Summary *of* Benefits *and* Disclosure *Form*

Primary EPO (Plan 3KR)
University of California

For University of California non-Medicare Members in the Imperial and San Luis Obispo Counties.
Effective 1/1/2012

Health Net®
A BETTER DECISION

DELIVERING CHOICES

When it comes to your health care, the best decisions are made with the best choices. **Health Net Life** (herein called HNL) offers an Exclusive Provider Organization (EPO) insurance plan (called "Primary EPO") an insurance plan that provides you with ways to help you receive the care you deserve. This *Summary of Benefits* (SB) answers basic questions about this versatile plan. If you have further questions, just contact the Member Services Department at the telephone number listed on the back cover and one of our friendly, knowledgeable representatives will be glad to help.

If you have further questions, contact us:

By phone at 1-800-539-4072

Or write to: Health Net Life Insurance Company
P.O. Box 10348
Van Nuys, CA 91410-0348

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. The plan's *Certificate*, which will be issued electronically on Health Net's website at www.healthnet.com/uc, contains the exact terms and conditions of your Health Net Life coverage. You should also consult the *Health Net Life EPO Group Insurance Policy (Policy)* (issued to your employer) to determine governing contractual provisions. It is important for you to carefully read this SB and the plan's *Certificate* thoroughly once received, especially those sections that apply to those with special health care needs. This SB includes a matrix of benefits in the section titled "Schedule of benefits and coverage."

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How the insurance plan works

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

SELECTION OF PHYSICIANS

- When you enroll with Health Net Life Primary EPO, you select one doctor from the Health Net Life Primary EPO Network to provide basic health care; this is your Primary Care Physician (PCP).
- HNL requires the designation of a Primary Care Physician. A Primary Care Physician provides and coordinates your medical care. You have the right to designate any Primary Care Physician who participates in our network and who is available to accept you or your family members, subject to the requirements of the physician group. For children, a pediatrician may be designated as the Primary Care Physician. Until you make this designation, HNL designates one for you. For information on how to select a Primary Care Physician and for a list of the participating Primary Care Physicians, refer to your Primary EPO Directory. The Primary EPO Directory is also available on the Health Net Life website at **www.healthnet.com/uc**.
- Whenever you or a covered dependent needs health care, your PCP will provide the medically necessary care. Specialist care is also available through your Health Net Life Primary EPO insurance plan, when authorized in advance through your PCP.
- You do not have to choose the same PCP for all members of your family. PCPs are listed in the Health Net Life Primary EPO Directory.

HOW TO CHOOSE A PHYSICIAN

Selecting a PCP is important to the quality of care you receive. To ensure you are comfortable with your choice, we suggest the following:

- Discuss any important health issues with your selected PCP; and
- Be sure that you and your family members have adequate access to medical care, by choosing a doctor located within 30 miles of your home or work.

SPECIALISTS AND REFERRAL CARE

If you need medical care that your PCP cannot provide, your PCP may refer you to a specialist or other health care provider for that care. Your PCP must authorize all treatments recommended by such provider.

You do not need prior authorization from HNL or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, refer to your Primary EPO Directory. The Primary EPO Directory is also available on the Health Net Life website at www.healthnet.com/uc.

HOW TO ENROLL

Complete the enrollment form found in the enrollment packet and return the form to your employer. If a form is not included, your employer may require you to use an electronic enrollment form or an interactive voice response enrollment system. Please contact your employer for more information.

Some hospitals and other providers do not provide one or more of the following services that may be covered under the plan's *Certificate* and that you or your dependents 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 you enroll. Call your prospective doctor, medical group, independent practice association or clinic, or call Health Net Life Member Services Department at the telephone number listed on the back cover to ensure that you can obtain the health care services that you need.

Schedule of benefits and coverage

This MATRIX is intended TO BE USED to help you compare coverage benefits and is a summary only. The *Certificate* should be consulted for a detailed description of coverage benefits and limitations.

Principal benefits and coverage matrix

Deductible ..... **None**
Lifetime maximum ..... **None**

Out-of-Pocket maximum (OOPM)

For each covered individual $1000
Two covered persons in a family $2000
Family (three or more covered persons) $3000

Once your payment for covered services and supplies equals the amount shown below in any one calendar year, no additional copayments or coinsurance for covered services and supplies are required for the remainder of that calendar year. Once an individual member in a family satisfies the individual out-of-pocket maximum, the remaining enrolled family members must continue to pay copayments for covered services until the total amount of copayment paid by the family reaches the family out-of-pocket maximum or each enrolled family member individually satisfies the individual out-of-pocket maximum. Payments for any supplemental benefits or services not covered by this insurance plan will not be applied to this calendar year out-of-pocket maximum unless otherwise noted. You will need to continue making payments for any additional benefits as described in the "Additional insurance plan benefits information" section of this SB.

Professional services

Visit to physician $15
Specialist consultations■,* $15
Surgeon or assistant surgeon service in Hospital▲ ..... Covered in full
Surgeon or assistant surgeon service in the physician group's office▲ $15
Administration of anesthetics ..... Covered in full
Transgender surgery and services** ..... Covered in full
Physician visit to your home $15
Prenatal and postnatal office visits⌖ ..... Covered in full
Normal delivery, cesarean section, newborn inpatient care⌖ ..... Covered in full
Treatment of complications of pregnancy, including medically necessary abortions⌖ ..... See note below*
Injectable contraceptives (including but not limited to Depo Provera) $15

Laboratory procedures and diagnostic imaging (including x-ray) ..... Covered in full

Rehabilitative therapy (includes physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy) $15

Organ and stem cell transplants (nonexperimental and noninvestigational) ..... Covered in full

Chemotherapy ..... Covered in full

Radiation therapy ..... Covered in full

Vision and hearing examinations (for diagnosis or treatment $15

■ *Self-referrals are allowed for obstetrics and gynecological services including preventive care, pregnancy and gynecological ailments. Copayment requirements may differ depending on the services provided.*

▲ *Surgery includes surgical reconstruction of a breast incident 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.*

** Applicable 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 office visits for preventive care are covered in full. 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.

** Chiropractic and acupuncture services are not a covered benefit, whether or not the services are approved by the Participating Providers.*

***Transgender surgery and related services, including travel, lodging and meal costs, require prior authorization. Transgender surgery and related services, including travel, lodging and meal costs, that are authorized by the Plan, are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Covered Person.*

Allergy treatment and other injections (except for infertility injection)

Allergy testing $15

Allergy injection services $15

Allergy serum ..... Covered in full

Immunization for occupational purposes 20%

Immunization for foreign travel 20%

All other injections (except for infertility injection)
Injectable drugs administered by a physician $15
Self-injectable drugs $15

Outpatient facility services

Outpatient facility services (other than surgery) ..... Covered in full
Outpatient surgery (hospital or outpatient surgery center charges only) ..... Covered in full

Hospital services

Semi-private hospital room or special care unit with ancillary services, including maternity care (unlimited days) $250
Hospitalization for infertility services 50%
Skilled nursing facility stay *(limited to 100 days each calendar year)* ..... Covered in full
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders) ..... Covered in full

The above inpatient hospitalization copayment or coinsurance is applicable for each admission of hospitalization for an adult, pediatric or newborn patient.

Radiological services

Laboratory procedures and diagnostic imaging (including x-ray) ..... Covered in full

Preventive care

Adult preventive care

Periodic health evaluations, including well-woman exam (age 18 and older)■ ..... Covered in full
Immunizations (age 18 and older) ..... Covered in full

Child preventive care

Periodic health evaluations, including newborn, well-baby care, and immunizations (birth through age 17)■ ..... Covered in full

■*Self-referrals are allowed for obstetrics and gynecological services including preventive care, pregnancy and gynecological ailments. Copayment requirements may differ depending on the services provided.*

For preventive health purposes, covered services include, but are not limited to, periodic health evaluations, diagnostic preventive procedures and preventive vision and hearing screening examinations, based on recommendations published in the U. S. Preventive Services Task Force. In addition, an annual cervical cancer screening test is covered and includes a Pap test, 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.

Emergency health coverage

Emergency room (professional and facility charges) $50

Urgent care center (professional and facility charges) $15

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

Ambulance services

Ground ambulance ..... Covered in full

Air ambulance ..... Covered in full

Prescription drug coverage

Please refer to the "Prescription drug program" section of this SB for applicable definitions, benefit descriptions and limitations. Copayments and deductibles for prescription drugs do not apply to the out-of-pocket maximum, except copayments and deductibles for peak flow meter and inhaler spacers used for the treatment of asthma, and diabetic supplies.

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

Level I drugs listed on the HNL Recommended Drug List (primarily generic) $5

Level II drugs listed on HNL Recommended Drug List (primarily brand name) and diabetic supplies (including insulin) ◆ $20

Level III drugs listed on the HNL Recommended Drug List (or drugs not listed on HNL Recommended Drug List)◆ $35

Lancets ..... Covered in full

Contraceptive devices (including diaphragms and cervical caps) $20

Mail-order program (up to a 90-day supply of maintenance drugs)

UC Walk – up Service (up to a 90-day supply of maintenance medications) at UC Medical Center Pharmacies

Level I drugs listed on the HNL Recommended Drug List (primarily generic)	$10
Level II drugs listed on the HNL Recommended Drug List (primarily brand name) and diabetic supplies (including insulin) ◆	$40
Level III drugs listed on the HNL Recommended Drug List (or drugs not listed on the HNL Recommended Drug List) ◆	$70
Lancets	Covered in full

For information about Health Net's Recommended Drug List, please call the Member Services Department at the telephone number on the back cover.

◆ *Generic drugs will be dispensed when a generic drug equivalent is available. When a brand name drug is dispensed and a generic equivalent is commercially available, the covered person must pay the difference between the generic equivalent and the brand name drug plus the Level I drug copayment.*

However, if the prescription drug order states "dispense as written," "do not substitute" or words of similar meaning in the physician's handwriting, only the Level II or Level III copayment, as appropriate, will be applicable.

✍ *Must be approved by Health Net and the covered person's physician group.*

Copayments for prescription drugs do not apply to the out-of-pocket maximum, except copayments for peak flow meters, inhaler spacers used for the treatment of asthma and diabetic supplies.

Percentage Copayments will be based on Health Net's contracted pharmacy rate.

If the retail price is less than the applicable copayment, then you will pay the retail price. Prescription drug covered expenses are the lesser of HNL's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.

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

Some drugs require prior authorization from HNL. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 72 hours, after HNL's receipt of the request and any additional information requested by HNL that is reasonably necessary to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 5 days, as appropriate and medically necessary, for the nature of the member's condition after HNL's receipt of the information reasonably necessary and requested by HNL to make the determination. For a copy of the Recommended Drug List, call Member Services at the number listed on the back cover of this booklet or visit our website at www.healthnet.com/uc.

Medical Supplies	
Durable medical equipment	Covered in full
Orthotics (such as bracing, supports and casts)	Covered in full
Corrective footwear	Covered in full
Diabetic equipment. See the "Prescription drug program" section of this SB for diabetic supplies benefit information.	Covered in full
Diabetic footwear	Covered in full
Prostheses	Covered in full

Diabetic equipment covered under the medical benefit (through "Diabetic equipment") includes blood glucose monitors designed for the visually impaired, insulin pumps and related supplies, and corrective footwear. 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 insulin syringes.

In addition, the following supplies are covered under the medical benefit as specified: visual aids (excluding eyewear) to assist the visually impaired with the proper dosing of insulin are provided through the prosthesis 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).

Home health services	
Home health services	Covered in full

Other services	
Medical social services	Covered in full
Diabetes education	Covered in full
Infertility services and supplies (including injections related to covered infertility services)✦	50%
Vasectomy	$15
Tubal ligation	$15
Sterilization of females performed in Participating Provider's office	$15
Sterilization of females performed in Hospital	Covered in full
Sterilization of males performed in Participating Provider's office	$15
Sterilization of males performed in Hospital	Covered in full

Removal of implanted contraceptives devices (including but not limited to Norplant)	$60
Hearing aids (2 standard aid(s) with a benefit maximum of $2,000 every 36 months)*	50%
Blood, blood plasma, blood derivatives and blood factors	Covered in full
Nuclear medicine	Covered in full
Renal dialysis	Covered in full
Hospice services	Covered in full

⌖ *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.*

**A standard hearing aid (analog or digital) is one that restores adequate hearing to the member and is determined medically necessary and authorized by the member's PPG.*

Limits of coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- Acupuncture services and supplies;
- Ambulance and paramedic services that do not result in transportation or that do not meet the criteria for emergency care, unless such services are medically necessary and prior authorization has been obtained.
- 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;
- Chiropractic services and supplies;
- Conception by medical procedures (IVF, GIFT and ZIFT);
- Cosmetic services and supplies;
- Custodial or live-in care;
- 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;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder. Your employer has independently contracted with United Behavioral Health, a specialized health care service plan, to provide mental health and substance abuse benefits;
- 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 plan's *Certificate*. 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;
- Orthoptics (eye exercises);
- Orthotics (such as bracing, supports and casts) that are not custom made to fit the member's body.
- Outpatient prescription drugs (except as noted under "Prescription drug program");
- Personal or comfort items;
- Physician self-treatment;
- Physician treating 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 or the PCP 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 for the treatment of chemical dependency (other than detoxification) are not covered. Your employer has independently contracted with United Behavioral Health, a specialized health care service plan, to provide mental health and substance abuse benefits;
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the plan's *Certificate*;
- Services related to educational and professional purposes;
- 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, 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 *Certificate*, which you will receive if you enroll in this insurance plan, will contain the full list.

Benefits and coverage

WHAT YOU PAY FOR SERVICES

The comprehensive benefits of your HNL Primary EPO insurance plan are described in the "Schedule of benefits and coverage" section. Please take a moment to look it over.

SPECIAL ENROLLMENT RIGHTS UNDER CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

The Children's Health Insurance Program (CHIP) is a joint federal and state funded program that provides comprehensive health care coverage for qualified uninsured children under the age of 19. In California, the CHIP plans are known as the Healthy Families Program and the Access for Infants and Mothers Program (AIM). The Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) creates a special enrollment period in which individuals and their dependent(s) are eligible to request enrollment in this plan within 60 days of becoming ineligible and losing coverage from the Healthy Families Program, Access for Infants and Mothers Program (AIM) or a Medi-Cal plan.

NOTICE OF REQUIRED COVERAGE

Benefits of this insurance plan provide coverage required by the Federal Newborns' and Mothers' Health Protection Act of 1996 and Women's Health and Cancer Right Act of 1998.

The Newborns' and Mothers' Health Protection Act of 1996 sets requirements for a minimum Hospital length of stay following delivery. Specifically, Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Women's Health and Cancer Right Act of 1998 applies to medically necessary mastectomies and requires coverage for prosthetic devices and reconstructive surgery on either breast provided to restore and achieve symmetry.

COVERAGE FOR NEWBORNS

Children born after your date of enrollment are automatically covered at birth. To continue coverage, the child must be enrolled through your employer before the 30th day of the child's life. If the child is not enrolled within 30 days of the child's birth:

- Coverage will end the 31st day after birth; and
- You will have to pay for all medical care provided after the 30th day of your baby's life.

EMERGENCIES

HNL covers emergency and urgently needed care throughout the world. If you are injured, feel severe pain, begin active labor or experience an unexpected illness that a reasonable person with an average knowledge of health and medicine would believe requires immediate treatment to prevent serious threat to your health (including severe mental illness and serious emotional disturbances of a child), seek care where it is immediately available. Depending on your circumstances, you may seek this care by going to your PCP (medical) or the Behavioral Health Administrator (mental illness or chemical dependency), or to the nearest emergency facility or by calling **911**.

You are encouraged to use appropriately the **911** emergency response system, in areas where the system is established and operating, when you have an emergency medical condition (including severe mental illness and serious emotional disturbances of a child) that requires an emergency response. All ambulance and ambulance transport services provided as a result of a **911** call will be covered, if the request is made for an emergency medical condition (including severe mental illness and serious emotional disturbances of a child).

Emergency care *means 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 believe requires immediate treatment (including severe mental illness and serious emotional disturbances of a child), and without immediate treatment, any of the following would occur: (a) 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); (b) his or her bodily functions, organs or parts would become seriously damaged; or (c) his or her bodily organs or parts would seriously malfunction. Emergency care also includes treatment of severe pain or active labor. Active labor means labor at the time that either of the following would occur: (a) there is inadequate time to effect safe transfer to another hospital prior to delivery; or (b) a transfer poses a threat to the health and safety of the covered person or her unborn child.*

Urgently Needed Care means any otherwise covered medical service that a reasonable person with an average knowledge of health and medicine would seek for treatment of an injury, unexpected illness or complication of an existing condition, including pregnancy, to prevent the serious deterioration of his or her health, but which does not qualify as Emergency Care, as defined in this section. This may include services for which a person should reasonably have known an emergency did not exist.

All follow-up care (including severe mental illness and serious emotional disturbances of a child*)* after the urgency has passed and your condition is stable, must be provided or authorized by your PCP (medical) or the Behavioral Health Administrator (mental illness or chemical dependency); otherwise, it will not be covered by HNL.

MEDICALLY NECESSARY CARE

All services that are medically necessary will be covered by your HNL Primary EPO insurance plan (unless specifically excluded under the insurance plan). All covered services or supplies are listed in the plan's *Certificate*; any other services or supplies are not covered.

SECOND OPINIONS

You have the right to request a second opinion when:

- Your PCP or a referral physician gives a diagnosis or recommends a treatment plan that you are not satisfied with;
- You are not satisfied with the result of treatment you have received;
- You are diagnosed with, or a treatment plan is recommended for, a condition that threatens loss of life, limb, or bodily function, or a substantial impairment, including but not limited to a serious chronic condition; or
- Your PCP or a referral physician is unable to diagnose your condition, or test results are conflicting.

To obtain a copy of HNL's second opinion policy, contact the Health Net Life Member Services Department at the phone number on the back cover.

CLINICAL TRIALS

Routine patient care costs for patients diagnosed with cancer who are accepted into phase I, II, III, or IV clinical trials are covered when medically necessary, recommended by your treating physician and authorized by HNL. The physician must determine that participation has a meaningful potential benefit to you and the trial has therapeutic intent. For further information, please refer to the plan's *Certificate*.

EXTENSION OF BENEFITS

If you are totally disabled when your employer ends its group services agreement with HNL, we will cover the treatment for the disability until one of the following occurs:

- A maximum of 12 consecutive months elapses from the termination date;
- Available benefits are exhausted;
- The disability ends; or
- You become enrolled in another insurance plan that covers the disability.

Your application for an extension of benefits for disability must be made to HNL within 90 days after your employer ends its agreement with us. We will require medical proof of the total disability at specified intervals.

CONFIDENTIALITY AND RELEASE OF YOUR INFORMATION

HNL knows that personal information in your medical records is private. Therefore, we protect your personal health information in all settings (including oral, written and electronic information). The only time we would release your confidential information without your authorization is for payment, treatment, health care operations (including, but not limited to utilization management, quality improvement, disease or case management programs) or when permitted or required to do so by law such as for, court order or subpoena. We will not release your confidential claims details to your employer or their agent. Often, HNL is required to comply with aggregated measurement and data reporting requirements. In those cases, we protect your privacy by not releasing any information that identifies our enrollees.

PRIVACY PRACTICES

Once you become a Health Net Life covered person, Health Net Life uses and discloses a covered person's protected health information and nonpublic personal financial information* for purposes of treatment, payment, health care operations, and where permitted or required by law. Health Net

Life provides covered persons with a Notice of Privacy Practices that describes how it uses and discloses protected health information; the individual's rights to access, to request amendments, restrictions, and an accounting of disclosures of protected health information; and the procedures for filing complaints. Health Net Life will provide you the opportunity to approve or refuse the release of your information for non-routine releases such as marketing. Health Net Life provides access to covered persons to inspect or obtain a copy of the covered person's protected health information in designated record sets maintained by Health Net Life. Health Net Life protects oral, written and electronic information across the organization by using reasonable and appropriate security safeguards. These safeguards include limiting access to an individual's protected health information to only those who have a need to know in order to perform payment, treatment, health care operations or where permitted or required by law. Health Net Life releases protected health information to plan sponsors for administration of self-funded plans but does not release protected health information to plan sponsors/employers for insured products unless the plan sponsor is performing a payment or health care operation function for the plan. Health Net Life's entire Notice of Privacy Practices can be found in the plan's *Certificate*, at www.healthnet.com/uc under "Privacy" or you may contact the Member Services Department at the telephone number listed on the back cover to obtain a copy.

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

TECHNOLOGY ASSESSMENT

New technologies are those procedures, drugs or devices that have recently been developed for the treatment of specific diseases or conditions or are new applications of existing procedures, drugs or devices. New technologies are considered investigational or experimental during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to be considered investigational or experimental if clinical study has not shown safety or effectiveness or if they are not considered standard care by the appropriate medical specialty. Approved technologies are integrated into HNL benefits.

HNL determines whether new technologies should be considered medically appropriate, or investigational or experimental, following extensive review of medical research by appropriately specialized physicians. HNL requests review of new technologies by an independent, expert medical reviewer in order to determine medical appropriateness or investigational or experimental status of a technology or procedure.

The expert medical reviewer also advises HNL when patients require quick determinations of coverage, when there is no guiding principle for certain technologies or when the complexity of a patient's medical condition requires expert evaluation.

Utilization management

Utilization management is an important component of health care management. Through the processes of pre-authorization, concurrent and retrospective review and care management, we evaluate the services provided to our covered persons to be sure they are medically necessary and

appropriate for the setting and time. These processes help to maintain HNL's high quality medical management standards.

PRE-AUTHORIZATION

Certain proposed services may require an assessment prior to approval. Evidence-based criteria are used to evaluate whether or not the procedure is medically necessary and planned for the appropriate setting (that is, inpatient, ambulatory surgery, etc.).

CONCURRENT REVIEW

This process continues to authorize inpatient and certain outpatient conditions on a concurrent basis while following a covered person's progress, such as during inpatient hospitalization or while receiving outpatient home care services.

DISCHARGE PLANNING

This component of the concurrent review process ensures that planning is done for a covered person's safe discharge in conjunction with the physician's discharge orders and to authorize post-hospital services when needed.

RETROSPECTIVE REVIEW

This medical management process assesses the appropriateness of medical services on a case-by-case basis after the services have been provided. It is usually performed on cases where pre-authorization was required but not obtained.

CARE OR CASE MANAGEMENT

Nurse care managers provide assistance, education and guidance to the covered persons (and their families) through major acute and/or chronic long-term health problems. The care managers work closely with the covered individual, their physicians and community resources.

If you would like additional information regarding HNL's utilization management process, please call the Health Net Life Member Services Department at the telephone number listed on the back cover.

Payment of premiums and charges

YOUR COINSURANCE, COPAYMENT AND DEDUCTIBLES

The comprehensive benefits of your HNL Primary EPO insurance plan are described in the "Schedule of benefits and coverage" section. Please take a moment to look it over.

PREPAYMENT PREMIUMS

Your employer will pay HNL your monthly premiums for you and all enrolled dependents. Check with your employer regarding any share that you may be required to pay. If your share ever increases, your employer will inform you in advance.

OTHER CHARGES

You are responsible for payment of your share of the cost of services covered by this insurance plan. Amounts paid by you are called copayments, which are described in the "Schedule of benefits and coverage" section of this SB. Beyond these charges the remainder of the cost of covered services will be paid by HNL.

When the total amount of deductibles and copayments you pay equals the out-of-pocket maximum shown in the "Schedule of benefits and coverage" section, you will not have to pay additional copayments for the rest of the year for most services provided or authorized by your PCP.

Payment for services not covered by this plan will not count toward the calendar year out-of-pocket maximum. Additionally, certain deductibles and copayments will not count toward the out-of-pocket maximum as shown in the "Schedule of benefits and coverage" section. For further information please refer to the plan's Certificate.

LIABILITY OF ENROLLEE FOR PAYMENT

If you receive health care services from doctors without receiving required authorization from your PCP, you are responsible for payment of expenses for these services.

Remember, services are only covered when provided or authorized by a PCP or the Behavioral Health Administrator, except for emergency or out-of-area urgent care. Consult the Primary EPO Directory for a full listing of HNL-contracted physicians.

Claims for covered expenses filed more than one year from the date of service will not be paid unless you can show that it was not reasonably possible to file your claim within that time limit and that you have filed as soon as was reasonably possible.

Facilities

Health care services for you and eligible members of your family will be provided at:

- The facilities of the physician group you chose at enrollment; or
- A nearby HNL-contracted hospital, if hospitalization is required.

Many HNL contracting physician groups have either a physician on call 24 hours a day or an urgent care center available to offer access to care at all times.

The physician group you choose will also have a contractual relationship with local hospitals (for acute, subacute and transitional care) and skilled nursing facilities. These are listed in your Primary EPO Directory.

PRIMARY CARE PHYSICIAN TRANSFERS

You may transfer to another PCP monthly. Simply contact HNL by the 15th of the month to have your transfer effective by the 1st of the following month. If you call after the 15th, your transfer will be effective the 1st of the second following month.

Transfer requests will generally be honored, unless you are confined to a hospital. (However, HNL may approve transfers under this condition for certain unusual or serious circumstances. Please call the HNL Member Services Department at the phone number on the back cover of this booklet for more information.)

CONTINUITY OF CARE

Transition of Care for New Enrollees

You may request continued care from a provider who does not contract with HNL if at the time of your enrollment with HNL you were receiving care for the conditions listed below. You must make this request within 15 days of your effective date.

Continuity of Care Upon Termination of Provider Contract

If HNL's contract with a PCP or other provider is terminated, HNL will transfer any affected covered individuals to another contracted PCP or provider to ensure that care continues. HNL will provide a written notice to affected covered person at least 60-days prior to termination of a contract with a PCP or an acute care hospital. In addition, the covered individual may request continued care from a provider whose contract is terminated if at the time of termination you were receiving care from such a provider for the conditions listed below.

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable copayments and any other exclusions and limitations of your insurance plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider's contract termination. You must request continued care within 30 days upon receiving notification of the provider's date of termination.

The following conditions are eligible for continuation of care:

- An acute condition;
- A serious chronic condition;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- A newborn (up to 36 months of age with a maximum duration of coverage of twelve months);
- A terminal illness; and
- A surgery or other procedure that has been authorized by HNL as part of a documented course of treatment.

If you would like more information on how to request continued care or to request a copy of HNL's continuity of care policy, please contact the Health Net Life Member Services Department at the phone number listed on the back cover.

Renewing, continuing or ending coverage

RENEWAL PROVISIONS

The contract between HNL and your employer is usually renewed annually. If your contract is amended or terminated, your employer will notify you in writing.

INDIVIDUAL CONTINUATION OF BENEFITS

Please examine your options carefully before declining coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

If your employment with your current employer ends, you and your covered dependents may qualify for continued group coverage under:

- **COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985).** For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside of California. Please check with your group to determine if you and your covered dependents are eligible.
- **Cal-COBRA Continuation Coverage.** If you have exhausted COBRA and you live in the Health Net Service Area, you may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if you began receiving federal COBRA coverage on or after January 1, 2003, have exhausted federal COBRA coverage, 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 the *Certificate* through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.
- **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.
- **HIPAA:** The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people covered under existing group health insurance plans to maintain coverage regardless of pre-existing conditions when they change jobs or are unemployed for brief periods of time. California law provides similar and additional protections. Applicants who meet the following requirements are eligible to enroll in a guaranteed issue individual health insurance plan from any health insurance plan that offers individual coverage, including HNL's Guaranteed HMO Plans, without medical underwriting. A health insurance plan cannot reject your application for guaranteed issue individual health coverage if you meet the following requirements, agree to pay the required premiums and live or work in the insurance plan's service area. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance. To be considered an eligible individual:

    1. The applicant must have a total of 18 months of coverage (including COBRA, if applicable) without a significant break (excluding any employer-imposed waiting periods) in coverage of more than 63 days.
    2. The most recent coverage must have been under a group health insurance plan. COBRA and Cal-COBRA coverage are considered group coverage.

3. The applicant must not be eligible for coverage under any group health insurance plan, Medicare or Medicaid, and must not have other health insurance coverage.
4. The individual's most recent coverage could not have been terminated due to fraud or non-payment of premiums.
5. If COBRA or Cal-COBRA coverage was available, it must have been elected and such coverage must have been exhausted.

For more information regarding guarantee issue coverage through HNL please call Our Individual Sales Department at **1-800-909-3447**. If you believe your rights under HIPAA have been violated, please contact the Department of Insurance at **1-888-927-HELP**.

Also, if you become ineligible for group coverage, you may convert from group coverage to a type of individual coverage called conversion coverage. Application must be made within 63 days of the date group coverage ends. Please contact the Health Net Life Member Services Department for information about conversion insurance plan coverage. Furthermore, you may be eligible for continued coverage for a disabling condition (for up to 12 months) if your employer terminates its agreement with HNL. Please refer to the "Extension of benefits" section of this SB for more information.

TERMINATION OF BENEFITS

Your coverage under this insurance plan ends when:

- The agreement between the employer covered under this insurance plan and Health Net Life ends;
- The employer covered under this insurance plan fails to pay premium charges; or
- You no longer work for the employer covered under this insurance plan.

If the employer covered under this insurance plan does not pay appropriate premium charges, benefits will end on the last day for which premium charges have been made, unless:

- You apply for conversion coverage within 31 days of that date; or
- You are totally disabled and apply for an extension of benefits for the disabling condition within 90 days.

If the person involved in any of the above activities is the enrolled employee, coverage under this insurance plan will end as well for any covered dependents.

If you have a disagreement with our insurance plan

The California Department of Insurance (CDI) is responsible for regulating disability insurance carriers (HNL is a disability insurance carrier). The CDI has a toll-free telephone number (**1-800-927-HELP**) to receive complaints regarding carriers.

If you have been unable to resolve a problem concerning your insurance coverage, after discussions with Health Net Life Insurance Company, or its agent or other representative, you may contact:

California Department of Insurance, Consumer Services Division
300 South Spring Street
South Tower
Los Angeles, CA 90013

COVERED PERSON GRIEVANCE AND APPEALS PROCESS

The California Department of Insurance (CDI) is responsible for regulating disability insurance carriers (HNL is a disability insurance carrier). The CDI has a toll-free telephone number (**1-800-927-HELP**) to receive complaints regarding carriers.

MEMBER GRIEVANCE AND APPEALS PROCESS

If you are dissatisfied with the quality of care that you have received or feel that you have been incorrectly denied a service or claim, you may file a grievance or appeal.

How to file a grievance or appeal:

You may call the telephone number listed on the back cover or submit the covered person grievance form through the HNL website at ***www.healthnet.com/uc.***

You may also write to:

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

Please include all the information from your Health Net identification card as well as details of your concern or problem.

HNL will acknowledge your grievance or appeal within five calendar days, review the information and tell you of our decision in writing within 15 days of receiving the grievance if the grievance pertains to a claims dispute or within 30 days of receiving the grievance for all other grievances. For conditions where there is an immediate and serious threat to your health, including severe pain or the potential loss of life, limb or major bodily function, HNL will notify you of the status of your grievance no later than three days from receipt of all the required information.

In addition, you can request an independent medical review of disputed health care services from the CDI if you believe that health care services eligible for coverage and payment under the insurance plan was improperly denied, modified or delayed by HNL or one of its contracting providers.

Also, if HNL denies your appeal of a denial for lack of medical necessity, or denies or delays coverage for requested treatment involving experimental or investigational drugs, devices, procedures or therapies, you can request an independent medical review of HNL's decision from the CDI if you meet eligibility criteria set out in the plan's Certificate.

ARBITRATION

If you are not satisfied with the result of the grievance and appeals process, you may submit the problem to binding arbitration. HNL uses binding arbitration to settle disputes, including medical malpractice. When you enroll in HNL, you agree to submit any disputes to arbitration, in lieu of a jury or court trial.

Additional insurance plan benefit information

The following insurance plan benefits show the copayments required for optional benefits available with your insurance plan. For a more complete description of copayments, and exclusions and limitations of service, please see the plan's *Certificate*.

Behavioral health services

Your employer has independently contracted with United Behavioral Health, a specialized health care service plan, to provide mental health and chemical dependency benefits. Covered services may be obtained by receiving a referral through United Behavioral Health at 1-888-440-8225. Care must be provided by a United Behavioral Health participating provider and approved by United Behavioral Health. Special provisions apply in the event of an emergency, and are described in detail in the United Behavioral Health Certificate.

Additional benefits are provided for those covered individuals having a diagnosis categorized as Severe Mental Illness. Please contact United Behavioral Health at 1-888-440-8225 for a complete schedule of your Mental Health and chemical dependency Benefits.

Prescription drug program

HNL is contracted with many major pharmacy chains, supermarket based pharmacies and privately owned neighborhood pharmacies in California. For a complete and up-to-date list of participating pharmacies, please visit our website at **www.healthnet.com/uc** under the Pharmacy Info portal or call the Health Net Life Member Services Department at the telephone number on the back cover.

UC WALK-UP SERVICE THROUGH UC MEDICAL CENTER PHARMACIES

To streamline access to prescription medications, Health Net and the UC Medical Center Pharmacies have partnered to offer UC members with the ability to fill up to a 90-day prescription for maintenance medications at any of the UC designated Medical Center Pharmacies. Just like Health Net's current Mail Order Program, members can now obtain up to a 90-day supply for only two copays, at one of the UC-designated Medical Center pharmacies.

PRESCRIPTIONS BY MAIL DRUG PROGRAM

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period), you have the option of filling it through our convenient Prescriptions By Mail

Drug Program. This program allows you to receive a 90-consecutive-calendar-day supply of maintenance medications. For complete information, call the Health Net Life Member Services Department at the telephone number on the back cover.

Schedule II narcotic drugs (which are drugs that have a high abuse risk as classified by the Federal Drug Enforcement Administration) are *not covered through mail order. For further information, please refer to the Certificate.*

THE HEALTH NET RECOMMENDED DRUG LIST

This insurance plan uses the Recommended Drug List. The Health Net Recommended Drug List (or the List) is the approved list of medications covered for illnesses and conditions. It was developed to identify the safest and most effective medications for Health Net Life covered persons while attempting to maintain affordable pharmacy benefits.

We specifically suggest to all HNL Primary EPO contracting PCPs and specialists that they refer to this List when choosing drugs for patients who are HNL covered persons. When your physician prescribes medications listed in the Recommended Drug List, it ensures that you are receiving a high quality prescription medication that is also of high value.

The Recommended Drug List is updated regularly, based on input from the HNL Pharmacy and Therapeutics (P&T) Committee. The Committee members are actively practicing physicians of various medical specialties and clinical pharmacists. Voting members are recruited from contracting physician groups throughout California based on their experience, knowledge and expertise. In addition, the P&T Committee frequently consults with other medical experts to provide additional input to the Committee. Updates to the Recommended Drug List and drug usage guidelines are made as new clinical information and new drugs become available. In order to keep the List current, the P&T Committee evaluates clinical effectiveness, safety and overall value through:

- Medical and scientific publications;
- Relevant utilization experience; and
- Physician recommendations.

To obtain a copy of HNL's most current Recommended Drug List, please visit our web site at **www.healthnet.com/uc**, under the pharmacy information, or call the Health Net Life Member Services Department at the telephone number on the back cover.

WHAT IS "PRIOR AUTHORIZATION?"

Some prescription medications require prior authorization. This means that your doctor must contact HNL in advance to provide the medical reason for prescribing the medication.

How to request prior authorization:

Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 24 hours after HNL's receipt of the request and any additional information requested by HNL that is reasonably necessary to make the determination.

Routine requests from physicians are processed in a timely fashion, not to exceed 5 days, as appropriate and medically necessary, for the nature of the covered person's condition after HNL's receipt of the information reasonably necessary and requested by HNL to make the determination.

Upon receiving your physician's request for prior authorization, HNL will evaluate the information submitted 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 HNL P&T Committee as well as physician specialist experts. Your physician may contact HNL to obtain the usage guidelines for specific medications.

If authorization is denied by HNL, you will receive written communication including the specific reason for denial. If you disagree with the decision, you may appeal the decision.

The appeal may be submitted in writing, by telephone or through e-mail. We must receive the appeal within 60 days of the date of the denial notice. Please refer to the plan's *Certificate* for details regarding your right to appeal.

- Call the Health Net Member Services Department at the phone number on the back cover;
- Visit www.healthnet.com/uc for information on e-mailing the Member Services Department; or

Write to:

Health Net Member Services Department
P.O. Box 10348
Van Nuys, CA 91410-0348

WHAT'S COVERED

Please refer to the "Schedule of benefits and coverage" section of this SB for the explanation of covered services and copayments.

This insurance plan covers the following:

Outpatient prescription medication:

- Level I drugs listed on the Recommended Drug List (primarily generic);
- Level II drugs listed on the Recommended Drug List (primarily brand name) and diabetic supplies (including insulin); and
- Level III drugs listed on the Recommended Drug List (or drugs not listed on the Recommended Drug List).

MORE INFORMATION ABOUT DRUGS THAT WE COVER

- Prescription drug covered expenses are the lesser of HNL's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.
- Prescription drug refills are covered, up to a 30-consecutive-day supply per prescription at a HNL contracted pharmacy for one copayment.
- If the pharmacy's retail price is less than the applicable copayment, you will only pay the pharmacy's retail price.
- Percentage copayments will be based on Health Net's contracted pharmacy rate.
- Mail order drugs are covered up to a 90-consecutive-calendar-day supply. When the retail pharmacy copayment is a percentage, the mail order copayment is the same percentage of the cost to HNL as the retail pharmacy copayment.

- For Level III Drugs, you will pay the greater of the Level II Drug copayment or the Level III coinsurance.
- Oral contraceptives and emergency contraceptives are covered. Vaginal contraceptives include diaphragms and cervical caps and are only covered when a physician performs a fitting examination and prescribes the device. Such devices are only available through a prescription from a pharmacy and are limited to one fitting and prescription per calendar year, unless additional fittings or devices are medically necessary. For a complete list of contraceptive products covered by HNL, please refer to the Recommended Drug List. Injectable contraceptives are covered when administered by a physician. If your physician determines that none of the methods specified as covered by the insurance plan are medically appropriate, then the insurance plan will provide coverage for another FDA approved contraceptive method as prescribed by your physician. Refer to the plan's *Certificate* for more information on contraceptives covered under the medical benefit.
- Diabetic supplies (blood glucose testing strips, lancets, needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (that is, 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. See diabetic equipment under the "Schedule of benefits and coverage" section of this SB for additional benefit information. For more information about diabetic equipment and supplies, please see "Endnotes" in the 'Schedule of benefits and coverage' section of this SB.

- Sexual dysfunction drugs which are drugs that establish, maintain or enhance sexual functioning are covered for sexual dysfunction when medically necessary. Sexual dysfunction drugs are covered when prior authorization is obtained from HNL. Injectable sexual dysfunction drugs must be dispensed through HNL's Specialty Pharmacy Vendor. These Prescription Drugs are covered for up to the number of doses or tablets specified in HNL's Recommended Drug List. For information about HNL's Recommended Drug List, please call the Member Services Department at the telephone number on the back cover.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

Services or supplies excluded under pharmacy services may be covered under the medical benefits portion of your insurance plan. Consult the plan's Certificate for more information. In addition to the exclusion and limitations listed below, prescription drug benefits are subject to the insurance plan's general exclusions and limitations.

- Allergy serum;
- Coverage for devices is limited to vaginal contraceptive devices and diabetic supplies. No other devices are covered even if prescribed by your physician;
- Drugs that require a prescription in order to be dispensed for the relief of nicotine withdrawal symptoms are covered up to a twelve week course of therapy per calendar year if you are concurrently enrolled in a comprehensive smoking cessation behavioral modification support program. The prescribing physician must request prior authorization for coverage. For information regarding smoking cessation behavioral modification support programs available through HNL, contact HNL Member Services at the telephone number on your HNL ID Card or visit the HNL website at www.healthnet.com/uc;
- Drugs prescribed for routine dental treatment;
- Drugs used for diagnostic purposes;
- Drugs prescribed for the treatment of obesity are covered when medically necessary for the treatment of morbid obesity. In such cases, the drugs will be subject to prior authorization from HNL;

- Drugs or medicines administered by a physician or physician's staff member;
- Drugs prescribed to shorten the duration of the common cold;
- Drugs prescribed for sexual dysfunction when not medically necessary, including drugs that establish, maintain, or enhance sexual function or satisfaction;
- Experimental drugs (those that are labeled "Caution - Limited by Federal Law to investigational use only"). If you are denied coverage of a drug because the drug is investigational or experimental you will have a right to Independent Medical Review. See "If you have a disagreement with our insurance plan" section of this SB for additional information;
- Hypodermic needles or syringes, except for specific brands of disposable insulin needles and syringes and specific brands of pen devices;
- Immunizing agents, injections (except for insulin), agents for surgical implantation, biological sera, blood, blood derivatives or blood plasma;
- Individual doses of medication dispensed in plastic, unit dose or foil packages unless medically necessary or only available in that form obtained through a prescription;
- Irrigation solutions and saline solutions;
- Limits on quantity, dosage and treatment duration may apply to some drugs. Medications taken on an "as-needed" basis may have a copayment 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;
- Medical equipment and supplies (including insulin), that are available without a prescription are covered when prescribed by a physician for the management and treatment of diabetes. Any other nonprescription drug, medical equipment or supply that can be purchased without a prescription drug order is not covered even if a physician writes a prescription drug order for such drug, equipment or supply. However, if a higher dosage form of a prescription drug or over-the counter (OTC) drug is only available by prescription, that higher dosage drug will be covered. If a drug that was previously available by prescription becomes available in an OTC form in the same prescription strength, then any prescription drugs that are similar agents and have comparable clinical effect(s) will only be covered when medically necessary and prior authorization is obtained from HNL;
- Prescription drugs filled at pharmacies that are not in the HNL pharmacy network or are not in California except in emergency or urgent care situations;
- Prescription drugs prescribed by a physician who is not a member physician or an authorized specialist are not covered, except when the physician's services have been authorized, or because of a medical emergency condition, illness or injury, for urgently needed care or as specifically stated;
- Replacement of lost, stolen or damaged medications;
- Maintenance drugs must be obtained through the mail order program in order to be covered. (See the "Prescriptions by Mail Drug Program" provision in "Prescription Drug Program" for details.)
- Services or supplies which are covered in full or for which you are not legally required to pay;
- 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; and
- Drugs prescribed for a condition or treatment not covered by this insurance plan are not covered. However, the insurance plan does cover drugs for medical conditions that result from nonroutine complications of a noncovered service.

This is only a summary. Consult the plan's *Certificate* to determine the exact terms and conditions of your coverage.

Notice of language services

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number on your ID card. For Individual and Family or Farm Bureau members please call 800-839-2172. Employer group members please call 800-522-0088. PPO members: for more help call the CA Dept. of Insurance at 1-800-927-4357. HMO members: for more help call the Department of Managed Health Care HMO Help Line at 1-888-HMO-2219. **English**

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que una persona le lea los documentos y que algunos se envíen en su idioma. Para solicitar ayuda, llámenos al número que aparece en su tarjeta de identificación. Para los afiliados de Individual y Familiar o de la Oficina Agrícola, llame al número 800-839-2172. Los afiliados de un grupo del empleador deben llamar al 800-522-0088. Afiliados de PPO: para obtener más ayuda llame al Departamento de Seguros de CA al 1-800-927-4357. Afiliados de HMO: para obtener más ayuda llame a la Línea de Ayuda del Departamento de Cuidado Médico de HMO al 1-888-HMO-2219. **Spanish**

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，部分文件可以翻譯成您的語言並寄送給您。欲取得協助，請撥打您會員卡上的電話號碼與我們聯絡。個人與家庭計畫或農業協會的會員請撥打 800-839-2172。僱主團體會員請撥打 800-522-0088。PPO 會員：欲取得更多協助，請致電加州保險局 1-800-927-4357。HMO 會員：欲取得更多協助，請致電醫療保健計畫管理局 HMO 協助專線 1-888-HMO-2219。 **Chinese**

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, xin gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị. Các hội viên Individual and Family hoặc Farm Bureau có thể gọi số 800-839-2172. Các hội viên trong chương trình bảo hiểm theo nhóm của hãng sở xin gọi số 800-522-0088. Các hội viên PPO: để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Các hội viên HMO: để được giúp đỡ thêm, xin gọi Đường Dây Trợ Giúp HMO của Sở Điều Quản Y Tế tại số 1-888-HMO-2219. **Vietnamese**

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 경우, 본인 ID 카드 상의 안내번호로 전화해 주십시오. 개인 및 가족 회원 혹은 Farm Bureau 회원께서는 800-839-2172번으로 전화해 주십시오. 고용주 그룹 회원께서는 800-522-0088번으로 전화해 주십시오. PPO 가입자: 보다 많은 도움이 필요하신 분은 캘리포니아 보험 담당국, 안내번호 1-800-927-4357번으로 문의하십시오. HMO 가입자: 보다 많은 도움이 필요하신 분은 보건관리부 (the Department of Managed Health Care)의 HMO 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오. **Korean**

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card. Para sa Individual at Family members, mangyaring tumawag sa 800-839-2172. Para sa employer group members, mangyaring tumawag sa 800-522-0088. Para sa PPO members: para sa karagdagang tulong, tumawag sa CA Dept. of Insurance sa 1-800-927-4357. Para sa HMO members: para sa karagdagang tulong, tumawag sa Department of Managed Health Care HMO Help Line sa 1-888-HMO-2219. **Tagalog**

Անվճար Լեզվական ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեր լեզվով: Օգնության համար, մեզ զանգահարեք ձեր ինքնության տոմսի վրա նշված համարով: Եթե անդամ եք Անհատական և Ընտանեկան կամ Ագարակային Գրասենյակի (Farm Bureau), զանգահարեք 800-839-2172 համարով: Գործատիրոջ Խմբի անդամներից խնդրվում է զանգահարել 800-522-0088 համարով: PPO-ի անդամներ՝ լրացուցիչ տեղեկության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: HMO-ի անդամներ՝ լրացուցիչ տեղեկության համար 1-888-HMO-2219 համարով զանգահարեք Կառավարված Առողջական Խնամքի Օգնության Գծին: **Armenian**

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочесть документы на вашем языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте; участники планов индивидуального или семейного страхования, а также планов страхования Фермерского бюро могут позвонить по телефону 800-839-2172. Участники плана группового страхования по месту работы могут позвонить по телефону 800-522-0088. Участники системы предпочтительного выбора (Preferred Provider Organization, PPO): для получения дополнительной помощи звоните в Министерство страхования штата Калифорния по телефону 1-800-927-4357. Участники организаций медицинского обслуживания (Health Maintenance Organizations, HMO): для получения дополнительной помощи звоните в справочную службу HMO Департамента организованного медицинского обслуживания по телефону 1-888-HMO-2219. **Russian**

無料の言語サービス。日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号までお問い合わせください。個人、家族会員、または、ファーム・ビューロー会員の方は、800-839-2172 まで、雇用者団体会員の方は、800-522-0088 までご連絡ください。PPO会員の方：更なるお問い合わせは、カリフォルニア州保険庁、 1-800-927-4357 までご連絡ください。HMO会員の方：更なるお問い合わせは、カリフォルニア州管理医療庁のHMO相談窓口、 1-888-466-2219 までご連絡ください。 **Japanese**

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید مدارک به زبان خودتان برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است تماس بگیرید. اعضاء «طرح افراد و خانواده ها» یا «طرح اداره مزارع» لطفاً به شماره 800-839-2172 تلفن کنند. اعضاء گروههای کارفرمایان لطفاً با شماره 800-522-0088 تماس بگیرند. اعضاء PPO: برای کسب اطلاعات بیشتر لطفاً با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. اعضاء HMO: برای کسب اطلاعات بیشتر به خط کمکی HMO در Department of Managed Health Care به شماره 1-888-HMO-2219 تلفن کنید. **Farsi**

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਜਾਂ ਫਾਰਮ ਬਿਊਰੋ ਮੈਂਬਰ ਕਿਰਪਾ ਕਰਕੇ 800-839-2172 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਇੰਪਲਾਇਰ ਗਰੁੱਪ ਦੇ ਮੈਂਬਰ ਕਿਰਪਾ ਕਰਕੇ 800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। PPO ਮੈਂਬਰ: ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। HMO ਮੈਂਬਰ: ਵਧੇਰੇ ਮਦਦ ਲਈ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਮੈਨੇਜਡ ਹੈਲਥ ਕੇਅਰ ਦੀ HMO ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। **Punjabi**

ការបកប្រែភាសាដោយឥតគិតថ្លៃ ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងឲ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន ។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក ។ សំរាប់សមាជិក បុគ្គលខ្លួន និងជាគ្រួសារ ឬសមាជិក Farm Bureau សូមទូរស័ព្ទទៅលេខ 800-839-2172 ។ សមាជិកក្រុមថ្នាក់ក្រុមហ៊ុននិយោជក សូមទូរស័ព្ទមកលេខ 800-522-0088 ។ សមាជិក PPO ៖ សំរាប់ជំនួយបន្ថែម សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រង នៃរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 ។ សមាជិក HMO ៖ សំរាប់ជំនួយបន្ថែម សូមទូរស័ព្ទទៅក្រសួងគ្រប់គ្រងសុខាភិបាល ខ្សែជំនួយ HMO តាមលេខ 1-888-HMO-2219 ។ **Khmer**

خدمات ترجمة بدون تكلفة. يمكنك الاستعانة بمترجم. يمكنك طلب قراءة وثائق وإرسال بعضها لك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك (ID). بالنسبة للأفراد وأعضاء الأسرة أو أعضاء Farm Bureau رجاء الاتصال بالرقم 800-839-2172. وبالنسبة لأعضاء مجموعات صاحب العمل رجاء الاتصال بالرقم 800-522-0088. أعضاء PPO: للحصول على المساعدة الإضافية يرجى الاتصال بالخط الخاص بإدارة التأمين الصحي لولاية كاليفورنيا على الرقم 1-800-827-4357. أعضاء HMO: للحصول على المساعدات الإضافية يرجى الاتصال بخط المساعدة لـ Department of Managed Health Care على الرقم 1-888-HMO-2219. **Arabic**

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi. Koj kom muaj ib tug neeg txhais lus rau koj los tau. Koj kom nyeem cov ntaub ntawv thiab xa ib co ntaub ntawv ua koj hom lus tuaj rau koj los tau. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID. Rau cov tswv cuab hauv pawg Tus Kheej thiab Tsev Neeg los sis Farm Bureau thov hu rau 800-839-2172. Cov tswv cuab hauv pawg tom chaw ua hauj lwm thov hu rau 800-522-0088. Cov tswv cuab hauv PPO: yog xav tau kev pab ntxiv hu tau CA Lub Koom Haum Saib Xyuas Txog Kev Tuav Pov Hwm ntawm 1-800-927-4357. Cov tswv cuab hauv HMO: yog xav tau kev pab ntxiv hu rau Lub Caj Meem Fai Saib Xyuas Txog Kev Tswj Txoj Kev Kho Mob (Department of Managed Health Care) HMO Tus Xov Tooj Muab Kev Pab ntawm 1-888-HMO-2219. **Hmong**

ບໍລິການພາສາໆໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດໄດ້ຮັບບໍລິການແປພາສາແລະມີຜູ້ອ່ານເອກກະສານໃຫ້ທ່ານຟັງເປັນພາສາຂອງທ່ານເອງ. ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມໝາຍເລກທີ່ລະບຸໄວ້ໃນບັດປະກັນໄພຂອງທ່ານ. ຂໍໃຫ້ສະມາຊິກລາຍບຸກຄົນແລະຄອບຄົວຫລືສະມາຊິກ Farm Bureau ໂທຕາມໝາຍເລກ 800-839-2172. ຂໍໃຫ້ສະມາຊິກກຸ່ມລູກຈ້າງໂທຕາມໝາຍເລກ 800-522-0088. ສະມາຊິກ PPO: ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອເພີ່ມຕື່ມ ໃຫ້ໂທໄປຫາກົມປະກັນໄພແຫ່ງລັດຄາລີຟໍເນັຍຕາມໝາຍເລກ 1-800-927-4357. ສະມາຊິກ HMO: ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອເພີ່ມຕື່ມ ໃຫ້ໂທຕາມສາຍດ່ວນ HMO ແຫ່ງກົມກຳກັບລະບົບຄຸ້ມຄອງການຮັກສາສຸຂະພາບ (Department of Managed Health Care) ຕາມໝາຍເລກ 1-888-HMO-2219. **Laotian**

Contact Us

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Large Group:
1-800-539-4072

1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

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

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