" section).
- Drugs when prescribed to shorten the duration of the common cold.
- Allergy desensitization products are not covered as Prescription Drugs, whether administered by injection or drops placed in the nose or mouth (transmucosal absorption), for the purpose of treating allergies by desensitization (to lessen or end the person's allergic reactions). (These products are sometimes described as "allergy serum.") Allergy serum is covered as a medical benefit. See the "Visits to a Health Care Provider's Office or Clinic" portion of the "Schedule of Benefits" section and the "Allergy Testing and Treatment" provision in the "Medical Benefits" section.

- Prescription Drugs or medicines delivered or administered to the patient by the attending Physician, or which are billed by a Hospital or Skilled Nursing Facility, or are covered under another section of this *Policy*.
- Drugs that require a prescription in order to be dispensed for the relief of nicotine withdrawal symptoms are covered if the Covered Person is concurrently enrolled in a comprehensive smoking cessation behavioral modification support program. The prescribing Physician must request Prior Authorization for coverage. 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.
- Hypodermic syringes and needles are limited to specific brands of insulin needles, syringes and specific brands of pen devices. Needles and syringes required to administer self-injected medications (other than insulin) will be provided through Our Specialty Pharmacy Vendor under the medical benefit. All other syringes and needles are not covered.
- Medications limited by law to Investigational use, prescribed for Experimental purposes or prescribed for indications not approved by the Food and Drug Administration (unless the drug is being prescribed or administered by a licensed health care professional for the treatment of a life-threatening or chronic and seriously debilitating condition) and the Off-Label use of the drug for that purpose has generally been recognized as safe and effective as described in this section.
- Injectables (other than insulin when prescribed by a Physician) are not covered. Surgically implanted drugs are covered under the medical benefit (see the "Surgically Implanted Drugs" provision in the "Medical Benefits" section).
- 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 "Medical Benefits" section). However, self-administered injectable drugs, as described in the Essential Rx Drug List, are covered.
- Drugs on the Essential Rx Drug List when Medically Necessary for treating sexual dysfunction are limited to a maximum of 8 doses in any 30 day period. Sexual dysfunction drugs are covered at the specialty drug Coinsurance.
- Vaginal, oral, transdermal and emergency contraceptives are covered, as described in this section. Vaginal contraceptives are limited to diaphragms and cervical caps, when a Physician performs a fitting examination and prescribes the device Such devices are only available through a prescription from a pharmacy. Injectable contraceptives are covered as a medical benefit when administered by a Physician.

  If Your Physician determines that none of the methods specified as covered by the Plan are medically appropriate then the Plan will provide coverage for another FDA approved prescription or contraceptive method as prescribed by Your Physician.
- Lost, stolen or damaged drugs are not covered. The Covered Person will have to pay the retail price for replacing them.
- 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.
- Supply amounts for prescriptions that exceed the Food and Drug Administration's (FDA) or HNL's indicated usage recommendation unless Medically Necessary and Prior Authorization is obtained from HNL.
- 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.

- Individual doses of medication dispensed in plastic, unit does, or foil packages (unit dose packaging) and dosage forms used for convenience as determined by HNL, unless Medically Necessary or only available in that form.
- Unit dose or "bubble" packaging (an individual dose of medication dispensed in plastic or foil packages).
- Drugs used for diagnostic purposes are not covered. Diagnostic drugs are covered under the medical benefit when Medically Necessary.
- Irrigation solutions and saline solutions are not covered.

NOTICE OF LANGUAGE SERVICES

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or please call 800-522-0088. PPO members: for more help call the CA Dept. of Insurance at 1-800-927-4357. HMO members: call the DMHC Helpline at 1-888-HMO-2219. **English**

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o llame al 800-522-0088. Afiliados a PPO: para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Afiliados a HMO: llame a la Línea de Ayuda del Departamento de Atención Médica Administrada de California (DMHC, por sus siglas en inglés) al 1-888-HMO-2219. **Spanish**

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，部分文件可以翻譯成您的語言並寄送給您。如需協助，請撥您會員卡所列的電話號碼或撥 800-522-0088 與我們聯絡。PPO 會員：如需其他協助，請致電 California 保險局，電話 1-800-927-4357。HMO 會員：請撥 DMHC 協助專線 1-888-HMO-2219。 **Chinese**

Dịch vụ ngôn ngữ miễn phí. Quý vị có thể được cấp thông dịch viên. Quý vị có thể được cấp người đọc văn bản cho quý vị hoặc nhận tài liệu, văn bản bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi cho chúng tôi tại số điện thoại trên thẻ hội viên của quý vị hoặc gọi số 800-522-0088. Hội viên chương trình PPO: Để được trợ giúp thêm, vui lòng gọi cho Sở Bảo hiểm CA tại số 1-800-927-4357. Hội viên chương trình HMO: xin gọi Đường dây trợ giúp của Sở DMHC tại 1-888-HMO-2219. **Vietnamese**

무료 언어 지원 서비스. 귀하는 통역사 서비스를 받으실 수 있습니다. 본인에게 편한 언어로 서류 낭독 서비스 및 번역 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상의 안내번호로 전화하시거나 800-522-0088번으로 연락해 주십시오. PPO 가입자: 더 많은 도움이 필요하신 분은 캘리포니아 보험 담당국, 안내번호 1-800-927-4357번으로 문의하십시오. HMO 가입자: DMHC 헬프라인, 안내번호 1-888-HMO-2219번으로 문의해 주십시오. **Korean**

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin. Maaari mong ipabasa sa iyo ang mga dokumento, at maaaring ipadala sa iyo ang ilan sa mga ito sa iyong wika. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o kaya mangyaring tumawag sa 800-522-0088. Para sa PPO members: para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Para sa HMO members: tawagan ang DMHC Helpline sa 1-888-HMO-2219. **Tagalog**

Անվճար Լեզվական Ծառայություններ: Կարող եք թարգմանիչ ստանալ: Փաստաթղթերը կարող են ձեզ համար ընթերցվել կամ ձեզ ուղարկվել ձեր լեզվով: Օգնության համար զանգահարեք մեզ ձեր ինքնության (ID) տոմսի վրա նշված համարով կամ խնդրում ենք զանգահարել 800-522-0088 համարով: PPO անդամներ՝ լրացուցիչ օգնության համար զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք (CA Dept. of Insurance) 1-800-927-4357 համարով: HMO անդամներ՝ զանգահարեք DMHC-ի Օգնության գծին՝ 1-888-HMO-2219 համարով: **Armenian**

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика. Вам могут прочесть ваши документы, а также выслать вам некоторые из них на вашем языке. Для получения помощи звоните нам по номеру телефона, указанному в вашей карточке-удостоверении, или по номеру 800-522-0088. Просим участников плана PPO для получения дополнительной помощи звонить в Министерство страхования (Department of Insurance) штата Калифорния по номеру 1-800-927-4357. Участников организаций медицинского обслуживания (HMO) просим обращаться в телефонную службу помощи Департамента организованного медицинского обслуживания (DMHC) по телефону 1-888-HMO-2219. **Russian**

無料の言語サービス。通訳がご利用になれ、書類を日本語でお読みします。また、書類によっては日本語版をお届けできるものもあります。サービスをご希望の方は、IDカード記載の番号または800-522-0088までご連絡ください。PPO加入者: その他のお問い合わせはカリフォルニア州保険庁、1-800-927-4357までご連絡ください。HMO加入者: DMHCヘルプライン、1-888-HMO-2219(1-888-466-2219)までご連絡ください。 **Japanese**

خدمات بی هزینه مربوط به زبان. می توانید از خدمات یک مترجم شفاهی برخوردار شوید. می توانید بگوئید تا نوشته ها به زبان خودتان برایتان خوانده شده و بعضی از آنها به زبان خودتان برایتان ارسال شوند. برای دریافت کردن کمک، به ما به شماره ای که روی کارت هویتتان قید شده است تلفن کنید و یا با شماره 800-522-0088 تماس بگیرید. اعضاء PPO: برای دریافت کمک بیشتر، با اداره بیمه کالیفرنیا به شماره 1-800-927-4357تماس بگیرید. اعضاء HMO : با خط تلفنی کمکی DMHC به شماره 1-888-HMO-2219تماس بگیرید. **Farsi**

ਭਾਸ਼ਾ ਦੀਆਂ ਮੁਫਤ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ। ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ ਅਤੇ ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਕਿਸੇ ਵੀ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ ਕਿਰਪਾ ਕਰਕੇ 800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। PPO ਮੈਂਬਰ: ਹੋਰ ਸਹਾਇਤਾ ਲਈ CA ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। HMO ਮੈਂਬਰ: DMHC ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। **Punjabi**

ការបកប្រែភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលជំនួយពីអ្នកបកប្រែបាន។ អ្នកអាចឲ្យគេអានឯកសារជូនអ្នក និងផ្ញើឯកសារខ្លះ ទៅឲ្យអ្នក ជាភាសាខ្មែរបាន។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខដែលមានកត់នៅលើប័ណ្ណ ID របស់អ្នក ឬសូមទូរស័ព្ទ ទៅលេខ 800-522-675-6110។ សមាជិក PPO: សំរាប់ជំនួយបន្ថែម សូមទូរស័ព្ទទៅ ក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357។ សមាជិក HMO: សូមទូរស័ព្ទទៅខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219។ **Khmer**

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم. يمكنك طلب قراءة وثائق وإرسال بعضها إليك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك (ID) أو رجاء الاتصال بالرقم 800-522-0088. أعضاء PPO: للحصول على المساعدة الإضافية يمكنهم الاتصال بـ CA Dept. of Insurance على الرقم 1-800-927-4357. أعضاء برنامج HMO: يمكنهم الاتصال بخط المساعدة التابع لـ DMHC بواسطة الرقم 1-888-HMO-2219. **Arabic**

Kev Pab Lus Tsis Muaj Nqi Them. Koj txais tau tus neeg txhais lus. Koj muab tau cov ntawv nyeem rau koj thiab ib co xa tuaj rau koj ua koj hom lus. Kom tau kev pab, hu rau peb ntawm tus xovtooj sau rau koj daim npav ID lossis thov hu 800-522-0088. Cov tswv cuab PPO: kom tau kev pab ntxiv hu rau lub CA Dept. of Insurance ntawm 1-800-927-4357. Cov tswv cuab HMO: hu rau lub DMHC Helpline ntawm 1-888-HMO-2219.

Hmong

Doo bąąh hiliní da hazaad bee haká'adoowołgo. Ata' halne'é ła' áka'adoolwołígíí jóki'. Naaltsoos binahjį' éé dahózinígíí hach'į' yíidooltah áádóó ła' hach'į' adoolyįįł t'áá hó hazaad k'ehjí. Aká'adoowoł biniiyé, nihich'į' hódíílnih béésh bee hane'é binumber bee néé hó'dolzin biniiyé nanitinígíí bikáá' éí doodaii kojį' hodíílnih 800-522-0088. PPO atah jilíįgo: t'áá náás bee shiká'anáá'doowoł ninizingo kojį' hodíílnih CA Dept of Insurancejį' éí 1-800-927-4357. HMO atah jilįjgo: kojį' hodíílnih DMHC béésh bee hane'é bee aká'a'áyeedjį' éí 1-888-HMO-2219.

Navajo

Contact us

Health Net PPO
Post Office Box 10196
Van Nuys, California 91410-0196

Customer Contact Center
Large Group:
1-800-676-6976
(for companies with 51 or
more employees)

Small Business Group:
1-800-361-3366
(for companies with 2-50 employees)

Individual & Family Plans:
1-888-926-4988
1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

Telecommunications Device for
the Hearing and Speech Impaired
1-800-995-0852

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