CERTIFICATE OF INSURANCE

A complete explanation of Your Plan

Platinum 90 PPO 0/15 + Child Dental

Important benefit information – please read

Dear Health Net Covered Person:

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

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

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

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

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

Our goal is to help you get the greatest benefit from your health care while fully and efficiently addressing your needs and concerns.

Thank you for choosing Health Net.

CALIFORNIA HEALTH BENEFIT EXCHANGE SHOP
PROGRAM SUPPLEMENT RIDER
TO
CERTIFICATE OF INSURANCE

This California Health Benefit Exchange Small Business Health Options (SHOP) Program Supplement Rider (the "Supplement") supplements Health Net Life Insurance Company's *Certificate of Insurance* (the "*Certificate*"). All of the provisions of the *Certificate*, into which this Supplement is inserted, are applicable to your coverage. This Supplement explains certain details that may duplicate what is already stated in that document. In the case of inconsistencies between the *Certificate* and this document, the provisions of this document will control.

This Supplement, the California Health Benefit Exchange SHOP Program Supplement Rider to the Group Policy, the Policy, the application of the Group, including the conditions of enrollment, underwriting criteria and the enrollment forms of the Group's eligible employees, shall constitute the entire agreement between the parties. All statements made by the Group or by any individual Covered Person shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to a claim under this Policy unless it is contained in a written application. After 24 months following the issuance of this Policy, Health Net Life Insurance Company (HNL) may not rescind the Policy for any reason, and shall not cancel the Policy, limit any of the provisions of the Policy, or raise premiums on the Policy due any omissions, misrepresentations or inaccuracies in the application form, whether willful or not.

I. DEFINITIONS

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP) is the program operated by the California Health Benefit Exchange, also known as Covered California through which a small employer (GROUP) can provide its employees and their dependents with access to one or more products offered by Health Plan or Health Insurer (HEALTH PLAN).

ELIGIBLE EMPLOYEE is an employee as defined in Section 1357.500(c) of California Health and Safety Code and in Section 10753(f) of California Insurance Code

ENROLLEE shall mean an individual and his or her eligible dependents, as defined by HEALTH PLAN, who lives or works in an approved Service Area, who meets the eligibility requirements of GROUP and HEALTH PLAN, who has made application to HEALTH PLAN through the SHOP Program, and for whom premiums have been paid by GROUP or individually as a COBRA participant.

QUALIFIED EMPLOYEE means any employee or former employee of a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP for himself or herself and, if the qualified employer offers dependent coverage through the SHOP, for his or her dependents.

SERVICE AREA shall mean that geographic area in which HEALTH PLAN is licensed to offer and provide QHPs to Small Group Employers.

SMALL GROUP EMPLOYER shall mean a "small employer" as defined in Section 1357.500(k) of California Health and Safety Code and in Section 10753(q) of California Insurance Code.

SMALL GROUP MARKET shall mean the aggregation of Small Group Employers in the state of California.

II. ELIGIBILITY AND ENROLLMENT

A. **Eligibility and Enrollment for Open Enrollment**

SHOP is responsible for determining eligibility for all GROUPs and applicant Employees of GROUP and their dependents. Except for special enrollments addressed below, coverage effective dates will be determined pursuant to 10 CCR Section 6536.

1. Employee Eligibility

   A Qualified Employee is an employee who has been offered coverage by his or her employer and who is an Eligible Employee.

2. Dependent Eligibility

   a. A dependent claiming eligibility hereunder as a spouse must be legally married to a Qualified Employee.

   b. A dependent claiming eligibility hereunder as a domestic partner must be a registered domestic partner, as defined in section 297 and 299.2 of the California Family Code. In order for an Employee's unregistered domestic partner to be eligible for coverage, the Employer must make an offer of coverage to the Employee's unregistered domestic partner and the eligibility of unregistered domestic partners must be documented in Employer's Employee Benefit Plan documents. It is the Employer's responsibility to ensure that unregistered domestic partnerships are eligible under the terms and conditions of the Employer's plan.

   c. A dependent child claiming eligibility hereunder must be born to, a step-child or legal ward of, adopted by, placed for adoption with, or placed in the foster care of the Eligible Employee or the Eligible Employee's spouse or domestic partner, a minor child ordered by a court to be covered by an employee's Plan, or a child for whom the employee has assumed a parent-child relationship, and under the age of 26 unless disabled. A non-disabled child's dependent coverage will terminate on the first day of the month following the dependent's 26th birthday.

   d. A dependent child age 26 or older who is incapable of self-support because of a physical or mental disability which existed continuously from a date prior to attainment of age 26 is eligible to initiate or continue dependent coverage until termination of such incapacity. A disabled child who is age 26 or over will be enrolled at the time of initial enrollment of the employee provided that satisfactory evidence of such disability is provided to the HEALTH PLAN, if requested by the HEALTH PLAN, within 60 days of receiving the request. The HEALTH PLAN shall provide this information to SHOP within 60 days of receipt by the HEALTH PLAN.

e. For a child that is enrolled, SHOP will provide a 90-day notice that a dependent is about to reach the age limit for dependent children and will lose coverage unless provided with written certification from a competent health care professional, within 60 days of receiving this 90-day notice, that the dependent meets the above conditions of being disabled. If SHOP fails to make the determination of whether the child is eligible to continue coverage before the child turns 26 years of age, coverage will continue pending the determination.

Documentation of eligibility and existence of the relationship of any dependent to the Qualified Employee may be requested at the time of enrollment and before a child attains the limiting age, but not more frequently than annually after the two-year period following a child's attainment of the limiting age.

B. **Eligibility and Enrollment for Special Enrollment**

1. Newly Eligible Employee

The SHOP must provide an employee who becomes a Qualified Employee outside of the initial or annual open enrollment period an enrollment period beginning on the first day of becoming a Qualified Employee. A newly Qualified Employee must have at least 30 days from the beginning of his or her enrollment period to select a QHP. The enrollment period must end no sooner than 15 days prior to the date that any applicable employee waiting period longer than 45 days would end if the employee made a plan selection on the first day of becoming eligible.

2. New Dependents – Spouse or Registered Domestic Partnership

An eligible spouse or registered domestic partner may be added to coverage at the time of initial enrollment of the Employee, at each open enrollment period of GROUP or due to one of the following special enrollment qualifying events if the application for coverage, along with any supporting documentation is received by SHOP within 30 calendar days of the event. Coverage will become effective on the first day of the month following the receipt of the application for coverage.

When an employee is newly married or has a newly registered domestic partnership, he or she must submit a stamped copy of the Marriage Certificate or the date the Declaration of Domestic Partnership is filed with the California Secretary of State if requested by SHOP.

When an employee gains a child dependent, the employee may enroll a spouse or registered domestic partner to the Plan during the same special enrollment period as the newly gained child dependent.

3. New Dependents - Birth/Adoption/Legal Guardianship/Assumption of a Parent-Child Relationship

An individual who becomes a new dependent, including a Qualified Employee who becomes a dependent, by virtue of birth, placement for adoption or foster care, assumption of a parent-child relationship, or legal guardianship is eligible for coverage under the Agreement, as modified by this Supplement, at other than the Employer's initial or annual open enrollment. The appropriate request form should be received by

SHOP within 30 days after such birth, placement for adoption, placement in foster care or effective date of a guardianship order. Coverage is to be effective upon the date of the birth, placement for adoption, foster care placement, assumption of parent-child relationship, or legal guardianship assignment unless the Employee requests the coverage to be effective on the first day of the month following the date of the birth, placement for adoption, foster care placement, assumption of parent-child relationship, or legal guardianship assignment. The first 31 days of coverage for such new or adopted child is automatic, regardless of whether the child is enrolled or not after this 31-day period.

If application is not received by the 30th day after the birth, adoption, placement, assignment, or assumption of parent-child relationship, the HEALTH PLAN providing coverage for the covered parent will only provide coverage for the first 31 days from the event under that parent's policy. After that time, the dependent child will no longer have coverage.

4. New Dependents – Unregistered Domestic Partnership

   If an employer offers coverage to unregistered domestic partners, the SHOP must receive an application for coverage of an unregistered domestic partner by the 30th day after the establishment of the unregistered domestic partnership. Coverage will be effective on the first of the month following the receipt of the application for coverage of the unregistered domestic partner by SHOP.

   Employers must agree to notify SHOP immediately upon termination of the unregistered domestic partnership.

5. Loss of Coverage – Qualified Employee and Dependents

   a. A Qualified Employee and/or an eligible spouse or registered domestic partner and/or eligible child dependent may be added to coverage at a time other than at initial enrollment of the Qualified Employee or at each open enrollment period of GROUP if they experience a loss of Minimum Essential Coverage (MEC), which includes but is not limited to, loss of coverage due to one of the events listed below. Receipt of the application for coverage and any supporting documents must be within 30 days of the event. Coverage will become effective on the first day of the month following the loss of coverage.

      i. termination of employment

      ii. termination of an employer sponsored plan

      iii. reduction in hours that results in a loss of eligibility

      iv. loss of coverage through Medicare or Medi-Cal or other government sponsored health care program

      v. exhaustion of COBRA and Cal-COBRA continuation coverage

      vi. loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status, and death of an employee

      vii. termination of employer contribution for coverage that is not COBRA continuation coverage

Voluntary termination of coverage, or loss of coverage due to failure to pay premiums on a timely basis or committing fraud or intentional misrepresentation of material fact in connection with the coverage do not constitute loss of MEC that entitles one to a Special Enrollment Period.

b. A Qualified Employee and/or an eligible spouse or registered domestic partner and/or eligible child dependent may be added to coverage at a time other than at initial enrollment of the Qualified Employee or at each open enrollment period of GROUP if they experience a loss of Minimum Essential Coverage due to the loss of coverage through Medicare or Medi-Cal or other government sponsored health care program. Receipt of the application for coverage and any supporting documents must be within 60 days of the event. Coverage will become effective on the first day of the month following the loss of coverage.

6. Other Special Enrollment Events

A Qualified Employee and/or an eligible spouse or registered domestic partner and/or eligible child dependent may be added to coverage at a time other than at initial enrollment of the Qualified Employee or at each open enrollment period of GROUP if they experience one of the events listed below. Receipt of the application for coverage and any supporting documents must be within 30 days of the event. Coverage will become effective on the first day of the month following the loss of coverage.

a. The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies.

b. The Qualified Employee, spouse or registered domestic partner or eligible dependent child's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct or inaction of an officer, employee, or agent of the Exchange or HHS or its instrumentalities or a non-Exchange entity providing enrollment assistance or conducting enrollment activities as evaluated and determined by the Exchange.

c. The Qualified Employee, spouse or registered domestic partner or eligible dependent child adequately demonstrates to the Exchange, or to the applicable regulator, with respect to health plans offered outside the Exchange, that the health plan, in which he or she is enrolled, substantially violated a material provision of its contract in relation to the Qualified Employee or his or her dependents.

d. A Qualified Employee or enrollee, or his or her eligible dependent gains access to new QHPs as a result of a permanent move

e. A Qualified Employee or dependent was released from incarceration.

f. A Qualified Employee or dependent is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.

g. A Qualified Employee who is an Indian, as defined by Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603(c)), and his or her dependent who is enrolled or is enrolling in a QHP through an Exchange on the same application as the Qualified Employee, may enroll in a QHP or change from one QHP to another one time per month.

h. A Qualified Employee or dependent loses pregnancy-related coverage described under Section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)) and Section 14005.18 of the Welfare and Institutions Code. The date of the loss of coverage is the last day the consumer would have pregnancy-related coverage. Receipt of the application for coverage and any supporting documents must be within 60 days of the event;

i. A Qualified Employee or dependent demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the applicable regulator, with respect to health benefit plans offered outside the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the employee or dependent because he or she was misinformed that he or she was covered under MEC.

j. A Qualified Employee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS and as determined by the Exchange on a case-by-case basis, that the individual meets other exceptional circumstances. Such circumstances include, but are not limited to, the following circumstances:

k. If a child who has been determined ineligible for Medi-Cal, and for whom a party other than the party who expects to claim him or her as a tax dependent is required by court order to provide health insurance coverage for the child, the child shall be eligible for a special enrollment period if otherwise eligible for enrollment in a QHP; and

l. A Qualified Employee or his or her dependent was receiving services from a contracting provider under another health plan for one of the conditions described below and the provider is no longer participating in that health plan:

   i. An acute condition. (An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.)

   ii. A serious chronic condition. (A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.)

   iii. A pregnancy. (A pregnancy is the three trimesters of pregnancy and the immediate postpartum period.)

   iv. A terminal illness. (A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less.)

v. The care of a newborn child between birth and age 36 months.

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

m. A Qualified Employee is a victim of domestic abuse or spousal abandonment, as defined by 26 Code of Federal Regulation 1.36B-2, including a dependent or unmarried victim within a household, are enrolled in minimum essential coverage and seek to enroll in coverage separate from the perpetrator of the abuse or abandonment. Dependents of the victim, who are on the same application as the victim, are also eligible to enroll at the same time as the victim.

n. A Qualified Employee or dependent applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medi-Cal, and is determined ineligible for Medi-Cal by the State Medi-Cal agency either after open enrollment has ended or more than 60 days after the qualifying event.

o. A Qualified Employee or dependent applies for coverage at the State Medi-Cal agency during the annual open enrollment period, and is determined ineligible for Medi-Cal after open enrollment has ended.

p. A Qualified Employee or his or her dependent adequately demonstrate to the Exchange that a material error related to plan benefits, service area or premium influenced your decision to purchase coverage through the Exchange.

q. A Qualified Employee and/or an eligible spouse or registered domestic partner and/or eligible child dependent may be added to coverage at a time other than at initial enrollment of the Qualified Employee or at each open enrollment period of GROUP if they become eligible for assistance, with respect to health insurance coverage under a SHOP, under a Medi-Cal plan (including any waiver or demonstration project conducted under or in relation to such a plan). Receipt of the application for coverage and any supporting documents must be within 60 days of the event. Coverage will become effective on the first day of the month following the loss of coverage.

III. VOLUNTARY TERMINATION, RENEWAL AND OTHER CHANGES

A. **Termination by Enrollee**

An Enrollee may terminate his or her coverage at the end of any month by providing GROUP with written notice of such intent to terminate up to the last day of the month in which the termination is to be effective. An Enrollee's coverage will terminate on the last day of the month in which the written notice is received or on a later date requested by the Enrollee, as long as that date is the last day of the month.

The coverage of an Enrollee terminating employment with GROUP or losing eligibility for coverage shall extend through the last day of the month in which his or her employment terminated or such eligibility was lost.

B. **Annual Enrollment and Renewal**

If the Qualified Employee does not enroll in a different QHP during his or her annual employee open enrollment period, the Qualified Employee will remain in the QHP selected in the previous year unless the Qualified Employee notifies employer to terminate his or her coverage from the QHP.

1. If the Qualified Employee's current QHP is not available, the Qualified Employee shall be enrolled in a QHP offered by the same Health Plan that is the same metal tier and the most similar to the Qualified Employee's current QHP, as determined by the SHOP on a case-by-case basis.
2. If the Health Plan of the QHP in which the Qualified Employee is currently enrolled is no longer available, or if another QHP is not available from the current HEALTH PLAN in the same metal tier, the Qualified Employee may be enrolled in the lowest cost QHP offered by a different Health Plan in the same metal tier as the Qualified Employee's current QHP, as determined by the SHOP on a case-by-case basis.

C. **Open Enrollment**

1. Enrollees electing to make open enrollment changes shall provide the Change Form to their employer for submission to the SHOP by the last day of the annual open enrollment period.
2. Enrollees are permitted to change their QHP during the first 30 days of the new plan year, provided that the newly selected QHP is offered by the same Health Plan.
    a. Requests to the SHOP received on the first through the fifteenth day of the month after effective date shall become retroactively effective to the first day of the month, unless the employer requests an effective date of the first of the following month.
    b. Requests to the SHOP received on the sixteenth day of the month up to the thirtieth day of the month after effective date shall become effective on the first day of the following month.

D. **Miscellaneous**

An Eligible Employee of GROUP who, at the time GROUP initially enters into the Agreement, as modified by this Supplement, had declined coverage through the SHOP and who did not have coverage from another source at that time must wait to enroll until the next open enrollment period unless he or she experiences a special enrollment qualifying event or period in the interim.

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INTRODUCTION TO HEALTH NET PREFERRED PROVIDER ORGANIZATION (PPO)

Plan HMU
330J

HEALTH NET PPO CERTIFICATE OF INSURANCE

ISSUED IN CONNECTION WITH THE HEALTH NET PPO GROUP INSURANCE POLICY

UNDERWRITTEN

BY

HEALTH NET LIFE INSURANCE COMPANY

Los Angeles, California

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

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

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

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

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

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

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

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

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

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

Out-of-Network Providers have not agreed to participate in the Health Net PPO program. You may choose to obtain Covered Services and Supplies from an Out-of-Network Provider. WHEN YOU USE AN OUT-OF-NETWORK PROVIDER, BENEFITS ARE SUBSTANTIALLY REDUCED AND YOU WILL INCUR A SIGNIFICANTLY HIGHER OUT-OF-POCKET EXPENSE. Your out-of-pocket expense is greater because: (i) You are responsible for a higher percentage cost of the benefits in comparison to the cost of benefits when services are provided by Preferred Providers; (ii) HNL's benefit for Out-of-Network Providers is based on HNL’s Maximum Allowable Amount; and (iii) You are financially responsible for any amounts these Out-of-Network Providers charge in excess of this amount.

When Services are not Available through a Preferred Provider: If HNL determines that the Medically Necessary care You require is not available within the PPO Preferred Provider network; HNL will authorize You to receive the care and will arrange for the required medically appropriate care from an available and accessible Out-of-Network Provider or facility. Covered Services and Supplies received from Out-of-Network Providers under these circumstances will be payable at the Preferred Provider level of coverage. Cost-sharing paid at the Preferred Provider level of coverage will apply toward the in-network Deductible and accrue to the in-network Out-of-Pocket Maximum and You will not be responsible for any amounts in excess of the Maximum Allowable Amount. If You need access to medically appropriate care that is not available in the PPO Preferred Provider network, or are being billed for amounts in excess of the Maximum Allowable Amount for Covered Services received under these circumstances, please call the Customer Contact Center at the number shown on your HNL ID card.

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

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

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

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

In order to be valid, that consent must meet all of the following requirements: (1) The consent shall be obtained by the Out-of-Network Provider in a document that is separate from the document used to obtain the consent for any other part of the care or procedure The consent shall not be obtained by the facility or any representative of the facility. The consent shall not be obtained at the time of admission or at any time when You are being prepared for surgery or any other procedure; (2) At the time consent is provided, the Out-of-Network Provider shall give You a written estimate of Your total out-of-pocket cost of care. The written estimate shall be based on the Out-of-Network Provider's billed charges for the service to be provided. The Out-of-Network Provider shall not attempt to collect more than the estimated amount without receiving separate written consent from You or Your authorized representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the provider to change the estimate; (3) The consent shall advise You that You may elect to seek care from a Preferred Provider or may contact HNL in order to arrange to receive the health service from a Preferred Provider for lower out-of-pocket costs; (4) The consent shall also advise You that any costs incurred as a result of Your use of the Out-of-Network benefit shall be in addition to Preferred Provider cost-sharing amounts and may not count toward the annual Out-of-Pocket Maximum on Preferred Provider benefits or a Deductible, if any, for in-network benefits; and (5) The consent and estimate shall be provided in the language spoken by You, in certain circumstances.

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

- Ancillary services, meaning:

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

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

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

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

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

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

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

Some Hospitals and other providers do not provide one or more of the following services that may be covered under this *Certificate* and that You might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. In order to determine from whom the above health care services may be available, HNL suggests You obtain this information prior to enrollment by calling prospective Physicians, Hospitals or clinics which contract with HNL or any other provider of choice. You may also obtain this information by calling HNL's Customer Contact Center at 1-888-926-5133 for the Exchange (Covered California™) plans or 1-800-522-0088 for off-Exchange plans.

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

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

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

THE TERMS "YOU" OR "YOUR," WHEN THEY APPEAR IN THIS *CERTIFICATE*, REFER TO THE PRINCIPAL COVERED PERSON (THE ENROLLED EMPLOYEE). THE TERMS "WE," "OUR," OR "US," WHEN THEY APPEAR IN THIS *CERTIFICATE*, REFER TO HNL. PLEASE REFER TO "COVERED PERSON" AND "HNL" IN THE "DEFINITIONS" SECTION FOR MORE INFORMATION.

Important Notice To California Certificate Holders

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

Health Net Life Insurance Company
P.O. Box 9103
Van Nuys, CA 91409-9103
1-800-522-0088

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

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

Platinum 90 PPO 0/15 + Child Dental

SCHEDULE OF BENEFITS

Health Net PPO

Plan HMU

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

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

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

Copayments and Coinsurance

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

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

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

Notes:

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

- If the Covered Person receives a non-emergency Covered Service at an in-network facility by an Out-of-Network Provider, the Covered Person will be responsible for the Preferred Provider Coinsurance and Deductible (as applicable) and the cost-sharing will accrue to the Out-of-Pocket Maximum for Preferred Providers.

Out-of-Pocket Limits on Expenses

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

For services or supplies provided by a Preferred Provider $4,500
For services or supplies provided by an Out-of-Network Provider..... $9,000

Family Out-of-Pocket Maximum: Each Covered Person is responsible only for meeting his or her individual Out-of-Pocket Maximum. However, if enrolled Covered Persons of the same family have paid Deductibles, Copayments and Coinsurance equal to the amounts shown below, the Out-of-Pocket Maximum will be considered to have been met for the entire family. No Deductibles, Copayment or Coinsurance for Covered Expenses shall be required from any enrolled Covered Person in that family for the remainder of that Calendar Year.

For services or supplies provided by a Preferred Provider $9,000
For services or supplies provided by an Out-of-Network Provider..... $18,000

Notes:

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

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

- Penalties paid for services for which Certification was required but not obtained.

- Cost sharing paid on Your behalf for Prescription Drugs obtained by You through the use of a Drug Discount, Coupon, or Copay Card provided by a Prescription Drug manufacturer will not apply toward Your Out-of-Pocket Maximum. Only what You actually pay will accrue towards Your Out-of-Pocket Maximum.

Medical Deductible

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

Calendar Year Deductibles

Calendar Year Deductible (for Preferred Provider services, per Covered Person)..... $0
Calendar Year Deductible (for Out-of-Network services, per Covered Person).....$1,000
Family Calendar Year Deductible (all enrolled members of a family, for Preferred Provider services, during a Calendar Year)..... $0
Family Calendar Year Deductible (all enrolled members of a family, for Out-of-Network services, during a Calendar Year).....$2,000

Notes:

- Any amount applied toward the Calendar Year Deductible for Covered Services and Supplies received from a Preferred Provider will only apply toward the Calendar Year Deductible for Preferred Providers and 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 only apply toward the Calendar Year Deductible for Out-of-Network Providers and 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.

Noncertification Penalties

	Preferred Providers	Out-of-Network
Medically Necessary services for which Certification was required but not obtained	$250	$500

Notes:

- **The noncertification penalty will not exceed the cost of the benefit to HNL.**

- **Certification is NOT a determination of benefits. Some of these services or supplies may not be covered under Your Plan. Even if a service or supply is certified, eligibility rules and benefit limitations will still apply. However, HNL will not rescind or modify Certification after a provider renders health care services in good faith and pursuant to the Certification, and will pay benefits under this Certificate for the services certified.**

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	$15	50%
At a Covered Person's home	$15	50%
Specialist consultation		
In a Physician's office	$30	50%
At a Covered Person's home	$30	50%
Telehealth consultation through the Select Telehealth Services Provider[1]	$0	Not Covered
Urgent Care services (for medical services)	$15	50%
Urgent Care services (for Mental Health and Substance Use Disorders)	$15	50%
Hearing examination (for diagnosis or treatment)	$15	50%
Vision examination (for refractive eye exams at an ophthalmologist) (age 19 and over; for birth to age 19, see "Child Needs Dental or Eye Care" below)	$30	50%
Vision examination (for refractive eye exams at an optometrist) (age 19 and over; for birth to age 19, see "Child Needs Dental or Eye Care" below)	$15	50%
Allergy serum	10%	50%
Allergy injections	$15	50%
Allergy testing	$30	50%
Acupuncture office visit	$15	50%
Medical social services	$15	50%
Patient education		
Diabetes education	$0	50%
Asthma education	$0	50%

Weight management education	$0	50%
Stress management education	$0	50%
Tobacco cessation education	$0	50%
Preventive Care Services	$0	50%

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, weight management intervention services, diabetes screening including intensive behavioral counseling intervention for individuals who test positive for abnormal levels of blood glucose, tobacco cessation intervention services, and preventive vision and hearing screening examinations. Refer to the "Preventive Care List of Services" section for details. If You receive any other Covered Services and Supplies in addition to Preventive Care Services during the same visit, You will also pay the applicable Copayment or Coinsurance for those services.
- Hearing examinations for newborns are covered at no cost to You and are not subject to any Deductible.
- Acupuncture Services are provided by HNL. HNL contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage. With this program, you may obtain care by selecting a contracted acupuncturist from the *ASH Plans Contracted Acupuncturist Directory*.
- Preferred Provider Copayments, Coinsurance, and Deductible (as applicable) will apply to Urgent Care services received outside the United States and will accumulate towards the Preferred Provider Out-of-Pocket Maximum.

[1] The designated Select Telehealth Services Provider for this plan is listed on Your HNL ID card. To obtain services, contact the Select Telehealth Services Provider directly as shown on Your ID card.

Outpatient Tests

	Preferred Providers	Out-of-Network
Laboratory tests	$15	50%
X-rays and diagnostic imaging [1]	$30	50%
Imaging (CT, PET, MRI) [2]	10%	50%

[1] Certification may be required. Please refer to the "Certification Requirements" section for details. Payment of benefits will be subject to the noncertification penalty as shown in this "Schedule of Benefits" section as set forth herein if Certification is required but not obtained.

[2] Certification is required, except in the case of an emergency. Please refer to the "Certification Requirements" section for details. A noncertification penalty will apply as shown in this "Schedule of Benefits" section if Certification is not obtained.

Outpatient Surgery and Services

	Preferred Providers	Out-of-Network
Facility fee		
Outpatient surgery and services [1, 2]	10%	50%
Physician/surgeon fees		
Surgery [1]	10%	50%
Anesthetics [3]	10%	50%
Sterilization of males	10%	50%
Sterilization of females [4]	$0	50%
Outpatient infusion therapy [1, 3]	10%	50%
Blood or Blood Products, and administration of blood or Blood Products [5]	10%	50%
Chemotherapy and radiation therapy [1, 3]	10%	50%
Nuclear medicine [3]	10%	50%
Organ, stem cell or tissue transplant (not Experimental or Investigational) [1]	10%	Not Covered
Renal dialysis	10%	50%

Notes:

- 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.

[1] Some outpatient surgical procedures and services require Certification. Please refer to the "Certification Requirements" section for details.

[2] A noncertification penalty will apply as set forth herein if Certification is required but not obtained for outpatient facilities services.

[3] The Coinsurance for these services applies to both the administration of the medication and the medication itself.

[4] 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.

[5] The Coinsurance for blood or Blood Products applies to both the administration of the medication and the medication itself, however, blood factors provided in an outpatient setting 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 (for medical care other than Mental Health and Substance Use Disorders)

	Preferred Providers	Out-of-Network
Emergency room care facility	$200	$200, Deductible waived
Emergency room care professional services	$0	$0, Deductible waived
Emergency medical transportation (air Ambulance or ground Ambulance)	$150	$150, Deductible waived

Services in an Emergency Room (for Mental Health and Substance Use Disorders)

	Preferred Providers	Out-of-Network
Emergency room care facility	$200	$200, Deductible waived
Emergency room care professional services	$0	$0, Deductible waived
Emergency medical transportation (air Ambulance or ground Ambulance)	$150	$150, Deductible waived

Notes:

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

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

Hospital Stay

	Preferred Providers	Out-of-Network
Facility fee [1, 2]	10%	50%
Confinement for bariatric (weight loss) surgery	10%	Not Covered
Physician/surgeon fees		
Surgery [1]	10%	50%
Anesthetics [3]	10%	50%
Physician visit to Hospital	10%	50%
Blood or Blood Products, and administration of blood or Blood Products [3]	10%	50%
Chemotherapy and radiation therapy [1, 3]	10%	50%
Nuclear medicine [3]	10%	50%
Organ, stem cell or tissue transplant (not Experimental or Investigational) [1]	10%	Not Covered
Renal dialysis	10%	50%

Notes:

- The Preferred Provider Copayment, Coinsurance and Deductible will apply if the Covered Person is admitted to a Hospital directly from an emergency room and will accumulate towards the Preferred Provider Out-of-Pocket Maximum. The Covered Person will remain responsible for amounts billed in excess of Covered Expenses (Maximum Allowable Amount) for the inpatient stay by an Out-of-Network Provider. You will not be reimbursed for any amounts in excess of Maximum Allowable Amount billed by an Out-of-Network Provider. The Covered Person should request a transfer to a preferred facility after their emergency condition has been stabilized to avoid incurring charges billed in excess of the Maximum Allowable Amounts.
- The above Coinsurance for inpatient Hospital or Special Care Unit services is applicable for each admission for the hospitalization of an adult, pediatric or newborn patient. For an inpatient stay for the delivery of a newborn, the newborn will not be subject to a separate Deductible and Coinsurance for inpatient Hospital services unless the newborn patient requires admission to a Special Care Unit or requires a length of stay greater than 48 hours for vaginal delivery or 96 hours for caesarean section
- If the Covered Person receives a non-emergency Covered Service at an in-network facility by an Out-of-Network Provider, the Covered Person will be responsible for the Preferred Provider Coinsurance and Deductible (as applicable) and the cost-sharing will accrue to the Out-of-Pocket Maximum for Preferred Providers.

[1] Certification is required for Hospital stay, except in the case of an emergency. Please refer to the "Certification Requirements" section for details.

[2] If Certification is not obtained for Hospital facility stay, payment will be subject to the noncertification penalty as shown in this "Schedule of Benefits"

[3] The Coinsurance for these services applies to both the administration of the medication and the medication itself.

Mental Health and Substance Use Disorders

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

Please refer to the "Need Immediate Attention" portion of this "Schedule of Benefits" section for the applicable Copayment or Coinsurance for Emergency Care related to Mental Health and Substance Use Disorders.

Mental Health

	Preferred Providers	Out-of-Network
Outpatient office visits (psychological evaluation or therapeutic session in an office or other outpatient setting, including individual and group therapy sessions, Urgent Care, medication management and drug therapy monitoring)[1]	$15	50%
Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care program, day treatment, partial hospitalization and other outpatient procedures including behavioral health treatment for pervasive developmental disorder or autism) [1]	10%, up to $15	50%
Inpatient facility [2]	10%	50%
Physician visit to Hospital, behavioral health facility or Residential Treatment Center	10%	50%

Substance Use Disorders

	Preferred Providers	Out-of-Network
Outpatient office visits (psychological evaluation or therapeutic session in an office or other outpatient setting, including individual and group therapy sessions, Urgent Care, medication management and drug therapy monitoring)	$15	50%
Outpatient services other than office visits (psychological and neuropsychological testing, outpatient detoxification, intensive outpatient care program, day treatment, partial hospitalization, medical treatment for withdrawal symptoms and other outpatient services)	10%, up to $15	50%
Inpatient facility [2]	10%	50%
Physician visit to Hospital, behavioral health facility or Residential Treatment Center	10%	50%
Inpatient detoxification [2]	10%	50%

Notes:

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

[1] Outpatient services include services for treating gender dysphoria. For benefits covered under outpatient office visits and outpatient services other than office visits, refer to the "Mental Health and Substance Use Disorders" section of the *Certificate*.

[2] Certification is required for inpatient facility stays, except in the case of an emergency. Please refer to the "Certification Requirements" section for details. Payment of benefits will be subject to the noncertification penalty as shown in this "Schedule of Benefits" section if Certification is not obtained.

Pregnancy

	Preferred Providers	Out-of-Network
Prenatal care and preconception visits	$0	50%
Preventive postnatal office visits	$0	50%

Non-Preventive postnatal office visits	$15	50%
Genetic testing of fetus	$15	50%
California Prenatal Screening Program administered by the California State Department of Public Health	$0	$0, Deductible waived
Delivery and all inpatient services		
Hospital [1]	10%	50%
Professional (including terminations of pregnancy and circumcision of newborn) [2]	10%	50%

Notes:

- Applicable Deductible, Copayment or Coinsurance requirements apply to any services and supplies required for the treatment of an illness or condition, including but not limited to, complications of pregnancy. For example, if the complication requires an office visit, then the office visit Copayment or Coinsurance will apply.
- Prenatal, postnatal and newborn care that are Preventive Care Services are covered in full by Preferred Providers and the Calendar Year Deductible does not apply. See "Preventive Care Services" in the "Visit to a Health Care Provider's Office or Clinic" provision above.

[1] HNL does not require Certification for maternity care. Certification is not needed for the first 48 hours of inpatient Hospital services following a vaginal delivery nor the first 96 hours following a cesarean section. However, please notify HNL within 24 hours following birth, or as soon as reasonably possible; no penalty will apply if notification is not received. Certification must be obtained if the Physician determines that a longer Hospital stay is Medically Necessary either prior to or following the birth.

[2] 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[1]	10%	50%
100 visits covered during a Calendar Year (combined for Preferred Providers and Out-of-Network Providers)[2]		
Rehabilitation services (physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and		

pulmonary rehabilitation therapy) [1]	$15	50%
Habilitative services (physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy)[1]	$15	50%
Confinement in a Skilled Nursing Facility Facility [3]	10%	50%
Physician visit to Skilled Nursing Facility	10%	50%
Durable Medical Equipment [4]	10%	50%
Orthotics (such as bracing, supports and casts) [4]	10%	50%
Corrective Footwear [1]	10%	50%
Diabetic equipment (including footwear)	10%	50%
Prostheses [4]	10%	50%
Hospice facility and outpatient care[3]	$0	50%
Office-based injections [1]	10%	50%
Self-injectable Drugs [5]	See note below	See note below
Infertility services (services that diagnose, evaluate or treat Infertility)	Not Covered	Not Covered

Notes:

- Confinement in a Skilled Nursing Facility is not subject to a maximum number of days.
- Diabetic equipment and Orthotics which are covered under the medical benefit include blood glucose monitors, insulin pumps and Corrective Footwear.
- Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under "Preventive Care Services" in "Visit to a Health Care Provider's Office or Clinic" in this section. For additional information, please refer to the "Preventive Care List of Services" section.
- Durable Medical Equipment is covered under the Preferred Provider cost share only when supplied by a HNL designated contracted vendor for Durable Medical Equipment. Preferred Providers that are not designated by HNL as a contracted vendor for Durable Medical Equipment are considered Out-of-Network Providers for purposes of determining coverage and benefits. Certification is required. Please refer to the "Certification Requirements" section for details. Payment of benefits will be subject to the noncertification penalty as shown in this "Schedule of Benefits" section if Certification is 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.
- Hospice Care provided by a Preferred Provider is covered at no charge to You regardless of the place of service.

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

[2] Home health care rehabilitative or habilitative services will each have a separate Calendar Year maximum of 100 visits. Both Preferred Provider and Out-of-Network visits count toward the separate 100 visit maximums for rehabilitative and habilitative Home Health Care Services. 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 4 hours per visit by a home health aide.

[3] Certification is required for Skilled Nursing Facility or Hospice stay. Certification is not required for outpatient (home-based) Hospice Care. Please refer to the "Certification Requirements" section for details. Payment of benefits will be subject to the noncertification penalty as shown in this "Schedule of Benefits" section if Certification is not obtained.

[4] Certification is required for Durable Medical Equipment, Orthotics and Prostheses. Please refer to the "Certification Requirements" section for details. Payment of benefits will be subject to the noncertification penalty as shown in this "Schedule of Benefits" section if Certification is not obtained.

[5] Injectable Drugs which are self-administered are covered under the pharmacy benefit. These Drugs are not covered under the medical benefits even if they are administered in a Physician’s office. Please refer to the "Outpatient Prescription Drugs" of this "Schedule of Benefits" section for the applicable Copayment or Coinsurance.

Outpatient Prescription Drugs

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

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

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

Benefit Maximums

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

Notes:

- Except for insulin, diabetic supplies (blood glucose testing strips, lancets, disposable needles & syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (i.e. opened in order to dispense the product in quantities other than those packaged). When a prescription is dispensed, You will receive the size of package and/or number of packages required for You to test the number of times Your Physician has prescribed for up to a 30-day period.
- Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order.
- Schedule II narcotic Drugs are not covered through mail order. Schedule II Drugs are Drugs classified by the Federal Drug Enforcement Administration as having a high abuse risk but also safe and accepted medical uses in the United States. A partial prescription fill, which is of a quantity less than the entire prescription, can be requested by You or Your Physician. Partial prescription fills are subject to a prorated Copayment or Coinsurance based on the amount of the prescription that is filled by the pharmacy.

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

Retail Pharmacy

	Participating Pharmacy	Nonparticipating Pharmacy
Tier 1 Drugs (most Generic Drugs and low-cost preferred Brand Name Drugs)	$10	Not Covered
Tier 2 Drugs are higher cost Generic Drugs and preferred Brand Name Drugs.	$25	Not Covered
Tier 3 Drugs are Prescription Drugs that are non-preferred Brand Name Drugs; Brand Name Drugs with generic equivalent on a lower tier; or Drugs that have a preferred alternative on a lower tier	$40	Not Covered
Preventive Drugs and women's contraceptives	$0	…Not Covered

Specialty Pharmacy Vendor

	Specialty Pharmacy
Tier 4 Drugs (Specialty Drugs) (Drugs made using biotechnology; Drugs that must be distributed through a specialty pharmacy; Drugs that require special training for self-administration; Drugs that require regular monitoring of care; and Drugs that cost more than six hundred dollars for a one-month supply)	10%, up to $250 per prescription

Maintenance Drugs through the Mail Order Program

	Mail Order Program
Tier 1 Drugs (most Generic Drugs and low-cost preferred Brand Name Drugs)	$20
Tier 2 Drugs are higher cost Generic Drugs and preferred Brand Name Drugs.	$50
Tier 3 Drugs are Prescription Drugs that are non-preferred Brand Name Drugs; Brand Name Drugs with generic equivalent on a lower tier; or Drugs that have a preferred alternative on a lower tier	$80
Preventive Drugs and women's contraceptives	$0

Notes:

- Your total out-of-pocket cost for orally administered anti-cancer Drugs will not exceed $250 for an individual prescription of up to a 30-day supply or $750 for a 90-day supply through mail order.
- Tier 4 Drugs will have a cost share maximum of $250 for an individual prescription of up to a 30-day supply.
- If the pharmacy's retail price for a drug is less than the applicable cost sharing amount, You will pay the pharmacy's retail price. What You actually pay will accrue to the Out-of-Pocket Maximum.
- Generic Drugs will be dispensed when a Generic Drug equivalent is available. We will cover Brand Name Drugs, including Tier 4 (Specialty Drugs), that have a generic equivalent only when the Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from HNL. Covered Brand Name Drugs are subject to the applicable Copayment or Coinsurance for Tier 2 Drugs, Tier 3 Drugs or Tier 4 (Specialty Drugs).
- Preventive Drugs and all women's contraceptive Drugs, devices, and other products, including those available over-the-counter that are approved by the Food and Drug Administration (FDA) are covered as shown above. Please see the "Preventive Drugs and Women's Contraceptives" provision in the "Outpatient Prescription Drug Benefits" portion of the "Plan Benefits" section for additional details. If Your Physician determines that none of the methods designated by HNL are medically appropriate for You, We shall cover some other FDA-approved prescription contraceptive method at no cost to You.
- Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order.
- Some Drugs may require Prior Authorization from HNL to be covered. You will be subject to a penalty of 50% of the Average Wholesale Price if Prior Authorization was not obtained, except for Emergency or Urgently Needed care.

- Generic or Brand Name Drugs not listed in the Essential Rx Drug List which are prescribed by Your Physician and not excluded or limited from coverage may be covered as an exception and are subject to the Tier 3 Drug Copayment or Coinsurance, as applicable. Specialty Drugs not listed on the Essential Rx Drug List that are covered as an exception would be subject to the Tier 4 (Specialty Drugs) Coinsurance. Refer to "Prior Authorization and Exception Request Process" under the "Outpatient Prescription Drug Benefits" portion of the "Plans Benefits" section for more information on the exception request process.
- 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. Maintenance Drugs on the Health Net Maintenance Drug List may also be obtained at a CVS retail pharmacy for up to a 90-day supply under the mail order program benefits. Maintenance Drugs are also available for up to a 30-day supply from any participating retail pharmacy.
- Some Specialty Drugs listed in the Essential Rx Drug List are not available through mail order.
- If a pharmaceutical manufacturer coupon is used, the coupon amounts for Prescription Drugs will not accrue toward Your Out-of-Pocket Maximum. Only what You actually pay will accrue towards Your Out-of-Pocket Maximum.
- "Split-fill" Program: For certain high cost orally-administered drugs, including anti-cancer drugs, HNL provides a free 14-day trial. Drugs under the Split-fill program are indicated in the Formulary with "SF" in the comment section. Health Net will approve the initial fill for a 14-day supply at no cost to you. If, after the initial fill, you are free of adverse effects and wish to continue on the drug, the subsequent fills will be dispensed for the full quantity as written by your Physician. You will be charged the applicable Copayment or Coinsurance for each subsequent fill, up to the Copayment and Coinsurance maximum for orally-administered anti-cancer drugs described above.

Child Needs Dental or Eye Care

Pediatric Dental Services

Refer to the "Child Needs Dental or Eye Care" portion of the "Plan Benefits" section of this *Certificate* for complete benefit information.

Benefit 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 Benefits	$0, Deductible waived	10%, Deductible waived
Preventive Benefits	$0, Deductible waived	10%, Deductible waived
Restorative Benefits	20%, Deductible waived	30%, Deductible waived
Periodontal Maintenance Services (D4910)	20%, Deductible waived	30%, Deductible waived
Endodontics	50%, Deductible waived	50%, Deductible waived
Periodontics (other than Periodontal Maintenance (D4910))	50%, Deductible waived	50%, Deductible waived
Maxillofacial Prosthetics	50%, Deductible waived	50%, Deductible waived
Implant Services	50%, Deductible waived	50%, Deductible waived
Prosthodontics (Removable)	50%, Deductible waived	50%, Deductible waived
Fixed Prosthodontics	50%, Deductible waived	50%, Deductible waived
Oral and Maxillofacial Surgery	50%, Deductible waived	50%, Deductible waived
Medically Necessary Orthodontics	50%, Deductible waived	50%, Deductible waived
Adjunctive Services	50%, Deductible waived	50%, Deductible waived

Pediatric Vision Services

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

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

The pediatric vision services benefits are provided by Health Net. Health Net contracts with Envolve Vision, Inc., a vision services provider panel, to administer the pediatric vision services benefits.

Vision Services Benefits

Routine eye exam limit: 1 per Calendar Year.....$0, Deductible waived
Exam Options:

- Standard Contact Lens Fit including Follow-up visit (routine applications of soft, spherical daily wear contact lenses for single vision prescriptions)
- Premium Contact Lens Fit including Follow-up visit (more complex applications, including, but not limited to toric, bifocal/multifocal, cosmetic color, post-surgical and gas permeable)

Lenses limit: 1 pair per Calendar Year,.....$0, Deductible waived
Including:

- Single vision, bifocal, trifocal, lenticular
- Glass, or Plastic, including polycarbonate
- Oversized and glass-grey #3 prescription sunglass lenses

Provider selected frames limit: 1 per Calendar Year.....$0, Deductible waived

Optional Lenses and Treatments.....$0, Deductible waived
Including:

- UV Treatment
- Tint (Fashion & Gradient & Glass-Grey)
- Standard Plastic Scratch Coating
- Standard Polycarbonate –
- Photochromic / Transitions Plastic
- Standard, Premium and Ultra Anti-Reflective Coating
- Polarized
- Standard, Premium, Select, and Ultra Progressive Lens
- Hi-Index Lenses
- Blended segment Lenses

- Intermediate vision Lenses
- Select or ultra-progressive lenses
- Premium Progressive Lens

Provider selected contact lenses, a one year supply is covered every Calendar Year (in lieu of eyeglass lenses): ..... $0, Deductible waived

- Disposables
- Conventional
- Medically Necessary[1]

Subnormal or Low Vision Services and Aids - one comprehensive low vision evaluation every 5 years; low vision aids, including high-power spectacles, magnifiers or telescopes (limited to one aid per year) and follow-up care (limited to 4 visits every 5 years) ..... $0, Deductible waived

[1] **Medically Necessary Contact Lenses**:

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

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

Medically Necessary Contact Lenses are dispensed in lieu of other eyewear.

ELIGIBILITY, ENROLLMENT AND TERMINATION

Who Is Eligible For Coverage

The Covered Services and Supplies of this plan are available to the following individuals as long as the principal Covered Person lives in California, all other Covered Persons live in the United States, and all Covered Persons meet the additional eligibility requirements set forth by California State law, applicable Federal law and as defined by the Group:

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

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

Age Limit for Children

Each child is eligible for coverage as a Dependent until the age of 26 (the limiting age).

Disabled Child

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

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

If You are *enrolling* a disabled child for new coverage, You must provide Covered California with proof of incapacity and dependency within 60 days of the date You receive a request for such information about the dependent child from Covered California.

Covered California must provide You notice at least 90 days prior to the date Your enrolled child reaches the age limit that coverage will terminate on the child's 26th birthday unless You provide documentation of disability and dependency. You must provide Covered California with proof of Your child's incapacity and dependency within 60 days of receipt of the notice. Coverage will continue until Covered California makes a determination as to the child's disability and dependency.

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

How to Enroll for Coverage

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

Employee

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

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

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

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

Newly Acquired Dependents

You are entitled to enroll newly acquired Dependents as follows:

Spouse: If You marry while You are covered by this plan, You may enroll Your new spouse (and Your spouse's eligible children) within 30 days of the date of marriage. Coverage begins on the first day of the month following the date the application for coverage is received.

Domestic Partner: If You are the principal Covered Person and You enter into a domestic partnership while You are covered by this plan, You may enroll Your new Domestic Partner (and his or her eligible children) within 30 days of the date a Declaration of Domestic Partnership is filed with the Secretary of State or other recognized state or local agency, or within 30 days of the formation of the domestic partnership according to Your Group's eligibility rules. Coverage begins on the first day of the month following the date the application for coverage is received.

Newborn Child: Newborn children will automatically be covered for 31 days (including the date of birth). If you do not enroll the newborn within 31 days, he or she is covered for only 31 days (including the date of birth). Enrollment for the newborn will be effective as of the date of birth or first of the month following the date of birth if requested by the principal Covered Person.

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

Coverage begins automatically and will continue for 31 days from the date of eligibility. You must enroll the child within 30 days for coverage to continue beyond the first 31 days. Covered California will require written proof of the right to control the child's health care when such child is enrolled. If an adopted child is enrolled within 30 days following adoption or date of placement for adoption (date of physical custody), coverage will be continuous from the date of adoption or date of placement for adoption (date of physical custody).

Legal Ward (Guardianship): If You or Your spouse or Domestic Partner becomes the legal guardian of a child, the child is eligible to enroll on the effective date of the court order, but coverage is not automatic. The child must be enrolled within 30 days of the effective date of the guardianship. Coverage will begin on the first day of the month after Covered California receives the enrollment request.

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

Other Child: Any child that You have assumed a parent-child relationship, in lieu of a parent-child relationship described above, as indicated by court order, intentional assumption of parental status, or assumption of parental duties by You, as certified by You at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled.

The child must be enrolled within 30 days of the effective date of the assumption of parental status. Coverage will begin on the first day of the month after Covered California receives the enrollment request.

Open Enrollment Period

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

Late Enrollment Rule

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

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

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

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

Exceptions to Late Enrollment Rule

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

1. **You Did Not Receive a Form To Sign or A Signed Form Cannot Be Produced**

   If You chose not to enroll when first eligible, the late enrollment rule will not apply to You:

   - If You never received from the Group or signed a form explaining the consequences of Your decision; or
   - Your signed form exists but cannot be produced as evidence of Your informed decision.

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

   If You or Your Dependents declined coverage in this plan, and You stated on the form the reason You or Your Dependents were not enrolling was because of coverage through another Group health plan, and the other coverage is or will be lost, the late enrollment exclusion will not apply to You or Your Dependents. Reasons for the loss of coverage include, but are not limited to:

   - The principal enrollee of the other plan has ceased being covered by that other plan, (except for either failure to pay premium contributions, or a "for cause" termination, such as fraud or misrepresentation of an important fact);
   - Loss of coverage because of termination of employment or reduction in the number of hours of employment;
   - Loss of coverage through an HMO or other individual arrangement because an individual ceases to reside, live or work in the service area;
   - Loss of coverage through an HMO or other arrangement in the group market because an individual ceases to reside, live or work in the service area, and no other benefit package is available to the individual;
   - The other plan was terminated and not replaced with other Group coverage;
   - The other Group stops making contributions toward employee's or dependent's coverage;
   - When the individual's plan ceases to offer any benefits to the class of similarly situated individuals that includes the individual;
   - The other principal enrollee or employee dies;
   - The principal enrollee and spouse or Domestic Partner are divorced or legally separated and this causes loss of the Group coverage;
   - Loss of coverage because cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan);

- The other coverage was federal COBRA or California COBRA, and the period of coverage ends; or
- Loss of minimum essential coverage for any other reason except failure to pay premiums or when the coverage is rescinded for fraud or intentional misrepresentation of material fact.

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

   If You or Your Dependents become ineligible and lose coverage under Medi-Cal, You and/or Your Dependent(s) will be eligible to enroll in this plan upon submitting a completed application form within 60 days of losing such coverage. If You and/or Your Dependent(s) wait longer than 60 days to enroll, You and/or Your Dependent(s) may not enroll until the next Open Enrollment period.

4. **Multiple Health Plans**

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

5. **Court Orders**

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

6. **Other Special Enrollment Triggering Events**

We shall allow an employee, and when specified below, his or her dependent, to enroll in or change health benefit plans as a result of the following triggering events:

- An employee or his or her dependent loses minimum essential coverage for any other reason except failure to pay premiums or when the coverage is rescinded for fraud or intentional misrepresentation of material fact.
- An employee gains a Dependent or becomes a Dependent through marriage, domestic partnership, birth, adoption, placement for adoption, assumption of a parent-child relationship as described under the "Newly Acquired Dependents" section above or through a child support order or other court order.
- An employee or his or her dependent’s enrollment or non-enrollment in the health plan is unintentional, inadvertent or erroneous and is the result of the error, misrepresentation, misconduct or inaction of an officer, employee or agent of Covered California or the health plan, or its instrumentalities, or a non-Covered California entity providing enrollment assistance or conducting enrollment activities as evaluated and determined by Covered California. In such cases, Covered California may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, misconduct or inaction.
- The enrollee adequately demonstrates to Covered California, as determined by Covered California on a case-by-case basis, that the health plan substantially violated a material provision of its contract in relation to the enrollee.

- An employee or enrollee, or his or her dependent gains access to new health plans as a result of a permanent move.
- An employee gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, or is or becomes a dependent of an Indian, and is enrolled in or is enrolling on the same application as the Indian (You may enroll in a health plan or change from one plan to another one time per month).
- An employee or his or her dependent loses eligibility for coverage under Medi-Cal.
- An employee or his or her dependent becomes eligible for assistance, with respect to health insurance coverage under Covered California, under Medi-Cal (including any waiver or demonstration project conducted under or in relation to such a plan);
- An employee or enrollee or his or her dependent has been released from incarceration.
- An enrollee or his or her dependent's prior plan substantially violated a material provision of the health coverage contract.
- An employee or his or her dependent was receiving services from a contracting provider under another health plan for one of the conditions described below and the provider is no longer participating in that health plan:
    a. An acute condition. (An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.)
    b. A serious chronic condition. (A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.)
    c. A pregnancy. (A pregnancy is the three trimesters of pregnancy and the immediate postpartum period.)
    d. A terminal illness. (A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less.)
    e. The care of a newborn child between birth and age 36 months.
    f. Performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured.
- An employee or his or her dependent demonstrates to the Exchange (Covered California™), with respect to health plans offered through Covered California, or to the California Department of Insurance, with respect to health plans offered outside Covered California that he or she did not enroll in a health plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under minimum essential coverage.
- An employee or enrollee or his or her dependent was a member of the reserve forces of the United States military or a member of the California National Guard returning from active duty.

- An employee or his or her dependent demonstrates to Covered California, in accordance with guidelines issued by the Department of Health and Human Services, that the individual meets other exceptional circumstances as Covered California may provide.
- An employee or enrollee is a victim of domestic abuse or spousal abandonment, as defined by 26 Code of Federal Regulation 1.36B-2, including a dependent or unmarried victim within a household, are enrolled in minimum essential coverage and seek to enroll in coverage separate from the perpetrator of the abuse or abandonment. Dependents of the victim, who are on the same application as the victim, are also eligible to enroll at the same time as the victim.
- An employee or his or her dependent apply for coverage through Covered California during the annual open enrollment period or due to a qualifying event and are assessed by Covered California as potentially eligible for Medi-Cal, and are determined ineligible for such coverage either after open enrollment has ended or more than 60 days after the qualifying event.
- An employee or his or her dependent apply for coverage with Medi-Cal during the annual open enrollment period and are determined ineligible for such coverage after open enrollment has ended.
- An employee or his or her dependent adequately demonstrate to Covered California that a material error related to plan benefits, service area or premium influenced your decision to purchase coverage through Covered California.
- An employee provides satisfactory documentary evidence to Covered California to verify eligibility following termination of enrollment due to failure to verify status within the required time period or are under 100 percent of the Federal poverty level and did not enroll while waiting for the United States Department of Health and Human Services to verify citizenship, status as a national or lawful presence.

If the exceptions in 2 or 4 apply, You must enroll within 30 days of the loss of coverage. If You wait longer than 30 days to enroll, You will be a late enrollee and may not enroll until the next Open Enrollment Period. A court ordered dependent may be added without any regard to Open Enrollment restrictions within 30 days of the court order.

Special Enrollment Rule For Newly Acquired Dependents

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

If the Employee Is Enrolled in this Plan

If You are covered by this plan as an employee of the Group, You can enroll a new dependent if You request enrollment within 30 days after childbirth, marriage, domestic partnership, adoption, placement for adoption (receiving physical custody), or assumption of a parent-child relationship. In addition, a court ordered dependent may be added without any regard to open enrollment restrictions.

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

If the Employee Declined Enrollment in this Plan

If You previously declined enrollment in this plan because of other Group coverage, and You gain a new dependent due to childbirth, marriage, adoption, placement for adoption or assumption of a parent-child relationship, You can enroll Yourself and the dependent within 30 days of childbirth, marriage, adoption or placement for adoption.

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

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

If You do not enroll Yourself, the new dependent and any other family members within 30 days of acquiring the new dependent, You will have to wait until the next Open Enrollment Period to do so.

The Effective Date of coverage for You and all Dependents who enroll within 30 days of childbirth, marriage, adoption, court ordered dependent or placement for adoption will be the same as for the new dependent.

- In the case of childbirth, the Effective Date will be the moment of birth or the first day of the following month if requested by the principal Covered Person;
- For marriage or domestic partnership, the Effective Date will be on the first day of the month following the date the application for coverage is received;
- Regarding adoption, the Effective Date will be the date of adoption or the date the employee or his or her spouse or Domestic Partner receives physical custody of the child or the first day of the following month after the date of adoption or receiving physical custody, if requested by the principal Covered Person; and
- Following assumption of a parent-child relationship, the Effective Date will be the first day of the month following the enrollment request.
- In the case of a Medical Child Support Order, the Effective Date will be the date the Group is notified of the court order.
- A court ordered dependent child is eligible to enroll on the effective date of the court order, but coverage is not automatic. You must enroll the child within 60 days of the effective date of the court order.

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

While You have 30 days within which to enroll the child, until You and Your child are formally enrolled and recorded as Covered Persons in HNL's computer system, We cannot verify coverage to any inquiring medical provider.

Special Reinstatement Rule For Reservists Returning From Active Duty

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

Special Reinstatement Rule Under USERRA

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

When Coverage Ends

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

All Covered Persons

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

Principal Covered Person and All Dependents

The principal Covered Person and all his or her Dependents will become ineligible for coverage at the same time if the principal Covered Person establishes primary residency outside of California, or otherwise loses eligibility for this plan.

Individual Covered Persons

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

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

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

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

- The Covered Person establishes primary residency outside the continental United States; or

- Your marriage or domestic partnership ends by divorce, annulment, or some other form of dissolution. Eligibility for Your enrolled spouse or Domestic Partner (now former spouse or Domestic Partner) and that spouse's or Domestic Partner's enrolled dependents, who were related to You only because of the marriage, will end.

Notice Of Ineligibility

It shall be Your responsibility to notify the Group of any changes that will affect Your eligibility or that of Your Dependents for services or benefits under this *Certificate*. HNL shall have no obligation to provide notification of ineligibility or termination of coverage to individual Covered Persons.

Coverage Options Following Termination

Please examine Your options carefully before declining coverage.

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

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

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

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

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

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

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

The Covered Person must submit the first payment within 45 days of delivering the completed enrollment form to HNL in accordance with the terms and conditions of the health plan contract. The

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Your continued coverage under this provision will cease on the earliest of:
  1. the end of the period of time for which the union has made payment for Your coverage, if the next premium due is not made;
  2. the premium due date for which premiums are received for less than 75% of the persons eligible to continue coverage because of the labor dispute;
  3. the premium due date on or following the date that You start full-time work with another Employer;
  4. the premium due date on or after the date You ceased to be at work because of the labor dispute for 6 months; or
  5. the premium due date on or after the labor dispute is resolved.
- If You have Dependents insured on the date You cease work, You must also continue their coverage in order to continue coverage for You.

Small Employer Cal-COBRA Continuation Coverage

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

Definitions

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

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

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

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

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

- Termination of employment for reasons other than gross misconduct. (For individuals who began receiving Small Employer Cal-COBRA continuation coverage prior to January 1, 2003, 18 months of coverage is available. For individuals who began receiving their Small Employer Cal-COBRA coverage on or after January 1, 2003, 36 months of coverage is available.)

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

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

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

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

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

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

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

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

Employer Replaces This Plan: If the agreement between HNL and the employer terminates, coverage with HNL will end. However, if the employer obtains coverage from another insurer or HMO, the

Covered Person may choose to continue to be covered by that new plan for the balance of the period that he or she could have continued to be covered by the HNL plan.

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

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

Who May Choose Small Employer Cal-COBRA Continuation Coverage?

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

Who May Not Choose Small Employer Cal-COBRA Continuation Coverage

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

- Is enrolled in Medicare;
- Is covered by another group health plan that does not contain a pre-existing condition limitation that prevents the individual from receiving the full benefits of such plan. (A group conversion plan is not a group health plan);
- If the individual is covered by another group health plan that does contain a pre-existing condition limitation preventing the individual from receiving the full benefits of that plan, the individual may choose Small Employer Cal-COBRA Continuation Coverage. Coordination of benefits will apply, and this Small Employer Cal-COBRA plan will be the primary plan;
- Is covered or could become covered by any federal laws regarding continuation of group health plan coverage;
- Fails to notify HNL of a Qualifying Event according to the requirements described below under "Notify HNL of Small Employer Cal-COBRA Qualifying Event;" or
- Fails to submit the initial premium payment in the correct amount as described below under "Payment for Small Employer Cal-COBRA."

Notify HNL Of Small Employer Cal-COBRA Qualifying Event

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

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

HNL Will Offer Small Employer Cal-COBRA To Covered Persons

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

Choosing Small Employer Cal-COBRA

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

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

Payment For Small Employer Cal-COBRA

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

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

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

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

When Does Small Employer Cal-COBRA Continuation Coverage End?

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

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

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

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

Extension of Benefits

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

You must submit a written request for these total disability benefits, which must include written certification by Your Physician that You are totally disabled. Covered California must receive this certification within 90 days of the date coverage ends under this *Certificate*. At least once every 90 days while benefits are extended, Covered California must receive proof that Your total disability is continuing. It shall be Your responsibility to ensure that Covered California is notified of any requested extension of benefits prior to the required 90-day intervals. Benefits are provided until whichever of the following occurs first:

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

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

CERTIFICATION REQUIREMENTS

Some of the Covered Expenses under this plan are subject to a requirement of Certification or the noncertification penalty shown in the "Schedule of Benefits" section will apply. All Certifications are performed by HNL or an authorized designee.

Certification is NOT a determination of benefits. Some of these services or supplies may not be covered under Your Plan. Even if a service or supply is certified, eligibility rules and benefit limitations will still apply. However, HNL will not rescind or modify Certification after a provider renders health care services in good faith and pursuant to the Certification, and will pay benefits under this Certificate for the services certified.

Services Requiring Certification

1. **Inpatient facility admissions**

   Any type of facility, including but not limited to:

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

2. **Outpatient procedures, services or equipment**

   - Acupuncture (after the initial consultation)
   - Ambulance: non-emergency air or ground Ambulance services
   - Bronchial thermoplasty
   - Capsule endoscopy
   - Clinical trials
   - Cardiac procedures
   - Chiropractic care
   - Dermatology such as Chemical exfoliation and electrolysis, dermabrasions and chemical peels, laser treatment or skin injections and implants
   - Diagnostic Procedures:
     - Advanced Imaging
       - Computerized Tomography (CT)
       - Computed Tomography Angiography (CTA)
       - Magnetic Resonance Angiography(MRA)

        - Magnetic Resonance Imaging(MRI)
        - Positron Emission Tomography(PET)
    - Cardiac Imaging
        - Coronary Computed Tomography Angiography (CCTA)
        - Echocardiography
        - Myocardial Perfusion Imaging (MPI)
        - Multigated Acquisition (MUGA) scan
- Durable Medical Equipment
    - Bi-level Positive Airway Pressure (BiPAP)
    - bone growth stimulator
    - continuous glucose monitoring
    - Continuous Positive Airway Pressure (CPAP)
    - custom-made items, including custom wheelchairs
    - hospital beds and mattresses
    - power wheelchairs and accessories
    - scooters
    - ventilators
- Ear Nose and Throat (ENT) procedures
- Enhanced External Counterpulsation (EECP)
- Experimental/Investigational services
- Genetic testing
- Implantable Pain pumps including insertion or removal
- Injections for intended use of steroid and/or pain management including epidural, nerve, nerve root, facet joint, trigger point and Sacroiliac (SI) joint injections.
- Occupational therapy (includes home setting), except when the therapy is Medically Necessary for treating a mental health diagnosis such as autism.
- Organ, tissue and stem cell transplant services, including pre-evaluation and pre-treatment services, and the transplant procedure. Transplants must be performed through Health Net's designated transplantation specialty network.
- Orthotics (custom made items)
- Outpatient pharmaceuticals:
    - Most self-injectable Drugs, excluding insulin, require Prior Authorization. Please refer to the Essential Rx Drug List to identify which Drugs require Prior Authorization.

  - All hemophilia factors through the Outpatient Prescription Drug benefit require Prior Authorization and must be obtained through the Specialty Pharmacy Vendor.
  - Certain Physician-administered Drugs require Prior Authorization, including newly approved Drugs whether administered in a Physician office, free-standing infusion center, home infusion, ambulatory surgery center, outpatient dialysis center, or outpatient Hospital. Refer to the Health Net Life website, www.healthnet.com, for a list of Physician-administered or medical benefit Drugs that require Certification for Medical Necessity review or to coordinate delivery through our contracted Specialty Pharmacy Vendor.
  - Most Specialty Drugs must have Prior Authorization through the Outpatient Prescription Drug benefit and may need to be dispensed through the Specialty Pharmacy Vendor. Please refer to the Essential Rx Drug List to identify which Drugs require Prior Authorization. Urgent or emergent Drugs that are Medically Necessary to begin immediately may be obtained at a retail pharmacy.
  - Other Prescription Drugs, as indicated in the Essential Rx Drug List may require Prior Authorization. Refer to the Essential Rx Drug List to identify which Drugs require Prior Authorization.
  - Biosimilars are required in lieu of branded Drugs
- Outpatient surgical procedures:
  - Ablative techniques for treating Barrett's esophagus and for treatment of primary and metastatic liver malignancies
  - Balloon sinuplasty
  - Bariatric procedures
  - Cochlear implants
  - Joint surgeries
  - Neuro or spinal cord stimulator
  - Orthognathic procedures (includes TMJ treatment)
  - Spinal surgery including, but not limited to, laminotomy, fusion, discectomy, vertebroplasty, nucleoplasty, stabilization and X-Stop
  - Uvulopalatopharyngoplasty (UPPP) and laser-assisted UPPP
  - Vestibuloplasty
- Physical therapy (includes home setting) except when the therapy is Medically Necessary for treating a mental health diagnosis such as autism.
- Prosthesis and corrective appliances
- Radiation therapy
- Reconstructive and cosmetic surgery, services, and supplies, including but not limited to:
  - Bone alteration or reshaping such as osteoplasty

- Breast reduction and augmentation except when following a mastectomy (includes gynecomastia or macromastia).
- 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.
- Excision, excessive skin and subcutaneous tissue (including lipectomy and panniculectomy) of the abdomen, thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad, and other areas.
- Eye or brow procedures such as blepharoplasty, brow ptosis or canthoplasty
- Gynecologic or urology procedures such as clitoroplasty, labiaplasty, vaginal rejuvenation, scrotoplasty, testicular prosthesis, vulvectomy
- Hair electrolysis, transplantation or laser removal
- Lift such as arm, body, face, neck, thigh
- Liposuction
- Nasal surgery such as rhinoplasty or septoplasty
- Otoplasty
- Treatment of varicose veins
- Vermilionectomy with mucosal advancement

- Speech therapy (includes home setting), except when the therapy is Medically Necessary for treating a mental health diagnosis such as autism or gender dysphoria.

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

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

Exceptions

Certification does not apply to outpatient procedures/services for the treatment, diagnosis and prevention of a Mental Health and Substance Use Disorder.

Certification is not needed for the first 48 hours of inpatient Hospital services following a vaginal delivery nor the first 96 hours following a cesarean section. However, please notify HNL within 24 hours following birth or as soon as reasonably possible; no penalty will apply if notification is not received. Certification must be obtained if the Physician determines that a longer Hospital stay is Medically Necessary either prior to or following the birth.

Certification is not required for the length of a Hospital stay for mastectomies, lymph node dissections and reconstructive surgery incident to a mastectomy (including lumpectomy).

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

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

- Five or more business days before the proposed admission date or the commencement of treatment, except when due to a medical emergency;
- 72 hours or sooner, taking into account the medical exigencies, for proposed services needed urgently.
- In the event of being admitted into a Hospital following outpatient emergency room or Urgent Care center services for Emergency Care; please notify HNL of the inpatient admission within 48 hours, or as soon as reasonably possible; or
- Before admission to a Skilled Nursing Facility or Hospice facility.

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

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

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

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

Concurrent Review

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

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

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

If concurrent review results in an Adverse Benefit Determination, the Covered Person will be notified sufficiently in advance of the reduction or termination to allow time to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. Refer to the "Resolution of Disputes" provision in this section if you disagree with Our decision.

Retrospective Review

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

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

Notification of Adverse Benefit Determination

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

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

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

of all information reasonably necessary and requested by HNL, HNL shall approve, modify, or deny the request for authorization within the timeframes specified above.

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

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

Effect on Benefits

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

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

Resolution of Disputes

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

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

PLAN BENEFITS

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

In addition, many of the Covered Services and Supplies listed herein are subject to Certification in many instances, prior to the expenses being incurred. If Certification is not obtained, the available benefits will be subject to the noncertification penalty shown in the "Schedule of Benefits" section. Please refer to the "Certification Requirements" section for further details.

An expense is incurred on the date You receive the service or supply for which the charge is made. HNL shall not pay for expenses incurred for any services or supplies in excess of any visit or benefit maximum described in the "Schedule of Benefits" section or elsewhere in this *Certificate* or for any service or supply excluded herein.

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

Telephone Triage & Screening Services

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

How Covered Expenses Are Determined

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

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

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

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

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

When Services are not Available through a Preferred Provider: If HNL determines that the Medically Necessary care You require is not available within the PPO Preferred Provider network, HNL will authorize You to receive the care and will arrange for the required medically appropriate care from an available and accessible Out-of-Network Provider or facility. Covered Services and Supplies received from Out-of-Network Providers under these circumstances will be payable at the Preferred Provider level of coverage. Cost-sharing paid at the Preferred Provider level of coverage will apply toward the in-network Deductible and accrue to the in-network Out-of-Pocket Maximum and You will not be responsible for any amounts in excess of the Maximum Allowable Amount. If You need access to medically appropriate care that is not available in the PPO Preferred Provider network, or are being billed for amounts in excess of the Maximum Allowable Amount for Covered Services received under these circumstances, please call the Customer Contact Center at the number shown on your HNL ID card.

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

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

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

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

In order to be valid, that consent must meet all of the following requirements: (1) The consent shall be obtained by the Out-of-Network Provider in a document that is separate from the document used to obtain the consent for any other part of the care or procedure The consent shall not be obtained by the facility or any representative of the facility. The consent shall not be obtained at the time of admission or at any time when You are being prepared for surgery or any other procedure; (2) At the time consent is provided, the Out-of-Network Provider shall give You a written estimate of Your total out-of-pocket cost of care. The written estimate shall be based on the Out-of-Network Provider's billed charges for the service to be provided. The Out-of-Network Provider shall not attempt to collect more than the estimated amount without receiving separate written consent from You or Your authorized representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the provider to change the estimate; (3) The consent shall advise You that You may elect to seek care from a Preferred Provider or may contact HNL in order to arrange to receive the health service from a Preferred Provider for lower out-of-pocket costs; (4) The consent shall also advise You that any costs incurred as a result of Your use of the Out-of-Network benefit shall be in addition to Preferred Provider cost-sharing amounts and may not count toward the annual Out-of-Pocket Maximum on Preferred Provider benefits or a Deductible, if any, for in-network benefits; and (5) The consent and estimate shall be provided in the language spoken by You, in certain circumstances.

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

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

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

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

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

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

Out-of-Pocket Limits on Expenses

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

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

Medical Deductibles

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

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

Visits to a Health Care Provider's Office or Clinic

Professional Services

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

Urgent Care

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

Vision and Hearing Examinations

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

Allergy Testing and Treatment

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

Acupuncture

Medically Necessary acupuncture services as 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 You (the diabetic) and Your covered Dependent about the disease process, medical nutrition therapy and the daily management of diabetic therapy.

In addition, HNL will cover tobacco cessation, asthma education, weight management classes and stress management classes that are provided by non-Physician 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, and in accordance with the following:

- Those evidence-based items or services that have, in effect, a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) https://uspreventiveservicestaskforce.org/uspstf/.
- Those immunizations for routine use in children, adolescents and adults that have, in effect, a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) https://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- With respect to women, those evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) https://www.hrsa.gov/womens-guidelines-2019.
- With respect to infants, children and adolescents, such evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the HRSA https://brightfutures.aap.org/Pages/default.aspx.

Your Physician will evaluate Your health status (including, but not limited to, Your risk factors, family history, gender and/or age) to determine the appropriate Preventive Care Services and frequency. HNL will not make its own determinations as to risk and will defer to the Physician's decision. Additional

information regarding Preventive Care Services may be accessed through (https://www.healthcare.gov/coverage/preventive-care-benefits/).

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

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

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 and screening; 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; CT and PET scans; MRIs; ultraviolet light treatments; and bone density scans (CT and DEXA). Mammography and genetic testing for purposes of Preventive Care Services and human immunodeficiency virus (HIV) screening are covered under the "Preventive Care Services" provision in this section.

Outpatient Surgery and Services

Professional Surgical Services

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

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

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

When multiple procedures are performed at the same time, Covered Expenses include the Contracted Rate or Maximum Allowable Amount (as applicable) for the first (or major) procedure and one-half the Contracted Rate or Maximum Allowable Amount for each additional procedure. HNL uses Medicare

guidelines to determine the circumstances under which claims for multiple surgeries will be eligible for reimbursement, in accordance with HNL's normal claims filing requirements. No benefit is payable for incidental surgical procedures, such as an appendectomy performed during gall bladder surgery.

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

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

Outpatient Services

Covered Expenses include:

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

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

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

Outpatient Surgical Center

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

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

Outpatient Infusion Therapy

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

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

Covered services include professional services (including clinical pharmaceutical support) to order, prepare, compound, dispense, deliver, administer or monitor covered Drugs or other covered substances used in infusion therapy. When available and indicated, infused medications will be administered in the home or a non-Hospital infusion suite setting.

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

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

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

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

- Non-Prescription Drugs or medications;
- Any drug labeled "Caution, limited by Federal Law to Investigational use" or Investigational Drugs not approved by the FDA;
- Drugs or other substances obtained outside of the United States;
- Homeopathic or other herbal medications not approved by the FDA;
- Drugs or devices not approved by the Food and Drug Administration (FDA) requiring a prescription either by federal or California law; however, Drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set for in California Insurance Code, Section 10123.195 have been met; or
- Supplies used by a health care provider that are incidental to the administration of infusion therapy, including but not limited to: cotton swabs, bandages, tubing, syringes, medications and solutions.

Radiation Therapy, Chemotherapy and Renal Dialysis Treatment

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

Organ, Tissue and Stem Cell Transplants

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

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

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

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

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

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

Organ donation extends and enhances lives and is an option that You may want to consider. For more information on organ donations, including how to elect to be an organ donor, please visit the Department of Health and Human Services organ donation website at www.organdonor.gov.

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

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

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

Need Immediate Attention

Emergency Care

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

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

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. When non-emergency transportation services are covered, the emergency transportation cost-share will apply.

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

Covered Services provided by an Out-of-Network air ambulance Provider will be payable at the Preferred Provider level of cost-sharing and Deductible, if applicable, and without balance billing (balance billing is the difference between a provider’s billed charge and the Maximum Allowable Amount) and will apply toward the in-network Deductible, if applicable, and accrue to the in-network Out-of-Pocket Maximum.

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

Certification is required for Hospital stay. Please refer to the "Certification Requirements" section for details. Payment of benefits for Hospital facility stay will be subject to the noncertification penalty shown in the "Schedule of Benefits" section if Certification is not obtained.

Bariatric (Weight Loss) Surgery

Bariatric surgery (modifying the gastrointestinal tract to reduce nutrient absorption) provided for the treatment of 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. Providers that are not designated as part of HNL’s network of Bariatric Surgery Performance Centers are considered Out-of-Network Providers,

even if they have a contract with HNL, for purposes of determining coverage and benefits for weight loss surgery and are not covered.

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

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

Covered travel-related expenses will be reimbursed as follows:

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

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

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

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

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

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

Radiation Therapy, Chemotherapy and Renal Dialysis Treatment

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

Mental Health and Substance Use Disorders

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

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

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

Telehealth services for Mental Health and Substance Use Disorders are covered. See the "Telehealth Services" and "Telehealth Consultations through the Select Telehealth Services Provider" provisions in the "Help Recovering or Other Special Health Needs" provision in this "Medical Benefits" section for more details.

The following benefits are provided:

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

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

Mental Health and Substance Use Disorders - Treatment of Mental Health and Substance Use Disorders are covered as shown in the "Schedule of Benefits" sections under " Mental Health and Substance Use Disorders" and “Need Immediate Attention.”

COVERED EXPENSES

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

Covered services include:

- Outpatient office visits for the treatment of Mental Health and Substance Use Disorders, including gender dysphoria by Physicians and other licensed providers, as described in this *Certificate*. Services include:

- outpatient crisis intervention,
- assessment and treatment services,
- Urgent Care services,
- specialized therapy including individual and group mental health evaluation and treatment, and
- psychological testing when necessary to evaluate Mental Health and Substance Use Disorders,
- outpatient services for the purpose of monitoring medication management and drug therapy monitoring; and
- in connection with gender dysphoria: Physician office visits for hormone therapy (including hormone injections) and Physician surgical consultations.

- Outpatient services other than office visits for the treatment of Mental Health and Substance Use Disorders, including gender dysphoria, as ordered by a Physician or other licensed provider described in this *Certificate*. Services include:
  - psychological and neuropsychological testing when necessary to evaluate Mental Health and Substance Use Disorder,
  - neurofeedback (biofeedback),
  - intensive outpatient care program,
  - day treatment programs,
  - partial hospitalization programs,
  - medical treatment for withdrawal symptoms;
  - electroconvulsive therapy, transcranial magnetic stimulation,
  - other outpatient procedures, and
  - in connection with gender dysphoria fertility preservation, speech therapy, and surgical services (such as hysterectomy, ovariectomy and orchiectomy, breast surgery, genital surgery, mastectomy, and other reconstructive surgeries Medically Necessary to create a normal appearance for the gender with which the person identifies including facial reconstruction, body contouring and tracheal shaving).
- Intensive outpatient care program is a treatment program that is utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week.
- Partial hospitalization/day treatment program is a treatment program that may be free-standing or Hospital-based and provides services at least four (4) hours per day and at least four (4) days per week.
- Intensive psychiatric treatment programs, including Hospital-based intensive outpatient care (partial hospitalization), multidisciplinary treatment in an intensive outpatient psychiatric treatment program, and treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis, and psychiatric observation for an acute psychiatric crisis.

- Behavioral Health Treatment (BHT) for Pervasive Developmental Disorder or Autism is covered as follows:
  - Professional services for behavioral health treatment, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Covered Person diagnosed with pervasive developmental disorder or autism, are covered as shown in the "Schedule of Benefits" section under "Mental Health and Substance Use Disorders."
  - A licensed Physician or licensed psychologist must establish the diagnosis 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 providing treatment to the Covered Person for whom the treatment plan was developed. The treatment must be administered by the Qualified Autism Service Provider or by qualified autism service professionals who are supervised by the treating Qualified Autism Service Provider or by qualified autism service paraprofessionals who are supervised by the treating Qualified Autism Service Provider or a qualified autism service professional.
  - The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated, and must be reviewed by the Qualified Autism Service Provider at least once every six months and modified whenever appropriate. The treatment plan must not be used for purposes of providing or for the reimbursement of respite, day care or educational services, or to reimburse a parent for participating in a treatment program.
  - HNL may deny coverage for treatment if it is not Medically Necessary. HNL will not deny coverage for Medically Necessary BHT for lack of cognitive, developmental, or IQ testing; or because services are available from a California Regional Center.

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

Covered Services and Supplies include:

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

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

Pregnancy

Care for Conditions of Pregnancy

Hospital and professional services will be covered, including prenatal and postnatal care, and delivery. Covered Expenses include prenatal diagnostic procedures and services provided by the California Prenatal Screening Program (formerly Expanded Alpha-Fetoprotein Program).

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

Preventive services for pregnancy, as listed in the U.S. Preventive Services Task Force A&B recommendations and Health Resources and Services Administration's (HRSA) Women's Preventive Service are covered as Preventive Care Services. Well-Woman Preventive Visits are covered without cost sharing when provided by a Preferred Provider, as appropriate for each individual woman as determined by their provider, without any specific limit to the number or frequency of visits.

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

Your Physician will not be required to obtain Certification for a Hospital stay that is equal to or less than 48 hours following vaginal delivery or 96 hours following cesarean section. Longer stays in the Hospital and scheduled cesarean section must be certified. If Certification is not obtained, payment of benefits will be subject to the noncertification penalty shown in the "Schedule of Benefits" section.

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

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

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

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

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

Help Recovering or Other Special Health Needs

Home Health Care Services

The services of a Home Health Care Agency in the Covered Person's home are covered when provided by a registered nurse or licensed vocational nurse and /or licensed physical, occupational, speech therapist or respiratory therapist. These services are in the form of visits that may include, but are not limited to, skilled nursing services, medical social services, rehabilitation and habilitation 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 certified 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. The following conditions must be met in order to receive Home Health Care Services:

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

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.

Home Health Care Services are limited to a maximum of 100 visits per Calendar Year. However, home health care rehabilitative and habilitative services are subject to a separate maximum limit of 100 visits per Calendar year. 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 4 hours per visit by a home health aide.

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

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

Rehabilitative Services

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

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

Habilitative Services

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

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

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

Cardiac Rehabilitation Therapy

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

Pulmonary Rehabilitation Therapy

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

Skilled Nursing Facility

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

Covered Expenses include:

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

- Physical, occupational, respiratory and speech therapy;
- Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Skilled Nursing Facility for use during Your stay;
- Durable Medical Equipment if the Skilled Nursing Facility ordinarily furnishes the equipment;
- Medical social services; and
- Blood transfusions, including blood processing, the cost of blood and unreplaced blood and Blood Products are covered. Self-donated (autologous) blood transfusions are covered only for a scheduled surgery that has been certified.

Payment of benefits for Skilled Nursing Facility services will be subject to the noncertification penalty shown in the "Schedule of Benefits" section as set forth herein if Certification is not obtained for the confinement.

Durable Medical Equipment

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

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

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

- Enteral and parenteral nutrition: enteral formula and additives, adult and pediatric, including for inherited diseases of metabolism; enteral feeding supply kits; enteral nutrition infusion pump; enteral tubing; gastrostomy/jejunostomy tube and tubing adaptor; nasogastric tubing; parenteral nutrition infusion pump; parenteral nutrition solutions; stomach tube; supplies for self-administered injections.
- Phototherapy (bilirubin) light with photometer.
- Lymphedema garments.
- Non-segmental home model pneumatic compressor for the lower extremities.

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

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

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

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

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

Some Durable Medical Equipment may not be covered as they are primarily for non-medical use.

Certification may be required. Please refer to the "Certification Requirements" section for details. Payment of benefits for Durable Medical Equipment and custom Orthotics will be subject to the noncertification penalty shown in the "Schedule of Benefits" section if Certification is required but not obtained.

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

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

Breastfeeding devices and supplies, including Hospital-grade breast pumps and double breast pump kit, as supported by HRSA guidelines, are covered as Preventive Care Services. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor. For additional information,

please refer to the "Preventive Care Services" provision in this "Plan Benefits" section and the "Preventive Care List of Services" section.

Diabetic Equipment

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

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

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

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

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

Prostheses

Prostheses are covered as follows:

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

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

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

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

In addition, the following prostheses are covered:

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

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

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

Hospice Facility and Outpatient Care

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

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

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

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

Payment of benefits for inpatient Hospice Care will be subject to the noncertification penalty shown in the "Schedule of Benefits" section if Certification is not obtained for the care. Certification is not required for outpatient (home-based) hospice care.

Family Planning

Contraceptives that are covered under the medical benefit include intrauterine devices (IUDs), injectable contraceptives and implantable rods. Contraceptives that are covered under the outpatient Prescription Drug benefits includes contraceptives for women that are either available over-the-counter or are only available with a Prescription Drug Order. Such contraceptives include oral contraceptives, contraceptive rings, patches, diaphragms, sponges, cervical caps, spermicides, female condoms, and emergency contraceptives.

Over-the-counter women's contraceptives that are covered under this Plan require a Prescription Drug Order. You must present the Prescription Drug Order at a Participating Pharmacy to obtain such contraceptives. For more information, please see the "Outpatient Prescription Drug Benefits" portion of this "Plan Benefits" section of this *Certificate*.

Sterilization of males is covered and is subject to the applicable Copayments or Coinsurance shown in the "Schedule of Benefits" section. Sterilization of females, patient education and counseling on contraception, are covered as Preventive Care Services.

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

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

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

Fertility Preservation

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

Implanted Lens(es) Which Replace the Organic Eye Lens

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

Reconstructive Surgery

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

This plan also covers Medically Necessary reconstructive surgery performed in connection with the treatment for gender dysphoria to create a normal appearance for the gender with which the Covered Person identifies.

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.

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

This does not include cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance or dental services or supplies or treatment for disorders of the jaw except as set out under the "Dental Services" and "Temporomandibular (Jaw) Joint Disorders" portions of the "General Limitations and Exclusions" section.

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

Breast Cancer

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

Phenylketonuria (PKU)

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

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

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

Other specialized formulas and nutritional supplements are not covered.

Pediatric Asthma

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

AIDS Vaccine

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

Osteoporosis

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

Degenerative Illness

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

Surgically Implanted Drugs

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

Dental Injury

Emergency Care of a Physician, while You are covered under this *Certificate*, treating an Accidental Injury to the natural teeth. You must be covered under this *Certificate* at the time such services are rendered. Medically Necessary related Emergency Hospital services will also be covered. Damage to natural teeth due to chewing or biting is not Accidental Injury. Dental appliances are not a Covered Expense except for children under 19 as shown below under the "Child Needs Dental or Eye Care" portion of this "Plan Benefits" section.

Dental Services

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

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

Clinical Trials

Routine patient care costs for patients' items and services furnished in connection with participation in an approved clinical trial are covered when Medically Necessary, authorized by HNL and either the Covered Person's treating Physician has recommended participation in the trial or the Covered Person

has provided medical and scientific information establishing eligibility for the clinical trial. Clinical trial services performed by Out-of-Network Providers are covered only when the protocol for the trial is not available through Preferred Providers within California. Services rendered as part of a clinical trial are subject to the reimbursement guidelines as specified in the law.

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

"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 or funded, which may include funding through in-kind donations by one of the following:

- The National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the federal 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;
- A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
- One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
    1. The United States Department of Veterans Affairs.
    2. The United States Department of Defense.
    3. The United States Department of Energy.
- The FDA as an Investigational new drug application.

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

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

Routine patient care costs include the following:

- Health care services typically provided absent a clinical trial.
- Health care services required solely for the provision of the Investigational drug, item, device or service.
- Health care services required for the clinically appropriate monitoring of the Investigational item or service.
- Health care services provided for the prevention of complications arising from the provision of the Investigational drug, item, device or service.

- Health care services needed for the reasonable and necessary care arising from the provision of the Investigational drug, item, device or service, including the diagnosis or treatment of the complications.

Routine patient care costs do not include:

- The Investigational drug, item, device or service itself.
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the Covered Person.
- Health care services which, except for the fact that they are not being provided in a clinical trial, are otherwise specifically excluded from coverage under this *Certificate*.
- Health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

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

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

Telehealth Services

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

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

Telehealth Consultations through the Select Telehealth Services Provider

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

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

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

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

Telehealth consultations through the Select Telehealth Services Provider do not cover:

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

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

Outpatient Prescription Drug Benefits

The preceding sections of this *Certificate* provide coverage for Prescription Drugs obtained while an inpatient in a Hospital or Skilled Nursing Facility. This plan also includes coverage for Prescription Drugs outside a Hospital or Skilled Nursing Facility setting. This outpatient Prescription Drug benefit is subject to a specific set of terms and conditions documented in this *Certificate* which You must be informed about in order to obtain the highest level of coverage under this benefit. The provisions which follow are in addition to, and do not replace, any other provision under this *Certificate* which may apply to Prescription Drugs. In addition, coverage is subject to exclusions and limitations as shown under the “Outpatient Prescription Drug Benefits” section in the "General Limitations and Exclusions" section. **Subject to the following provisions, all Medically Necessary Prescription Drugs are covered.**

Covered Drugs and Supplies

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

Some Drugs require Prior Authorization from HNL to be covered. If you are denied Prior Authorization, you may request an independent review or go through the binding arbitration remedy set forth in the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" and "Arbitration" provisions of the "Coverage Decisions and Disputes Resolution" section of this *Certificate*.

Prescription Drugs listed in the Health Net Essential Rx Drug List are covered, when prescribed by a Physician, an authorized referral Specialist or an emergent or Urgent Care Physician. The fact that a drug is listed in the Essential Rx Drug List does not guarantee that Your Physician will prescribe it for You for a particular medical condition.

HNL will also make a coverage exception to cover Medically Necessary Drugs that are not listed on the Essential Rx Drug List. Refer to "Prior Authorization and Exception Request Process" later in this section on how to request a coverage exception.

In addition, HNL covers "disposable devices that are Medically Necessary for the administration of a covered outpatient Prescription Drug, such as spacers and inhalers for the administration of aerosol outpatient Prescription Drugs, and syringes for self-injectable outpatient Prescription Drugs that are not dispensed in pre-filled syringes. We shall provide coverage for the Medically Necessary dosage and quantity of a drug prescribed for the treatment of a medical condition consistent with professionally recognized standards of practice.

Tier 1 Drugs and Tier 2 Drugs

Tier 1 Drugs are most Generic Drugs and low-cost preferred Brand Name Drugs. Tier 2 Drugs are higher cost Generic Drugs and preferred Brand Name Drugs.

Tier 3 Drugs

Tier 3 Drugs are Prescription Drugs that are non-preferred Brand Name Drugs, Brand Name Drugs with generic equivalent on a lower tier, or Drugs that have a preferred alternative on a lower tier.

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 may be covered as an exception and are subject to the Tier 3 Drug Copayment or Coinsurance, as applicable. Refer to "Prior Authorization and Exception Request Process" later in this section on how to request a coverage exception.

Tier 4 Drugs (Specialty Drugs)

Tier 4 (Specialty Drugs) include Drugs that are made using biotechnology; Drugs that are distributed through a specialty pharmacy; Drugs that require special training for self-administration; Drugs that require regular monitoring of care by a specialty pharmacy; and Drugs that cost more than six hundred dollars for a one-month supply. Note, insulin and other self-administered injectable Drugs that do not meet the above Specialty Drugs criteria are covered on a lower drug tier as specified in the Essential Rx Drug List.

Certain Specialty Drugs, as specified on the Essential Rx Drug List, may need to be dispensed through a Specialty Pharmacy Vendor and are limited to no more than a 30-day supply per fill. The Specialty Pharmacy Vendor will deliver your medication to you by mail or common carrier. These Drugs are subject to the applicable Copayments or Coinsurances listed under "Outpatient Prescription Drugs" in the "Schedule of Benefits." Specialty Drugs not listed on the Essential Rx Drug List that are covered as an exception would be subject to the Tier 4 Copayment or Coinsurance shown in the "Schedule of Benefits."

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

Generic Equivalents to Brand Name Drugs

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

Off-Label Drugs

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

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

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

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

A. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted;

B. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

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

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

Diabetic Drugs and Supplies

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

Preventive Drugs and Women's Contraceptives

Preventive Drugs, including smoking cessation Drugs, and women's contraceptives are covered as shown in the "Schedule of Benefits" section of this *Certificate*. Covered preventive Drugs are over-the-counter Drugs or Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations.

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

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

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

You may use the Prior Authorization and Exception Request Process to obtain coverage at no cost for a therapeutic equivalent of a contraceptive that is not on the Essential Rx Drug List, such as the brand name equivalent of a covered generic contraceptive. If your Physician submits a Prior Authorization request when Medically Necessary, your contraceptive will be covered at no cost to you. This request is not subject to denial by HNL.

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

Smoking Cessation Coverage

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

Over-the-counter smoking cessation Drugs that are covered under this Plan require a Prescription Drug Order. You must present the Prescription Drug Order at a Health Net Participating Pharmacy to obtain such Drugs. For all FDA-approved tobacco cessation medications, no limits will be imposed on the

number of days that are covered, regardless of whether the medications are taken alone or in combination.

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

Compounded Drugs

Compounded Drugs are prescription orders that have at least one ingredient that is Federal Legend or state restricted in a therapeutic amount as Medically Necessary and are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form and require a prescription order for dispensing. 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 3 Drug Copayment and is subject to Prior Authorization by HNL and Medical Necessity. HNL covers compounded medication(s) when:

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

Schedule II Narcotic Drugs

Schedule II Drugs are Drugs classified by the Federal Drug Enforcement Administration as having a high abuse risk but also safe and accepted medical uses in the United States. A partial prescription fill, which is of a quantity less than the entire prescription, can be requested by you or your Physician. Partial prescription fills are subject to a prorated Copayment or Coinsurance based on the amount of the prescription that is filled by the pharmacy. Schedule II narcotic Drugs are not covered through mail order.

"Split-fill" Program

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

The Essential Rx Drug List

What Is the Health Net Essential Rx Drug List?
HNL developed the Essential Rx Drug List to identify the safest and most effective medications for HNL Covered Persons while attempting to maintain affordable pharmacy benefits. We specifically suggest to all Preferred Providers that they refer to this Essential Rx Drug List when choosing Drugs for

patients who are HNL Covered Persons. When Your Physician prescribes medications listed in the Essential Rx Drug List, it is ensured that You are receiving a high quality and high value prescription medication. In addition, the Essential Rx Drug List identifies whether a Generic version of a Brand Name Drug exists, and whether the drug requires Prior Authorization. If the Generic version exists, it will be dispensed instead of the Brand Name version.

HNL also covers Drugs that are not on the Essential Rx Drug List. If a drug is not on the Essential Rx Drug List, Prior Authorization is required as shown in "Prior Authorization and Exception Request Process" below.

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

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

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

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

Who Is on the Health Net Pharmacy and Therapeutics Committee and How Are Decisions Made?

The Pharmacy and Therapeutics Committee ("Committee") develops, maintains, and oversees the Essential Rx Drug List. The Committee meets each quarter, and maintains written documentation of its decisions and the rationale informing its decisions.

Committee membership includes actively practicing Physicians of various medical specialties from Health Net contracting Physician groups, and clinical pharmacists. HNL recruits voting members from contracting Physician groups throughout California based on their experience, knowledge and expertise. Frequently, the Committee consults external medical Physician experts for additional medical input. A vote is taken before a drug is added to the Essential Rx Drug List based on the medical input from these external Physician experts who are not employees of HNL. Neither voting members of the Committee nor the external medical professionals with whom the Committee consults are HNL employees, and this ensures decisions are unbiased and without conflicts of interest.

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

a. Developing and documenting procedures to ensure appropriate drug review and inclusion;

b. Basing clinical decisions on the strength of the scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and other related information;

c. Considering the therapeutic advantages of Drugs in terms of safety and efficacy when selecting formulary Drugs;

d. Reviewing policies that guide exceptions and other utilization management processes, including drug utilization review, quantity limits, and therapeutic interchange;

e. Evaluating and analyzing treatment protocols and procedures related to the insurer's formulary at least annually;

f. Reviewing and approving all clinical prior authorization criteria, step therapy protocols, and quantity limit restrictions applied to each covered drug;

g. Reviewing new United States Food and Drug Administration-approved Drugs and new uses for existing Drugs;

h. Ensuring HNL's Essential Rx Drug List cover a range of Drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all disease states, and do not discourage enrollment by any group of insureds; and

i. Ensuring HNL's Essential Rx Drug List provides appropriate access to Drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time.

Prior Authorization and Exception Request 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. Step therapy exceptions are also subject to the Prior Authorization process. You may refer to our website at www.healthnet.com to review the Drugs that require a Prior Authorization as noted in the Essential Rx Drug List.

Requests for Prior Authorization, including step therapy exceptions, may be submitted electronically or by telephone (at the phone number shown on Your HNL ID card) or facsimile 1-800-314-6623. Urgent requests from Physicians (including Pain medications for terminally ill Covered Persons) for authorization are processed, and prescribing providers notified of HNL's determination as soon as possible, not to exceed 24 hours, after HNL's receipt of the request. A Prior Authorization request is urgent when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function.

Routine requests from Physicians are processed, and prescribing providers notified of HNL's determination in a timely fashion, not to exceed 72 hours following receipt of the request. For both urgent and routine requests, HNL must also notify the insured or his or her designee of its decision. If HNL fails to respond within the required time limit, the Prior Authorization request is deemed granted.

If a drug is not on the Essential Rx Drug List, your Physician can ask for an exception. To request an exception, your Physician can submit a Prior Authorization request along with a statement supporting the request. Requests for Prior Authorization may be submitted electronically or by telephone or

facsimile. If we approve an exception for a drug that is not on the Essential Rx Drug List, the non-preferred Brand Name Drug tier (Tier 3) or Specialty Copayment (Tier 4) applies. If You are suffering from a condition that may seriously jeopardize Your life, health, or ability to regain maximum function, or if You are undergoing a current course of treatment using a drug that is not on the Essential Rx Drug List, then You, Your designee or Your Physician can request an expedited review. Expedited requests for an exception will be processed, and You, Your designee and the prescribing providers will be notified, within 24 hours after HNL's receipt of the request. Standard requests for an exception will be processed, and You, Your designee and the prescribing provider will be notified within 72 hours after HNL's receipt of the request. Exceptions based on your medical condition will be for the duration of your medical condition.

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

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

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

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

Once a medication is approved, its authorization becomes effective immediately. The approval will be for the duration of the prescription for maintenance medications or a specified time frame for other medications. HNL will cover Drugs not on the Essential Rx Drug List for the duration of the prescription, including refills, when a Covered Person receives such coverage through a standard exception request. When a Covered Person obtains coverage for Drugs not on the Essential Rx Drug List through an expedited exception request, HNL will cover such Drugs for the duration of the exigency.

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

If you are denied Prior Authorization, you may request an independent review or go through the binding arbitration remedy set forth in the "Independent Medical Review of Grievances Involving a Disputed

Health Care Service" and "Arbitration" provisions of the "Coverage Decisions and Disputes Resolution" section of this *Certificate*.

Step Therapy

Step therapy is a process in which You may need to use one type of Prescription Drug before HNL will cover another one. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. Exceptions to the step therapy process are subject to Prior Authorization. However, if You were taking a Prescription Drug for a medical condition under a previous plan before enrolling in this Health Net PPO plan, You will not be required to use the step therapy process to continue using the Prescription Drug.

Retail Pharmacies and the Mail Order Program

Tier 1, Tier 2 and Tier 3, Tier 4 (Specialty) Drugs Dispensed by a Participating Pharmacy

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

If refills are stipulated on the Prescription Drug Order, a Participating Pharmacy may dispense up to a 30-consecutive-calendar-day supply for each Prescription Drug Order or for each refill at the appropriate time interval or a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives when dispensed or furnished at one time

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

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

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

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

Specialty Drugs Dispensed by the Specialty Pharmacy Vendor

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

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

Tier 1, Tier 2 and Tier 3 Drugs or Tier 4 Specialty Drugs Dispensed by a Nonparticipating Pharmacy

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

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

- Pay the full cost of the Prescription Drug that is dispensed; and
- Submit a claim to HNL for reimbursement of a Covered Expense.
- You may then be entitled to reimbursement, minus the applicable Copayment, Coinsurance and/or Deductible, in accordance with the terms of this *Certificate*.

Claim forms will be provided by HNL upon request.

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

Tier 1, Tier 2 and Tier 3 Drugs Dispensed Through the Mail Service Prescription Drug Program

If Your prescription is for a Maintenance Drug, You shall be entitled to have a Prescription Drug Order filled through a mail delivery program selected by HNL. Through this program You can receive through the mail up to a 90-consecutive-calendar-day supply of a Maintenance Drug when so prescribed or a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives when dispensed or furnished at one time. In some cases a 90-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan, according to FDA or HNL usage guidelines. The lesser of the applicable mail order Copayments or Coinsurance or the mail order pharmacy's retail price will be required for Drugs listed in the Essential Rx Drug List.

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

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

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

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

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

Child Needs 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.

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

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. 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. 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.

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

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 the difference between HNL's Maximum Allowable Amount and the dentist's total billed charges. Non-Network Benefits are determined based on the "Maximum Allowable Amount" for pediatric Dental Services as calculated by HNL, based on available data resources of competitive fees in that geographic area and must not exceed the fees that the Dental Provider would charge any similarly situated payor for the same services for each Covered Dental Service. The data resources of competitive fees are supplied by FAIR Health, which are updated twice a year. HNL reimburses non-Network Dental Providers at 55% of FAIR Health rates. The actual charge made by a non-Network Dental Provider for a Covered Dental Service may exceed the Maximum Allowable Amount. 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 Maximum Allowable Amount. 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 Medically 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 *Certificate*.

Teledentistry Benefits

This dental plan covers Medically Necessary Teledentistry benefits as described in the "Pediatric Dental Services" portion of the "Schedule of Benefits." Teledentistry services must be provided by a Health Net Participating Dental Provider from our network.

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 *Certificate*.

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.

Benefits for Pediatric Dental Services

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

A. Medically Necessary.

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

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

Pediatric Dental Essential Health Benefits:

CDT Codes	Procedure Code Description

Diagnostic

D0120 .....Periodic oral evaluation - established patient
D0140 .....Limited oral evaluation – problem focused
D0145 .....Oral evaluation for a patient under three years of age and counseling with primary caregiver
D0150 .....Comprehensive oral evaluation – new or established patient
D0160 .....Detailed and extensive oral evaluation – problem focused, by report
D0170 .....Re-evaluation – limited, problem focused (established patient; not post- operative visit)
D0171 .....Re-evaluation – post –operative office visit
D0180 .....Comprehensive periodontal evaluation – new or established patient
D0210 .....Intraoral - complete series of radiographic images
D0220 .....Intraoral - periapical first radiographic image
D0230 .....Intraoral - periapical each additional radiographic image
D0240 .....Intraoral - occlusal radiographic image
D0250 .....Extra oral - first radiographic image
D0251 .....Extra-oral - posterior dental radiographic image
D0270 .....Bitewing - single radiographic image
D0272 .....Bitewings - two radiographic images
D0273 .....Bitewings - three radiographic images
D0274 .....Bitewings - four radiographic images
D0277 .....Vertical bitewings - 7 to 8 radiographic images
D0310 .....Sialography
D0320 .....Temporomandibular joint arthrogram, including injection
D0322 .....Tomographic survey
D0330 .....Panoramic radiographic image
D0340 .....Cephalometric radiographic image
D0350 .....Oral/Facial photographic images
D0351 .....3D photographic image
D0460 .....Pulp vitality tests
D0470 .....Diagnostic casts
D0502 .....Other oral pathology procedures, by report
D0601 .....Caries risk assessment and documentation, with a finding of low risk
D0602 .....Caries risk assessment and documentation, with a finding of moderate risk
D0603 .....Caries risk assessment and documentation, with a finding of high risk
D0701 .....Panoramic radiographic image – image capture only
D0702 .....2-D cephalometric radiographic image – image capture only

D0703 .....2-D oral/facial photographic image obtained intra-orally or extra-orally –image capture only
D0704 .....3-D photographic image – image capture only
D0705 .....Extra-oral posterior dental radiographic image – image capture only
D0706 .....Intraoral – occlusal radiographic image – image capture only
D0707 .....Intraoral – periapical radiographic image – image capture only
D0708 .....Intraoral – bitewing radiographic image – image capture only
D0709 .....Intraoral – complete series of radiographic images – image capture only
D0999 .....Unspecified diagnostic procedure, by report

Preventive

D1110 .....Prophylaxis – adult
D1120 .....Prophylaxis – child
D1206 .....Topical application of fluoride varnish
D1208 .....Topical application of fluoride
D1310 .....Nutritional counseling for control of dental disease
D1320 .....Tobacco counseling for the control and prevention of oral disease
D1321 .....Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use
D1330 .....Oral hygiene instructions
D1351 .....Sealant – per tooth
D1352 .....Preventive resin restoration in a moderate to high carries risk patient - permanent tooth
D1353 .....Sealant repair – per tooth
D1354 .....Interim caries arresting medicament application - per tooth
D1355 .....Caries preventive medicament application – per tooth
D1510 .....Space maintainer-fixed – unilateral – per quadrant
D1516 .....Space maintainer – fixed – bilateral, maxillary
D1517 .....Space maintainer – fixed – bilateral, mandibular
D1520 .....Space maintainer-removable – unilateral – per quadrant
D1526 .....Space maintainer – removable – bilateral, maxillary
D1527 .....Space maintainer – removable – bilateral, mandibular
D1551 .....Re-cement or re-bond bilateral space maintainer - maxillary
D1552 .....Re-cement or re-bond bilateral space maintainer - mandibular
D1553 .....Re-cement or re-bond unilateral space maintainer - per quadrant
D1556 .....Removal of fixed unilateral space maintainer - per quadrant
D1557 .....Removal of fixed bilateral space maintainer - maxillary
D1558 .....Removal of fixed bilateral space maintainer - mandibular
D1575 .....Distal shoe space maintainer-fixed-unilateral – per quadrant

Restorative

D2140 .....Amalgam – one surface, primary or permanent
D2150 .....Amalgam – two surfaces, primary or permanent
D2160 .....Amalgam – three surfaces, primary or permanent
D2161 .....Amalgam – four or more surfaces, primary or permanent
D2330 .....Resin-based composite – one surface, anterior

D2331 .....Resin-based composite – two surfaces, anterior
D2332 .....Resin-based composite – three surfaces, anterior
D2335 .....Resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2390 .....Resin-based composite crown, anterior
D2391 .....Resin-based composite – one surface, posterior
D2392 .....Resin-based composite – two surfaces, posterior
D2393 .....Resin-based composite – three surfaces, posterior
D2394 .....Resin-based composite – four or more surfaces, posterior
D2710 .....Crown – resin - based composite (indirect)
D2712 .....Crown - 3/4 resin-based composite (indirect)
D2721 .....Crown – resin with predominantly base metal
D2740 .....Crown – porcelain/ceramic substrate
D2751 .....Crown – porcelain fused to predominantly base metal
D2781 .....Crown – 3/4 cast predominantly base metal
D2783 .....Crown – 3/4 porcelain/ceramic
D2791 .....Crown – full cast predominantly base metal
D2910 .....Re-cement inlay, onlay, or partial coverage restoration
D2915 .....Re-cement cast or prefabricated post and core
D2920 .....Re-cement crown
D2921 .....Reattachment of tooth fragment, incisal edge or cusp
D2928 .....Prefabricated porcelain/ceramic crown – permanent tooth
D2929 .....Prefabricated porcelain/ceramic crown - primary tooth
D2930 .....Prefabricated stainless steel crown – primary tooth
D2931 .....Prefabricated stainless steel crown – permanent tooth
D2932 .....Prefabricated resin crown
D2933 .....Prefabricated stainless steel crown with resin window
D2940 .....Protective restoration
D2941 .....Interim therapeutic restoration – primary dentition
D2949 .....Restorative foundation for an indirect restoration
D2950 .....Core buildup, including any pins
D2951 .....Pin retention – per tooth, in addition to restoration
D2952 .....Post and core in addition to crown, indirectly fabricated
D2953 .....Each additional indirectly fabricated post – same tooth
D2954 .....Prefabricated post and core in addition to crown
D2955 .....Post removal
D2957 .....Each additional prefabricated post -same tooth
D2971 .....Additional procedures to construct new crown under existing partial denture framework
D2980 .....Crown repair, necessitated by restorative material failure
D2999 .....Unspecified restorative procedure, by report

Endodontics

D3110 .....Pulp cap – direct (excluding final restoration)
D3120 .....Pulp cap – indirect (excluding final restoration)

D3220 .....Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction application of medicament
D3221 .....Pulpal debridement, primary and permanent teeth
D3222 .....Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development
D3230 .....Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)
D3240 .....Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)
D3310 .....Endodontic therapy, anterior tooth (excluding final restoration)
D3320 .....Endodontic therapy, bicuspid tooth (excluding final restoration)
D3330 .....Endodontic therapy, molar tooth (excluding final restoration)
D3331 .....Treatment of root canal obstruction; non-surgical access
D3333 .....Internal root repair of perforation defects
D3346 .....Retreatment of previous root canal therapy – anterior
D3347 .....Retreatment of previous root canal therapy – bicuspid
D3348 .....Retreatment of previous root canal therapy – molar
D3351 .....Apexification/Recalcification/Pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection etc.)
D3352 .....Apexification/Recalcification/Pulpal regeneration - interim medication replacement
D3410 .....Apicoectomy/Periradicular surgery – anterior
D3421 .....Apicoectomy/Periradicular surgery – bicuspid (first root)
D3425 .....Apicoectomy/Periradicular surgery – molar (first root)
D3426 .....Apicoectomy/Periradicular surgery – (each additional root)
D3430 .....Retrograde filling – per root
D3471 .....Surgical repair of root resorption - anterior
D3472 .....Surgical repair of root resorption – premolar
D3473 .....Surgical repair of root resorption – molar
D3910 .....Surgical procedure for isolation of tooth with rubber dam
D3999 .....Unspecified endodontic procedure, by report

Periodontics

D4210 .....Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bound spaces per quadrant
D4211 .....Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant
D4249 .....Clinical crown lengthening – hard tissue
D4260 .....Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant
D4261 .....Osseous surgery (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces, per quadrant
D4265 .....Biologic materials to aid in soft and osseous tissue regeneration
D4341 .....Periodontal scaling and root planing – four or more teeth per quadrant
D4342 .....Periodontal scaling and root planing – one to three teeth, per quadrant

D4346 .....Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation
D4355 .....Full mouth debridement to enable comprehensive evaluation and diagnosis
D4381 .....Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
D4910 .....Periodontal maintenance
D4920 .....Unscheduled dressing change (by someone other than treating dentist)
D4999 .....Unspecified periodontal procedure, by report

Prosthodontics, removable

D5110 .....Complete denture – maxillary
D5120 .....Complete denture – mandibular
D5130 .....Immediate denture – maxillary
D5140 .....Immediate denture – mandibular
D5211 .....Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
D5212 .....Mandibular partial denture – resin base (including any conventional clasps, rest and teeth)
D5213 .....Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rest and teeth)
D5214 .....Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rest and teeth)
D5221 .....Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)
D5222 .....Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth
D5223 .....Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)
D5224 .....Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)
D5410 .....Adjust complete denture – maxillary
D5411 .....Adjust complete denture – mandibular
D5421 .....Adjust partial denture – maxillary
D5422 .....Adjust partial denture – mandibular
D5511 .....Repair broken complete denture base, mandibular
D5512 .....Repair broken complete denture base, maxillary
D5520 .....Replace missing or broken teeth – complete denture (each tooth)
D5611 .....Repair resin denture base, mandibular
D5612 .....Repair resin denture base, maxillary
D5621 .....Repair cast framework, mandibular
D5622 .....Repair cast framework, maxillary
D5630 .....Repair or replace broken clasp
D5640 .....Replace broken teeth – per tooth
D5650 .....Add tooth to existing partial denture
D5660 .....Add clasp to existing partial denture
D5730 .....Reline complete maxillary denture (chairside)

D5731 .....Reline complete mandibular denture (chairside)
D5740 .....Reline maxillary partial denture (chairside)
D5741 .....Reline mandibular partial denture (chairside)
D5750 .....Reline complete maxillary denture (laboratory)
D5751 .....Reline complete mandibular denture (laboratory)
D5760 .....Reline maxillary partial denture (laboratory)
D5761 .....Reline mandibular partial denture (laboratory)
D5850 .....Tissue conditioning, maxillary
D5851 .....Tissue conditioning, mandibular
D5862 .....Precision attachment, by report
D5863 .....Overdenture – complete maxillary
D5864 .....Overdenture – partial maxillary
D5865 .....Overdenture – complete mandibular
D5866 .....Overdenture – partial mandibular
D5899 .....Unspecified removable prosthodontic procedure, by report

Maxillofacial Prosthetics

D5911 .....Facial moulage (sectional)
D5912 .....Facial moulage (complete)
D5913 .....Nasal prosthesis
D5914 .....Auricular prosthesis
D5915 .....Orbital prosthesis
D5916 .....Ocular prosthesis
D5919 .....Facial prosthesis
D5922 .....Nasal septal prosthesis
D5923 .....Ocular prosthesis, interim
D5924 .....Cranial prosthesis
D5925 .....Facial augmentation implant prosthesis
D5926 .....Nasal prosthesis, replacement
D5927 .....Auricular prosthesis, replacement
D5928 .....Orbital prosthesis, replacement
D5929 .....Facial prosthesis, replacement
D5931 .....Obturator prosthesis, surgical
D5932 .....Obturator prosthesis, definitive
D5933 .....Obturator prosthesis, modification
D5934 .....Mandibular resection prosthesis with guide flange
D5935 .....Mandibular resection prosthesis without guide flange
D5936 .....Obturator prosthesis, interim
D5937 .....Trismus appliance (not for TMD treatment)
D5951 .....Feeding aid
D5952 .....Speech aid prosthesis, pediatric
D5953 .....Speech aid prosthesis, adult
D5954 .....Palatal augmentation prosthesis
D5955 .....Palatal lift prosthesis, definitive
D5958 .....Palatal lift prosthesis, interim
D5959 .....Palatal lift prosthesis, modification

D5960 .....Speech aid prosthesis, modification
D5982 .....Surgical stent
D5983 .....Radiation carrier
D5984 .....Radiation shield
D5985 .....Radiation cone locator
D5986 .....Fluoride gel carrier
D5987 .....Commissure splint
D5988 .....Surgical splint
D5991 .....Topical Medicament Carrier
D5999 .....Unspecified maxillofacial prosthesis, by report

Implant Services

D6010 .....Surgical placement of implant body: endosteal implant
D6011 .....Surgical access to an implant body (second stage implant surgery)
D6013 .....Surgical placement of mini implant
D6040 .....Surgical placement: eposteal implant
D6050 .....Surgical placement: transosteal implant
D6055 .....Connecting bar - implant supported or abutment supported
D6056 .....Prefabricated abutment - includes modification and placement
D6057 .....Custom fabricated abutment - includes placement
D6058 .....Abutment supported porcelain/ceramic crown
D6059 .....Abutment supported porcelain fused to metal crown (high noble metal)
D6060 .....Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061 .....Abutment supported porcelain fused to metal crown (noble metal)
D6062 .....Abutment supported cast metal crown (high noble metal)
D6063 .....Abutment supported cast metal crown (predominantly base metal)
D6064 .....Abutment supported cast metal crown (noble metal)
D6065 .....Implant supported porcelain/ceramic crown
D6066 .....Implant supported crown (porcelain fused to high noble alloys)
D6067 .....Implant supported crown (high noble alloys)
D6068 .....Abutment supported retainer for porcelain/ceramic FPD
D6069 .....Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070 .....Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071 .....Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072 .....Abutment supported retainer for cast metal FPD (high noble metal)
D6073 .....Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074 .....Abutment supported retainer for cast metal FPD (noble metal)
D6075 .....Implant supported retainer for ceramic FPD
D6076 .....Implant supported retainer FPD (high noble alloys)
D6077 .....Implant supported retainer for metal FPD (high noble alloys)
D6080 .....Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis
D6081 .....Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure
D6082 .....Implant supported crown - porcelain fused to predominantly base alloys

D6083 .....Implant supported crown - porcelain fused to noble alloys
D6084 .....Implant supported crown - porcelain fused to titanium and titanium alloys
D6085 .....Provisional implant crown
D6086 .....Implant supported crown - predominantly base alloys
D6087 .....Implant supported crown - noble alloys
D6088 .....Implant supported down - titanium and titanium alloys
D6090 .....Repair implant supported prosthesis, by report
D6091 .....Replacement of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment
D6092 .....Re-cement implant/abutment supported crown
D6093 .....Re-cement implant/abutment supported fixed partial denture
D6094 .....Abutment supported crown titanium and titanium alloys
D6095 .....Repair implant abutment, by report
D6096 .....Remove broken implant retaining screw
D6097 .....Abutment supported crown - porcelain fused to titanium and titanium alloys
D6098 .....Implant supported retainer - porcelain fused to predominantly base alloys
D6099 .....Implant supported retainer for FPD - porcelain fused to noble alloys
D6100 .....Implant removal, by report
D6110 .....Implant/abutment supported removable denture for edentulous arch-maxillary
D6111 .....Implant/abutment supported removable denture for edentulous arch-mandibular
D6112 .....Implant/abutment supported removable denture for partially edentulous arch-maxillary
D6113 .....Implant/abutment supported removable denture for partially edentulous arch-mandibular
D6114 .....Implant/abutment supported fixed denture for edentulous arch-maxillary
D6115 .....Implant/abutment supported fixed denture for edentulous arch-mandibular
D6116 .....Implant/abutment supported fixed denture for partially edentulous arch-maxillary
D6117 .....Implant/abutment supported fixed denture for partially edentulous arch-mandibular
D6120 .....Implant supported retainer - porcelain fused to titanium and titanium alloys
D6121 .....Implant supported retainer for metal FPD - predominantly base alloys
D6122 .....Implant supported retainer for metal FPD - noble alloys
D6123 .....Implant supported retainer for metal FPD - titanium and titanium alloys
D6190 .....Radiographic/Surgical implant index, by report
D6191 .....Semi-precision abutment – placement
D6192 .....Semi-precision attachment – placement
D6194 .....Abutment supported retainer crown for FPD (titanium and titanium alloys)
D6199 .....Unspecified implant procedure, by report

Fixed Prosthodontics

D6211 .....Pontic – cast predominantly base metal
D6241 .....Pontic – porcelain to predominantly base metal
D6245 .....Pontic – porcelain/ceramic
D6251 .....Pontic – resin with predominantly base metal
D6721 .....Crown – resin with predominantly base metal
D6740 .....Crown – porcelain/ceramic

D6751 .....Crown – porcelain fused to predominantly base metal
D6781 .....Crown – 3/4 cast predominantly base metal
D6783 .....Crown – 3/4 porcelain/ceramic
D6784 .....Retainer Crown 3/4 - titanium and titanium alloys
D6791 .....Crown – full cast predominantly base metal
D6930 .....Re-cement fixed partial denture
D6980 .....Fixed partial denture repair, necessitated by restorative material failure
D6999 .....Unspecified fixed prosthodontic procedure, by report

Oral and Maxillofacial Surgery

D7111 .....Extraction, coronal remnants – deciduous tooth
D7140 .....Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210 .....Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220 .....Removal of impacted tooth – soft tissue
D7230 .....Removal of impacted tooth – partially bony
D7240 .....Removal of impacted tooth – completely bony
D7241 .....Removal of impacted tooth – completely bony, with unusual surgical complications
D7250 .....Surgical removal of residual tooth roots (cutting procedure)
D7260 .....Oroantral fistula closure
D7261 .....Primary closure of a sinus perforation
D7270 .....Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 .....Surgical access of an unerupted tooth
D7283 .....Placement of device to facilitate eruption of impacted tooth
D7285 .....Biopsy of oral tissue – hard (bone, tooth)
D7286 .....Biopsy of oral tissue – soft
D7290 .....Surgical repositioning of teeth
D7291 .....Transseptal fiberotomy/supra crestal fiberotomy, by report
D7310 .....Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7311 .....Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7320 .....Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7321 .....Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7340 .....Vestibuloplasty – ridge extension (secondary epithelialization)
D7350 .....Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
D7410 .....Excision of benign lesion up to 1.25 cm
D7411 .....Excision of benign lesion greater than 1.25 cm
D7412 .....Excision of benign lesion, complicated
D7413 .....Excision of malignant lesion up to 1.25 cm

D7414 .....Excision of malignant lesion greater than 1.25 cm
D7415 .....Excision of malignant lesion, complicated
D7440 .....Excision of malignant tumor – lesion diameter up to 1.25 cm
D7441 .....Excision of malignant tumor – lesion diameter greater than 1.25 cm
D7450 .....Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm
D7451 .....Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm
D7460 .....Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm
D7461 .....Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm
D7465 .....Destruction of lesion(s) by physical or chemical method, by report
D7471 .....Removal of lateral exostosis (maxilla or mandible)
D7472 .....Removal of torus palatinus
D7473 .....Removal of torus mandibularis
D7485 .....Surgical reduction of osseous tuberosity
D7490 .....Radical resection of maxilla or mandible
D7510 .....Incision and drainage of abscess – intraoral soft tissue
D7511 .....Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
D7520 .....Incision and drainage of abscess – extraoral soft tissue
D7521 .....Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
D7530 .....Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540 .....Removal of reaction producing foreign bodies, musculoskeletal system
D7550 .....Partial ostectomy/sequestrectomy for removal of non-vital bone
D7560 .....Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610 .....Maxilla – open reduction (teeth immobilized, if present)
D7620 .....Maxilla – closed reduction (teeth immobilized, if present)
D7630 .....Mandible – open reduction (teeth immobilized, if present)
D7640 .....Mandible – closed reduction (teeth immobilized, if present)
D7650 .....Malar and/or zygomatic arch – open reduction
D7660 .....Malar and/or zygomatic arch – closed reduction
D7670 .....Alveolus – closed reduction, may include stabilization of teeth
D7671 .....Alveolus – open reduction, may include stabilization of teeth
D7680 .....Facial bones – complicated reduction with fixation and multiple surgical approaches
D7710 .....Maxilla – open reduction
D7720 .....Maxilla – closed reduction
D7730 .....Mandible – open reduction
D7740 .....Mandible – closed reduction
D7750 .....Malar and/or zygomatic arch – open reduction
D7760 .....Malar and/or zygomatic arch – closed reduction
D7770 .....Alveolus – open reduction stabilization of teeth
D7771 .....Alveolus, closed reduction stabilization of teeth
D7780 .....Facial bones – complicated reduction with fixation and multiple surgical approaches
D7810 .....Open reduction of dislocation

D7820 .....Closed reduction of dislocation
D7830 .....Manipulation under anesthesia
D7840 .....Condylectomy
D7850 .....Surgical discectomy, with/without implant
D7852 .....Disc repair
D7854 .....Synovectomy
D7856 .....Myotomy
D7858 .....Joint reconstruction
D7860 .....Arthrotomy
D7865 .....Arthroplasty
D7870 .....Arthrocentesis
D7871 .....Non-arthroscopic lysis and lavage
D7872 .....Arthroscopy – diagnosis, with or without biopsy
D7873 .....Arthroscopy – surgical: lavage and lysis of adhesions
D7874 .....Arthroscopy – surgical: disc repositioning and stabilization
D7875 .....Arthroscopy – surgical: synovectomy
D7876 .....Arthroscopy – surgical: discectomy
D7877 .....Arthroscopy – surgical: debridement
D7880 .....Occlusal orthotic device, by report
D7881 .....Occlusal orthotic device adjustment
D7899 .....Unspecified TMD therapy, by report
D7910 .....Suture of recent small wounds up to 5 cm
D7911 .....Complicated suture – up to 5 cm
D7912 .....Complicated suture – greater than 5 cm
D7920 .....Skin graft (identify defect covered, location and type of graft)
D7922 .....Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site
D7940 .....Osteoplasty – for orthognathic deformities
D7941 .....Osteotomy – mandibular rami
D7943 .....Osteotomy – mandibular rami with bone graft; includes obtaining the graft
D7944 .....Osteotomy – segmented or subapical
D7945 .....Osteotomy – body of mandible
D7946 .....LeFort I (maxilla – total)
D7947 .....LeFort I (maxilla – segmented)
D7948 .....LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft
D7949 .....LeFort II or LeFort III – with bone graft
D7950 .....Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones – autogenous or nonautogenous, by report
D7951 .....Sinus augmentation with bone or bone substitutes via a lateral open approach
D7952 .....Sinus augmentation with bone or bone substitute via a vertical approach
D7955 .....Repair of maxillofacial soft and/or hard tissue defect
D7961 .....Buccal/labial frenectomy (frenulectomy)
D7962 .....Lingual frenectomy (frenulectomy)
D7963 .....Frenuloplasty
D7970 .....Excision of hyperplastic tissue – per arch
D7971 .....Excision of pericoronal gingiva

D7972 .....Surgical reduction of fibrous tuberosity
D7979 .....Non-surgical Sialolithotomy
D7980 .....Sialolithotomy
D7981 .....Excision of salivary gland, by report
D7982 .....Sialodochoplasty
D7983 .....Closure of salivary fistula
D7990 .....Emergency tracheotomy
D7991 .....Coronoidectomy
D7995 .....Synthetic graft – mandible or facial bones, by report
D7997 .....Appliance removal (not by dentist who placed appliance), includes removal of archbar
D7999 .....Unspecified oral surgery procedure, by report

Medically Necessary Orthodontia

D8080 .....Comprehensive orthodontic treatment of the adolescent dentition Handicapping malocclusion
D8080 .....Comprehensive orthodontic treatment of the adolescent dentition cleft palate - primary dentition
D8080 .....Comprehensive orthodontic treatment of the adolescent dentition cleft palate - mixed dentition
D8080 .....Comprehensive orthodontic treatment of the adolescent dentition cleft palate - permanent dentition
D8080 .....Comprehensive orthodontic treatment of the adolescent dentition facial growth management - primary dentition
D8080 .....Comprehensive orthodontic treatment of the adolescent dentition facial growth management - mixed dentition
D8080 .....Comprehensive orthodontic treatment of the adolescent dentition facial growth management - permanent dentition
D8210 .....Removable appliance therapy
D8220 .....Fixed appliance therapy
D8660 .....Pre-orthodontic treatment visit
D8670 .....Periodic orthodontic treatment visit (as part of contract) Handicapping malocclusion
D8670 .....Periodic orthodontic treatment visit (as part of contract) cleft palate - primary dentition
D8670 .....Periodic orthodontic treatment visit (as part of contract) cleft palate - mixed dentition
D8670 .....Periodic orthodontic treatment visit (as part of contract) cleft palate - permanent dentition
D8670 .....Periodic orthodontic treatment visit (as part of contract) facial growth management - primary dentition
D8670 .....Periodic orthodontic treatment visit (as part of contract) facial growth management - mixed dentition
D8670 .....Periodic orthodontic treatment visit (as part of contract) facial growth management - permanent dentition

D8680 .....Orthodontic retention (removal of appliances, construction and placement of retainer(s))
D8681 .....Removable orthodontic retainer adjustment
D8696 .....Repair of orthodontic appliance - maxillary
D8697 .....Repair of orthodontic appliance - mandibular
D8698 .....Re-cement or re-bond fixed retainer - maxillary
D8699 .....Re-cement or re-bond fixed retainer - mandibular
D8701 .....Repair of fixed retainer, includes reattachment - maxillary
D8702 .....Repair of fixed retainer, includes reattachment - mandibular
D8703 .....Replacement of lost or broken retainer - maxillary
D8704 .....Replacement of lost or broken retainer - mandibular
D8999 .....Unspecified orthodontic procedure, by report

Adjunctive General Services

D9110 .....Palliative (emergency) treatment of dental Pain – minor procedure
D9120 .....Fixed partial denture sectioning
D9210 .....Local anesthesia not in conjunction with operative or surgical procedures
D9211 .....Regional block anesthesia
D9212 .....Trigeminal division block anesthesia
D9215 .....Local anesthesia in conjunction with operative or surgical procedures
D9222 .....Deep sedation/analgesia – first 15 minutes
D9223 .....Deep sedation/general anesthesia – each 15 minute increment
D9230 .....Inhalation of nitrous oxide/anxiolysis analgesia
D9239 .....Intravenous moderate (conscious) sedation/analgesia – first 15 minutes
D9243 .....Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment
D9248 .....Non-intravenous conscious sedation
D9310 .....Consultation diagnostic service provided by dentist or Physician other than requesting dentist or Physician
D9311 .....Consultation with a medical health professional
D9410 .....House/Extended care facility call
D9420 .....Hospital or ambulatory surgical center call
D9430 .....Office visit for observation (during regularly scheduled hours) - no other services performed
D9440 .....Office visit – after regularly scheduled hours
D9610 .....Therapeutic parenteral drug, single administration
D9612 .....Therapeutic parenteral drug, two or more administrations, different medications
D9910 .....Application of desensitizing medicament
D9930 .....Treatment of complications (post-surgical) – unusual circumstances, by report
D9950 .....Occlusion analysis – mounted case
D9951 .....Occlusal adjustment – limited
D9952 .....Occlusal adjustment – complete
D9995 .....Teledentistry - synchronous; real-time encounter
D9996 .....Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review
D9997 .....Dental case management - patients with special health care needs
D9999 .....Unspecified adjunctive procedure, by report

Pediatric Dental Exclusions and Limitations:

Services that exceed the limitations listed below are not covered.

Periodic Oral Evaluations (D0120)

Periodic oral evaluations are limited to 1 every 6 months per provider.

Prophylaxis (D1110 and D1120)

Prophylaxis services (cleanings) are limited to 1 every 6 months.

Fluoride treatment (D1206 and D1208)

Fluoride treatment is covered once 1 every 6 months.

Intraoral radiographic images

D0210 - Intraoral - complete series of radiographic images are limited to once per provider every 36 months.

D0420 - Intraoral - occlusal radiographic image are limited to 2 every 6 months per provider.

Bitewing x-rays (D0274)

Bitewings - four radiographic images are limited to once every 6 months per provider.

Panoramic film x-rays (D0330)

Panoramic radiographic images are limited to once every 36 months.

Dental Sealant (D1351)

Dental sealant per tooth is limited to the first, second and third permanent molars that occupy the second molar position once per tooth every 36 months per provider.

Replacement of a restoration (D2140 – D2394)

Replacement of a restoration is covered only when it is defective, as evidenced by conditions such a recurrent caries or fracture, and replacement is Medically Necessary.

Prefabricated Crowns (D2929 – D2933)

Prefabricated Crowns – primary teeth are covered once every 12 months.

Prefabricated Crowns – permanent teeth are covered once every 36 months.

Gingivectomy or gingivoplasty (D4210 or D4211) and osseous surgery (D4260 and D4261)

Gingivectomy or gingivoplasty and osseous surgery are limited to once per quadrant every 36 months.

Periodontics (other than Maintenance) (D4341 and D4342)

Periodontal scaling and root planning, and subgingival curettage are limited to once per quadrant every 24 months.

Periodontal Maintenance (D4910)

Periodontal maintenance is covered once in a calendar quarter only in the 24 month period following the last scaling and root planing.

Fixed bridgework (D6200 – D6999)

Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is optional treatment (that is, it is an upgrade) and HNL will only pay for the partial; the Covered Person is responsible for the difference in cost to upgrade to a fixed bridge. A fixed bridge is covered once in a 5-year period when it is necessary to replace a missing permanent anterior tooth. Fixed bridges used to replace missing posterior teeth are optional (that is, it is an upgrade) when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic. HNL will only pay for the partial; the Covered Person is responsible for the difference in cost to upgrade to a fixed bridge.

Fixed bridges are optional (that is, it is an upgrade) when provided in connection with a partial denture on the same arch. HNL will only pay for the partial; the Covered Person is responsible for the difference in cost to upgrade to a fixed bridge. 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 a full mouth reconstruction, which is optional treatment (that is, it is an upgrade). HNL will only pay for the partial; the Covered Person is responsible for the difference in cost to upgrade to a fixed bridge. Fixed bridges are also covered when medical conditions or employment preclude the use of a removable partial denture.

Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair. Also covered one in a 5-year period when medical conditions or employment preclude the use of a removable partial denture.

Full upper and/or lower dentures (D5000 – D5899)

Full upper and/or lower dentures 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.

Relines (D5730 – D5761)

Office or laboratory relines covered six months after the date of service for immediate dentures an immediate overdenture and cast metal partial dentures that required extractions.

Office or laboratory relines covered 12 months after the date of service for complete (remote) dentures, a complete (remote) overdenture and cast metal partial dentures that do not require extractions.

Tissue Conditioning (D5850 and D5851)

Tissue conditioning is limited to twice per denture in a 36 month period.

Medically Necessary Orthodontia (D8080, D8210, D8220, D8660 - D8681, D8696 - D8999)

Benefits for Medically Necessary comprehensive orthodontic treatment must be for a Covered Person who has one of the medical conditions handicapping malocclusion, cleft palate and facial growth management cases. Orthodontic care is covered when Medically Necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

a. Only those cases with permanent dentition shall be eligible for Medically Necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.

b. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is begun.

c. Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.

d. The automatic qualifying conditions are:

   i. cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,

   ii. craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,

   iii. a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,

   iv. a crossbite of individual anterior teeth causing destruction of soft tissue,

   v. an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,

   vi. a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

If a Covered Person does not score 26 or above on the HLD Index, nor meet one of the six automatic qualifying conditions, he/she may be eligible for an exception if Medical Necessity is documented.

Adjunctive Services:

a. Palliative (emergency) treatment (D9110), for treatment of dental Pain, limited to once per day, per Covered Person.

b. House/extended care facility calls (D9410), once per Covered Person per date of service.

c. One Hospital or ambulatory surgical center call (D9420) per day per provider per Covered Person.

d. Teledentistry Services (D9995 and D9996)

   i. Teledentistry benefits are limited to twice in a 12-month period. This plan does not cover Teledentistry beyond the two sessions in a 12-month period.

Pediatric Dental Exclusions

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

IMPORTANT: If you opt to receive dental services that are not covered services under this *Certificate*, 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 *Certificate*.

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.

1. Services which, in the opinion of the attending dentist, are not necessary to the Covered Person's dental health.
2. Cosmetic dental care.
3. 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. Denial of Experimental procedures or Investigational services is subject to Independent Medical Review (please refer to the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "Coverage Decisions and Disputes Resolution" section for more information).
4. Services that were provided without cost to the Covered Person by State government or an agency thereof, or any municipality, county or other subdivisions.
5. Hospital charges of any kind.
6. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Covered Person becomes eligible for such services.
7. Dispensing of Drugs not normally supplied in a dental office.
8. The cost of precious metals used in any form of dental benefits.
9. Dental Services that are received in an Emergency Care setting for conditions that are not emergencies if the Covered Person reasonably should have known that an Emergency Care situation did not exist.

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. Please refer to "Notice of Claim" in the "Miscellaneous Provisions" section.

Complaint Procedures

If you disagree with a determination by HNL, you can appeal the determination. The complaint and appeals process, including independent medical review from the California Department of Insurance, is described in the "Grievance and Appeals Process" and "Independent Medical Review of Grievances

Involving a Disputed Health Care Service" sections in the “Coverage Decisions and Disputes Resolution” section of this *Certificate*. You may also call HNL at the telephone number on your ID card.

Complaint Resolution

If you have a concern or question regarding the provision of Dental Services or benefits under the *Certificate*, 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 California Department 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 California Department 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 are not urgent situations.

If you are not satisfied with our decision, you have the right to take your complaint to the California Department 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.

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

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

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

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

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

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

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

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

Medically Necessary Contact Lenses are dispensed in lieu of other eyewear.

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

Notice and Proof of Claim and Claim Forms

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

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

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

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

HNL's Vision Claim address is:

Health Net Vision/Claims
P.O. Box 8504
Mason, OH 45040-7111

Covered Persons are required to submit to HNL in writing an itemized statement of the charges incurred by the Covered Person, along with a completed claim form, to request reimbursement. Claim forms can be obtained by calling Customer Service Monday through Friday at (866) 392-6058 from 5:00 a.m. to 8:00 p.m. Pacific Standard Time. HNL will furnish the Covered Person a claim form within 15 days of the Covered Person’s request. If HNL does not furnish the claim form within 15 days, the Covered Person shall be deemed to have complied with the requirements of this *Certificate* as to proof of loss upon submitting, within the time fixed in this *Certificate* for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. Pharmacy claims do not require a completed claim form, but must have an original receipt for the prescription with the patient’s name and must be in English and in U.S. currency.

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

Payment of Claims

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

GENERAL LIMITATIONS AND EXCLUSIONS

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

Medical Services and Supplies

Not Medically Necessary

Services or supplies that are not Medically Necessary, as defined in the "Definitions" section. However, the *Certificate* does cover Preventive Care Services, voluntary family planning services and Medically Necessary services for medical conditions directly related to non-covered services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery).

Excess Charges

Amounts charged by Out-of-Network Providers for covered medical services and treatment that are in excess of the Maximum Allowable Amount, as defined in the "Definitions" section. However, if medically appropriate care cannot be provided within the network, HNL shall arrange for the required care with available and accessible providers outside the network, with the patient responsible for paying only cost-sharing in an amount equal to the cost-sharing they would have paid for provision of that or a similar service in-network. In addition to in-network copayments and coinsurance, in-network cost sharing includes applicability of the in-network Deductible and accrual of cost sharing to the in-network Out-of-Pocket Maximum.

Clinical Trials

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

- The Investigational drug, item, device or service itself;
- Services provided to satisfy data collection and analysis needs which are not used for clinical management;
- Health care services that are specifically excluded from coverage under this *Certificate*; and
- Items and services provided free of charge by the research sponsors to Covered Persons in the trial.

Cosmetic Services and Supplies

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

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

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

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

In connection with the treatment for gender dysphoria, this plan covers reconstructive surgery that is Medically Necessary to create a normal appearance for the gender with which the Covered Person identifies.

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

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

Breast reconstruction surgery and dental or orthodontic services for cleft palate procedures are subject to the Certification requirements described in the "Certification Requirements" section of this *Certificate*. However, Hospital stays related to mastectomies and lymph node dissections will be determined solely by the Physician and Certification for determining the length of stay will not be required.

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

Dental Services

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

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

Temporomandibular (Jaw) Joint Disorders

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

Surgery and Related Services for Disorders of the Jaw (Often Referred to as "Orthognathic Surgery" or "Maxillary and Mandibular Osteotomy")

Used for the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw or associated bone joints, except when such procedures are Medically Necessary. However, spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints (whether custom fit or not), dental implants and other dental appliances are not covered for Covered Persons age 19 and over under any circumstances.

Dietary or Nutritional Supplements

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

Refractive Eye Surgery

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

Reconstruction of Prior Surgical Sterilization Procedures

Services to reverse voluntary surgically induced Infertility.

Infertility Services

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

- Conception by medical procedures, such as artificial insemination, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or any process that involves harvesting, transplanting or manipulating a human ovum. Also not covered are services or supplies (including injections and injectable medications) which prepare the Covered Person to receive these services.
- Collection, storage or purchase of sperm or ova.

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

Fertility Preservation

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

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

Prenatal Genetic Testing and Diagnostic Procedures

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

Experimental or Investigational Procedures

Experimental or Investigational Drugs, devices, procedures or other therapies are only covered when:

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

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

Immunizations or Inoculations

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

Custodial or Domiciliary Care

This *Certificate* does not cover assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine) for which facilities or services of a general acute Hospital are not medically required. Furthermore, custodial or domiciliary care in Residential Treatment Centers is not covered. This exclusion does not apply to assistance with activities of daily living that is provided as part of covered Hospice, Skilled Nursing Facility, Home Health Care Services or inpatient Hospital care.

Noneligible Hospital Confinements

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

Noneligible Institutions

Any services or supplies furnished by a noneligible institution, which is an institution other than a legally operated Hospital, Hospice or Medicare-approved Skilled Nursing Facility, Residential Treatment Center or which is primarily a place for the aged, a nursing home, or any similar institution, regardless of how designated. This exclusion does not apply to services required for S Mental Health and Substance Use Disorders, autism or pervasive developmental disorder.

Nonlicensed Provider

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

Sober Living Facilities

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

Private Rooms

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

Private Duty Nursing

Inpatient and outpatient services (including incremental nursing) provided by a private duty nurse, except as Medically Necessary and not in excess of the visit maximum for Home Health Care Services. Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a Hospital or Skilled Nursing Facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2

hours in the morning and 2 hours in the evening) that exceeds a total of six hours in any 24-hour period. Private Duty Nursing may be provided in an Inpatient or outpatient setting, or in a non-institutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care" and includes any portion of shift care services. Private Duty Nursing provided as Home Health Care Services may not exceed a maximum of 3 visits per day, up to 2 hours per visit.

Noncovered Items

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

- Alteration of Your residence to accommodate Your physical or medical condition, including the installation of elevators.
- Disposable supplies for home use, however, ostomy and urological supplies, items for Home health care, Hospice Care items including incontinence supplies, breastfeeding equipment and supplies as covered under the "Preventive Care List of Services" section, items as described in the "Durable Medical Equipment" provision under the "Plan Benefits" section and equipment for the management of diabetes are covered. In addition, disposable devices that are Medically Necessary for the administration of a covered outpatient Prescription Drug, such as spacers and inhalers for the administration of aerosol outpatient Prescription Drugs, and syringes for self-injectable outpatient Prescription Drugs that are not dispensed in pre-filled syringes are covered.
- Exercise equipment and charges for activities or facilities normally intended or used for physical fitness and/or weight loss including music and/or exercise programs/videos, swim memberships, gym memberships, personal trainers, exercise classes fees, online fees for weight loss applications/programs or those associated with software for exercise equipment, meal prepping organizations and home meal delivery. Refer to the “Preventive Care List of Services” section for details about coverage for behavioral counseling interventions to promote a healthy diet and physical activities for adults with certain risk factors.
- Hygienic equipment, Jacuzzis and spas.
- 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. However, Medically Necessary compression burn garments and lymphedema wraps, light compression bandages, manual compression bandages and moderate compression bandages are covered.
- Orthotics and Corrective Footwear, except as described in the "Durable Medical Equipment" and "Diabetic Equipment" provisions of the "Plan Benefits" section.
- Other Orthotics, including Corrective Footwear, not mentioned above, that are not Medically Necessary and custom made for the Covered Person. Corrective Footwear must also be permanently attached to an Orthotic device meeting coverage requirements under this *Certificate*.
- Durable Medical Equipment not prescribed by a Physician.
- Personal or comfort items.
- Air purifiers, air conditioners and humidifiers.

- Hearing aids, except for implanted hearing aids.
- Food supplements (except as specifically stated in the "Outpatient Infusion Therapy" and the "Phenylketonuria (PKU)" provisions of the "Plan Benefits" section of this *Certificate*).
- Nutritional counseling, except diabetes nutritional counseling and preventive care, or as specifically provided in the "Patient Education," "Phenylketonuria (PKU)," "Mental Health and Substance Use Disorders" or "Outpatient Infusion Therapy" provisions of the "Plan Benefits" section of this *Certificate*.

Transplants

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

Duplicate Coverage

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

Medicare

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

Workers' Compensation

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

Expenses Before Coverage Begins

Services received before the Covered Person’s Effective Date.

Expenses After Termination of Coverage

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

Services for Which You Are Not Legally Obligated to Pay

Services for which no charge is made to You in the absence of insurance coverage, except services received at a charitable research Hospital which is not operated by a governmental agency.

Physician Self-Treatment

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

Services Provided by Immediate Family Members

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

Crime

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

Nuclear Energy

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

Governmental Agencies

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

Totally Disabled on Your Effective Date

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

For the purposes of coordinating benefits under this *Certificate*, if You are entitled to an extension of benefits from the insurance carrier providing coverage to Your prior group health plan, and state law permits such arrangements, the insurance carrier providing coverage to Your prior group health plan shall be considered the primary plan (paying benefits first) and benefits payable under this *Certificate* shall be considered the secondary plan (paying any excess Covered Expenses), up to 100% of total Covered Expenses.

Routine Foot Care

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

Surrogate Pregnancy

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

Chiropractic Services

Expenses related to chiropractic adjustments, manipulations and therapy.

Foreign Travel or Work Assignment

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

Home Birth

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

Educational and Employment Services

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

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

Nonstandard Therapies or Admissions

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) or when Medically Necessary for the treatment of a Mental Health and Substance Use Disorder, and as otherwise specified in the "Plan Benefits" section), hypnotherapy, crystal healing therapy, yoga, hiking, rock

climbing and any other type of sports activity are not covered. This plan does not cover admissions for wilderness center training, for a situational or environmental change, or as an alternative to placement in a foster home or halfway house.

Outpatient Prescription Drug Benefits

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

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

Additional exclusions and limitations:

Drugs Covered by Another Section

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

Noncovered Services

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

No-Charge Items

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

Nonprescription (Over-the-Counter) Drugs, Equipment and Supplies

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

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

Nonparticipating Pharmacies

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

Diagnostic Drugs

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

Drugs Prescribed for Cosmetic or Enhancement Purposes

Drugs that are prescribed for the following non-medical conditions are not covered: hair loss, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes and cognitive performance. Examples of Drugs that are excluded when prescribed for such conditions include, but are not limited to, Latisse, Renova, Vaniqa, Propecia or Lustra. This exclusion does not exclude coverage for Drugs when pre-authorized as Medically Necessary to treat a diagnosed medical condition affecting memory, including but not limited to, Alzheimer's dementia, Medically Necessary Drugs to treat sexual dysfunction and Medically Necessary Drugs to treat obesity.

Dietary or Nutritional Supplements

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

Allergy Serum

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

Nonapproved Uses, Investigational or Experimental Drugs

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

Irrigation Solutions

Irrigation solutions and saline solutions are not covered.

Sexual Dysfunction Drugs

Drugs on the Essential Rx Drug List when Medically Necessary for treating sexual dysfunction are limited to the quantity listed on the Essential Rx Drug List.

Food and Drug Administration (FDA)

Supply amounts for prescriptions that exceed the FDA's or HNL's indicated usage recommendation are not covered unless Medically Necessary and Prior Authorization is obtained from HNL. Drugs that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S., but are not approved by the FDA, may be covered when Medically Necessary. If a Covered Person has a life-threatening or seriously debilitating condition and requests coverage of a non-FDA approved drug for an Experimental or Investigational purpose, he or she is entitled to IMR if Health Net delays, denies, or modifies the coverage. For more information, please refer to the "Independent Medical Review of Investigational or Experimental Therapies" provision in the "Coverage Decisions and Disputes Resolution" section in this *Certificate*.

Quantity Limitations

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

Unit Dose or "Bubble" Packaging

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

Lost, Stolen or Damaged Drugs

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

Schedule II Narcotic Drugs

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

Hypodermic Syringes and Needles

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

Drug Discount or Coupon or Copay Card

Cost-sharing paid on Your behalf for any Prescription Drugs obtained by You through the use of a Drug Discount, Coupon, or Copay Card provided by a Prescription Drug manufacturer will not apply toward

Your plan Deductible or Out-of-Pocket Maximum. What you actually pay will accrue toward your Out-of-Pocket Maximum. Exceptions include:

a. A prescription drug required under a United States Food and Drug Administration Risk Evaluation and Mitigation Strategy for the purpose of monitoring or facilitating the use of that Prescription Drug in a manner consistent with the approved labeling of the Prescription Drug.

b. A single-tablet drug regimen for treatment or prevention of human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) that is as effective as a multitablet regimen, unless, consistent with clinical guidelines and peer-reviewed scientific and medical literature, the multitablet regimen is clinically equally effective or more effective and is more likely to result in adherence to the drug regimen.

c. Covered Persons that have completed any applicable step therapy or Prior Authorization requirements for the branded Prescription Drug as mandated by HNL.

Pediatric Dental Services

Refer to the "Pediatric Dental Services" portion of the "Plan Benefits" section of this *Certificate* for the dental exclusions and limitations.

Pediatric Vision Services

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

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

Additional exclusions and limitations:

No-Charge items

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

Medical Treatment

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

Optional Frames

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

Nonprescription Eyewear

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

Additional Eyewear

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

Drugs

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

Lost, Stolen or Broken Eyewear

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

Orthoptics

Orthoptics or vision training is not covered.

GENERAL PROVISIONS

Term of Certificate

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

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

Coordination of Benefits

Explanation

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

Purpose

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

Administration

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

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

- **COVERED EMPLOYEE**: HNL is the **Primary Plan** with responsibility for first payment, **except** when (a) You are covered by another group health plan or insurer as the employee and that plan has covered You longer than the HNL plan or (b) the group plan or insurer does not contain a "COB" provision similar to this one.

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

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

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

Facility of Payment

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

Right to Receive and Release Necessary Information

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

Services Instead of Cash Payments

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

Right of Recovery

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

Medicare Coordination of Benefits (COB)

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

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

For services and supplies covered under Medicare Part A and Part B, claims are first submitted by Your provider or by You to the Medicare administrative contractor for determination and payment of allowable amounts. The Medicare administrative contractor then sends Your medical care provider a Medicare Summary Notice (MSN), (formerly an Explanation of Medicare Benefits (EOMB)). In most cases, the MSN will indicate that the Medicare administrative contractor has forwarded the claim to HNL for secondary coverage consideration. HNL will process secondary claims received from the Medicare administrative contractor. Secondary claims not received from the Medicare administrative contractor must be submitted to HNL by You or the provider of service, and must include a copy of the MSN. HNL and/or Your medical provider is responsible for paying the difference between the Medicare paid amount and the amount allowed under this plan for the covered services described in this *Certificate*, subject to any limits established by Medicare COB law. This Plan will cover benefits as a

secondary payer only to the extent services are coordinated by Your Physician and authorized by HNL as required under this *Certificate*.

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

For answers to questions regarding Medicare, contact:

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

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

COVERAGE DECISIONS AND DISPUTES RESOLUTION

Notification of HNL's Initial Benefit Determination

Timing of Notice:

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

For Urgent Care claim:

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

For concurrent care decisions:

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

If concurrent review results in an Adverse Benefit Determination, the Covered Person will be notified sufficiently in advance of the reduction or termination to allow time to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

For all other claims:

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

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

In the case of a post-service claim, the Covered Person shall be notified of relevant decisions within a reasonable period of time, but no later than 30 calendar days following the receipt of the claim by HNL, HNL may extend this time period for up to 15 additional days if an extension is necessary due to matters beyond HNL's control. HNL will notify the Covered Person, prior to the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which HNL expects to render a decision. In the case in which HNL requires additional information that is necessary to make Our determination, the notice of extension shall describe the required information and the time frame (that is at least 45 days from the Covered Person's receipt of the notice) to provide the specified information.

Manner and Content of Notice of an Adverse Benefit Determination:

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

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

HNL will provide the following upon request:

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

Grievance and Appeals Process

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

- A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review; or

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

If You are not satisfied with efforts to solve a problem with HNL or a medical provider, before filing an arbitration proceeding, You must file a grievance or appeal against HNL by calling the Customer Contact Center at **1-800-522-0088** or by submitting a Member Grievance Form through HNL website at www.healthnet.com. You must file Your grievance or appeal with HNL within 365 calendar days following the date of the incident or action that caused Your grievance. You may also file a complaint in writing by sending information to:

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

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

Health Net will issue a final benefit determination upon receiving a single grievance, or internal appeal request. HNL shall notify the Covered Person of Our decision in writing or electronically within the following time frames:

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

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

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

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

- Copies of, all documents, records, and other information relevant to the claim;
- An internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination;
- If the Adverse Benefit Determination is based on a Medical Necessity or Experimental treatment or similar exclusion or limitation, an explanation of the scientific or clinical judgment used for the determination.

Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an independent medical review (IMR) of Disputed Health Care Services from the California Department of Insurance (CDI) at 1-800-927-4357 or on their website at www.insurance.ca.gov, if You believe that health care services eligible for coverage and payment under Your HNL plan have been improperly denied, modified or delayed by HNL. A "Disputed Health Care Service" is any health care service eligible for coverage and payment under Your HNL plan that has been denied, modified or delayed by HNL or one of its contracting providers, in whole or in part because the service is not Medically Necessary.

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

Eligibility

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

- Your provider has recommended a health care service as Medically Necessary, You have received urgent or Emergency Care that a provider determined to have been Medically Necessary; or in the absence of provider recommendation You have been seen by a Physician for the diagnosis or treatment of the medical condition for which You seek IMR;
- The Disputed Health Care Service has been denied, modified or delayed by HNL, based in whole or in part on a decision that the health care service is not Medically Necessary; and

- You have filed a grievance with HNL and the disputed decision is upheld by HNL or the grievance remains unresolved after 30 days. Within the next six months, You may apply to the Department for IMR or later, if the Department agrees to extend the application deadline. If Your grievance requires expedited review You may bring it immediately to the Department's attention. The Department may waive the requirement that You must follow HNL's grievance process in extraordinary and compelling cases.

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

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

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

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

Independent Medical Review of Investigational or Experimental Therapies

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

Eligibility

- You must have a life-threatening or seriously debilitating condition;
- Your Physician must certify to HNL that You have a life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving Your condition or are otherwise medically inappropriate and there is no more beneficial therapy covered by HNL;

- Either (a) Your contracting Physician has recommended a drug, device, procedure, or other therapy that the Physician certifies in writing is likely to be more beneficial to You than any available standard therapies, or (b) You, or the Your Physician who is a licensed, board-certified or board-eligible Physician qualified to practice in the area of practice appropriate to treat Your condition, has requested a therapy that, based on two documents from the medical and scientific evidence, as defined below, is likely to be more beneficial for You than any available standard therapy. The Physician certification shall include a statement of the evidence relied upon by the Physician in certifying his or her recommendation. Nothing in this provision shall be construed to require HNL to pay for the services of a noncontracting Physician that are not otherwise covered pursuant to the contract.
- You have been denied coverage by HNL for the recommended or requested therapy; and
- If not for HNL's determination that the recommended or requested treatment is Experimental or Investigational, it would be covered.

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

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

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

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

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
2. Peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database of Health Services Technology Assessment Research (HSTAR).
3. Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act.
4. Either of the following reference compendia:
    a. The American Hospital Formulary Service's Drug Information.
    b. The American Dental Association Accepted Dental Therapeutics.
5. Any of the following reference compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
    a. The Elsevier Gold Standard's Clinical Pharmacology.
    b. The National Comprehensive Cancer Network Drug and Biologics Compendium.
    c. The Thomson Micromedex DrugDex.

6. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.
7. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

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

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

Arbitration

As a condition to becoming a HNL Covered Person, **YOU AGREE TO SUBMIT ALL DISPUTES RELATING TO OR ARISING OUT OF YOUR HNL MEMBERSHIP TO INDIVIDUAL FINAL AND BINDING ARBITRATION, EXCEPT DISPUTES CONCERNING ADVERSE BENEFIT DETERMINATIONS AS DEFINED IN 45 CFR 147.136, AND YOU AGREE NOT TO PURSUE CLASS ARBITRATION. Likewise, HNL agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both You and HNL are bound to use binding bilateral arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes.** However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by HNL's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Sometimes disputes or disagreements may arise between You (including Your enrolled Dependents, heirs or personal representatives) and HNL regarding the construction, interpretation, performance or

breach of this *Certificate*, or regarding other matters relating to or arising out of Your HNL membership. Typically such disputes are handled and resolved through the HNL Grievance, Appeal and Independent Medical Review process described above, and you must attempt to resolve your dispute by utilizing that process before instituting arbitration. However, in the event that a dispute is not resolved in that process, HNL uses binding bilateral arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. However, You are not required to participate in final, binding arbitration to resolve disputes concerning Adverse Benefit Determinations and are entitled to pursue any remedies available under the law. In addition, disputes with HNL involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

HNL's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is $500,000 or less ($50,000 or less with respect to disputes with HNL involving alleged professional liability or medical malpractice), the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $500,000 or $50,000, whichever is applicable. In the event that total amount of damages is over $500,000 or $50,000, whichever is applicable, the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

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

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

Health Net Life Insurance Company
Attention: Legal Department
P.O. Box 4504
Woodland Hills, CA 91365-4504

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

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

Medical Malpractice Disputes

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

SPECIFIC PROVISIONS

Recovery of Benefits Paid by HNL

When You Are Injured

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

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

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

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

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

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

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

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

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

Steps the Covered Person Must Take

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

- Telling HNL and the medical providers the name and address of the responsible party, if You know it, the name and address of his or her lawyer, if he or she is using a lawyer, the name and address of any insurance company involved with Your injuries and describing how the injuries were caused;
- Completing any paperwork that HNL or the medical providers may reasonably require to assist in enforcing the lien;
- Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions;
- Notifying the lienholders immediately upon You or Your lawyer receiving any money from the responsible parties, any insurance companies, or any other source;
- Pay the health care lien from any recovery, settlement or judgment, or other source of compensation and all reimbursement due HNL for the full cost of benefits paid under HNL that are associated with injuries through a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether You are made whole or fully compensated for Your loss;
- Do nothing to prejudice HNL's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery the full cost of all benefits paid by HNL; and
- Hold any money that You or Your lawyer receive from the responsible parties or, from any other source, in trust and reimbursing HNL and the medical providers for the amount of the lien as soon as You are paid.

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

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

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

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

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

Surrogacy Arrangements

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

Your Responsibility for Payment to HNL

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

Assignment of Your Surrogacy Payments

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

Duty to Cooperate

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

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

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

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

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

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

Out-of-State Providers

Health Net PPO allows Covered Persons access to participating providers outside their state of residence. If You are traveling outside Your state of residence, require medical care or treatment, and use a provider from the travel network, Your out-of-pocket expenses may be lower than those incurred when You use an Out-of-Network Provider.

When You obtain services outside Your state of residence through the travel network, You will be subject to the same Copayments, Coinsurances, Deductibles, maximums and limitations as You would be if You obtained services from a Preferred Provider in Your state of residence. There is the following exception: Covered Expenses will be calculated based on the lower of (i) the actual billed charges or (ii) the charge that the out-of-state provider network is allowed to charge, based on the contract between HNL and the network. In a small number of states, local statutes may dictate a different basis for calculating Your Covered Expenses.

The travel network consists of providers who participate in a network (other than the Health Net PPO network), as shown on Your HNL ID card, that agrees to provide discounted health care services to HNL Covered Persons.

Second Medical Opinion

The second opinion consultation is a consultation by an appropriately qualified healthcare professional, and may include recommendations for additional x-ray, laboratory services or treatment. You may seek a second opinion consultation from a Provider without first receiving authorization from HNL. However, services recommended by the second opinion consultation may be subject to Certification. Please refer to the "Certification Requirements" section to determine which services are subject to Certification. When a Covered Person receives a second opinion, he or she will be responsible for any applicable Deductible, Copayments or Coinsurance. Reasons for a second opinion include, but are not limited to, the following:

- If the Covered Person questions the reasonableness or necessity of recommended surgical procedures.
- If the Covered Person questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious Chronic condition.

- If clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and the Covered Person requests an additional diagnosis.
- If the treatment plan in progress is not improving the medical condition of the Covered Person within an appropriate period of time given the diagnosis and plan of care, and Covered Person requests a second opinion regarding the diagnosis or continuance of the treatment.
- If the Covered Person has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

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

MISCELLANEOUS PROVISIONS

Form or Content of the Certificate

No agent or employee of HNL is authorized to change the form or content of this *Certificate*. Any changes can be made only through an endorsement authorized and signed by an officer of HNL.

Benefits Not Transferable

No person other than You is entitled to receive benefits to be furnished by HNL under this *Certificate*. Such right to benefits is not transferable. **Fraudulent use of such benefits will result in cancellation of Your eligibility under this Certificate and appropriate legal action.**

Transfer of Medical Records

A health care provider may charge a reasonable fee for the preparation, copying, postage or delivery costs for the transfer of your medical records. Any fees associated with the transfer of medical records are the Covered Person's responsibility.

Notice of Claim

Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any covered loss, or as soon thereafter as reasonably possible. Notice may be given to Us at 21281 Burbank Blvd., Woodland Hills, CA 91367, or to any of Our authorized agents or mailed to Us at P.O. Box 9040, Farmington, MO 63640-9040. Notice should include information sufficient for Us to identify the Covered Person.

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

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

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

If you need to file a claim for covered Acupuncture Services provided by American Specialty Health Plans of California, Inc. (ASH Plans), you must file the claim with ASH Plans within one year after receiving those services. You must use ASH Plans' forms in filing the claim and you should send the claim to ASH Plans at the address listed in the claim form or to ASH Plans at:

American Specialty Health Plans of California, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans will give you claim forms on request. For more information regarding claims for covered Acupuncture Services, you may call ASH Plans at 1-800-678-9133 or you may write ASH Plans at the address given immediately above.

Claim Forms

When We receive notice of a claim, We will furnish You with Our usual forms for filing proof of loss. If We do not do so within 15 days, You can comply with the requirements for furnishing proof of loss by submitting written proof within the time fixed in this *Certificate* for filing such proofs of loss. Such written proof must cover the occurrence, the character and the extent of the loss.

Proofs of Loss

Written proof of loss must be furnished to Us at P.O. Box 9040, Farmington, MO 63640-9040, in case of claim for loss for which this *Certificate* provides any periodic payment contingent upon continuing loss, within 90 days after the end of the period of time for which claim is made; in the case of claim for any other loss, written proof of loss must be furnished within 90 days after the date of the loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if proof is furnished as soon as reasonably possible. Except in the absence of legal capacity, however, We are not required to accept proofs more than one year from the time proof is otherwise required.

Expenses for Copying Medical Records

We will reimburse the Covered Person or provider for reasonable expenses incurred in copying medical records requested by Us.

Time of Payment of Claims

We will pay benefits promptly upon receipt of due written proof of loss. HNL will reimburse each complete claim, or portion thereof, whether in-state or out-of-state, as soon as practical, but no later than 30 working days after receipt of the complete claim by HNL. 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.

Within 30 working days after receipt of the complete claim by HNL, HNL may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied. The notice will identify the contested or denied portion(s) of the claim, and the specific reasons for such contention or denial, as supported by the factual and legal bases known to HNL at that time.

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

Indemnities payable under this *Certificate* for any loss other than loss for which this *Certificate* provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this *Certificate* provides periodic

payment will be paid and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Life Claim

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Covered Person. Any other accrued indemnities unpaid at the Covered Person's death may, at the option of HNL, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Covered Person.

If any indemnity of this *Certificate* shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, HNL may pay such indemnity, up to an amount not exceeding $1,000 to any relative by blood or connection by marriage or domestic partnership of the insured or beneficiary who is deemed by HNL to be equitably entitled thereto. Any payment made by HNL in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the Covered Person in the application or otherwise all or a portion of any indemnities provided by this *Certificate* on account of Hospital, nursing, medical, or surgical services may, at the HNL's option and unless the Covered Person requests otherwise in writing not later than the time of filing proofs of that loss, be paid directly to the person or persons having paid for the hospitalization or medical or surgical aid, or to the Hospital or person rendering those services; but it is not required that the service be rendered by a particular Hospital or person.

Cash Benefits

In most instances, You will not need to file a claim when You receive Covered Services and Supplies from a Preferred Provider. If You use an Out-of-Network Provider and file a claim, HNL will reimburse You for the amount You paid for Covered Expenses, less any applicable Deductible, Copayment or Coinsurance. If You signed an assignment of benefits and the provider presents it to Us, We will send the payment directly to the provider. You must provide proof of any amounts that You have paid.

If a parent who has custody of a child submits a claim for cash benefits on behalf of the child who is subject to a Medical Child Support Order, HNL will send the payment to the custodial parent.

Claims Denial

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

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

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

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

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

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

Payment to Providers or Covered Persons:

- **Direct Payment**. Benefit payment for Covered Expenses will be made directly to:
  1. **Contracting Hospitals:** Hospitals which have Provider Service Agreements with HNL to provide services to Covered Persons.
  2. **Providers of Ambulance transportation and certified nurse midwives or licensed midwives:** As required by the California Insurance Code, this must occur, even if written assignment has not been made by You. However, if the submitted provider's statement or bill indicates that the charges have been paid in full, payment will be made to You.
  3. **Other providers of service not mentioned above, Hospital and professional:** when You assign benefits to them in writing.
- **Joint Payment**. Benefit payment for Covered Expenses will be made jointly to other providers and You when a written assignment stipulates joint payment.

- **Direct Payment to You**. In situations not described above, payment will be made to You. HNL reserves the right to recover an overpayment if all or some of the payment made by Us directly to You exceeded the benefits under the *Certificate*. If an overpayment is discovered, we will notify You within 6 months of the date of the error. In the case of an error prompted by representations or nondisclosure of claimants or third parties, We will notify You within fifteen (15) calendar days after the date of discovery of such error. The notice will include the cause of the error and the amount of the overpayment. You will have 30 days to dispute the overpayment, and if We are notified within the time allotted of Your disagreement that an overpayment occurred, the overpayment will not be deducted from future benefits.

Payment When You Are Unable to Accept

If a claim is unpaid at the time of Your death or if You are not legally capable of accepting it, it will be paid to Your estate or any relative or person who may legally accept on Your behalf.

Physical Examination and Autopsy

HNL, at its expense, has the right and opportunity to examine or request an examination of any Covered Person whose injury or sickness is the basis of a claim as often as is reasonably required while the claim is pended and to make an autopsy in case of death where it is not forbidden by law.

Change of Beneficiary

Unless the Covered Person makes an irrevocable designation or beneficiary, the right to change of beneficiary is reserved to the Covered Person and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this *Certificate* or to any change of beneficiary or beneficiaries, or to any other changes in this *Certificate*.

Dependent Coverage Outside California

Dependents living outside California and away from the primary residence of the principal Covered Person can still obtain Preferred Provider coverage within the United States, as described in the "Out-of-State Providers" provision in the "Specific Provisions" section. Outside the United States, coverage is limited to Emergency Care and Urgent Care, as described below under "Foreign Travel or Work Assignment" in this "Miscellaneous Provisions" section.

Foreign Travel or Work Assignment

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

Workers' Compensation Insurance

This *Certificate* is not in lieu of and does not affect any requirement for, or coverage by, Workers' Compensation Insurance.

Diethylstilbestrol

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

Notice

Any notice required of HNL shall be sufficient if mailed to the holder of the Group Policy at the address appearing on the records of HNL. This *Certificate*, however, will be posted electronically on HNL's website at www.healthnet.com. The Group can opt for the Covered Person to receive this *Certificate* online. By registering and logging on to HNL's website, Covered Persons can access, download and print this *Certificate*, or can choose to receive it by U.S. mail, in which case HNL will mail this *Certificate* to each Covered Person's address on record.

If notice is required of You or the Group, it will be sufficient if mailed to Covered California.

Interpretation of *Certificate*

The laws of the State of California shall be applied to interpretations of this *Certificate*.

Legal Actions

No action at law or in equity may be brought to recover benefits prior to the expiration of 60 days after written Proof of Loss has been furnished. No such action may be brought after a period of 3 years (or the period required by law, if longer) after the time limits stated in the Proofs of Loss section.

Misstatement of Age

If the age of any Covered Person covered under this *Certificate* has been misstated, there shall be an adjustment of the premium for this *Certificate* so that there shall be paid to the insurer the premium for the coverage of such Covered Person at his correct age, and the amount of the insurance coverage shall not be affected.

Clerical Error

No clerical error on the part of the Group applying for coverage shall affect the insurance, or amount thereof, of any Covered Person, provided proper premium adjustment is made upon discovery of such error.

Non-Regulation of Providers

This Health Net PPO plan does not regulate the amounts charged by providers of medical care, except to the extent that the rates for the Covered Services and Supplies are negotiated with Preferred Providers.

Free Choice of Provider

As a Covered Person in this Health Net PPO plan, you are not required to select a primary care provider. This Health Net PPO plan does not interfere with Your right to select any properly licensed Hospital, Physician (including Specialists and behavioral health care providers), laboratory or other health care professional or facility that provides services or supplies covered by this plan. However, Your choice of provider may affect the amount of benefits payable. To identify a Preferred Provider, visit the HNL website at www.healthnet.com or contact the Customer Contact Center at the telephone number on Your HNL ID card to obtain a copy of the Preferred Provider Directory.

Timely Access to Care

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

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

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

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

- **Physician appointments for primary care:** within 10 business days of request for an appointment.
- **Physician appointments for Specialist care:** within 15 business days of request for an appointment.
- **Urgent Care appointment with Physician:** within 48 hours of request for an appointment.
- **Urgent Care appointments for services that require Certification:** within 96 hours of the request for an appointment.
- **Routine Check-up/Physical Exam:** within 30 business days of request for an appointment.
- **Non-urgent appointments with a non-Physician mental health care or substance use disorder provider:** within 10 business days of request for an appointment.
- **Non-urgent appointments for ancillary services:** within 15 business days of request for an appointment.
- **Urgent appointments for pediatric oral and vision services:** within 72 hours of request for an appointment.
- **Non-urgent appointments for pediatric oral and vision services**: within 36 business days of request for an appointment.
- **Preventive appointments for pediatric oral and vision services:** within 40 business days of request for an appointment.

Providing of Care

HNL is not responsible for providing any type of Hospital, medical or similar care. HNL is also not responsible for the quality of any type of Hospital, medical or similar care.

Continuity of Care

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

Termination of Provider or Facility Contract:

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

Covered Persons New to HNL Due to Termination of Prior Coverage:

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

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

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

Conditions Eligible for Continuity of Care:

1. An acute condition a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition;

2. A serious chronic condition (a medical condition due to disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.) Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by HNL in consultation with the Covered Person and the terminated provider and consistent with good professional practice, not to exceed 12 months from the contract termination date, or 12 months from the effective date of coverage for a new Covered Person;
3. A pregnancy (including the duration of the pregnancy and the immediate postpartum period.) Completion of Covered Services shall be provided for the duration of the pregnancy;
4. Maternal mental health (completion of covered services shall not exceed 12 month from the diagnosis or from the end of pregnancy, whichever occurs later);
5. A terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less.) Completion of Covered Services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new Covered Person;
6. The care of a newborn child between birth and age 36 months Completion of Covered Services under this provision shall not exceed 12 months from the contract termination date, or 12 months from the effective date of coverage for a new Covered Person;
7. Performance of a scheduled surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a new Covered Person.

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

Relationship of Parties

The relationship, if any, between HNL and any health care providers is that of an independent contractor relationship. Physicians, Hospitals, Skilled Nursing Facilities and other health care providers and community agencies are not agents or employees of HNL. HNL shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by You while receiving care from any health care provider. Neither the Group nor any Covered Person is the agent or representative of HNL. Neither shall be liable for any acts or omissions of HNL, its agents or employees.

HNL retains the right to designate or replace an administrator to perform certain functions for providing the Covered Services and Supplies of this *Certificate*. If HNL does designate or replace any administrator, HNL will inform You of all new procedures. Any administrator designated by HNL is an independent contractor and not an employee or agent of HNL.

Technology Assessment

New technologies are those procedures, Drugs or devices that have recently been developed for the treatment of specific diseases or conditions or are new applications of existing procedures, Drugs or

devices. New technologies are 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 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 are 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 are no guiding principles for certain technologies or when the complexity of a patient's medical condition requires expert evaluation. If HNL denies, modifies or delays coverage for Your requested treatment on the basis that it is Experimental or Investigational, You may request an independent medical review (IMR) of HNL's decision from the Department of Insurance. Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" in the "Coverage Decisions and Disputes Resolution" section for additional details.

Confidentiality of Medical Records

A STATEMENT DESCRIBING HNL'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Health Care Plan Fraud

Health care plan fraud is a felony that can be prosecuted. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Your Responsibility

As a Covered Person, You must:

- File accurate claims. If someone else, such as Your spouse or Domestic Partner or another Dependent who is a Covered Person, files claims on Your behalf, You should review the form before You sign it;
- Review the explanation of benefits (EOB) form when it is returned to You. Make certain that benefits have been paid correctly based on Your knowledge of the expenses incurred and the services rendered;
- Never allow another person to seek medical treatment under Your identity. If Your ID card is lost, You should report the loss to Us immediately; and
- Provide complete and accurate information on claims forms and any other information forms. Attempt to answer all questions to the best of Your knowledge.

To maintain the integrity of Your health plan, We encourage You to notify Us whenever a provider:

- bills You for services or treatments that You have never received;

- asks You to sign a blank claim form; or
- asks You to undergo tests that You feel are not needed.

If You are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if You know of or suspect any illegal activity, call Our toll-free hotline at the number shown on Your HNL ID card. All calls are strictly confidential.

DEFINITIONS

This section defines words that will help You understand Your Plan. These words appear throughout this *Certificate* with the initial letter of the word in capital letters.

Accidental Injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental Injury does not include illness, infection (except infection of a cut or nonsurgical wound) or damage to the teeth or dental prosthesis caused by chewing.

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit based on a determination of eligibility for coverage, the application of any utilization review, and a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. This also includes a rescission of coverage, regardless of whether the rescission adversely affects payment for any particular benefit at the time of the rescission.

Ambulance means an automobile or airplane (fixed wing or helicopter), which is specifically designed and equipped for transporting the sick or injured. It must have patient care equipment, including at least a stretcher, clean linens, first aid supplies and oxygen equipment. It must be staffed by at least two persons who are responsible for the care and handling of patients. One of these persons must be trained in advanced first aid. The vehicle must be operated by a business or agency which holds a license issued by a local, state, or national governmental authority authorizing it to operate Ambulances.

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

Bariatric Surgery Performance Center is a provider in HNL's designated network of California bariatric surgical centers and surgeons that perform weight loss surgery. Providers that are not designated as part of HNL's network of Bariatric Surgery Performance Centers are considered Out-of-Network Providers, even if they have a contract with HNL, for purposes of determining coverage and benefits for weight loss surgery and are not covered.

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

Brand Name Drug is a Prescription Drug or medicine that has been registered under a brand or trade name by its manufacturer and is advertised and sold under that name, and indicated as a brand in the Medi-Span or similar national Database.

Calendar Year is the twelve-month period that begins at 12:01 a.m. Pacific Time on January 1 of each year.

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

Certification refers to the process of obtaining approval from Us in advance of receiving certain services and supplies covered under this *Certificate*. The "Schedule of Benefits" section of this *Certificate* shows the penalties applicable to those expenses that are not certified in accordance with the provisions of this *Certificate*. The requirements for Certification are described in the "Certification Requirements" section of this *Certificate*.

Coinsurance is the percentage of the Covered Expenses for which You are responsible, as specified in the "Schedule of Benefits" section.

Compounded Drugs are prescription orders that have at least one ingredient that is Federal Legend in a therapeutic amount as Medically Necessary and are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form and require a prescription order for dispensing.

Contracted Rate is the rate that Preferred Providers are allowed to charge You, based on a contract between HNL and such provider. Covered Expenses for services provided by a Preferred Provider will be based on the Contracted Rate.

Copayment is a fixed dollar fee charged to You for Covered Services and Supplies when You receive them. The amount of each Copayment is indicated in the "Schedule of Benefits" section.

Corrective Footwear includes specialized shoes, arch supports and inserts and is custom made for Covered Persons who suffer from foot disfigurement. Foot disfigurement includes, but is not limited to, disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by accident or developmental disability.

Covered Dental Service is a Dental Service or Dental Procedure for which benefits are provided under this *Certificate*.

Covered Expenses are the maximum charges for which HNL will pay benefits for each covered service or supply (including covered services related to Mental Health and Substance Use Disorders). The amount of Covered Expenses varies by whether You obtain services from a Preferred Provider or an Out-of-Network Provider. Covered Expenses are the lesser of the billed charge or: (i) Contracted Rate for the services or supplies provided by a Preferred Provider; (ii) the Maximum Allowable Amount for the services or supplies from an inpatient Hospital, Skilled Nursing Facility, Home Health Care Agency, for Outpatient surgery or for Emergency Care received during Foreign Travel or Work Assignment, provided by an Out-of-Network Provider; or (iii) for the cost of services or supplies from any other Out-of-Network Provider, the Maximum Allowable Amount.

Covered Person is the enrolled employee (referred to as "You" or "Your" or the "principal Covered Person") or his or her Dependent who is covered under this *Certificate*.

Covered Services and Supplies means Medically Necessary services and supplies that are payable or eligible for reimbursement, subject to any Deductibles, Copayments, Coinsurance, benefit limitations or maximums, under the *Certificate*.

Custodial Care is care that is rendered to a patient to assist in support of the essentials of daily living such as help in walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets and supervision of medications which are ordinarily self-administered, and for which the patient:

- Is disabled mentally or physically and such disability is expected to continue and be prolonged;
- Requires a protected, monitored, or controlled environment whether in an institution or in the home; and
- Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

Deductible is a set amount You pay for specified Covered 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 *Certificate* is in effect, provided such care or treatment is a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dependents are individuals who meet the eligibility requirements for coverage under this *Certificate* and have been enrolled by the principal Covered Person (employee).

Domestic Partner is, for the purposes of this *Certificate*, a person eligible for coverage as a Dependent provided that the partnership is with the principal Covered Person and who is a registered domestic partner and meets all domestic partnership requirements under specified by section 297 or 299.2 of the California Family Code.

Drug Discount or Coupon or Copay Card means cards or Coupons typically provided by a drug manufacturer to discount the Copayment and/or Coinsurance or Your other out-of-pocket costs.

Drugs are: (1) medications that require a prescription either by California or Federal law; (2) insulin, and disposable hypodermic insulin needles and syringes; (3) pen delivery systems for the administration of insulin, as Medically Necessary; (4) diabetic testing supplies (including lancets, lancet puncture devices, blood and urine testing strips, and test tablets); (5) over-the-counter (OTC) Drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B; (6) contraceptive Drugs and devices, including oral contraceptives, contraceptive rings, patches, diaphragms, sponges, cervical caps, spermicides, female condoms female OTC contraceptive products when ordered by a Physician or Health Care Provider, and emergency contraceptives; or (7) inhalers and inhaler spacers for the management and treatment of asthma.

Durable Medical Equipment

- Serves a medical purpose (its reason for existing is to fulfill a medical need or health condition, it is not for convenience and/or comfort and it is not useful to anyone in the absence of a health condition);
- Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities;
- Withstands repeated use; and
- Is appropriate for use in a home setting.

Effective Date is the date on which You become covered or entitled to benefits under this *Certificate*. Enrolled Dependents may have a different Effective Date than the principal Covered Person if they are added later to the plan.

Eligible Dental Expenses for Covered Dental Services, incurred while the *Certificate* 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 is the Maximum Allowable Amount, 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 serious danger);
- His or her bodily functions, organs or parts would become seriously damaged; or
- His or her bodily organs or parts would seriously malfunction.

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

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

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

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

Emergency Care will also include additional screening, examination and evaluation by a Physician (or other health care provider acting within the scope of his or her license) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate such condition, within the capability of the facility.

A "psychiatric emergency medical condition" means a Mental Health or Substance Use Disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the Mental Health or Substance Use Disorder.

See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" under "Coverage Decisions and Disputes Resolution" for the procedure to request an Independent Medical Review of a Plan denial of coverage for Emergency Care.

Essential Health Benefits are a set of health care service categories (as defined by the Affordable Care Act and section 10112.27 of the California Insurance Code) that must be covered by all health benefits plans starting in 2014. Categories include: ambulatory patient services, emergency services,

hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, Prescription Drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including dental and vision care.

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

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

- It is currently the subject of active and credible evaluation (e.g., clinical trials or research) to determine:
  a. clinical efficacy;
  b. therapeutic value or beneficial effects on health outcomes, or
  c. 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.

Generic Drug is the pharmaceutical equivalent of a Brand Name Drug whose patent has expired and is available from multiple manufacturers as set out in the Medi-Span or similar third party database as used by HNL. The Food and Drug Administration must approve the Generic Drug as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

Group is the business organization (usually and employer or trust) to which HNL has issued the Policy to provide the benefits of this Plan.

Health Net Essential Rx Drug List (also known as Essential Rx Drug List) is a list of the Prescription Drugs that are covered by this Plan. Drugs not on the Essential Rx Drug List that are Medically Necessary are also covered. It is prepared and updated by HNL and distributed to Covered Persons, Physicians and Participating Pharmacies and posted on the HNL website at www.healthnet.com under the pharmacy information. Some Drugs in the Essential Rx Drug List require Prior Authorization from HNL in order to be covered. Refer to "Prior Authorization and Exception Request Process" in the "Outpatient Prescription Drug Benefits" section on how to request a coverage exception for a drug that is not on the Essential Rx Drug List.

Health Net Life Insurance Company (HNL or Health Net) is a life and disability insurance company regulated by the California Department of Insurance. The term "We," "Our" or "Us" when they appear in this *Certificate* refer to HNL.

Health Net PPO is the Preferred Provider Organization (PPO) plan described in this *Certificate*, which allows You to obtain medical benefits from either a network of Preferred Providers with whom HNL has

contracted to provide services at the Contracted Rate; or else any Out-of-Network Provider. Health Net PPO is underwritten by HNL.

Health Net PPO Service Area is the United States.

Home Health Care Agency is an organization licensed by the state in which it is located to provide Home Health Care Services, certified by Medicare or accredited by Joint Commission on the Accreditation of Healthcare Organizations.

Home Health Care Services are services, including skilled nursing services, provided by a licensed Home Health Care Agency to a Covered Person in his or her place of residence that is prescribed by the Covered Person's attending Physician as part of a written plan. Home Health Care Services are covered if the Covered Person is homebound, under the care of a contracting Physician, and requires Medically Necessary skilled nursing services, physical, speech, occupational therapy, or respiratory therapy or medical social services. Only Intermittent Skilled Nursing Services are covered benefits under this plan. See also "Intermittent Skilled Nursing Services" and "Private Duty Nursing."

Hospice is a facility or program that provides a caring environment for meeting the physical and emotional needs of the terminally ill. The Hospice and its employees must be licensed according to applicable state and local laws and certified by Medicare.

Hospice Care is care that is designed to provide medical and supporting care to the terminally ill and their families. Hospice Care is designed to be provided primarily in Your home.

Hospital is a place that maintains and operates organized facilities licensed by the state in which they are located for the diagnosis, care, and treatment of human illnesses to which persons may be admitted for overnight stay, but which does not include Skilled Nursing Facility or Hospice, and which is accredited or certified either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by Medicare.

Infertility means either (1) the presence of a demonstrated condition recognized by a licensed Physician and surgeon as a cause of Infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Intermittent Skilled Nursing Services are services requiring the skilled services of a registered nurse or LVN, which do not exceed 6 hours in total, provided either continuously or intermittently, in a 24-hour period. Home health aide services are covered under the Home health care benefit if the Covered Person's condition requires the services of a nurse, physical therapist, occupational therapist, or speech therapist.

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

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

- It is currently the subject of active and credible evaluation (e.g., clinical trials or research) to determine:
  a. clinical efficacy;
  b. therapeutic value or beneficial effects on health outcomes, or

c. benefits beyond any established medical based alternative.

- It is the subject of an active and credible evaluation and does not have final clearance from applicable governmental regulatory bodies (such as the US Food and Drug Administration "FDA") and unrestricted market approval for use in the treatment of a specified medical condition or the condition for which authorization of the service is requested.
- The most recent peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals do not conclude, or are inconclusive in finding, that the service is safe and effective for the treatment of the condition for which authorization of the service is requested.

Maintenance Drugs are Prescription Drugs (excluding Specialty Drugs) taken continuously to manage chronic or long term conditions where Covered Persons respond positively to a drug treatment plan with a specific medication at a constant dosage requirement.

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

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

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

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

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

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

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

a. Maximum Allowable Amount for professional and ancillary services shall be 100% of FAIR Health's Medicare gapfilling methodology. Services or supplies not priced by gapfilling methodology shall be the lesser of: (1) the average amount negotiated with Preferred Providers within the geographic region for the same Covered Services or Supplies provided; (2) 50th percentile of FAIR Health database of professional and ancillary services not included in FAIR Health Medicare gapfilling methodology; (3) 100% of Medicare Allowable Amount for the same Covered Services or Supplies under alternative billing codes published by Medicare; or (4) 50% of the Out-of-Network Provider's billed charges for Covered Services. A similar type of database or valuation service will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination.

b. Maximum Allowable Amount for facility services shall be the lesser of: (1) the average amount negotiated with Preferred Providers within the geographic region for the same Covered Services or Supplies provided; (2) 100% of the derived amount using a method developed by Data iSight for facility services (a data service that applies a profit margin factor to the estimated costs of the services rendered), or a similar type of database or valuation service, which will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination; (3) 150% of the Medicare Allowable Amount for the same Covered Services or Supplies under alternative billing codes published by Medicare; or (4) 50% of the Out-of-Network Provider's billed charges for Covered Services.

- ***Maximum Allowable Amount for Out-of-Network Emergency Care*** will be the greatest of: (1) the median of the amounts negotiated with Preferred Providers for the emergency service provided, excluding any in-network Copayment or Coinsurance; (2) the amount calculated using the same method HNL generally uses to determine payments for Out-of-Network providers, excluding any in-network Copayment or Coinsurance; or (3) the amount paid under Medicare Part A or B, excluding any in-network Copayment or Coinsurance. Emergency Care provided by an Out-of-Network Provider is subject to the Preferred Provider level of cost-sharing (and Deductible, if applicable) based on this MAA amount. You are not responsible for any charges in excess of the amount other than the Preferred Provider level of cost-sharing (and Deductible, if applicable).
- ***Maximum Allowable Amount for non-emergent services at an in-network (PPO network) health facility, at which, or as a result of which, You receive non-emergent Covered Services by an Out-of-Network Provider***, the non-emergent services provided by the Out-of-Network Provider will be payable at the greater of the average Contracted Rate or 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered unless otherwise agreed to by the noncontracting individual health professional and HNL.
- ***Maximum Allowable Amount for covered outpatient pharmaceuticals*** (including but not limited to injectable medications) dispensed and administered to the patient, in an outpatient setting, including, but not limited to, Physician office, outpatient Hospital facilities, and services in the patient's home, will be the lesser of billed charges or the Average Wholesale Price for the drug or medication.

- ***Maximum Allowable Amount for pediatric Dental Services*** is calculated by HNL based on available data resources of competitive fees in that geographic area and must not exceed the fees that the Dental Provider would charge any similarly situated payor for the same services for each Covered Dental Service. The data resources of competitive fees are supplied by FAIR Health, which are updated twice a year. HNL reimburses non-Network Dental Providers at 55% of FAIR Health rates. You must pay the amount by which the non-Network provider's billed charge exceeds the Eligible Dental Expense.

The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses. See "Schedule of Benefits," "Plan Benefits" and "General Limitations and Exclusions" sections for specific benefit limitations, maximums, Certification requirements and payment policies that limit the amount we pay for certain Covered Services and Supplies.

In addition to the above, from time to time, we also contract with vendors that have contracted fee arrangements with providers ("Third Party Networks"). In the event we contract with a Third Party Network that has a contract with the Out-of-Network Provider, we may, at our option, use the rate agreed to by the Third Party Network as the Maximum Allowable Amount. Alternatively, we may, at our option, refer a claim for Out-of-Network Services to a fee negotiation service to negotiate the Maximum Allowable Amount for the service or supply provided directly with the Out-of-Network Provider. In either of these two circumstances, You will not be responsible for the difference between billed charges and the Maximum Allowable Amount. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance at the Out-of-Network level.

NOTE: When the Centers for Medicare and Medicaid Services (CMS) adjusts the Medicare Allowable Amount, HNL will adjust, without notice, the Maximum Allowable Amount based on the CMS schedule currently in effect. Claims payment will be determined according to the schedule in effect at the time the charges are incurred. Claims payment will also never exceed the amount the Out-of-Network Provider charges for the service or supply. You should contact the Customer Contact Center if You wish to confirm the Covered Expenses for any treatment or procedure You are considering.

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

Maximum Allowable Cost for any Prescription Drug is the maximum charge HNL will allow for Generic Drugs, or for Brand Name Drugs that have a generic equivalent. A list of Maximum Allowable Costs is maintained, on our pharmacy claims processor's website. The Maximum Allowable Cost refers to the upper limit or maximum amount that HNL will pay the pharmacy for Generic Drugs and Brand Name Drugs that have generic versions available ("multi-source brands").

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

Medical Child Support Order is a court judgment or order that, according to state or federal law, requires group health plans that are affected by that law to provide coverage to a child or children who is the subject of such an order. HNL will honor such orders.

Medically Necessary (or Medical Necessity)

For services other than Mental Health or Substance Use Disorders: Medically Necessary (or Medical Necessity) means health care services and outpatient Prescription Drug benefits that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, or health condition, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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

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

For these purposes:

- "Generally accepted standards of Mental Health and Substance Use Disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of Mental Health and Substance Use Disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.
- "Health care provider" means any of the following:
    - A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

- An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.
- A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 10144.51 of the Insurance Code and Section 1374.73.
- An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.
- An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.
- A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.
- A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.
- A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

For Pediatric Dental Services, Medically Necessary means Dental Services and supplies under this *Certificate* which are based on accepted dental practices and meet 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.
- 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 orthodontic benefits, when Medically Necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

(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 *Certificate*. The definition of Necessary used in this *Certificate* relates only to Benefits under this *Certificate* 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.

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

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

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

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

Nonparticipating Pharmacy is a facility not authorized by HNL to be a Participating Pharmacy.

Open Enrollment Period is a period of time each Calendar Year, during which individuals who are eligible for coverage in this Plan may enroll for the first time, or if You were enrolled previously, may add Your eligible Dependents.

The Group decides the exact dates for the Open Enrollment Period.

Changes requested during the Open Enrollment Period become effective on the first day of the calendar month following the date the request is submitted, or on any date approved by Us.

Orthotics (such as bracing, supports and casts) are rigid or semi-rigid devices that are externally affixed to the body and designed to be used as a support or brace to assist the Covered Person with the following:

- To restore function; or
- To support, align, prevent, or correct a defect or function of a body part; or
- To improve natural function; or
- As part of habilitative services to keep, learn, or improve skills and functioning; or
- To restrict motion.

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

Out-of-Pocket Maximum is the maximum dollar amount of Deductibles, Copayments and Coinsurance for which You or Your family must pay for medical, outpatient Prescription Drug, pediatric dental and pediatric vision Covered Expenses during a Calendar Year. After that maximum is reached for services provided by a Preferred Provider, and out-of-network Emergency Care (including emergency Hospital care and emergency transportation) your payment responsibilities for Copayments and Coinsurance will no longer apply for Covered Expenses incurred during the remainder of that Calendar Year, as shown in the "Schedule of Benefits" section. Penalties paid for services which were not certified as required will not be applied to the Out-of-Pocket Maximum, and your responsibility for these penalties will continue to apply to these expenses after the Out-of-Pocket Maximum is reached. For a family plan, an individual is responsible only for meeting the individual Out-of-Pocket Maximum. Deductibles, Copayments and Coinsurance for out-of-network Emergency Care, including emergency Hospital care and emergency medical transportation accrues to the in-network Out-of-Pocket Maximum.

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

Pain means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder or condition.

Participating Pharmacy is a facility authorized by HNL to dispense Prescription Drugs to persons eligible for benefits under the terms of this *Certificate*. A list of Participating Pharmacies and a detailed explanation of how the program operates has been provided or will be provided by HNL.

Participating Vision Provider is an optometrist, ophthalmologist or optician licensed to provide Covered Services and who or which, at the time care is rendered to a Covered Person, has a contract in effect with Health Net to furnish care to the Covered Person. 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 or certified under applicable state law to practice where the care is provided, is rendering a service within the scope of that license or certification, is providing a service for whom benefits are specified in this *Certificate*, and when benefits would be payable if the services were provided by a Physician as defined above:

  Dentist (D.D.S.)

  Optometrist (O.D.)

  Dispensing optician

  Podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)

  Psychologist

  Chiropractor (D.C.)

  Certified nurse midwife or licensed midwife

  Nurse Practitioner

  Physician Assistant

  Clinical social worker (M.S.W. or L.C.S.W.)

  Marriage, family and child counselor (M.F.C.C.)

  Physical therapist (P.T. or R.P.T.)

  Speech pathologist

  Audiologist

  Occupational therapist (O.T.R.)

  Psychiatric mental health nurse

  Respiratory care practitioner

  Acupuncturist (A.C.)

- Other Mental Health and Substance Use Disorder providers, including, but not limited to the following:

  Chemical Dependency Counselor (L.C.D.C.), Licensed Professional Counselor (L.P.C.)

Preferred Provider Organization is a health care provider arrangement whereby HNL contracts with a group of Physicians or other medical care providers who have contracted to furnish services at the negotiated rate known as the Contracted Rate.

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

Prescription Drug is a drug or medicine that can be obtained only by a Prescription Drug Order. All Prescription Drugs are required to be labeled "Caution, Federal Law Prohibits Dispensing Without a Prescription." An exception is insulin and other diabetic supplies, which are considered to be covered Prescription Drugs.

Prescription Drug Covered Expenses are the maximum charges HNL will allow for each Prescription Drug Order. The amount of Prescription Drug Covered Expenses varies by whether a Participating or Nonparticipating Pharmacy dispenses the order. It is not necessarily the amount the pharmacy will bill. Any expense incurred which exceeds the following amounts is not a Prescription Drug Covered Expense: (a) for Prescription Drug Orders dispensed from a Participating Pharmacy, or through the mail service program, the Prescription Drug Allowable Charge; or (b) for Prescription Drug Orders dispensed by a Nonparticipating Pharmacy in emergency or urgent situations, the lesser of the Maximum Allowable Cost or the Average Wholesale Price.

Prescription Drug Allowable Charge is the charge that Participating Pharmacies and the mail service program have agreed to charge Covered Persons, based on a contract between HNL and such provider.

Prescription Drug Order is a written or verbal order or refill notice for a specific drug strength and dosage form (such as a tablet, liquid, syrup or capsule) directly related to the treatment of an illness, injury or health condition and which is issued by the attending Physician within the scope of his or her professional license.

Preventive Care Services (including services for the detection of asymptomatic diseases) are services provided under a Physician's supervision and which include, but are not limited to, the following:

- Reasonable health appraisal examinations on a periodic basis.
- A variety of family planning services.
- Preventive prenatal and postnatal care in accordance with the guidelines of the Health Resources and Services Administration (HRSA).
- Vision and hearing testing for Covered Persons.
- Immunizations for children in accordance with the recommendations of the American Academy of Pediatrics and immunizations for adults as recommended by the U.S. Public Health Service.
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.
- For women, evidence-informed preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the HRSA.
- Venereal disease tests.
- Cytology examinations on a reasonable periodic basis.
- Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided through HNL.

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF).

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

Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a Hospital or Skilled Nursing Facility. Except for home health nursing services, Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of six hours in any 24-hour period. Private Duty Nursing may be provided in an inpatient or outpatient setting, or in a non-institutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care" and includes any portion of shift care services.

Professional Vision Services include examination, material selection, fitting of eyeglasses or contact lenses, related adjustments, instructions, etc.

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

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

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

- A qualified autism service paraprofessional is an unlicensed and uncertified individual who: (1) is supervised by a Qualified Autism Service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice; (2) provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (3) meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations; (4) has adequate education, training, and experience as certified by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers, and (5) is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

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

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

Skilled Nursing Facility is an institution that is licensed by the appropriate state and local authorities to provide skilled nursing services. In addition, Medicare must approve the facility as a participating Skilled Nursing Facility.

Special Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for the care of patients 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, as noted in the Essential Rx Drug List, may require Prior Authorization from HNL and may need to 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.

Specialty Pharmacy Vendor is a pharmacy contracted with HNL specifically to provide Specialty Drugs.

Teledentistry refers to the use of telehealth systems and methodologies in dentistry. **Teledentistry can include patient care and education.** See the definition of "Telehealth Services" below. Teledentistry is covered under the dental benefit and is subject to the limitation shown in the "Pediatric Dental Exclusions and Limitations" section under "Child Needs Dental or Eye Care" in the " Plan Benefits" section.

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

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

Transplant Performance Center is a provider in HNL's designated network in California for solid organ, tissue and stem cell transplants and transplant-related services, including evaluation and follow-up care. For purposes of determining coverage for transplants and transplant-related services, HNL's network of Transplant Performance Centers includes any providers in HNL's designated supplemental resource network. Providers, even if they have a contract with HNL, 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 and are not covered.

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

PREVENTIVE CARE LIST OF SERVICES

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

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

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

- Those evidence-based items or services that have, in effect, a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) https://uspreventiveservicestaskforce.org/uspstf/.
- Those immunizations for routine use in children, adolescents and adults that have, in effect, a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) https://www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- With respect to women, those evidence-informed preventive care and screening provided for in comprehensive guideline supported by the Health Resources and Services Administration (HRSA) https://www.hrsa.gov/womens-guidelines-2019.
- With respect to infants, children and adolescents, such evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the HRSA https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

Your Physician will evaluate Your health status (including, but not limited to, Your risk factors, family history, gender and/or age) to determine the appropriate Preventive Care Services and frequency. HNL will not make its own determinations as to risk and will defer to the Physician's decision. Additional information regarding Preventive Care Services may be accessed through (https://www.healthcare.gov/coverage/preventive-care-benefits/).

Preventive Care Services for children include:

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

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

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

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

Preventive Care Services for women include:

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

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

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

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

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

  Limited to one (1) screening and counseling per year as part of annual well visit.
- Preeclampsia prevention. Low-dose aspirin is recommended as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia. Counseling is provided at the discretion of your Physician.
- Preeclampsia (PE) screening for pregnant women. All pregnant women should be screened for preterm PE. Biomarkers offer a potential for early diagnosis and effective treatments. Screenings are provided at each prenatal care visit and repeated as needed at the discretion of your Physician.
- Rh incompatibility screening follow-up testing for women. This test often is done at the first prenatal visit. The results from this test also can suggest how severe the baby's hemolytic anemia has become. Screenings are at the discretion of your Physician. Rh (D) immunoglobulin is a medication used to prevent RhD isoimmunization in mothers who are RhD negative and to treat idiopathic thrombocytopenic purpura in people who are Rh positive. It is often given both during and following pregnancy. It may also be used when RhD negative people are given RhD positive blood. If an Rh(D)-positive or weakly Rh(D)-positive (e.g., Du-positive) infant is delivered, a dose of Rh(D) immunoglobulin should be repeated postpartum, preferably within 72 hours after delivery or at the discretion of your Physician.
- Sexually transmitted infections counseling and screenings for women. Screenings and counseling for sexually transmitted diseases include: Chlamydia, Gonorrhea, HIV, Genital Herpes, Syphilis, Trichomoniasis, HPV, genital warts and cervical cancer, as recommended at the discretion of your Physician.

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

Preventive Care Services for adults include:

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

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

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

  - Pertussis
  - Pneumococcal
  - Rubella
  - Tetanus
  - Varicella (Chickenpox)

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

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

IMPORTANT NOTICES

Covered Persons' Rights and Responsibilities, and Obligations Statement

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

Covered Persons have the right to:

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

Covered Persons have the responsibility and obligation to:

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

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Covered Entities Duties:

Health Net** (referred to as "we" or "the Plan") is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Health Net is required by law to maintain the privacy of your protected health information (PHI), provide You with this Notice of our legal duties and privacy practices related to Your PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of your unsecured PHI. PHI is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

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

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

- Uses or disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice.

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

Internal Protections of Oral, Written and Electronic PHI:

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

These are some of the ways we protect your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes. We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

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

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

    In our health care operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its health care operations. This includes the following:
    - quality assessment and improvement activities
    - reviewing the competence or qualifications of health care professionals
    - case management and care coordination
    - detecting or preventing health care fraud and abuse
- ***Group Health Plan/Plan Sponsor Disclosures*** - We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

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

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

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

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

- ***Research*** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

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

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

Marketing - We will request Your written authorization to use or disclose Your PHI for marketing purposes with limited exceptions, such as when We have face-to-face marketing communications with You or when We provide promotional gifts of nominal value.

Psychotherapy Notes - We will request Your written authorization to use or disclose any of Your psychotherapy notes that We may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Individual's Rights

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

- ***Right to Revoke an Authorization*** - You may revoke your authorization at any time, the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.
- ***Right to Request Restrictions*** - You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment or health care operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.

- ***Right to Request Confidential Communications*** - You have the right to request that We communicate with You about Your PHI by alternative means or to alternative locations. This right only applies in the following circumstances: (1) the communication discloses PHI including all or part of the medical information or provider name and address relating to receipt of sensitive services, or (2) disclosure of PHI including all or part of the medical information or provider name and address could endanger You if it is not communicated by the alternative means or to the alternative location You want. You do not have to explain the reason for Your request, but Your request must clearly state that either the communication discloses PHI including all or part of the medical information or provider name and address relating to receipt of sensitive services or that disclosure of PHI including all or part of the medical information or provider name and address could endanger You if the communication means or location is not changed. We must accommodate Your request if it is reasonable and specifies the alternative means or location where You PHI should be delivered.
- ***Right to Access and Receive a Copy of your PHI*** - You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.
- ***Right to Amend your PHI*** - You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- ***Right to Receive an Accounting of Disclosures*** - You have the right to receive a list of instances within the last 6 years period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.
- ***Right to File a Complaint*** - If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

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

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

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

Contact Information

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

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

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

Financial Information Privacy Notice

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

We collect personal financial information about you from the following sources:

- Information We receive from You on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about Your transactions with us, Our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information

We do not disclose personal financial information about Our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of Our general business practices, We may, as permitted by law, disclose any of the personal financial information that We collect about You, without Your authorization, to the following types of institutions:

- To Our corporate affiliates such as other insurers;
- To nonaffiliated companies for Our everyday business purposes, such as to process Your transactions, maintain Your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on Our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect Your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access Your personal financial information.

Questions About this Notice

If You have any questions about this notice, please **call the toll-free phone number on the back of Your ID card** or contact HNL at **1-800-522-0088**.

Nondiscrimination Notice

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

Health Net:

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

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

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

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

Health Net Life Insurance Company Appeals & Grievances
PO Box 10348
Van Nuys, CA 91410-0348

Fax: 1-877-831-6019

Email: Member.Discrimination.Complaints@healthnet.com (Covered Persons) or Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

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

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

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

Language Assistance Services

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

Notice of Language Services

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

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

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

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

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

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

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

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

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

Navajo
Doo bą́ą́h ílínígóó saad bee háká ada'iiyeed. Ata' halne'ígíí da ła' ná hádídóot'įįł. Naaltsoos da t'áá shí shizaad k'ehjí shichį' yídooltah nínízingo t'áá ná ákódoolníił. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíjį' hodíílnih ninaaltsoos nanitingo bee néého'dolzinígíí hodoonihjį' bikáá' éí doodago kojį' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojį' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí kojį' hólne' 1-888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí kojį' hólne' 1-800-522-0088 (TTY: 711).

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

Panjabi (Punjabi)

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

Russian

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

Spanish

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

Tagalog

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

Thai

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

Vietnamese

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

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

FLY017549EH00 (12/17)

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Contact us

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

Customer Contact Center
Large Group:
1-800-522-0088 TTY:711
(for companies with 101 or
more employees)

Small Business Group:
Exchange plans 1-888-926-5133 TTY: 711
Off-Exchange plans 1-800-522-0088
(for companies with 1-100 employees)

Individual & Family Plans:
1-800-839-2172 TTY: 711
1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

www.healthnet.com

For information or questions related to Covered California, visit www.coveredca.com