Summary *of* Benefits

Primary EPO • Insurance Plan EZ1

DELIVERING CHOICES

When it comes to your health care, the best decisions are made with the best choices. **Health Net Life** Insurance Company (herein called HNL) offers an Exclusive Provider Organization (EPO) insurance plan that provides you with ways to help you receive the care you deserve. This *Summary of Benefits* (SB) document answers basic questions about this versatile plan. If you have further questions, contact the Customer Contact Center at (800) 250-5226 and one of our friendly, knowledgeable representatives will be glad to help.

If you have further questions, contact us:

By phone at 1-800-250-5226

Or write to: Health Net Life Insurance Company
P.O. Box 9103
Van Nuys, CA 91409-9103

This insurance plan is underwritten by Health Net Life Insurance Company and administered by Health Net of California, Inc. (Health Net).

This *Summary of Benefits* (SB) is only a summary of your health insurance plan. Your student *Benefit Handbook*, which you will receive after you enroll, contains the exact terms and conditions of your Health Net Life coverage. You should also consult the *Health Net EPO Blanket Student Accident and Sickness Insurance Policy (here in called the Policy)* (to be issued to Stanford University) to determine governing contractual provisions. It is important for you to carefully read this SB and your student *Benefit Handbook* thoroughly, once received, especially those sections that apply to special health care needs. This SB includes a matrix of benefits in the section titled, "Schedule of Benefits and Coverage."

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Welcome to Cardinal Care, a Medical benefits program for Stanford University students by Health Net Life.

Please read the following information so you will know from whom or what group of providers health care may be obtained.

How the insurance plan works

The benefits under this insurance plan are managed by Vaden Health Center (VHC) for Tier 1, and through Health Net Participating Providers for Tier 2. Except in an emergency or for other urgent medical circumstances, services provided by out-of-network providers are not covered under this HNL Insurance Plan.

Under Cardinal Care, Health Net Life provides two tiers of coverage: Tier 1 for care referred by VHC to Stanford University Medical Center (SUMC) or Menlo Medical Clinic, or Tier 2 for care provided by a HNL Participating Provider without a referral from VHC.

The type of provider you choose will determine the level of coverage that will apply for services covered by this Plan.

Tier 1:

To access Tier 1: The Vaden Health Center provides primary care services, counseling and psychological services, and pharmacy services. For Tier 1 benefits, Cardinal Care requires all students to first seek services at Vaden Health Center (except in an emergency or for other urgent medical circumstances). If necessary, VHC will refer Covered Persons to SUMC or Menlo Medical Clinic/UHA for specialty services covered by the Cardinal Care plan. This referral is needed for the specialty services to be covered at Tier 1. All Tier 1 services must be provided or arranged by VHC, SUMC or Menlo Medical Clinic/UHA with the exception of emergency and urgently needed care anywhere in the world.

A Covered Person enrolled in Cardinal Care will be referred at no extra cost to a Health Net Life physician group or Hospital not affiliated with SUMC or Menlo Medical Clinic/UHA if the required service is unavailable at VHC, SUMC or Menlo Medical Clinic/UHA.

Tier 2:

Tier 2 services are those rendered by providers who have agreed to participate in the HNL PPO network. They have agreed to provide Covered Persons with health care and to accept a special contracted rate as payment in full for services which are covered under this plan. Your share of the cost for covered services is based on that contracted rate.

Covered services are payable by HNL only when you access care, services, or supplies from the designated Participating Providers of this insurance plan except routine care performed outside of the United States.

How to Obtain Care-Tier 1
Tier 1 coverage applies:

- When the Covered Person receives medical care through VHC and is referred to SUMC or Menlo Medical Clinic/UHA. VHC will provide authorization for all medical care for Tier 1 benefits except for Emergency Care or Urgently Needed Care. The Health Net Life Cardinal Care ID Card Shows the VHC addresses and telephone number.

- All medical care and supplies which you obtain must be provided by, authorized by, or arranged by VHC in order for the services to be covered at the Tier 1 level of coverage.

Vaden Health Center (VHC) providers:

- Are responsible for providing initial and primary care;
- Maintain the continuity of patient care; and
- Authorize referrals for Specialist care

For information on providers please call the Health Net Life Customer Contact Center at (800) 250-5226.

Specialists and Referral Care

Sometimes, you may need care that VHC cannot provide. At such times, you will be referred by VHC to a Specialist or other health care provider for that care. As necessary, VHC will refer Cardinal Care members to SUMC or Menlo Medical Clinic/UHA for specialty services.

How to Obtain Care-Tier 2
Tier 2 coverage applies:

- When you receive medical care in California from a Health Net Life Participating Provider listed in the Health Net Network Directory without referral from VHC. In the event that you desire to see a provider for care or services without a referral from VHC, you have the option to see one of the HNL's Participating Providers. Simply find the provider you wish to see in the Health Net Life Participating Provider Directory and schedule an appointment.
- When you are outside of California to locate preferred providers near you contact the HNL dedicated Customer Contact Center at (800) 250-5226.
- When accessing care outside of the United States you may see any provider

You can obtain the Health Net Network Directory by calling the Health Net Life Customer Contact Center at (800) 250-5226 or the Participating Provider information is also available through the Health Net website (www.healthnet.com/cardinalcare).

Emergency medical services will be covered at the Tier 1 level anywhere in the world. Non-emergency care out of the United States will be covered at Tier 2 level. International claims will not require prior authorization.

MENTAL DISORDERS AND CHEMICAL DEPENDENCY CARE

HNL contracts with MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator), to administer behavioral health services for mental disorders and chemical dependency conditions.

HOW TO ENROLL

Stanford students are automatically enrolled in Cardinal Care at the beginning of each academic year. Cardinal Care coverage begins September 1 and ends on August 31 each year. Students who do not opt out of Cardinal Care are covered the entire academic year; during breaks as well as in any non-registered quarter. Students who have alternative health insurance coverage that meets minimum requirements set by the University may waive Cardinal Care, but must do so by applicable deadlines.

Some hospitals and other providers do not provide one or more of the following services that may be covered under your *Policy* 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**
- **Abortion**

You should obtain more information before enrollment by calling HNL's Customer Contact Center at (800) 250-5226 to ensure that you can obtain the health care services that you need.

Schedule of Benefits and Coverage

THIS MATRIX IS INTENDED TO HELP YOU UNDERSTAND COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE STUDENT BENEFIT HANDBOOK SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Principal benefits and coverage matrix

Deductibles	Tier 1	Tier 2
Deductible	$100	$500

Out-of-Pocket maximum (OOPM)	Tier 1	Tier 2
For covered services and supplies (Per Covered Person)	$2000	$4000

Once your payment for covered services and supplies (combined for Tier 1 and Tier 2) equals the amount shown above in any one plan year, no additional copayments or coinsurance for covered medical services and supplies are required for the remainder of that plan year.

Payments for any supplemental benefits or services not covered by this insurance plan will not be applied to this plan year out-of-pocket maximum unless otherwise noted. The following expenses will not be counted, nor will these expenses be paid at 100% after the Out-of-Pocket Maximum has been reached:

- *Penalties for non-certification inpatient/outpatient services.*

Professional services	Tier 1	Tier 2
Visit to physician✉	$25 Deductible waived	$25 Deductible waived
Specialist consultations✉	$35 Deductible waived	30%
Prenatal office visits⌖◘	Covered in full Deductible waived	Covered in full Deductible waived
Postnatal office visits⌖◘	$25 Deductible waived	30%
Normal delivery, cesarean section, newborn inpatient care*⌖◘	Covered in full Deductible waived	30%
Treatment of complications of pregnancy⌖*	See note below**	See note below**
Physician visit to hospital or skilled nursing facility	Covered in full Deductible waived	30%
Surgeon or assistant surgeon services (excluding bariatric surgery)▲,*	Covered in full Deductible waived	30%
Surgeon or assistant surgeon services (for bariatric surgery)*	Covered in full Deductible waived	30%

Gender reassignment surgery (including anesthesia)*,◈	Covered in full Deductible waived	30%
Administration of anesthetics (excluding bariatric surgery)*	Covered in full Deductible waived	30%
Administration of anesthetics (for bariatric surgery)*	Covered in full Deductible waived	30%
Rehabilitative therapy (includes physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)*	$35 Deductible waived	$40
Habilitative services (including ABA therapy/services)*	$35 Deductible waived	$40
Organ and stem cell transplants (nonexperimental and noninvestigational)*	Covered in full Deductible waived	30%
Chemotherapy	$35 Deductible waived	30%
Radiation therapy*	$35 Deductible waived	30%
Vision and hearing examinations (for diagnosis or treatment)	$35 Deductible waived	30%
Vision examinations (for refractive eye examinations)	$35 Deductible waived	$35 Deductible waived

◘ *Prenatal, postnatal and newborn care office visits for preventive care are covered in full. See copayment listings for preventive care services below. If the primary purpose of the office visit is unrelated to a preventive service or if other non-preventive services are received during the same office visit, the above copayment will apply for the non-preventive services.*

▲ *Surgery includes surgical reconstruction of a breast incidenalt to mastectomy, including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema. While HNL and your PCP will determine the most appropriate services, the length of hospital stay will be determined solely by your PCP.*

◈ *These copayments apply to professional services only. Services that are rendered in a hospital are also subject to the hospital services copayment. See "Hospital services" in this section to determine if any additional copayments may apply.*

✉*Copayments under Tier1and Tier 2 are waived for physician visits rendered by a Vaden Health Center clinician.*

**These services require certification for coverage. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $500 penalty will be charged for Tier 1 and Tier 2 inpatient services and a $100 penalty will be charged for Tier 1 and Tier 2 outpatient services.*

Φ *Gender reassignment surgery included Genital Reconstructive Surgery (includes hysterectomy, oophorectomy, and mastectomy requires prior authorization from HNL. The Gender reassignment surgery must be performed by an HNL qualified provider in conjunction with gender transformation treatment. The treatment plan must conform to Harry Benjamin International Gender Dysphoria Association (HBIGDA), now called WPATH (World Professional Association of Transgender Health), standards. Additionally, beyond the actual surgery no cosmetic procedures are covered. If the Covered Person lives more than 100 miles from the nearest authorized Gender reassignment surgery facility, the Covered Person (companion not covered) is 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 Certified Gender reassignment surgery. All requests for travel expense reimbursement must :be pre-approved. Approved travel-related expenses will be reimbursed as follows:*

1. *Transportation for the Covered Person to and from the HN qualified provider 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).*
2. *Hotel accommodations for the Covered Person not to exceed $100 per day for the pre-surgical work-up, pre-surgical visit and the follow-up visit, up to (2) days per trip or as Medically Necessary. Limited to one room, double occupancy.*
3. *Other reasonable expenses not to exceed $25 per day, up to two (2) days per trip for the pre-surgical workup, 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. HNL will not prepay (i.e. in advance) travel, lodging and meal expenses. Reimbursement will be provided after the submission of the claims reimbursement form, along with receipts for pre-approved expenses. The authorization number must be provided on all the claim forms. For use of a personal car, the Covered Person must provide the purpose of the trip, the date and location. Receipts for tolls and parking need to be presented before reimbursement will be approved. Any mileage will be reimbursed at the federal mileage allowance rate.

Allergy treatment and other injections (except for infertility injections)	Tier 1	Tier 2
Allergy testing	$35 Deductible waived	30%
Allergy serum	$0 Deductible waived	30%
Allergy injection services	$25 Deductible waived	30%
Immunization for occupational purposes	Not covered	Not covered
Immunization for foreign travel	Not covered	Not covered
Injections (except for infertility Injectable drugs administered by a physician, (office based injectable medication, per dose)*	$25 Deductible waived	30%
Self-injectable drugs*,■	Refer to Pharmacy Benefits	Refer to Pharmacy Benefits

Hormone therapy treatment related to Gender Identity Disorder (GID) is covered.

■*Certain injectable drugs which are considered self-administered injectable drugs are covered under the pharmacy benefit. If you need to have the provider administer the Self-Injectable Drug, you will need to obtain the Self-Injectable Drug through the Specialty Pharmacy Vendor or a contracted retail pharmacy and bring it with you to the provider office. Alternatively, you can coordinate delivery of the Self-Injectable Drug directly to the provider office through the Specialty Pharmacy Vendor. Please refer to the "Specialty Pharmacy Vendor" portion of this "Schedule of Benefits and Coverage" section for the applicable copayment or coinsurance.*

*****_These services require certification for coverage. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $500 penalty will be charged for Tier 1 and Tier 2 inpatient services and a $100 penalty will be charged for Tier 1 and Tier 2 outpatient services._

Injections for the treatment of infertility are described below in the "Infertility services" section.

Outpatient services	Tier 1	Tier 2
Outpatient facility services (other than surgery; except for infertility services and bariatric surgery)	Covered in full Deductible waived	30%
Outpatient facility services (other than surgery; for bariatric services)*	Covered in full Deductible waived	30%
Outpatient surgery (hospital or outpatient surgery center charges only; except for infertility services and bariatric surgery)*	$250	30%
Outpatient surgery (hospital or outpatient surgery center charges only; for bariatric surgery)*	$250	30%
Gender reassignment Outpatient Services *ⓘ	$250	30%

*****_These services require certification for coverage. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained a $500 penalty will be charged for Tier 1 and Tier 2 inpatient services and a $100 penalty will be charged for Tier 1 and Tier 2 outpatient services._

ⓘ _Gender reassignment surgery included Genital Reconstructive Surgery (includes hysterectomy, oophorectomy, and mastectomy requires prior authorization from HNL. The Gender reassignment surgery must be performed by an HNL qualified provider in conjunction with gender transformation treatment. The treatment plan must conform to Harry Benjamin International Gender Dysphoria Association (HBIGDA), now called WPATH (World Professional Association of Transgender Health), standards. Additionally, beyond the actual surgery no cosmetic procedures are covered. If the Covered Person lives more than 100 miles from the nearest authorized Gender reassignment surgery facility, the Covered Person (companion not covered) is 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 Certified Gender reassignment surgery. All requests for travel expense reimbursement must :be pre-approved. Approved travel-related expenses will be reimbursed as follows:_

1. _Transportation for the Covered Person to and from the HN qualified provider 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)._
2. _Hotel accommodations for the Covered Person not to exceed $100 per day for the pre-surgical work-up, pre-surgical visit and the follow-up visit, up to (2) days per trip or as Medically Necessary. Limited to one room, double occupancy._
3. _Other reasonable expenses not to exceed $25 per day, up to two (2) days per trip for the pre-surgical workup, 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. HNL will not prepay (i.e. in advance) travel, lodging and meal expenses. Reimbursement will be provided after the submission of the claims reimbursement form, along with receipts for pre-approved expenses. The authorization number must be provided on all the claim forms. For use of a personal car, the Covered Person must provide the purpose of the trip, the date and location. Receipts for tolls and parking need to be presented before reimbursement will be approved. Any mileage will be reimbursed at the federal mileage allowance rate.

 *Outpatient care for infertility is described below in the "Infertility services" section.*

Hospital services	Tier 1	Tier 2
Semi-private hospital room or special care unit with ancillary services, including maternity care (unlimited days; excluding Severe Mental Illness, Mental Disorders, Chemical dependency, and Bariatric) services*	$500	30%
Semi-private hospital room or special care unit (unlimited days for Bariatric) services*	$500	30%
Skilled nursing facility stay*	$500	30%
Gender reassignment Inpatient Services *,ⓘ	$500	30%

The above copayment or coinsurance for inpatient hospital or special care unit services is applicable for each admission for the hospitalization of an adult, pediatric or newborn patient. If a newborn patient requires admission to a special care unit, a separate copayment for inpatient hospital services for the newborn patient will apply.

**These services require certification for coverage. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $500 penalty will be charged for Tier 1 and Tier 2 inpatient services and a $100 penalty will be charged for Tier 1 and Tier 2 outpatient services.*

Inpatient care for infertility is described below in the "Infertility services" section.

ⓘ *Gender reassignment surgery included Genital Reconstructive Surgery (includes hysterectomy, oophorectomy, and mastectomy requires prior authorization from HNL. The Gender reassignment surgery must be performed by an HNL qualified provider in conjunction with gender transformation treatment. The treatment plan must conform to Harry Benjamin International Gender Dysphoria Association (HBIGDA), now called WPATH (World Professional Association of Transgender Health), standards. Additionally, beyond the actual surgery no cosmetic procedures are covered. If the Covered Person lives more than 100 miles from the nearest authorized Gender reassignment surgery facility, the Covered Person (companion not covered) is 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 Certified Gender reassignment surgery. All requests for travel expense reimbursement must :be pre-approved. Approved travel-related expenses will be reimbursed as follows:*

1. *Transportation for the Covered Person to and from the HN qualified provider 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).*
2. *Hotel accommodations for the Covered Person not to exceed $100 per day for the pre-surgical work-up, pre-surgical visit and the follow-up visit, up to (2) days per trip or as Medically Necessary. Limited to one room, double occupancy.*
3. *Other reasonable expenses not to exceed $25 per day, up to two (2) days per trip for the pre-surgical workup, 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. HNL will not prepay (i.e. in advance) travel, lodging and meal expenses. Reimbursement will be provided after the submission of the claims reimbursement form, along with receipts for pre-approved expenses. The authorization number must be provided on all the claim forms. For use of a personal car, the Covered Person must provide the purpose of the trip, the date and location. Receipts for tolls and parking need to be presented before reimbursement will be approved. Any mileage will be reimbursed at the federal mileage allowance rate.

Radiological services	Tier 1	Tier 2
Laboratory procedures and diagnostic imaging (including x-ray)*	Covered in full Deductible waived	30%
CT, SPECT, MRI, MUGA and PET**	$50 Deductible waived	30%

**These services require certification for coverage. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $500 penalty will be charged for Tier 1 and Tier 2 inpatient services and a $100 penalty will be charged for Tier 1 and Tier 2 outpatient services.*

***For providers in Stanford Hospital & Clinics, Lucille Salter Packard Children's Hospital and Clinics, and Lucille Packard Children's Hospital Medical Group and Menlo Medical Clinic, complex radiology services will be covered at Tier 1 cost share regardless of the contract or lack of contract with the provider.*

Preventive care	Tier 1	Tier 2
The following benefits are not subject to the plan year deductible		
Preventive care services for children (through age 16)	Covered in full Deductible waived	Covered in full Deductible waived
Preventive care services for adults (age 17 and older)	Covered in full Deductible waived	Covered in full Deductible waived

Preventive care services are covered for children and adults, as directed by your physician, based on the guidelines from the U.S. Preventive Services Task Force Grade A&B recommendations, the Advisory Committee on Immunization Practices that have been adopted by the Center for Disease Control and Prevention, the guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA).

Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA.

One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it. Breast pumps can be obtained by calling the Customer Contact Center at the phone number listed on the back cover of this booklet.

Emergency health coverage	Tier 1	Tier 2
Emergency room (professional and facility charges)	$100 Deductible waived	$100 Deductible waived
Urgent care center (professional and facility charges)	$50 Deductible waived	$50 Deductible waived

The copayment for emergency room or urgent care center will not apply if the covered person is admitted as an inpatient directly from the emergency room or urgent care center.

Care referred by Vaden Health Center or emergency services will be covered at the Tier 1 level. Outside of California, First Health Providers coordinate the non-emergency services which are paid at the Tier 2 level of benefits.

When you receive non-emergency medically necessary care outside the United States, you will receive Tier 2 benefits. If you have questions, before or during travel, you may call HNL Customer Contact Center at 1-800-250-5226 or 1-818-676-6767.

International claims will not require prior authorization.

Ambulance services	Tier 1	Tier 2
Ground ambulance*	Covered in full Deductible waived	Covered in full
Air ambulance*	Covered in full Deductible waived	Covered in full

**These services require certification for coverage. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $500 penalty will be charged for Tier 1 and Tier 2 inpatient services and a $100 penalty will be charged for Tier 1 and Tier 2 outpatient services.*

Prescription drug coverage

Retail participating pharmacy (up to a 30-day supply)

Tier 1 drugs listed on the Essential Rx Drug List (primarily generic)	$10
Tier 2 drugs listed on the Essential Rx Drug List (primarily preferred brand name) and diabetic supplies (including insulin) ◆	$35
Tier 3 drugs listed on the Essential Rx Drug List (or non-preferred drugs not listed on the Essential Rx Drug List) ◆	$50
Lancets	Covered in full
Oral infertility drugs	50%
Preventive drugs, including smoking cessation drugs and women's contraceptives	Covered in full

Specialty Pharmacy Vendor

Specialty drugs when listed in the Essential Rx Drug List	$50

For information about HNL's Essential Rx Drug List, please call the Customer Contact Center at the telephone number on the back cover.

Orally administered anti-cancer drugs will have a copayment and coinsurance maximum of $200 for an individual prescription of up to a 30-day supply.

◆ *Generic drugs will be dispensed when a generic drug equivalent is available. We will cover brand name drugs that have generic equivalents 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 for Tier 2 drugs or Tier 3 drugs.

A Physician must obtain HNL's Prior Authorization for coverage of Brand Name Drugs that have generic equivalents.

If the usual and customary charge is less than the applicable copayment, then you will pay the usual and customary charge. Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's usual and customary charge for covered prescription drugs.

Self-administered injectable drugs are covered when prior authorization is obtained from HNL and the drugs are dispensed through the VHC Pharmacy, HNL's Specialty Pharmacy Vendor, or HNL's contracted retail pharmacy. Please note that needles and syringes required to administer the self-injectable medication are covered only when obtained through the Specialty Pharmacy Vendor.

- *Self-administered injectable medications are defined as drugs that are:*
- *Medically necessary;*
- *Administered by the patient or family member; either subcutaneously or intramuscularly;*
- *Deemed safe for self-administration as determined by HNL's Pharmacy and Therapeutics committee.*

** Preventive drugs, including smoking cessation drugs, and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the Covered Person, and are not subject to the deductible. Preventive drugs are prescribed over-the-counter drugs or are prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations.*

If a brand name drug is dispensed, and a generic equivalent is commercially available, you will be required to pay the difference in cost between the generic and brand name drug. However, if a brand named drug is medically necessary and the physician obtains prior authorization from Health Net, then the brand name drug will be dispensed at no charge.

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

This plan uses the Essential Rx Drug List. The HNL Essential Rx Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by HNL and distributed to HNL contracted physicians and participating pharmacies. The Essential Rx Drug List also shows which drugs are Tier 1, Tier 2 or Tier 3, so you know which copayment applies to the covered drug. Drugs that are not on the Essential Rx Drug List (that are not excluded or limited from coverage) are also covered at the Tier 3 drug copayment.

Some drugs require prior authorization from HNL. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed two business days or 72 hours, whichever is less, after Health Net Life's receipt of the request and any additional information requested by Health Net Life that is reasonably necessary to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed two business days, as appropriate and medically necessary, for the nature of the member's condition after Health Net Life's receipt of the information reasonably necessary and requested by Health Net Life to make the determination. For a copy of the Essential Rx Drug List, call the Customer Contact Center at the number listed on the back cover of this booklet or visit our website at www.healthnet.com.

Medical Supplies	Tier 1	Tier 2
Durable medical equipment*◆	Covered in full Deductible waived	30%
Orthotics (such as bracing, supports and casts)*	Covered in full Deductible waived	30%
Diabetic equipment. See the "Prescription drug program" section of this SB for diabetic supplies benefit information.	Covered in full Deductible waived	30%

Diabetic footwear ..... Covered in full..... 30%
Deductible waived

Prostheses* ..... Covered in full..... 30%
Deductible waived

◆*Durable medical equipment includes coverage for 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).*

Diabetic equipment covered under the medical benefit (through "Diabetic Equipment"), includes blood glucose monitors designed for the visually impaired, insulin pumps and related supplies. In addition, the following supplies are covered under the medical benefit as specified: diabetic footwear, visual aids (excluding eyewear) to assist the visually impaired with the proper dosing of insulin are provided through the prostheses benefit; Glucagon is provided through the self-injectable benefit. Self-management training, education and medical nutrition therapy will be covered only when provided by licensed health care professionals with expertise in the management or treatment of diabetes (provided through the patient education benefit). Diabetic equipment and supplies covered under the prescription drug benefit include insulin, specific brands of blood glucose monitors and testing strips, Ketone urine testing strips, lancets and lancet puncture devices, specific brands of pen delivery systems for the administration of insulin (including pen needles) and specific brands of insulin syringes.

Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under "Preventive care" in this section.

**These services require certification for coverage. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $500 penalty will be charged for Tier 1 and Tier 2 inpatient services and a $100 penalty will be charged for Tier 1 and Tier 2 outpatient services.*

Mental disorder and chemical dependency Benefits

Benefits are administered by MHN Services, an affiliate behavioral health administrative services company. Covered services are payable by MHN only when you access care from Participating Mental Health Professionals except in emergencies. A special network of providers has been contracted for Stanford students only; this network is locally available in addition to MHN's full national network of providers.

Please call the MHN Customer Service Center at (800) 327-0307 for any additional information.

OUT-OF-POCKET MAXIMUM

For covered services or supplies (per Covered Person, combined with Medical) $2000

ADDITIONAL DEDUCTIBLES

Emergency room deductible (per visit) $100

Severe Mental Illness and Serious Emotional Disturbances of a Child

Outpatient office visits (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring)* $25
Deductible waived

Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care program, day treatment, partial hospitalization and other outpatient procedures including behavioral health treatment for pervasive developmental disorder or autism)..... Covered in full
Deductible waived

Physician visit to hospital, participating behavioral health facility or residential treatment center..... Covered in full
Deductible waived

Inpatient facility*..... $500

Other Mental Disorders

Outpatient office visits (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring)* $25
Deductible waived

Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care program, day treatment, partial hospitalization and other outpatient services) ..... Covered in full
Deductible waived

Physician visit to hospital, participating behavioral health facility or residential treatment center..... Covered in full
Deductible waived

Inpatient facility*..... $500

Chemical Dependency

Outpatient office visits (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring) $25
Deductible waived

Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care program, day treatment, partial hospitalization, medical treatment for withdrawal symptoms, and other outpatient services)■ ..... Covered in full
Deductible waived

Physician visit to hospital, participating behavioral health facility or residential treatment center	Covered in full Deductible waived
Inpatient facility*	$500
Acute care detoxification*	$500

**These services require certification for coverage. If certification is required but not obtained, your benefit reimbursement level will be reduced, both in-network and out-of-network, to 50% of covered expenses.*

Exceptions:

The emergency room deductible will be waived if the Covered Person is admitted to a Hospital directly from an emergency room.

***** *Each group therapy session requires only one half of a private office visit copayment.*

Home health services	Tier 1	Tier 2
Home health services (copayment required for each day home health visits occur)	$25 Deductible waived	30%
Combined maximum number of visits during a Plan year	*100*	*100*

Other services	Tier 1	Tier 2
Sterilization Vasectomy	$50 Deductible waived	$100
Sterilization Tubal ligation	Covered in full Deductible waived	Covered in full Deductible waived
Blood, blood plasma, blood derivatives and blood factors (except for drugs used to treat hemophilia, including blood factors) *,**	Covered in full Deductible waived	30%
Drugs used to treat hemophilia, including blood factors*,**	Refer to Pharmacy Benefits	Refer to Pharmacy Benefits
Nuclear medicine	$35 Deductible waived	30%
Renal dialysis	$25 Deductible waived	30%
Hospice services*	Covered in full Deductible waived	30%

**These services require certification for coverage. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $500 penalty will be charged for Tier 1 and Tier 2 inpatient services and a $100 penalty will be charged for Tier 1 and Tier 2 outpatient services.*

*** Drugs used to treat hemophilia, including blood factors, are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefit even if they are administered in a Physician's office. If you need to have the provider administer the Specialty Drug, you will need to obtain the Specialty Drug through the Specialty Pharmacy Vendor and bring it with you to the provider's office. Alternatively, you may be able to coordinate delivery of the Specialty Drug directly to the provider's office through the Specialty Pharmacy Vendor.*

 *Infertility services and supplies are described below in the "Infertility services" section.*

Infertility services	Tier 1	Tier 2
Infertility services and supplies (to diagnose or evaluate infertility)⌖,*	50%	50%

Notes:

Infertility services include prescription drugs, professional services, inpatient care, outpatient care and treatment by injections.

Infertility services include gamete intrafallopian transfer (GIFT), artificial insemination (AI) and intrauterine insemination (IUI) and all covered services that prepare the member to receive these procedures, are covered only for the HNL member.

Injections for Infertility are covered only when provided in connection with services that are covered by this Plan.

⌖These copayments apply to professional services only. Services that are rendered in a hospital are also subject to the hospital services copayment. See "Hospital services" in this section to determine if any additional copayments may apply.

**Inpatient Infertility services require certification for coverage. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $500 penalty will be charged for Tier 1 and Tier 2 inpatient services and a $100 penalty will be charged for Tier 1 and Tier 2 outpatient services.*

Chiropractic services	Tier 1	Tier 2
Chiropractic care*	$25 Deductible waived	30%
Combined maximum visits per plan year	*15*	*15*

Acupuncture services	Tier 1	Tier 2
Acupuncture care*	$25 Deductible waived	30%

**These services require certification for coverage. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $500 penalty will be charged for Tier 1 and Tier 2 inpatient services and a $100 penalty will be charged for Tier 1 and Tier 2 outpatient services.*

Pediatric Dental Services (birth through the end of the month in which the Covered Person turns 19 years of age)

We provide toll-free access to our Customer Service Associates to assist the Covered Person with benefit coverage questions, resolving problems or changing their dental office. Customer Service can be reached Monday through Friday at **1-866-249-2382** 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.

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 and 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**
Oral Surgery	**50%, Deductible waived**	**50%, Deductible waived**
Endodontics	**50%, Deductible waived**	**50%, Deductible waived**
Periodontics	**50%, Deductible waived**	**50%, Deductible waived**
Crown and Fixed Bridge	**50%, Deductible waived**	**50%, Deductible waived**
Removable Prosthetics	**50%, Deductible waived**	**50%, Deductible waived**
Medically Necessary Orthodontics	**50%, Deductible waived**	**50%, Deductible waived**
Adjunctive Services	**50%, Deductible waived**	**50%, Deductible waived**

- **Pediatric Dental Exclusions and Limitations:**

Periodic Oral Evaluations
Periodic oral evaluations are limited to 1 every 6 months.

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

Fluoride treatment
Fluoride treatment is covered once 1 every 6 months.

Intraoral radiographic images
Intraoral - complete series of radiographic images are limited to once every 24 months.
intraoral - occlusal radiographic image are limited to 2 every 6 months.

Bitewing x-rays
Bitewing x-rays in conjunction with periodic examinations are limited to one series of 4 films in any 6-month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.

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

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

Dental Sealant
Dental sealant treatments are limited to the first, second and third permanent molars that occupy the second molar position.

Replacement of a restoration
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.

Crowns
Prefabricated Crowns – primary teeth are covered once every 12 months.
Prefabricated Crowns – permanent teeth are covered once every 36 months.
Replacement prefabricated crowns necessary in primary teeth within the first 12 months and permanent teeth within the first 36 months are covered.

Only acrylic crowns and stainless crowns are benefit for children under 12 years of age. If other types of crowns are chosen the covered person will pay the difference in cost for children under 12 years of age. The covered dental benefit level will be that of an acrylic crown.

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

Periodontics (other than Maintenance)
Periodontal scaling and root planning, and subgingival curettage are limited to once per quadrant every 24 months.

Periodontal Maintenance
Periodontal maintenance is covered once every 12 months per quadrant.

Fixed bridgework
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 considered 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 considered 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 considered 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
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 and Tissue Conditioning
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 dentures, a complete (remote) overdenture and cast metal partial dentures that do not require extractions.

Tissue conditioning is limited to two per denture.

Medically Necessary Orthodontia:

- 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.

Adjunctive Services:

Adjunctive services, including anesthesia, professional visits and consults, behavior management, post-surgical complications, and occlusal guards, are covered:

a. Palliative treatment (relief of pain).
b. Palliative (emergency) treatment, for treatment of dental pain, limited to once per day, per covered person.
c. House/extended care facility calls, once per member per date of service.
d. One hospital or ambulatory surgical center call per day per provider per covered person.
e. The following anesthesia services are covered in conjunction with oral surgery, as well as for other purposes when medically necessary:
    i. deep sedation/general anesthesia, each 15 minute increment
    ii. intravenous moderate (conscious) sedation/analgesia – each 15 minute increment
    iii. non-intravenous conscious sedation
    iv. inhalation of nitrous oxide/analgesia, anxiolysis
f. Occlusal guards when medically necessary for covered persons from 12 to 19 years of age when covered person has permanent dentition.

Pediatric Dental Exclusions

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 "Specific Provisions" section of the *Benefit Handbook* 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 become 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 subscriber reasonable should have known that an Emergency Care situation did not exist.

Pediatric Vision Plan Benefits(birth through the end of the month in which the Covered Person turns 19 years of age)

We provide toll-free access to our Customer Service Associates to assist the Covered Person with benefit coverage questions, resolving problems or changing their vision office. Customer Service can be reached Monday through Friday at **1-866-392-6058** 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.

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

Routine eye exam limit: 1 per Plan Year Exam Options: Standard Contact Lens Evaluation, Fit and Follow-up visit (routine applications of soft, spherical daily wear contact lenses for single vision prescriptions) Premium Contact Lens Evaluation, Fit and Follow-up visit (more complex applications, including, but not limited to toric, bifocal/multifocal, cosmetic color, post-surgical and gas permeable)	$0 Copayment, Deductible waived
Lenses limit: 1 pair per Plan Year, including • Single vision, bifocal, trifocal, lenticular • Glass, or Plastic, including polycarbonate • Oversized and glass-grey #3 prescription sunglass lenses	$0 Copayment, Deductible waived
Provider selected frames limit: 1 per Plan Year	$0 Copayment, Deductible waived
Optional Lenses and Treatments including • UV Treatment • Tint (Fashion & Gradient & Glass-Grey) • Standard Plastic Scratch Coating • Standard Polycarbonate – • Photocromatic / Transitions Plastic • Standard, Premium and Ultra Anti-Reflective Coating • Polarized • Standard, Premium, Select, and Ultra Progressive Lens • Hi-Index Lenses • Blended segment Lenses • Intermediate vision Lenses • Select or ultra progressive lenses	$0 Copayment, Deductible waived
• Premium Progressive Lens	$0 Copayment, Deductible waived
Provider selected contact lenses, a one year supply is covered every Plan Year (in lieu of eyeglass lenses): • Disposables • Conventional • Medically Necessary*	$0 Copayment, Deductible waived
Subnormal or Low Vision Services and Aids - one comprehensive low vision evaluation every 5 years; low vision aids, including high-power spectacles, magnifiers or telescopes (limited to one aid per year) and follow-up care (limited to 4 visits every 5 years).	$0 Copayment, Deductible waived

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

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

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

Pediatric Vision Services Exclusions: The following items are excluded when obtained while receiving Pediatric Vision Services:

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

Limits of coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- Air or ground ambulance and paramedic services that are not emergency care or which do not result in a patient's transportation will not be covered unless certification is obtained and services are medically necessary.
- Artificial insemination for reasons not related to infertility;
- Care for mental health care as a condition of parole or probation, or court-ordered treatment and testing for mental disorders, except when such services are medically necessary;
- Certain injectable drugs which are considered self-administered are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefits even if they are administered in a Physician's office. If you need to have a provider administer the Specialty Drug, you will need to obtain the Specialty Drug through the Specialty Pharmacy Vendor and bring it with you to the provider office. Alternatively, you can coordinate delivery of the Specialty Drug directly to the provider's office through the Specialty Pharmacy Vendor.
- Conception by medical procedures (IVF and ZIFT);
- Conditions resulting from the release of nuclear energy when government funds are available;
- Except for podiatric devices to prevent or treat diabetes-related complications, corrective footwear is not covered unless medically necessary, custom made for the covered person and permanently attached to a medically necessary orthotic device that is also a covered benefit under this plan;
- Cosmetic services and supplies;
- Custodial or live-in care;
- Dental (except for Pediatric Dental Services). However, Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures are covered. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate;
- Dietary or nutritional supplements, except when prescribed for the treatment of Phenylketonuria (PKU);
- Disposable supplies for home use;
- Experimental or investigational procedures, except as set out under the "Clinical trials" and "If you have a disagreement with our insurance plan" sections of this SB;
- Genetic testing is not covered except when determined by HNL to be medically necessary. The prescribing physician must request prior authorization for coverage;
- Hearing aids;
- Hypnosis;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder;
- Non-eligible institutions. This insurance plan only covered services or supplies provided by a legally operated hospital, Medicare-approved skilled nursing facility or other property licensed facility as specified in the student Benefit Handbook. Any institution that is primarily a place for the aged, nursing home or similar institution, regardless of how it is designated, is not an eligible institution. Services or supplies provided by such institutions are not covered;
- Nontreatable disorders;
- Outpatient prescriptions drugs or medications (except as noted under "Prescription drug program");
- Orthoptics (eye exercises);
- Personal or comfort items;
- Physician self-treatment;
- Physician treatment of immediate family members;
- Private rooms when hospitalized, unless medically necessary;
- Private-duty nursing;

- Refractive eye surgery unless medically necessary, recommended by your treating physician and authorized by HNL;
- Reversal of surgical sterilization;
- Routine physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp or other nonpreventive purposes;
- Services and supplies for the collection, preservation and storage of umbilical cord blood, cord blood stem cells and adult stem cells;
- Services and supplies not authorized by HNL according to HNL's procedures;
- Services for surrogate pregnancy are covered when the surrogate is an HNL covered person. However, when compensation is obtained for the surrogacy, the HNL shall have a lien on such compensation to recover its medical expenses;
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of your student Benefit Handbook;
- Services related to educational and professional purposes; except for behavioral health treatment for pervasive developmental disorder or autism;
- State hospital treatment, except as the result of an emergency or urgently needed care;
- Stress, except when rendered in connection with services provided for a treatable mental disorder;
- Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary; and
- Treatment of obesity, weight reduction or weight management, bariatric services, except for treatment of morbid obesity.

The above is a partial list of the principal exclusions and limitations applicable to the medical portion of your HNL insurance plan. The student Benefit Handbook, which you will receive if you enroll in this insurance plan, will contain the full list.

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 1-800-250-5226 (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

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 ákódoolníłł. 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 ầu 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)

Contact Us

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

Customer Contact Center:

1-800-250-5226

Telecommunications Device
for the Hearing and Speech Impaired:
1-800-995-0852

www.healthnet.com/cardinalcare