CERTIFICATE OF INSURANCE

A complete explanation of Your plan

PPO (Plan 4CR)

Important benefit information – please read

Health Net®
LIFE INSURANCE COMPANY

PPO847LRG(1/13)

Dear Health Net Covered Person:

This is Your new Health Net PPO Certificate of Insurance.

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

Thank You for choosing Health Net.

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INTRODUCTION TO HEALTH NET PREFERRED PROVIDER ORGANIZATION (PPO)

Plan 4CR

HEALTH NET PPO CERTIFICATE OF INSURANCE

ISSUED IN CONNECTION WITH THE HEALTH NET PPO GROUP INSURANCE POLICY

UNDERWRITTEN
BY

HEALTH NET LIFE INSURANCE COMPANY

Los Angeles, California

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

HNL believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that Your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Your Group or to HNL's Customer Contact Center at the phone number on the back of Your HNL ID Card. If You are enrolled in an employer plan that is subject to ERISA, 29 U.S.C. 1001 et seq, You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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

Preferred Providers are providers who have agreed to participate in HNL's Preferred Provider Organization program (PPO), which is called Health Net PPO. They have agreed to provide You Covered Services and Supplies as explained in this *Certificate* and accept a special Contracted Rate, called the Contracted Rate, as payment in full. Your share of costs is based on this Contracted Rate. Preferred Providers are listed on the HNL website at www.healthnet.com, or You can contact the Customer Contact Center at the telephone number on Your HNL ID Card to obtain a copy of the Preferred Provider Directory.

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

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

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

Some Hospitals and other providers do not provide one or more of the following services that may be covered under this *Certificate* and that You might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. In order to determine from whom the above health care services may be available, HNL suggests You obtain this information prior to enrollment by calling prospective Physicians, Hospitals or clinics which contract with HNL or any other provider of choice. You may also obtain this information by calling HNL's Customer Contact Center at 1-888-893-1572.

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

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

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

If You Are Enrolled In A Plan That Is Subject To ERISA, 29 U.S.C. 1001 et seq., a federal law regulating some plans:

IN ADDITION TO THE RIGHTS SET FORTH IN THIS *CERTIFICATE*, YOU MAY HAVE RIGHTS UNDER APPLICABLE STATE LAW OR REGULATIONS AND/OR UNDER THE FEDERAL ERISA STATUTE.

If You Are Enrolled In A Plan That Is Not Subject To ERISA:

IN ADDITION TO THE RIGHTS SET FORTH IN THIS *CERTIFICATE*, YOU MAY HAVE RIGHTS UNDER APPLICABLE STATE OR FEDERAL LAWS OR REGULATIONS.

Contact Your Employer to determine if You are enrolled in a Plan that is subject to ERISA.

Important Notice To California Certificate Holders

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

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

1-888-893-1572

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

California Department of Insurance
Office of the Ombudsman
300 South Spring Street
South Tower
Los Angeles, CA 90013
1-800-927-HELP or 1-800-927-4357
www.insurance.ca.gov

SCHEDULE OF BENEFITS

Health Net PPO
Plan 4CR

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

Medical Benefits

Please see the "Certification Requirement" portion of the "Plan Benefits" section of this *Certificate* for a list of services and supplies which require Certification.

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

Out-of-Pocket Maximum

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

Individual Out-of-Pocket Maximum through a Preferred Provider $1500
Individual Out-of-Pocket Maximum through an Out-of-Network Provider $1500
Family Out-of-Pocket Maximum through a Preferred Provider $3000
Family Out-of-Pocket Maximum through an Out-of-Network Provider.....$3000

Note: Any Copayments or Coinsurance paid for the services of a Preferred Provider which are Covered Expenses will apply toward the Out-of-Pocket Maximum for Out-of-Network Providers. In addition, Coinsurance paid for the services of an Out-of-Network Provider will apply toward the Out-of-Pocket Maximum for Preferred Providers.

Once the OOPM is satisfied, then the eligible benefits are paid at 100% for the remainder of the Calendar Year in addition to the next Calendar Year.

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

- Covered Expenses incurred for Chiropractic

Copayments and Coinsurance

You may be required to pay out-of-pocket charges for specific services and supplies. These charges are known as Copayments and Coinsurance.

Copayments: Copayments are fixed dollar amount charges, shown below, for which You are responsible. We will pay 100% of Covered Expenses for the services listed below after the Copayment is made.

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

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

Notes:

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

Services in an Emergency Room or Urgent Care Center

	Preferred Providers	Out-of-Network
Emergency room care (facility and professional services)	$0	10%
Urgent care (facility and professional services)	$0	10%

Note:

- For all services which meet the criteria for Emergency Care, the Coinsurance will be the percentage shown for Preferred Providers, even if the services were provided by an Out-of-Network Provider.

Authorized Hospital and Skilled Nursing Facility Services

	Preferred Providers	Out-of-Network
Unlimited days of care in a semi-private room or Special Care Unit including ancillary (additional) services	$0	10%
Confinement for Infertility services	$0	10%
Christian Science sanatorium	Not Covered	10%
Confinement in a Skilled Nursing Facility	$0	10%
Outpatient surgery (Hospital or Outpatient Surgical Center charges only, except for Infertility services)	$0	10%
Outpatient services (other than surgery, except for Infertility services)	$0	10%
Routine nursery care for newborns	$0	10%

Notes:

- Inpatient and outpatient care for Infertility is described below in the "Infertility Services" section.
- Other professional services performed in the outpatient department of a Hospital, Outpatient Surgical Center or other licensed outpatient facility such as a visit to a Physician (office visit), laboratory and x-ray services, physical therapy, etc., may require a Copayment or Coinsurance when these services are performed. Look under the headings for the various services such as office visits, neuromuscular rehabilitation and other services to determine any additional Copayments or Coinsurances that may apply.

- Screening colonoscopy and sigmoidoscopy procedures (for the purposes of colorectal cancer screening) will be covered under the "Preventive Care Services" section below. Diagnostic endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an outpatient facility require the Copayment or Coinsurance applicable for outpatient facility services.
- The Preferred Provider Coinsurance will apply if the Covered Person is admitted to a Hospital directly from an emergency room or urgent care center. The Covered Person will remain responsible for amounts billed in excess of Covered Expenses (Maximum Allowable Amounts) for the inpatient stay by an Out-of-Network Provider. You will not be reimbursed for any amounts in excess of Maximum Allowable Amounts billed by an Out-of-Network Provider.
- The above Coinsurance for inpatient Hospital or Special Care Unit services is applicable for each admission for the hospitalization of an adult, pediatric or newborn patient. If a newborn patient requires admission to a Special Care Unit, a separate Copayment for inpatient Hospital services will apply.

Mental Disorders and Chemical Dependency Benefits

Covered services provided for the treatment of Mental Disorders and Chemical Dependency are subject to the Copayments as required for the services when provided for a medical condition.

Severe Mental Illness or Serious Emotional Disturbances of a Child	**Preferred Providers**	**Out-of-Network**
Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting)	$0	10%
Outpatient professional consultation (psychological evaluation or therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day)	$0	10%
Intensive outpatient care or partial hospitalization/day treatment	$0	10%
Physician visit to Hospital, Behavioral Health Facility or Residential Treatment Center	$0	10%
Inpatient services	$0	10%

Other Mental Disorders	**Preferred Providers**	**Out-of-Network**
Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting)	$0	10%
Intensive outpatient care or partial hospitalization/day treatment	$0	10%
Physician visit to Hospital, Behavioral Health Facility or Residential Treatment Center	$0	10%
Inpatient Services	$0	10%

Chemical Dependency	**Preferred Providers**	**Out-of-Network**
Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting) for Chemical Dependency	$0	10%
Intensive outpatient care or partial hospitalization/day treatment	$0	10%
Inpatient Services	$0	10%
Detoxification (acute care for Chemical Dependency)	$0	10%

Office Visits

	Preferred Providers	**Out-of-Network**
Visit to a Physician's office	$0	10%
Visit to a Christian Science Practitioner	Not Covered	10%
Specialist consultation	$0	10%
Vision examinations (age 18 and older)	Not covered	Not covered

Hearing examinations (age 18 and older)	Not covered	Not covered
Annual routine physical examination	Not Covered	Not Covered
Physician visit to Covered Person's home	$0	10%
Vision or hearing examination (for diagnosis or treatment, including refractive eye examinations) (birth through age 17)	$0	10%

Preventive Care Services

	Preferred Providers	Out-of-Network
Preventive care services for children (through age 17)	$0	10%
Preventive care services for adults (age 18 and older)	$0	10%

Notes:

- Covered Services and Supplies include, but are not limited to, annual preventive physical examinations, immunizations, well-woman examinations and preventive vision and hearing screening examinations. Refer to the "Preventive Care Services" portion of the "Plan Benefits" section for details.
- If You receive any other Covered Services and Supplies in addition to Preventive Care Services during the same visit, You will also pay the applicable Copayment or Coinsurance for those services.

Allergy and Injection Services

	Preferred Providers	Out-of-Network
Allergy testing	$0	10%
Allergy serum	$0	10%
Allergy injection services (serum not included)	$0	10%
Immunizations for occupational purposes or foreign travel	$0	10%
Other Immunizations	$0	10%
Injections (except for Infertility)	$0	10%
Self-injectable drugs	$0	10%

Notes:

- Injections for the treatment of Infertility are described below in the "Infertility Services" section.
- Certain injectable drugs which are considered self-administered are not covered under the medical benefits even if they are administered in a Physician's office.

Care for Conditions of Pregnancy

	Preferred Providers	Out-of-Network
Normal delivery, cesarean section, prenatal and postnatal care	$0	10%
Complications of pregnancy, including Medically Necessary terminations of pregnancy	See note below	See note below
Elective terminations of pregnancy	$0	10%
Genetic testing of fetus	$0	10%
Circumcision of newborn (birth through 30 days) *	$0	10%

Notes:

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.

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

Family Planning

	Preferred Providers	Out-of-Network
Sterilization of males	$0	10%
Sterilization of females	$0	10%
Intrauterine device (IUD)	$0	10%

Notes:

The diagnosis, evaluation and treatment of Infertility are described below in the "Infertility Services" section.

The above Copayments apply to professional services only. Services that are rendered in a Hospital are also subject to the Hospital services Copayment. Look under the "Authorized Hospital and Skilled Nursing Facility Services" heading to determine any additional Copayments that may apply.

Infertility Services

	Preferred Providers	Out-of-Network
Infertility services (all covered services that diagnose, evaluate or treat Infertility)	$0	10%

Notes:

- Infertility services include professional services, inpatient and outpatient care and treatment by injections.
- Refer to the "Family Planning" provision in the "Plan Benefits" section and the "Conception by Medical Procedures" provision in the "General Limitations and Exclusions" section for additional information.

Medical Supplies

	Preferred Providers	Out-of-Network
Durable Medical Equipment*	$0	10%
Orthotics (such as bracing, supports and casts)	$0	10%
Corrective Footwear	$0	10%
Diabetic equipment	$0	10%
Diabetic footwear	$0	10%
Prostheses	$0	10%
Hearing aids	$0	$0
Combined Lifetime Maximum	*$1,500*	*$1,500*
Blood or Blood Products	$0	10%

Notes:

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

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

Home Health Care Services

	Preferred Providers	Out-of-Network
Home Health Care Services	$0	10%

Hospice Care

	Preferred Providers	Out-of-Network
Hospice Care	$0	10%

Acupuncture and Chiropractic Services

	Preferred Providers	Out-of-Network
Acupuncture	$0	10%
Chiropractic services*	10%	10%
Combined Maximum payable by HNL per Calendar Year	*$1500*	*$1500*

Note:

*Does not apply to OOPM

Certification may be required. Please refer to the "Certification Requirement" portion of the "Plan Benefits" section for details.

Ambulance

	Preferred Providers	Out-of-Network
Air Ambulance	$0	$0
Ground Ambulance	$0	$0

Other Professional Services

	Preferred Providers	Out-of-Network
Physician visit to Hospital or Skilled Nursing Facility	$0	10%
Surgery	$0	10%
Administration of anesthetics	$0	10%
Diagnostic imaging (including x-ray) and laboratory procedures	$0	10%
Chemotherapy	$0	10%
Radiation therapy	$0	10%
Nuclear medicine	$0	10%
Organ, stem cell or tissue transplant (not Experimental or Investigational)	$0	10%
Companion and donor travel**	$0	10%
Renal dialysis	$0	10%
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy*	$0	10%
Medical social services	$0	10%
Diabetes education	$0	Not Covered
Outpatient infusion therapy	$0	10%
Number of days for each supply of injectable Prescription Drugs and other substances, for each delivery	*14*	*14*

Note:

*Certification may be required. Please refer to the "Certification Requirement" portion of the "Plan Benefits" section for details.

**Companion and donor travel is limited to the cost of one round trip coach airfare. Additionally, hotel or motel accommodations are limited to the same number of days the member is confined in a hospital or medical facility.

ELIGIBILITY, ENROLLMENT AND TERMINATION

Who Is Eligible For Coverage

The covered services and supplies of this Plan are available to eligible employees or retirees and their dependents as long as they live in the continental United States, either work or live in the Health Net Service Area and meet the additional eligibility requirements of the Group as specified in Southern California Edison Company's Summary Plan Description.

How to Enroll for Coverage

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

Employee

Application for enrollment for an employee must be made to the Group within the timeframe established by the group as specified in Southern California Edison Company's Summary Plan Description.

Newly Acquired Dependents

You are entitled to enroll newly acquired dependents as specified in Southern California Edison Company's Summary Plan Description.

Late Enrollment Rule

Please refer to Southern California Edison Company's Plan Description for details concerning late enrollment.

Special Enrollment Rule For Newly Acquired Dependents

Please refer to Southern California Edison Company's Summary Plan Description for details concerning late enrollment.

Special Reinstatement Rule For Reservists Returning From Active Duty

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

Special Reinstatement Rule Under USERRA

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

Replacement Of Coverage Provision

This provision applies only to persons covered under the Employer's prior group plan ("Prior Plan") on the date it canceled and who are eligible for coverage under this *Certificate* on its effective date. The Prior Plan must be replaced by this *Certificate* within 60 days.

All persons covered under the Prior Plan are covered under this *Certificate*. However, some benefits of this *Certificate* may be reduced or denied. These benefits are described below:

A person may have a preexisting condition. Medical benefits under this *Certificate* may be reduced or denied for a specified time because of that condition (see the "Pre-Existing Conditions" provision in the "General Limitations and Exclusions" section). Coverage for that condition during this time will be limited to the lesser of:

- any benefits available under the Prior Plan if it had remained in force; or
- any benefits available under this *Certificate* without the preexisting condition.

If a person is totally disabled and extended benefits are payable under the Prior Plan, no benefits are payable under this *Certificate* for the condition that caused the Total Disability.

If a person remains totally disabled, benefits are payable under this *Certificate* until the earlier of the following:

- 12 months from the date the Prior Plan stopped; or
- the date the benefits would otherwise stop under this *Certificate*.

Certain children will be included as Dependents eligible for health coverage under this *Certificate* regardless of age. The child must have been covered under the Prior Plan. The child must meet the following conditions:

- the child is mentally or physically handicapped;
- the child is not capable of self-support; and
- the child depends mainly on You for support.

You must give proof to HNL that the child meets these conditions, when requested.

When Coverage Ends

You must notify the Group of changes that will affect Your eligibility. The Group will send the appropriate request to HNL according to current procedures. HNL is not obligated to notify You that You are no longer eligible or that Your coverage has been terminated.

All Covered Persons

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

Principal Covered Person and All Dependents

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

Individual Covered Persons

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

- The Covered Person no longer meets the eligibility requirements established by the Group and HNL. This will include a child subject to a Medical Child Support Order, according to state or federal law, who becomes ineligible on the earlier of:
  1. The date established by the order; or
  2. The date the order expired.
- The Covered Person establishes primary residency outside the United States;
- The Covered Person becomes eligible for Medicare and assigns Medicare benefits to another health maintenance organization or competitive medical plan; or
- Your marriage or domestic partnership ends by divorce, annulment or some other form of dissolution. Eligibility for Your enrolled spouse (now former spouse) and that spouse's enrolled Dependents, who were related to You only because of the marriage, will end.

Notice Of Ineligibility

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

Coverage Options Following Termination

Please examine Your options carefully before declining coverage. 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 coverage through this *Certificate* ends, the terminated Covered Person may be eligible for additional periods of coverage under this or other types of plans through HNL as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conversion Coverage
Described below in the subsection titled "Conversion Coverage."

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

- Continuation of coverage requires:

  1. Your payment to the union which represents You of the monthly premium required for this coverage;

  2. The union collecting such payments from at least 75% of the persons who cease to work because of the labor dispute; and

  3. The timely payment of premiums to Us by the union or unions as required under the Policy for proper payment of premiums.

- If any premium due is unpaid on the date work ceases, there will be no continuation unless such premium is paid by Your Employer or the union prior to the next premium due date.
- The amount of Your monthly payment for continued coverage will be equal to the full group monthly cost for the coverage, including any portion usually paid by the Employer, and, except as provided in the bullet item immediately below, such premium rate will be the applicable rate then in effect for coverage under the Policy, on the date work ceases.

- The premium rates for coverage may be increased by 20% on the premium due date on or next after the date work ceases due to the labor dispute. Such increase will apply during the time coverage is continued under this provision. We still have the right to increase the premium rates before, during and after the date work ceases, if We would have had the right to increase rates under the Policy, had work not ceased.
- Your continued coverage under this provision will cease on the earliest of:

  1. The end of the period of time for which the union has made payment for Your coverage, if the next premium due is not made;
  2. The premium due date for which premiums are received for less than 75% of the persons eligible to continue coverage because of the labor dispute;
  3. The premium due date on or following the date that You start full-time work with another Employer;
  4. The premium due date on or after the date You ceased to be at work because of the labor dispute for 6 months; or
  5. The premium due date on or after the labor dispute is resolved.

- If You have Dependents insured on the date You cease work, You must also continue their coverage in order to continue coverage for You.

HIPAA

The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people covered under existing group health 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 plan from any health plan that offers individual coverage without medical underwriting. A health 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 plan's service area. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance. To be considered an eligible individual:

- 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.
- The most recent coverage must have been under a group health plan. COBRA and Cal-COBRA coverage are considered group coverage.
- The applicant must not be eligible for coverage under any group health plan, Medicare or Medicaid, and must not have other health insurance coverage.
- The individual's most recent coverage could not have been terminated due to fraud or nonpayment of premiums.
- 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 **1-800-927-HELP**.

Extension of Benefits

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

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

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

For the purpose of this extension, You shall be considered totally disabled when, as a result of bodily injury or disease, You are unable to engage in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience and not, engaged in any employment or occupation for wage or profit. A Dependent shall be considered totally disabled when he or she is prevented from performing all regular and customary activities usual for a person of that age and family status.

Conversion Coverage

Benefits and premiums under a conversion agreement are not the same as those provided under this *Certificate*.

Who Is Eligible For Conversion Coverage

All Covered Persons covered under this *Certificate* are entitled to obtain conversion coverage if the reason for loss of this Group coverage is:

- The Group Policy between HNL and the Group was terminated, whether such termination was initiated by the Group or HNL and regardless of the reasons for termination; or
- The Covered Person lost the eligibility for coverage as described in this "Eligibility, Enrollment and Termination" section of this *Certificate* with the exceptions as noted below.

Who Is Not Eligible For Conversion Coverage

- Your Dependents who were not covered under this *Certificate* when Your coverage ends; or
- Covered Persons who have coverage under any other individual or Group policy.

How to Apply for Conversion Coverage

You must request and complete an application form and send it to HNL within 63 days of the last day of coverage.

Anyone eligible to enroll in the HNL conversion plan who does not enroll when Group coverage ends, will not be allowed to do so at a later date.

Conversion coverage must become effective immediately following the date Group coverage ends. There can be no lapse in coverage. The Covered Person must pay all required premiums to ensure that coverage is continuous.

PLAN BENEFITS

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

In addition, many of the Covered Services and Supplies listed herein are subject to Certification in many instances, prior to the expenses being incurred. Please refer to the "Certification Requirement" subsection for further details.

An expense is incurred on the date You receive the service or supply for which the charge is made. HNL shall not pay for expenses incurred for any services or supplies in excess of any visit or benefit maximum described in the "Schedule of Benefits" section or elsewhere in this *Certificate*, nor for any service or supply excluded herein.

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

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

How Covered Expenses Are Determined

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

Preferred Providers

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

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

Out-of-Network Provider

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

Since the Out-of-Network Provider has **not** agreed to accept the Maximum Allowable Amount as payment in full, the amount billed by the Out-of-Network Provider may exceed the Maximum Allowable Amount. You will need to pay that excess amount, in addition to Copayments or Coinsurance payment required. You are always responsible for services or supplies not covered by this plan. Once the Maximum Allowable Amount is determined, the amount that HNL pays on Out-of-Network Provider and the amount which will be your responsibility are determined as follows:

- HNL pays an Out-of-Network Provider an amount equal to the Maximum Allowable Amount, less any Copayments and/or Coinsurance applicable to the Covered Expense for the service or supply that You receive.
- The portion of the Maximum Allowable Amount that will be your responsibility is any Copayments and/or Coinsurance applicable to the Covered Expense for the service or supply that You receive.
- Unless the Out-of-Network Provider has agreed to accept the Maximum Allowable Amount as payment in full, as described in the definition of Maximum Allowable Amount, the amount billed by the Out-of-Network Provider may exceed the Maximum Allowable Amount. You will be responsible for that excess amount, in

addition to any Copayments and/or Coinsurance payment required. In addition, You are always responsible for services or supplies not covered by this plan.

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

Out-of-Pocket Maximum

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

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

Certification Requirement

Some of the Covered Expenses under this plan are subject to a requirement of Certification in order for full benefits to be available. All Certifications are performed by HNL.

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

Services Requiring Certification

Services requiring Certification include but are not limited to:

- Inpatient admissions

  Any type of facility, including but not limited to:

  1. Acute rehabilitation center
  2. Chemical dependency facility
  3. Hospice
  4. Hospital
  5. Mental health facility
  6. Skilled Nursing Facility

- Ambulance: non-emergency air or ground Ambulance services
- Bariatric-related services: non-surgical bariatric-related consultations and services
- Clinical trials
- Custom Orthotics
- Durable Medical Equipment:

  1. Bone growth stimulator
  2. Continuous positive airway pressure (CPAP)
  3. Custom-made items
  4. Hospital beds
  5. Power wheelchairs
  6. Scooters

- Experimental/Investigational services and new technologies.

- Home Health Care Services including home uterine monitoring, Hospice, nursing, occupational therapy, physical therapy, speech therapy and tocolytic services
- Hospice Care
- Intensity modulated radiation therapy (IMRT)
- Neuro or spinal cord stimulator
- Occupational and speech therapy.
- Organ, tissue and stem cell transplant services, including pre-evaluation and pre-treatment services and the transplant procedure
- Outpatient Diagnostic Imaging:
    1. CT (Computerized Tomography)
    2. MRA (Magnetic Resonance Angiography)
    3. MRI (Magnetic Resonance Imaging)
    4. PET (Positron Emission Tomography)
    5. Nuclear cardiology procedures, including SPECT (Single Photon Emission Computed Tomography)
- Outpatient pharmaceuticals
    1. Self-injectables
    2. Hemophilia factors and intravenous immunoglobulin (IVIG)
    3. Certain Physician-administered drugs, whether administered in a Physician office, free-standing infusion center, ambulatory surgery center, outpatient dialysis center or outpatient Hospital. Refer to the Health Net Life website, www.healthnet.com, for a list of Physician-administered drugs that require Certification.
- Outpatient physical, cardiac and pulmonary rehabilitation therapy, chiropractic care and acupuncture (exceeding 12 visits), subject to any benefit maximums stated in the "Schedule of Benefits" section.
- Outpatient surgical procedures including:
    1. Abdominal, ventral, umbilical, incisional hernia repair
    2. Bariatric procedures
    3. Blepharoplasty
    4. Breast reductions and augmentations
    5. Mastectomy for gynecomastia
    6. Orthognathic procedures (includes TMJ treatment)
    7. Rhinoplasty
    8. Treatment of varicose veins
    9. Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
    10. Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate
- Prosthesis over $2,500 in billed charges
- Stereotactic radiosurgery and stereotactic body radiotherapy (SBRT)
- Tocolytic services (intravenous drugs used to decrease or stop uterine contractions in premature labor)

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

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

Exceptions

Certification is not needed for the first 48 hours of inpatient Hospital services following a vaginal delivery nor the first 96 hours following a cesarean section. However, HNL should be notified within 24 hours following birth. Certification must be obtained for a scheduled cesarean section or if the Physician determines that a longer Hospital stay is Medically Necessary either prior to or following the birth.

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

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

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

Certification Procedure

Certification must be requested by You within the following periods:

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

In order to obtain Certification, You or Your Physician are responsible for contacting HNL as shown on Your HNL Identification Card before receiving any service requiring Certification. If You receive any such service and do not follow the procedures set forth in this section, Your benefits may be reduced by a percentage stated in the "Schedule of Benefits" section of this *Certificate*.

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

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

Effect on Benefits

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

Resolution of Disputes

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

- Either You or Your Physician must contact HNL to request reconsideration of the decision. Additional information may be requested or the treating Physician may be consulted in any reconsideration. A written reconsideration decision will be provided; and
- If You remain dissatisfied with the reconsideration decision, please refer to the "General Provisions" section of this *Certificate* for more information.

Medical Benefits

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

Hospital

Inpatient Services

Covered Expenses include:

- Accommodations as an inpatient in a room of two or more beds, at the Hospital's most common semi-private room rate;
- Services in Special Care Units;
- Operating, delivery and special treatment rooms;
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services;
- Physical therapy;
- Radiation therapy, chemotherapy and renal dialysis treatment;
- Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Hospital for use during Your stay; and
- Blood transfusions, including blood processing, the cost of blood and unreplaced blood and Blood Products are covered. Self-donated (autologous) blood transfusions are covered only for a scheduled surgery that has been certified. However, this *Certificate* does not cover treatments which use umbilical cord blood, cord blood stem cells and adult stem cells (nor their collection, preservation and storage) as such treatments are considered to be Experimental or Investigational in nature. (Please refer to "Independent Medical Review of Investigational or Experimental Therapies" in the "General Provisions" section for additional information.)

Outpatient Services

Covered Expenses include:

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

Certification may be required. Please refer to the "Certification Requirement" portion of this "Plan Benefits" section for details.

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

Outpatient Surgical Center

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

Skilled Nursing Facility

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

Covered Expenses include:

- Accommodations in a room of two or more beds. Payment will be made based on the Skilled Nursing Facility's prevailing charge for two-bed room accommodations;
- Special treatment rooms;
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services;
- Physical, occupational and speech therapy;
- Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Skilled Nursing Facility for use during Your stay; and
- Blood transfusions, including blood processing, the cost of blood and unreplaced blood and Blood Products are covered. Self-donated (autologous) blood transfusions are covered only for a scheduled surgery that has been certified. However, this *Certificate* does not cover treatments which use umbilical cord blood, cord blood stem cells and adult stem cells (nor their collection, preservation and storage) as such treatments are considered to be Experimental or Investigational in nature. (Please refer to "Independent Medical Review of Investigational or Experimental Therapies" in the "General Provisions" section for additional information.)

Custodial Care is not covered.

Professional Services

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

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

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

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

When multiple procedures are performed at the same time, Covered Expenses include the Contracted Rate or Maximum Allowable Amount (as applicable) for the first (or major) procedure and one-half the Contracted Rate or Maximum Allowable Amount for each additional procedure. HNL uses Medicare guidelines to determine the circumstances under which claims for multiple surgeries will be eligible for reimbursement, in accordance with HNL's normal claims filing requirements. No benefit is payable for incidental surgical procedures, such as an appendectomy performed during gall bladder surgery.

HNL uses Medicare guidelines to determine which procedures are eligible for separate professional and technical components.

Diagnostic Imaging (Including X-Ray) and Laboratory Procedures

All prescribed diagnostic imaging (including x-ray) and laboratory procedures, services and materials, including cancer screening tests.

Home Health Care Services

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

Home Health Care Services must be ordered by Your Physician, approved by HNL and provided under a treatment plan describing the length, type and frequency of the visits to be provided. The following conditions must be met in order to receive Home Health Care Services:

- The skilled nursing care is appropriate for the medical treatment of a condition, illness, disease or injury;
- The Covered Person is homebound because of illness or injury (this means that the Covered Person is normally unable to leave home unassisted, and, when the Covered Person does leave home, it must be to obtain medical care, or for short, infrequent non-medical reasons such as a trip to get a haircut, or to attend religious services or adult day care);
- The Home Health Care Services are part-time and intermittent in nature; a visit lasts up to 4 hours in duration in every 24 hours; and
- The services are in place of a continued hospitalization, confinement in a Skilled Nursing Facility, or outpatient services provided outside of the Covered Person home.

Custodial Care services and Private Duty Nursing, as described in the "Definitions" section and any other types of services primarily for the comfort or convenience of the Covered Person, are not covered even if they are available through a Home Health Care Agency. Home Health Care Services do not include Private Duty Nursing or shift care. Private Duty Nursing (or shift care, including any portion of shift care services) is not a covered benefit under this plan even if it is available through a Home Health Care Agency or is determined to be Medically Necessary. See the "Definitions" section.

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

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

Self-Injectable Drugs

Self-injectable drugs are covered when prescribed by a Physician and dispensed by a licensed pharmacy.

When a self-injectable drug is prescribed, You have the option of having Your prescription filled through HNL's contracted Specialty Pharmacy Vendor. However, needles and syringes required to administer the self-injected medications are covered only when obtained through the contracted Specialty Pharmacy Vendor. The Specialty Pharmacy Vendor will charge You for the appropriate Copayment or Coinsurance shown in the "Schedule of Benefits" section. HNL will reimburse the Specialty Pharmacy Vendor directly. The Specialty Pharmacy Vendor may contact You directly to coordinate the delivery of Your medications.

If You do not fill Your prescription through the Specialty Pharmacy vendor, You must obtain authorization from HNL for the drug and pay the full cost of the prescription to the pharmacist at the time the drug is dispensed. Then You must file a claim for reimbursement. HNL will first subtract any charges billed in excess of the Covered Expense. Then HNL will subtract the applicable Copayment or Coinsurance shown for Preferred Providers or Out-of-Network Providers (as applicable, depending on the provider who wrote the prescription) in the "Schedule of Benefits" section. You will be reimbursed for the remainder.

Outpatient Infusion Therapy

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

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

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

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

All services must be billed and performed by a provider licensed by the state. Only a 14-day supply will be dispensed per delivery.

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

- Non-Prescription Drugs or medications;
- Any drug labeled "Caution, limited by Federal Law to Investigational use" or Investigational drugs not approved by the FDA;
- Drugs or other substances obtained outside of the United States;
- Homeopathic or other herbal medications not approved by the FDA;
- FDA approved drugs or medications prescribed for indications that are not approved by the FDA, or which do not meet medical community standards (except for non-Investigational FDA approved drugs used for off-label indications when the conditions of state law have been met);
- Growth hormone treatment; or
- Supplies used by a health care provider that are incidental to the administration of infusion therapy, including but not limited to: cotton swabs, bandages, tubing, syringes, medications and solutions.

Ambulance Services

Air or ground, Ambulance and Ambulance transport services provided through a Preferred Provider or an Out-of-Network Provider as a result of a "**911**" emergency response system call will be covered when the criteria for Emergency Care, as defined in this *Certificate*, have been met.

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

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

Acupuncture

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

Diabetes Education

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

Hospice Care

Hospice Care is care that is reasonable and necessary to control or manage terminal illness or related conditions. Hospice Care benefits are designed to be provided primarily in Your home. To be considered terminally ill, a Covered Person must have been given a medical prognosis of one year or less to live.

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

- All Medically Necessary services and supplies furnished by the Hospice. This includes doctors' and nurses' services, homemaker services and drugs;
- Up to five consecutive days of respite care. Respite care is furnished to a person in an inpatient setting in order to provide relief for family members or others caring for that person; and
- All of these services and supplies will be provided or arranged by the Hospice. Payment by HNL for Hospice Care benefits shall not exceed the amount per day set forth in the "Schedule of Benefits" section.

Radiation Therapy, Chemotherapy and Renal Dialysis Treatment

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

Bariatric (Weight Loss) Surgery

Bariatric surgery provided for the treatment of morbid obesity is covered when Medically Necessary authorized by HNL and performed at a Bariatric Surgery Performance Center by an HNL Bariatric Surgery Performance Center network surgeon who is affiliated with the HNL Bariatric Surgery Performance Center. Preferred Providers that are not designated as part of HNL's network of Bariatric Surgery Performance Centers are considered Out-of-Network Providers for purposes of determining coverage and benefits for weight loss surgery.

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

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

Approved travel-related expenses will be reimbursed as follows:

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

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

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

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

Prostheses

Prostheses are covered as follows:

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

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

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

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

In addition, the following prostheses are covered, but not subject to the benefit maximum shown in the "Schedule of Benefits" section:

- If all or part of a breast is surgically removed for Medically Necessary reasons, reconstructive surgery and a prosthesis incident to the mastectomy (including lumpectomy) are covered; and
- Prostheses for restoring a method of speaking (but not including electronic voice boxes) following a laryngectomy are covered.

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

Certification may be required. Please refer to the "Certification Requirement" portion of this section for details.

Durable Medical Equipment

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

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

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

Corrective Footwear (including specialized shoes, arch supports and inserts) is covered when Medically Necessary and custom made for the Covered Person.

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

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

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

Some Durable Medical Equipment may have specific quantity limits or may not be covered as they are considered primarily for non-medical use. Orthotics are not subject to such quantity limits.

Certification may be required. Please refer to the "Certification Requirement" portion of this section for details. Coverage for Durable Medicare Equipment is subject to the limitations described in the "Noncovered Items"

portion of the "General Limitations and Exclusions" section. Please refer to the "Schedule of Benefits" section for applicable Copayment or Coinsurance.

Implanted Lens(es) Which Replace the Organic Eye Lens

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

Rehabilitative Services

Rehabilitative services (including physical, occupational and speech therapy,) when Medically Necessary and continuous functional improvement in response to the treatment plan is demonstrated by objective evidence, in accordance with the "Schedule of Benefits" section, except as stated in the "General Limitations and Exclusions" section.

Cardiac Rehabilitation Therapy

Cardiac rehabilitation therapy, when Medically Necessary and continuous functional improvement in response to the treatment plan is demonstrated by objective evidence, in accordance with the "Schedule of Benefits" section, except as stated in the "General Limitations and Exclusions" section.

Pulmonary Rehabilitation Therapy

Pulmonary rehabilitation therapy, when Medically Necessary and continuous functional improvement in response to the treatment plan is demonstrated by objective evidence, in accordance with the "Schedule of Benefits" section, except as stated in the "General Limitations and Exclusions" section.

Allergy Testing and Treatment

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

Reconstructive Surgery

Reconstructive surgery to restore and achieve symmetry including surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or create a normal appearance to the extent possible, unless the surgery offers only a minimal improvement in Your appearance. This includes reconstructive surgery to restore and achieve symmetry incident to mastectomy (including lumpectomy) and Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate. This does not include cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance or dental services or supplies or treatment for disorders of the jaw except as set out under the "Dental Services" and "Temporomandibular (Jaw) Joint Disorders" portions of the "General Limitations and Exclusions" section.

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

Diabetic Equipment and Supplies

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

- Insulin pumps and all related necessary supplies
- Corrective Footwear to prevent or treat diabetes-related complications
- Blood glucose monitors (including those designed to assist the visually impaired) and blood glucose 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
- Specific brands of disposable insulin needles and syringes

Your Physician must contact the Health Net Pharmacy Department for prior authorization before You can obtain the following covered items upon presentation of Your prescription at a contracting Health Net Pharmacy: specific brands of pen delivery systems, specific brands of disposable insulin needles and syringes, and disposable pen needles.

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

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

Hearing Aids

Standard hearing devices (analog or digital), which typically fit in or behind the outer ear, used to restore adequate hearing to the Covered Person and determined to be Medically Necessary are covered.

Vision and Hearing Examinations

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

Preventive Care Services

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

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

- U.S. Preventive Services Task Force Grade A & B recommendations (www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm)
- The Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Center for Disease Control and Prevention (www.cdc.gov/vaccines/recs/ACIP/)

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

- Periodic health evaluations
- Preventive vision and hearing screening
- Blood pressure, diabetes, and cholesterol tests
- Many cancer screenings, including FDA-approved human papillomavirus (HPV) screening test, mammograms and colonoscopies
- Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression, and reducing alcohol use
- Routine immunizations against diseases such as measles, polio, or meningitis
- Flu and pneumonia shots
- Counseling, screening, and immunizations to ensure healthy pregnancies
- Regular well-baby and well-child visits
- Well-woman visits

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

Phenylketonuria (PKU)

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

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

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

Other specialized formulas and nutritional supplements are not covered.

Osteoporosis

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

Surgically Implanted Drugs

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

Dental Injury

Emergency Care of a Physician, while You are covered under this *Certificate,* treating an Accidental Injury to the natural teeth. You must be covered under this *Certificate* at the time such services are rendered. Medically Necessary related Emergency Hospital services will also be covered. Damage to natural teeth due to chewing or biting is not Accidental Injury. Dental appliances are not a Covered Expense.

Care for Conditions of Pregnancy

Hospital and professional services will be covered, including prenatal and postnatal care, and delivery. Covered Expenses include prenatal diagnostic procedures in the case of high-risk pregnancies.

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

Your Physician will not be required to obtain Certification for a Hospital stay that is equal to or less than 48 hours following vaginal delivery or 96 hours following cesarean section. Longer stays in the Hospital and scheduled cesarean section must be certified.

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

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

Please notify HNL upon confirmation of pregnancy.

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

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

Organ, Tissue and Stem Cell Transplants

Organ, tissue and stem cell transplants that are not Experimental or Investigational are covered, only if the transplant is authorized and certified by HNL. Please refer to the "Certification Requirement" portion of this section for information on how to obtain Certification.

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

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

- Companion and donor travel;
- For the enrolled Covered Person who receives the transplant; and
- For the donor (whether or not an enrolled Covered Person). Benefits are reduced by any amounts paid or payable by the donor's own coverage. Only Medically Necessary services related to the organ donation are covered.

If You receive services authorized by HNL for an organ, tissue or stem cell transplant from an Out-of-Network Provider, Hospital or other health care provider, Covered Services will be reimbursed at the amount contracted and agreed to by HNL and the Out-of-Network Provider, Hospital or health care provider when possible. In such cases, the Covered Person will only be responsible for payment of Coinsurance as stated in the "Schedule of Benefits" section of this *Certificate*.

Evaluation of potential candidates is subject to the Certification Requirement. More than one evaluation (including tests) at more than one transplant center will not be authorized unless it is determined to be Medically Necessary.

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

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

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

Family Planning

This *Certificate* covers counseling and planning for contraception or problems of fertility, fitting examination for a vaginal contraceptive device (diaphragm and cervical cap) and insertion or removal of an intrauterine device (IUD). However, the IUD, diaphragm or cervical cap itself is not a covered benefit under this Plan.

Contraceptives that are covered under the medical benefit include injectable and implantable contraceptives.

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

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

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 the Covered Person's treating Physician and authorized by HNL. The Physician must determine that participation has a meaningful potential to benefit the

Covered Person and the trial has therapeutic intent. Clinical trial services performed by Out-of-Network Providers are covered only when the protocol for the trial is not available through Preferred Providers. Services rendered as part of a clinical trial subject to the reimbursement guidelines as specified in the law. The treatment shall be provided in a clinical trial that involves either a drug that is exempt from federal regulation in relation to a new drug application, or is approved by one of the following:

- The National Institutes of Health;
- The FDA as an Investigational new drug application;
- The Department of Defense; or
- The Veterans' Administration.

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

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

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

Chiropractic Services

Chiropractic services are covered in accordance with the "Schedule of Benefits" section, when the services are provided by a Contracted Chiropractor located in the State of California.

An initial examination is covered to determine the nature of Your problem. Subsequent visits are covered up to the maximum number of visits stated in the "Schedule of Benefits" section, when determined to be Medically Necessary for the treatment of a Neuro-Musculoskeletal Disorder, as described in the proposed Chiropractic Treatment Plan.

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

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

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

The following services or supplies are not covered under this benefit:

- Examinations or treatments for conditions other than those related to Neuro-Musculoskeletal Disorders, and physical therapy not associated with spinal, muscle or joint manipulation
- Laboratory services
- Surgical procedures
- Durable Medical Equipment, drugs or medications (prescription or non-prescription)
- Hypnotherapy, behavior training, sleep therapy and weight programs
- Massage therapy
- Thermography
- Magnetic Resonance Imaging and any types of diagnostic radiology, other than x-rays
- Transportation costs including local Ambulance charges
- Education programs, non-medical self-care, self-help training or any related diagnostic testing
- Vitamins, minerals, nutritional supplements or other similar products

Mental Health Care and Chemical Dependency Benefits

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

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

The following benefits are provided:

Serious Emotional Disturbances of a Child - The treatment and diagnosis of Serious Emotional Disturbances of a Child under the age of 18 is covered as shown in the "Schedule of Benefits" section.

Severe Mental Illness - Treatment of Severe Mental Illness is covered as shown in the "Schedule of Benefits" section.

Covered services include treatment of:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders)
- Autism
- Anorexia nervosa
- Bulimia nervosa

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

Covered services include:

- Outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy and rehabilitative care that is related to Chemical Dependency
- Medication management care, when appropriate.
- Intensive outpatient care program which is a treatment program that is utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week.
- Partial hospitalization/day treatment program which is a treatment program that may be free-standing or Hospital-based and provides services at least four (4) hours per day and at least four (4) days per week.
- Behavioral Health Treatment for Pervasive Developmental Disorder or Autism: Professional services for behavioral health treatment, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Covered Person diagnosed with the Severe Mental Illnesses of pervasive developmental disorder or autism, are covered as shown in the "Schedule of Benefits" section under "Mental Disorders and Chemical Dependency Benefits."
    - The treatment must be prescribed by a licensed Physician, or developed by a licensed psychologist, and must be provided under a documented treatment plan prescribed, developed and approved by a Qualified Autism Service Provider providing treatment to the Covered Person for whom the treatment plan was de-

veloped. The treatment must be administered by the Qualified Autism Service Provider or by qualified autism service professionals and paraprofessionals who are supervised and employed by the treating Qualified Autism Service Provider.

- A licensed Physician or licensed psychologist must establish the diagnosis of pervasive development disorder or autism. In addition, the Qualified Autism Service Provider must submit the initial treatment plan to HNL.
- Prior Certification is not required for these outpatient services, however, prior notification is required. Notification must include documentation that a licensed Physician or licensed psychologist has established the diagnosis of pervasive developmental disorder or autism. In addition, the Qualified Autism Service Provider must submit the initial treatment plan to HNL.
- The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated, and must be reviewed by the Qualified Autism Service Provider at least once every six months and modified whenever appropriate. The treatment plan must not be used for purposes of providing or for the reimbursement of respite, day care or educational services, or to reimburse a parent for participating in a treatment program.
- The Qualified Autism Service Provider must submit updated treatment plans to HNL for continued behavioral health treatment beyond the initial six months and at ongoing intervals of no more than six-months thereafter. The updated treatment plan must include documented evidence that progress is being made toward the goals set forth in the initial treatment plan.

HNL may deny coverage for continued treatment if the requirements above are not met or if ongoing efficacy of the treatment is not demonstrated.

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

Covered Services and Supplies include:

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

Detoxification - Inpatient services for acute detoxification and treatment of acute medical conditions relating to Chemical Dependency are covered.

GENERAL LIMITATIONS AND EXCLUSIONS

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

Medical Services and Supplies

Not Medically Necessary
Services or supplies which HNL determines are not Medically Necessary, as defined in the "Definitions" section. This includes any services, supplies or expenses received or incurred beyond the scope of Certification given, as described under the "Certification Requirement" portion of the "Plan Benefits" section of this *Certificate*. However, the *Certificate* does cover Medically Necessary services for medical conditions directly related to non-covered services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery).

Excess Charges
Amounts charged by Out-of-Network Providers for covered medical services and treatment which HNL determines to be in excess of the Maximum Allowable Amount, as defined in the "Definitions" section.

Pre-Existing Conditions
Services or supplies received for the treatment of a Pre-Existing Condition during the first 6-consecutive months of Your coverage under this *Certificate* (including any waiting period). Except that:

- This limitation shall not apply to a newly born or newly adopted child;
- This limitation shall not apply to conditions of pregnancy;
- This limitation shall not apply to children under the age of 19; and
- If You were covered under Creditable Coverage, the length of time of Your Creditable Coverage will be used to reduce or eliminate the 6-month period during which the Pre-Existing Condition limitation applies.

  You must have also been eligible for coverage under this *Certificate*:

  1. Within 180 days of the date the Creditable Coverage ended due to the following reasons:
     a. Your employment ended;
     b. The availability of medical coverage offered through employment or sponsored by an employer was terminated; or
     c. An employer's contribution toward medical coverage ended.
  2. Within 62 days of the date the Creditable Coverage ended for reasons other than those stated in (1.) above.

  In either circumstance, You must have applied for coverage under this *Certificate* within 30 days of the date You become eligible. If You do not enroll within the 30-day period, You must wait until the next Group Open Enrollment Period to enroll. Upon enrollment, credit for Creditable Coverage will be applied toward the Pre-Existing Condition limitation, subject to the requirements described above in (1.) and (2.).

These limitations shall apply only to the medical benefits that are described in the "Plan Benefits" section of this *Certificate*. Payment of any other type of benefit described in this *Certificate* for a Pre-Existing Condition shall not constitute waiver of this exclusion for other services You may receive for that condition.

Ambulance Services
Paramedic and air or ground Ambulance 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.

Clinical Trials

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

- Drugs or devices that are not approved by the FDA;
- Services other than health care services, including but not limited to cost of travel, or costs of other non-clinical expenses;
- Services provided to satisfy data collection and analysis needs which are not used for clinical management;
- Health care services that are specifically excluded from coverage under this *Certificate*; and
- Items and services provided free of charge by the research sponsors to Covered Persons in the trial.

Cosmetic Services and Supplies

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

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

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

Then, the following are covered:

- Surgery to excise, enlarge, reduce or change the appearance of any part of the body;
- Surgery to reform or reshape skin or bone;
- Surgery to excise or reduce skin or tissue; or
- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

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

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

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

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

Dental Services

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

- General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the Covered Person requires that an ordinarily non-covered dental service which would normally be treated in a dentist's office and without general anesthesia must instead be treated in a Hospital or Outpa-

tient Surgical Center. The general anesthesia and associated facility services, must be Medically Necessary, subject to the other limitations and exclusions of this *Certificate* and will only be covered under the following circumstances (a) Covered Persons who are under seven years of age or, (b) Covered Persons who are developmentally disabled or (c) Covered Persons whose health is compromised and general anesthesia is Medically Necessary.

- Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

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

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

Temporomandibular (Jaw) Joint Disorders

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

Surgery And Related Services For Disorders of the Jaw (often referred to as "Orthognathic Surgery" or "Maxillary and Mandibular Osteotomy")

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

Dietary or Nutritional Supplements

Dietary, nutritional supplements and specialized formulas are not covered except when prescribed for the treatment of Phenylketonuria (PKU) (see the "Phenylketonuria (PKU)" provision in the "Plan Benefits" section).

Refractive Eye Surgery

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

Optometrics, Vision Therapy And Orthoptics

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

Outpatient Speech Therapy

However, outpatient speech therapy in relation to surgery, injury or non-congenital organic disease is not excluded.

Sex Change
Any procedure or treatment designed to alter physical characteristics of the Covered Person to those of the opposite sex, and any other treatment or studies related to sex transformations.

Reconstruction of Prior Surgical Sterilization Procedures
Services to reverse voluntary surgically induced Infertility.

Conception by Medical Procedures
Services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include but are not limited to:

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

Fertility Preservation
Fertility preservation treatments are covered as shown under “Family Planning” in the “Plan Benefits” section. However, the following services and supplies are not covered:

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

Genetic Testing and Diagnostic Procedures
Genetic testing is covered when determined by HNL to be Medically Necessary. The prescribing Physician must request Prior Authorization for coverage. Genetic testing will not be covered for non-medical reasons or when a Covered Person has no medical indication or family history of a genetic abnormality.

Experimental Or Investigational Procedures
Experimental or Investigational drugs, devices, procedures or other therapies are only covered when:

- Independent review deems them appropriate as described in the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "General Provisions" section of this *Certificate*; or
- Clinical trials for cancer patients are deemed appropriate according to the "Medical Benefits" portion of the "Plan Benefits" section.

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

Routine Physical Examinations
Routine physical examinations (including psychological examinations or drug screening) that are not medically indicated or Physician directed and are obtained for the purposes of checking Your general health in the absence of symptoms or other nonpreventive purpose are not covered. Examples include exams taken to obtain employment, or exams administered at the request of a third party, such as a school, camp or sports organization. Any physical, psychological, vision or hearing exams which are not related to treatment of illness or injury are not covered, except exams for preventive health purposes, as specifically stated under "Preventive Care Services" in the "Plan Benefits" section of this *Certificate.*

Immunizations Or Inoculations
This plan does not cover immunizations and injections for foreign travel or occupational purposes.

Services Not Related To Covered Illness Or Injury
Any services not related to the diagnosis or treatment of a covered illness or injury.

Custodial Or Domiciliary Care
Regardless of the type of facility. Custodial Care is not covered even when the patient is under the care of a supervising or attending Physician and services are being ordered and prescribed to support and generally maintain the patient's condition, or provide for the patient's comforts, or ensure the manageability of the patient. Furthermore, Custodial Care is not covered even if ordered and prescribed services and supplies are being provided by a registered nurse, a licensed vocational nurse, a licensed practical nurse, a Physician assistant or physical therapist.

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

Noneligible Hospital Confinements
Inpatient room and board charges in conjunction with a Hospital stay not meeting Medical Necessity and/or primarily for environmental change, personal convenience or custodial in nature are not covered.

Noneligible Institutions
Any services or supplies furnished by a noneligible institution, which is an institution other than a legally operated Hospital or Medicare-approved Skilled Nursing Facility, or which is primarily a place for the aged, a nursing home or any similar institution, regardless of how designated.

Private Rooms
Expenses in excess of a Hospital's (or other inpatient facility's) most common semi-private room rate.

Private Duty Nursing
Inpatient and outpatient services (including incremental nursing) provided by a private duty nurse. Shift care and any portion of shift care services are not covered.

Hyperkinetic Syndromes, Learning Disabilities, Behavioral Problems or Mental Retardation
Regardless of the type of service. However, certain of the above conditions shall be covered as shown in the "Schedule of Benefits" section of this *Certificate*, provided that their level of severity meets the criteria described in the "Definitions" section under "Serious Emotional Disturbances of a Child" and/or "Severe Mental Illness."

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

- Alteration of Your residence to accommodate Your physical or medical condition, including the installation of elevators.
- Disposable supplies for home use.
- Exercise equipment, including treadmills and charges for activities or facilities normally intended or used for physical fitness.
- Hygienic equipment, Jacuzzis and spas.
- Corrective appliances, except prostheses, casts, splints. Surgical dressings are limited to primary dressings, i.e., a therapeutic and protective covering applied directly to lesions either on the skin or opening to the skin required as a result of a surgical procedure performed by a Physician.
- Orthodontic appliances to treat dental conditions related to the treatment of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders).
- Support appliances such as stockings, over the counter support devices or Orthotics, and devices or Orthotics for improving athletic performance or sports-related activities.

- Orthotics and Corrective Footwear, except as described in the "Durable Medical Equipment" and "Diabetic Equipment" provisions of the "Plan Benefits" section.
- Other Orthotics, including Corrective Footwear, not mentioned above, that are not Medically Necessary and custom made for the Covered Person. Corrective Footwear must also be permanently attached to an Orthotic device meeting coverage requirements under this *Certificate*.
- Personal or comfort items.
- Air purifiers, air conditioners and humidifiers.
- Food supplements (except as specifically stated in the "Outpatient Infusion Therapy" provision of the "Plan Benefits" section of this *Certificate*).
- Educational services or nutritional counseling, except as specifically provided in the "Diabetes Education" "Mental Disorders and Chemical Dependency Benefits" or "Outpatient Infusion Therapy" provisions of the "Plan Benefits" section of this *Certificate.*

Treatment of Obesity
Treatment or surgery for obesity, weight reduction or weight control, except when provided for morbid obesity.

Transplants
Experimental or Investigational organ, stem cell and tissue transplants.

Duplicate Coverage
If You are covered by more than one plan, benefits will be determined by applying provisions of the "Coordination of Benefits" portion of the "General Provisions" section of this *Certificate*.

Medicare
All benefits provided under this *Certificate* shall be reduced by any amount to which You are entitled under the program commonly referred to as Medicare when federal law permits Medicare to pay before a group health plan.

Workers' Compensation
If You require services for which benefits are in whole or in part either payable or required to be provided under any Workers' Compensation or Occupational Disease Law, HNL will provide covered benefits to which You are entitled and will pursue recovery from the Workers' Compensation carrier liable for the cost of medical treatment related to Your illness or injury.

Expenses Before Coverage Begins
Services received before the Covered Person's Effective Date.

Expenses After Termination of Coverage
Services received after midnight on the effective date of cancellation of coverage under this *Certificate* ends regardless of when the illness, disease, injury or course of treatment began, except as specifically stated under the "Extension of Benefits" portion of the "Eligibility, Enrollment and Termination" section of this *Certificate*.

Services For Which You Are Not Legally Obligated To Pay
Services for which no charge is made to You in the absence of insurance coverage, except services received at a charitable research Hospital which is not operated by a governmental agency.

Physician Self-Treatment
Self-treatment rendered in a non-emergency (including, but not limited to, prescribed services, supplies and drugs). Physician self-treatment occurs when Physicians provide their own medical services, including prescribing their own medication, ordering their own laboratory test and self-referring for their own services. Claims for emergency self-treatment are subject to review by HNL.

Services Provided by Immediate Family Members
Professional services or provider referrals (including, but not limited to, prescribed services, supplies and drugs) received from a person who lives in Your home or who is related to You by blood, marriage or domestic partnership. Covered Persons who receive routine or ongoing care from a member of their immediate family may be reassigned to another Physician.

Acts of War
Conditions caused by acts of war, whether or not declared.

Crime
Conditions caused by Your commission (or attempted commission) of a felony unless the condition was an injury resulting from an act of domestic violence or an injury resulting from a medical condition.

Nuclear Energy
Conditions caused by release of nuclear energy, when government funds are available.

Governmental Agencies
Any services provided by or for which payment is made by a local, state or federal government agency. This exclusion does not apply to Medi-Cal, Medicaid or Medicare.

Totally Disabled on Your Effective Date
Generally, under the federal Health Insurance Portability and Accountability Act, HNL cannot deny You benefits due to the fact that You are totally disabled on Your Effective Date. However, if on Your Effective Date You are totally disabled and pursuant to state law You are entitled to an extension of benefits from the insurance carrier providing coverage to Your prior group health plan, benefits of this *Certificate* will be coordinated with benefits payable by the insurance carrier providing coverage to Your prior group health plan, so that not more than 100% of Covered Expenses are provided for services rendered to treat the disabling condition under both plans.

For the purposes of coordinating benefits under this *Certificate*, if You are entitled to an extension of benefits from the insurance carrier providing coverage to Your prior group health plan, and state law permits such arrangements, the insurance carrier providing coverage to Your prior group health plan shall be considered the primary plan (paying benefits first) and benefits payable under this *Certificate* shall be considered the secondary plan (paying any excess Covered Expenses), up to 100% of total Covered Expenses. No extension will be granted unless HNL receives written certification of such total disability from Your Physician within 90 days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by HNL.

Routine Foot Care
This Plan does not cover services for treatment of corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes.

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

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

Methadone Treatment
Methadone maintenance for the purpose of long term opiate craving reduction is not covered.

Unlisted Services
Any services or supplies not specifically listed in this *Certificate* as Covered Expenses.

Rehabilitative Services

Rehabilitation therapy is limited to services after an acute episode of care for chronic conditions, an acute illness or injury or an acute exacerbation of such an illness or injury. In addition, rehabilitation therapy services (physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy) are not covered when provided in connection with the treatment of the following conditions:

- Psychosocial speech delay (includes delayed language development)
- Mental retardation or dyslexia
- Attention deficit disorders and associated behavior problems
- Developmental articulation and language disorders

However, some of the above conditions shall be covered as shown in the "Schedule of Benefits" section, if Medically Necessary as described in the definitions of "Serious Emotional Disturbances of a Child" and/or "Severe Mental Illness," and continuous functional improvement in response to the treatment plan is demonstrated by objective evidence.

Rehabilitation therapy for physical impairments in Covered Persons with Severe Mental Illness, including pervasive developmental disorder and autism, that develops or restores, to the maximum extent practicable, the functioning of an individual, is considered Medically Necessary when criteria for rehabilitation therapy are met.

Foreign Travel Or Work Assignment

If You receive services or obtain supplies in a foreign country, benefits will be payable for Emergency Services only.

Telephone Consultations

Consultations with a Physician or other provider which are conducted over the telephone.

Home Birth

A birth which takes place at home will be covered only when the criteria for Emergency Care, as defined in this *Certificate*, have been met.

Aversion Therapy

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

Educational and Employment Services

Except for services related to behavioral health treatment for pervasive development disorder or autism are covered as shown in the "Medical Benefits" portion of “Plan Benefits” section, all other services related to educational and professional purposes are not covered. Examples of excluded services include education and training for non-medical purposes such as:

- Vocational rehabilitation.
- Employment counseling, training or educational therapy for learning disabilities.
- Investigations required for employment.
- Education for obtaining or maintaining employment, or for professional certification.
- Education for personal or professional growth, development or training.
- Academic education during residential treatment.
- Behavioral training

Electro-Convulsive Therapy

Electro-Convulsive therapy is not covered except as authorized by HNL.

Nonabstinence-Based Treatment
Chemical Dependency treatment not based on abstinence is not covered.

Noncovered Treatments
The following types of treatment are only covered when Medically Necessary or when provided in connection with covered treatment for a Mental Disorder or Chemical Dependency:

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

Treatment of delirium, dementia, amnesic disorders (as defined in the DSM-IV) and mental retardation other than Medically Necessary Services for accompanying behavioral and/or psychological symptoms if amenable to psychotherapeutic or psychiatric treatment, is not covered.

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

Nonstandard Therapies
Services that do not meet national standards for professional medical or mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, sleep therapy, biofeedback (except for certain physical disorders, such as incontinence and chronic Pain, and as otherwise preauthorized by the Plan), hypno-therapy and crystal healing therapy are not covered.

Nontreatable Disorders
Mental Disorders or conditions of Chemical Dependency that HNL determines are not likely to improve with generally accepted methods of treatment are not covered.

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

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

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

Treatment Related to Judicial or Administrative Proceedings
Medical, mental health care or Chemical Dependency services as a condition of parole or probation, and court-ordered treatment and testing are limited to Medically Necessary covered services.

GENERAL PROVISIONS

Term Of Certificate

This *Certificate* shall remain in effect for the period of time specified in the Policy held by the Group, subject to the payment of premiums as required and subject to the right of HNL and the Group to terminate or modify it, including the right to change premiums, in accordance with the terms of the Group Policy. Notice of modification or termination will be sent to the holder of the Group Policy. HNL will not provide notice of such changes to Covered Persons of this plan unless it is required to do so by law. The Group may have obligations under state or federal law to provide notification of these changes to the Covered Persons under this plan. Modification shall not affect the right to benefits provided under this *Certificate* in connection with a Hospital confinement commencing prior to such date.

Covered Persons who are totally disabled on the date coverage under this *Certificate* ends may be eligible for continuation of coverage. See the "Conversion Coverage" and "Extension of Benefits" portions of the "Eligibility, Enrollment and Termination" section of this *Certificate*.

Customer Contact Center Interpreter Services

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

Covered Persons' Rights and Responsibilities Statement

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

Covered Persons have the right to:

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

Covered Persons have the responsibility to:

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

Coordination of Benefits

Explanation
Benefits provided under this *Certificate* are subject to coordination with benefits payable to You for eligible expenses by any other group coverage including any Hospital, surgical or medical benefit policy, service plan contract, group prepayment plan, coverage through any governmental program or provided by any state or federal statute, as permitted by applicable law.

Purpose
Coordination of Benefits (COB) determines responsibility for payment of eligible expenses among insurers providing group coverage to You, so that the total of all reasonable expenses for Covered Services and Supplies will be paid up to the stated limits of each coverage, but not to exceed total expenses incurred for those services and supplies.

Administration
If You are known to have group coverage through any other health plan or insurer, responsibility for payment of benefits is determined by following the Rules Establishing the Order of Benefits Determination, formulated by the Insurance Commissioner of the State of California and incorporated in this *Certificate*. Such rules determine the order of payment responsibilities between HNL and any other applicable group insurer, by establishing which is the **Primary Plan** and which is the **Secondary Plan**. (For Medicare coordination of benefits, please refer to the "Medicare Coordination of Benefits (COB)" portion of this section.)

The Covered Person's coverage is subject to the same limitations, exclusions and other terms of this Certificate whether HNL is the Primary Plan or the Secondary Plan.

- **COVERED EMPLOYEE:** HNL is the **Primary Plan** with responsibility for first payment, except when (a) You are covered by another group health plan or insurer as the employee and that plan has covered You longer than the HNL plan or (b) the group plan or insurer does not contain a "COB" provision similar to this one.
- **SPOUSE:** HNL is the **Primary Plan** with responsibility for first payment, except when (a) the spouse is covered under another group health plan or insurer as the employee or (b) the other group plan or insurer does not contain a "COB" provision similar to this one.
- **CHILD:** Determination of the **Primary Plan** will be based on the following:
  1. The insurer, under whom the child is covered as a principal Covered Person, employee or primary individual, shall be the **Primary Plan** for that child;
  2. If the child is not covered as specified above and is covered as a dependent under the insurers of both parents, then the insurer of the parent whose date of birth, but not year of birth, occurs earlier in a Calendar Year shall be the **Primary Plan** for dependent children covered under their group health plan. The insurer of the parent whose birthday occurs later in the Calendar Year shall be the **Secondary Plan** for dependent children covered under their group health plan;
  3. Group health plan as determined above is the **Primary Plan** with responsibility for first payment, unless the Rules Establishing the Order of Benefit Determination are affected because of a divorce and assignment of legal custody of the child. **If the Mother has legal custody**, her group plan or insurer pays first; the stepfather's (if any) group plan or insurer pays second; and the natural father's third. **If the Father has legal custody**, his group plan or insurer pays first; the stepmother's (if any) pays second and the natural mother's third; or

4. However, if the child's parents are separated or divorced and there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses of that child, then the group health plan of the parent with such court-ordered financial responsibility shall be the **Primary Plan**. The group health plan of the other parent shall be the **Secondary Plan**.

When the points above do not establish an order of benefit determination, the insurer or group health plan who has covered the person for the longer period of time shall be the **Primary Plan** and the other insurer shall be the **Secondary Plan**, provided that:

- The benefits of a group health plan or insurer covering the person as a laid off or retired employee or dependent of such person, shall be determined after the benefits of any other insurer or group health plan covering such person as an employee, other than a laid off or retired employee or dependent of such person; and
- If either group health plan does not have a provision regarding laid off or retired employees, which results in each insurer or group health plan determining its benefits after the other, then the provisions of statement above shall not apply.

Facility of Payment

If payments which should have been made under this *Certificate* are made by any other group health plan or insurer, HNL shall have the right to pay over to such health plan or insurer any amount HNL determines to be warranted in order to satisfy the intent of this provision. Any amounts so paid shall be deemed to be benefits under this *Certificate* and to the extent of such payments, HNL shall be fully discharged from liability under this *Certificate*.

Right to Receive and Release Necessary Information

HNL may obtain or release any information considered to be necessary for "COB" with respect to any person claiming benefits under this *Certificate* without consent of or notice to You or any other person or organization. However, HNL shall not be required to determine the existence of any other group plan or insurer, or the benefits payable under such plan or insurer, when computing benefits due to You covered under this *Certificate*.

Services Instead of Cash Payments

When another group health plan or insurer provides services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid. The reasonable cash value of any services provided to the covered individual by any service organization group plan shall be deemed an expense incurred by the individual and the liability of HNL under this *Certificate*.

Right of Recovery

Whenever HNL's payment for covered services exceeds the maximum amount of payment necessary to satisfy the intent of this provision, HNL shall have the right to recover those excessive amounts from any group health plan, any organization or any persons.

Medicare Coordination of Benefits (COB)

When You reach age 65, You may become eligible for Medicare based on age. You may also become eligible for Medicare before reaching age 65 due to disability or end stage renal disease. We will solely determine whether we are the primary plan or the secondary plan with regard to services to a Covered Person enrolled in Medicare in accordance with the Medicare Secondary Payer rules established under the provisions of Title XVIII of the Social Security Act and its implementing regulations. Generally, those rules provide that:

If You are enrolled in Medicare Part A and Part B, and are not an active employee or Your employer group has less than twenty employees, then this plan will coordinate with Medicare and be the secondary plan. This Plan also coordinates with Medicare if You are an active employee participating in a Trust through a small employer, in accordance with Medicare Secondary Payer rules. (If You are not enrolled in Medicare Part A and Part B, HNL will provide coverage for Medically Necessary Covered Services without coordination with Medicare.)

For services and supplies covered under Medicare Part A and Part B, claims are first submitted by Your provider or by You to the Medicare administrative contractor for determination and payment of allowable amounts. The Medicare administrative contractor then sends Your medical care provider a Medicare Summary Notice (MSN), (formerly an Explanation of Medicare Benefits (EOMB)). In most cases, the MSN will indicate that the Medicare administrative contractor has forwarded the claim to HNL for secondary coverage consideration. HNL will process secondary claims received from the Medicare administrative contractor. Secondary claims not received from the

Medicare administrative contractor must be submitted to HNL by You or the provider of service, and must include a copy of the MSN. HNL and/or Your medical provider is responsible for paying the difference between the Medicare paid amount and the amount allowed under this plan for the covered services described in this *Certificate*, subject to any limits established by Medicare COB law. This Plan will cover benefits as a secondary payer only to the extent services are coordinated by Your Physician and authorized by HNL as required under this *Certificate*.

If either You or Your spouse is over the age of 65 and You are actively employed, neither You nor Your spouse is eligible for Medicare Coordination of benefits, unless You are employed by a small employer and pertinent Medicare requirements are met.

For answers to questions regarding Medicare, contact:

- Your local Social Security Administration office or call **1-800-772-1213**;
- The Medicare Program at **1-800-MEDICARE (1-800-633-4227)**;
- The official Medicare website at www.medicare.gov;
- The Health Insurance Counseling and Advocacy Program (HICAP) at **1-800-434-0222**, which offers health insurance counseling for California seniors; or
- Write to:

  Medicare Publications
  Department of Health and Human Services
  Centers for Medicare and Medicaid Services
  6325 Security Blvd.
  Baltimore, MD 21207

Grievance and Appeals Process

Appeal, complaint or grievance means any dissatisfaction expressed by You or Your representative concerning a problem with HNL, a medical provider or Your coverage under this *Certificate,* including an adverse benefit determination as set forth under the Affordable Care Act (ACA). An adverse benefit determination means a decision by HNL to deny, reduce, terminate or fail to pay for all or part of a benefit that is based on:

- Rescission of coverage, even if it does not have an adverse effect on a particular benefit at that time; or
- Determination of an individual's eligibility to participate in this Health Net plan; or
- Determination that a benefit is not covered; or
- An exclusion or limitation of an otherwise covered benefit based on a Pre-Existing Condition exclusion or a source-of-injury exclusion; or
- Determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

If You are not satisfied with efforts to solve a problem with HNL or a medical provider, You may file a grievance or appeal against HNL by calling the Customer Contact Center at the telephone number on Your HNL ID Card or by submitting a Member Grievance Form through the HNL website at www.healthnet.com. You must file Your grievance or appeal with HNL within 365 calendar days following the date of the incident or action that caused Your grievance. You may also file a complaint in writing by sending information to:

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

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

day or 30-day time limit, a letter is sent to the Covered Person by the 15th or 30th calendar day informing him or her of the reason for the pended status.

If your concern involves the Mental Disorders and Chemical Dependency program, call MHN Services at **1 888 426-0030**, or write to:

MHN Services
Attention: Appeals & Grievances
P.O. Box 10697
San Rafael, CA 94912

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

Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an independent medical review (IMR) of Disputed Health Care Services from the Department of Insurance (Department) if You believe that health care services eligible for coverage and payment under Your HNL plan have been improperly denied, modified or delayed by HNL. A "Disputed Health Care Service" is any health care service eligible for coverage and payment under Your HNL plan that has been denied, modified or delayed by HNL or one of its contracting providers, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available. You will not pay any application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. HNL will provide You with an IMR application form and HNL's grievance response letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause You to forfeit any statutory right to pursue legal action against HNL regarding the Disputed Health Care Service.

Eligibility

Your application for IMR will be reviewed by the Department to confirm that it meets all the eligibility requirements of the law for IMR which are set out below:

- Your provider has recommended a health care service as Medically Necessary, You have received urgent or Emergency Care that a provider determined to have been Medically Necessary; or in the absence of provider recommendation You have been seen by a Physician for the diagnosis or treatment of the medical condition for which You seek IMR;
- The Disputed Health Care Service has been denied, modified or delayed by HNL, based in whole or in part on a decision that the health care service is not Medically Necessary; and
- You have filed a grievance with HNL and the disputed decision is upheld by HNL or the grievance remains unresolved after 30 days. Within the next six months, You may apply to the Department for IMR or later, if the Department agrees to extend the application deadline. If Your grievance requires expedited review You may bring it immediately to the Department's attention. The Department may waive the requirement that You must follow HNL's grievance process in extraordinary and compelling cases.

If Your case is eligible for IMR, the dispute will be submitted to a medical Specialist who will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made in Your case from the IMR. If the IMR determines the service is Medically Necessary, HNL will provide benefits for the Disputed Health Care Service in accordance with the terms and conditions of this *Certificate*. If the case is not eligible for IMR, the Department will advise You of Your alternatives.

For non-urgent cases, the IMR organization designated by the Department must provide its determination within 30 days of receipt of the application for review and the supporting documents. For urgent cases involving an imminent and serious threat to Your health, including, but not limited to, serious Pain, the potential loss of life, limb, or major bodily function or the immediate and serious deterioration of Your health, the IMR organization must provide its determination within three business days.

For more information regarding the IMR process or to request an application form, please contact the Customer Contact Center at the telephone number on Your HNL ID Card.

Independent Medical Review of Investigational or Experimental Therapies

HNL does not cover Experimental or Investigational drugs, devices, procedures or therapies. However, if HNL denies or delays coverage for requested treatment on the basis that it is Experimental or Investigational and You meet the eligibility criteria set out below, You may request an independent medical review (IMR) of HNL's decision from the Department of Insurance.

Eligibility

- You must have a life-threatening or seriously debilitating condition;
- Your Physician must certify to HNL that You have a life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving Your condition or are otherwise medically inappropriate and there is no more beneficial therapy covered by HNL;
- Your Physician must certify that the proposed Experimental or Investigational therapy is likely to be more beneficial than available standard therapies, or as an alternative, You may submit a request for a therapy that, based on documentation presented from medical and scientific evidence, is likely to be more beneficial than available standard therapies;
- You have been denied coverage by HNL for the recommended or requested therapy; and
- If not for HNL's determination that the recommended or requested treatment is Experimental or Investigational, it would be covered.

If HNL denies coverage of the recommended or requested therapy and You meet the eligibility requirements, HNL will notify You within five business days of its decision and Your opportunity to request an external review of HNL's decision through IMR. HNL will provide You with an application form to request an IMR of HNL's decision. The IMR process is in addition to any other procedures or remedies that may be available. You will not pay any application or processing fees of any kind for IMR. You have the right to provide information in support of Your request for IMR. If Your Physician determines that the proposed therapy should begin promptly, he or she may request expedited review and the experts on the IMR panel will render a decision within seven days of the request. If the IMR panel recommends that HNL cover the recommended or requested therapy, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which You are entitled. A decision not to participate in the IMR process may cause You to forfeit any statutory right to pursue legal action against HNL regarding the denial of the recommended or requested therapy. For more information, please contact the Customer Contact Center at the telephone number on Your HNL ID Card.

Arbitration

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

As a condition to becoming a HNL Covered Person, You agree to submit all disputes You may have with HNL, except those described below, to final and binding arbitration. Likewise, HNL agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both You and HNL are bound to use binding arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by HNL's binding

arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

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

If the parties fail to reach an agreement during this time frame, then either party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

Arbitration can be initiated by submitting a demand for arbitration to HNL at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

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

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this *Certificate*, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that state or federal law provide for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Covered Person, HNL may assume all or portion of a Covered Person's share of the fees and expenses of the arbitration. Upon written notice by the Covered Person requesting a hardship application, HNL will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the Litigation Administrator at the address provided above.

Persons who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are *not* required to submit disputes about certain "adverse benefit determinations" made by HNL to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by HNL to deny, reduce, terminate or not pay for all or a part of a benefit. However, You and HNL may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Medical Malpractice Disputes

HNL and the health care providers that provide services to You through this plan are each responsible for their own acts or omissions and are ordinarily not liable for the acts or omissions or costs of defending others.

SPECIFIC PROVISIONS

Recovery of Benefits Paid by HNL

When You Are Injured

If You are ever injured through the actions of another person or yourself (responsible party), HNL will provide benefits for all Covered Services and Supplies that You receive through this plan. However, if You receive money or are entitled to receive money because of Your injuries, You must reimburse whether through a settlement, judgment or any other payment associated with Your injuries, HNL or the medical providers for retain the right to recover the value of any services provided to You under this *Certificate*.

As used throughout this provision, the term responsible party means any party actually or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness or condition. The term responsible party includes the liability insurer of such party or any insurance coverage.

Some examples of how You could be injured through the actions of a responsible party are:

- You were in a car accident; or
- You slip and fall in a store.

HNL's rights of recovery apply to any and all recoveries made by You or on Your behalf from the following sources, including but not limited to:

- Payments made by a third party or any insurance company on behalf of a third party;
- Uninsured or underinsured motorist coverage;
- Personal injury protection, no fault or any other first party coverage;
- Workers Compensation or Disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' insurance coverage, umbrella coverage; and
- Any other payments from any other source received as compensation for the responsible party's actions.

By accepting benefits under this Plan, You acknowledge that HNL has a right of reimbursement that attaches when this Plan has paid for health care benefits for expenses incurred due to the actions of a responsible party and You or Your representative recovers or is entitled to recover any amounts from a responsible party.

Under California law, HNL's legal right to reimbursement creates a health care lien on any recovery.

By accepting benefits under this Plan, You also grant HNL an assignment of Your right to recover medical expenses from any medical payment coverage available to the extent of the full cost of all covered services provided by the Plan and You specifically direct such medical payments carriers to directly reimburse the plan on Your behalf.

Steps the Covered Person Must Take

If You are injured because of a responsible party, You must cooperate with HNL's and the medical providers' efforts to obtain reimbursement, including:

- Telling HNL and the medical providers the name and address of the responsible party, if You know it, the name and address of his or her lawyer, if he or she is using a lawyer, the name and address of any insurance company involved with Your injuries and describing how the injuries were caused;
- Completing any paperwork that HNL or the medical providers may reasonably require to assist in enforcing the lien;
- Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions;
- Notifying the lienholders immediately upon You or Your lawyer receiving any money from the third responsible parties, or any insurance companies, or any other source;

- Pay the health care lien from any recovery, settlement or judgment, or other source of compensation and all reimbursement due HNL for the full cost of benefits paid under the Plan that are associated with injuries through a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss;
- Do nothing to prejudice HNL's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery the full cost of all benefits paid by the plan; and
- Hold any money that You or Your lawyer receive from the responsible parties or, from any other source, in trust and reimbursing HNL and the medical providers for the amount of the lien as soon as You are paid.

How the Amount of the Covered Person's Reimbursement is Determined

The following section is not applicable to Workers' Compensation liens and may not apply to certain ERISA plans, Hospital liens, Medicare plans and certain other programs and may be modified by written agreement.*

Your reimbursement to HNL or the medical provider under this lien is based on the value of the services received and the costs of perfecting this lien. For the purposes of determining the lien amount, the value of the services depends on how the provider was paid, as summarized below, and will be calculated in accordance with California Civil Code Section 3040, or as otherwise permitted by law.

- The amount of the reimbursement owed to HNL or the medical provider will be reduced by the percentage that the recovery is reduced if a judge, jury or arbitrator determines that You were responsible for some portion of Your injuries;
- The amount of the reimbursement owed HNL or the medical provider will also be reduced by a prorata share for any legal fees or costs paid from money You received; and
- The amount You will be required to reimburse HNL or the medical provider for services received under this plan will not exceed one-third of the money You receive if You engage a lawyer or one-half of the money received if a lawyer is not engaged.

* *Reimbursement related to Workers' Compensation benefits, ERISA plans, Hospital liens, Medicare and other programs not covered by California Civil Code, Section 3040 will be determined in accordance with the provisions of this Certificate and applicable law.*

Recovery of Benefits Paid by HNL Under A Surrogate Parenting Agreement

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

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

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

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

- Informing HNL of any surrogacy compensation agreement and providing a copy when requested by HNL;
- Completing any paperwork that HNL or the medical providers may reasonably require to assist in enforcing the lien;
- Promptly responding to inquiries from the lienholders;
- Notifying the lienholders immediately upon you or your lawyer receiving the compensation; and

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

Your reimbursement to HNL or the medical provider under this lien is based on the value of the services you receive and the costs of perfecting this lien. For purposes of determining the lien amount, the value of the services depends on how the provider was paid and will be calculated in accordance with California Civil Code, Section 3040, or as otherwise permitted by law.

Refund To HNL of Overpayment Of Benefits

If We pay health benefits for expenses incurred on account of You or Your Dependent, You or any other person or organization that was paid must make a refund to Us if:

- All or some of the expenses were not paid by You or Your Dependent or did not legally have to be paid;
- All or some of the payment made by Us exceeded the benefits under the *Certificate*; or
- All or some of the expenses were recovered from or paid by a source other than this *Certificate*. This may include payments made as a result of claims against a third party of negligence, wrongful acts or omissions.

The refund equals the amount We paid in excess of the amount it should have paid under this *Certificate*. In the case of recovery from or payment by a source other than this *Certificate*, the refund equals the amount of the recovery or payment up to the amount We paid.

If the refund is due from another person or organization, You and Your Dependent agree to help Us get the refund when requested.

If You, or any other person or organization that was paid, do not promptly refund the full amount, We may reduce the amount of any future benefits that are payable under this *Certificate*. The reduction will equal the amount of the required refund.

Out-of-State Providers

Health Net PPO has created a program which allows Covered Persons access to participating providers outside their state of residence. These providers participate in a network, other than the HNL PPO network, that agrees to provide discounted health care services to HNL Covered Persons. This program is through the out-of-state provider network shown on Your HNL ID Card and is limited to Covered Persons traveling outside their state of residence.

If You are traveling outside Your state of residence, require medical care or treatment, and use a provider from the out-of-state provider network, Your out-of-pocket expenses may be lower than those incurred when You use an Out-of-Network Provider.

When You obtain services outside Your state of residence through the out-of-state provider network, You will be subject to the same Copayments, Coinsurances, maximums and limitations as You would be if You obtained services from a Preferred Provider in Your state of residence. There is the following exception: Covered Expenses will be calculated based on the lower of (i) the actual billed charges or (ii) the charge that the out-of-state provider network is allowed to charge, based on the contract between HNL and the network. In a small number of states, local statutes may dictate a different basis for calculating Your Covered Expenses.

Second Medical Opinion

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

- If the Covered Person questions the reasonableness or necessity of recommended surgical procedures.
- If the Covered Person questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious Chronic condition.

- If clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and the Covered Person requests an additional diagnosis.
- If the treatment plan in progress is not improving the medical condition of the Covered Person within an appropriate period of time given the diagnosis and plan of care, and Covered Person requests a second opinion regarding the diagnosis or continuance of the treatment.
- If the Covered Person has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

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

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

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

MISCELLANEOUS PROVISIONS

Form or Content of the Certificate
No agent or employee of HNL is authorized to change the form or content of this *Certificate*. Any changes can be made only through an endorsement authorized and signed by an officer of HNL.

Benefits Not Transferable
No person other than You is entitled to receive benefits to be furnished by HNL under this *Certificate*. Such right to benefits is not transferable. **Fraudulent use of such benefits will result in cancellation of Your eligibility under this *Certificate* and appropriate legal action.**

Time Limit on Certain Defenses
After this *Certificate* has been in force for a period of two years, no statements, except fraudulent misstatement, made by the Group contained in the application and no statements relating to insurability made by any Covered Person eligible for coverage under this *Certificate* can be contested or used to deny any claim.

Transfer of Medical Records
A health care provider may charge a reasonable fee for the preparation, copying, postage or delivery costs for the transfer of your medical records. Any fees associated with the transfer of medical records are the Covered Person's responsibility.

Notice of Claim
Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any covered loss, or as soon thereafter as reasonably possible. Notice may be given to Us at 21281 Burbank Blvd., Woodland Hills, CA 91367, or to any of Our authorized agents or mailed to Us at P.O. Box 9103, Van Nuys, CA 91409-9103. Notice should include information sufficient for Us to identify the Covered Person.

Claim Forms
When We receive notice of a claim, We will furnish You with Our usual forms for filing proof of loss. If We do not do so within 15 days, You can comply with the requirements for furnishing proof of loss by submitting written proof within the time fixed in this *Certificate* for filing such proofs of loss. Such written proof must cover the occurrence, the character and the extent of the loss.

Proofs of Loss
Written proof of loss of time on account of disability (where periodic payments depend upon continuing loss), must be given to Us at 21281 Burbank Blvd., Woodland Hills, CA 91367, within 90 days after the end of the period of time for which claim is made; in the case of claim for any other loss, written proof of loss must be furnished within 90 days after the date of the loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if proof is furnished as soon as reasonably possible. Except in the absence of legal capacity, however, We are not required to accept proofs more than one year from the time proof is otherwise required.

Expenses for Copying Medical Records
We will reimburse the Covered Person or provider for reasonable expenses incurred in copying medical records requested by Us.

Time of Payment of Claims
We will pay benefits promptly upon receipt of due written proof of loss.

Cash Benefits
In most instances, You will not need to file a claim when You receive Covered Services and Supplies from a Preferred Provider. If you use an Out-of-Network Provider and file a claim, HNL will reimburse You for the amount You paid for Covered Expenses, Copayment or Coinsurance. If You signed an assignment of benefits and the provider presents it to Us, We will send the payment directly to the provider. You must provide proof of any amounts that You have paid.

If a parent who has custody of a child submits a claim for cash benefits on behalf of the child who is subject to a Medical Child Support Order, HNL will send the payment to the custodial parent.

Payment to Providers or Covered Persons:

- **Direct Payment.** Benefit payment for Covered Expenses will be made directly to:
  1. **Contracting Hospitals**: Hospitals which have Provider Service Agreements with HNL to provide services to Covered Persons.
  2. **Providers of Ambulance transportation and certified nurse midwives**: As required by the California Insurance Code, this must occur, even if written assignment has not been made by You. However, if the submitted provider's statement or bill indicates that the charges have been paid in full, payment will be made to You.
  3. **Other providers of service not mentioned above, Hospital and professional**: when You assign benefits to them in writing.
- **Joint Payment.** Benefit payment for Covered Expenses will be made jointly to other providers and You:
  1. When a written assignment stipulates joint payment.
  2. When the benefit payment is $2,000 or greater and the submitted bill indicates that there is a balance due.
  3. Joint payment will not be made to contracting Hospitals and providers of Ambulance services. Payment to them will be direct as described in "Direct Payment" provision above.
- **Direct Payment to You.** In situations not described above, payment will made to You.

Payment When You Are Unable To Accept
If a claim is unpaid at the time of Your death or if You are not legally capable of accepting it, it will be paid to Your estate or any relative or person who may legally accept on Your behalf.

Physical Examination
HNL, at its expense, has the right to examine or request an examination of any Covered Person whose injury or sickness is the basis of a claim as often as is reasonably required while the claim is pended.

Foreign Travel or Work Assignment
Benefits will be provided for Emergency Care received in a foreign country. Determination of Covered Expenses will be based on the amount that is no greater than the Maximum Allowable Amount (as determined by HNL) in the USA for the same or a comparable service. The Maximum Allowable Amount is defined in the "Definitions" section.

Workers' Compensation Insurance
This *Certificate* is not in lieu of and does not affect any requirement for, or coverage by, Workers' Compensation Insurance.

Notice
Any notice required of HNL shall be sufficient if mailed to the holder of the Group Policy at the address appearing on the records of HNL. This *Certificate*, however, will be posted electronically on HNL's website at www.healthnet.com. The Group can opt for the Covered Person to receive this *Certificate* online. By registering and logging on to HNL's website, Covered Persons can access, download and print this *Certificate*, or can choose to receive it by U.S. mail, in which case HNL will mail this *Certificate* to each Covered Person's address on record.

If notice is required of You or the Group, it will be sufficient if mailed to the HNL office at the address listed on the back cover of this *Certificate*.

Interpretation of Certificate
The laws of the State of California shall be applied to interpretations of this *Certificate*.

Legal Actions
No action at law or in equity may be brought to recover benefits prior to the expiration of 60 days after written Proof of Loss has been furnished. No such action may be brought after a period of 3 years (or the period required by law, if longer) after the time limits stated in the Proofs of Loss section.

Non-Regulation of Providers

This Health Net PPO plan does not regulate the amounts charged by providers of medical care, except to the extent that the rates for the Covered Services and Supplies are negotiated with Preferred Providers.

Free Choice of Provider

As a Covered Person in this Health Net PPO plan, You are not required to select a primary care provider. This Health Net PPO plan does not interfere with Your right to select any properly licensed Hospital, Physician (including Specialists and behavioral health care providers) or other health care professional or facility that provides services or supplies covered by this plan. However, Your choice of provider may affect the amount of benefits payable. To identify a Preferred Provider, visit the HNL website at www.healthnet.com or contact the Customer Contact Center at the telephone number on Your HNL ID Card to obtain a copy of the Preferred Provider Directory.

Continuity of Care

If HNL's contract with a Preferred Provider is terminated, You may elect continued care by that provider if, at the time of termination, You were receiving care for an acute condition, serious chronic condition, pregnancy, newborn, terminal illness or a scheduled surgery. For more information on how to request continued care, please contact the Customer Contact Center at the telephone number on Your HNL ID Card.

Providing of Care

HNL is not responsible for providing any type of Hospital, medical or similar care. HNL is also not responsible for the quality of any type of Hospital, medical or similar care.

Relationship of Parties

The relationship, if any, between HNL and any health care providers is that of an independent contractor relationship. Physicians, Hospitals, Skilled Nursing Facilities and other health care providers and community agencies are not agents or employees of HNL. HNL shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by You while receiving care from any health care provider. Neither the Group nor any Covered Person is the agent or representative of HNL. Neither shall be liable for any acts or omissions of HNL, its agents or employees.

HNL retains the right to designate or replace an administrator to perform certain functions for providing the Covered Services and Supplies of this *Certificate*. If HNL does designate or replace any administrator, HNL will inform You of all new procedures. Any administrator designated by HNL is an independent contractor and not an employee or agent of HNL.

Confidentiality of Medical Records

A STATEMENT DESCRIBING HNL'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Technology Assessment

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

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

The expert medical reviewer also advises HNL when patients require quick determinations of coverage, when there is no guiding principle for certain technologies or when the complexity of a patient’s medical condition requires expert evaluation. If HNL denies, modifies or delays coverage for Your requested treatment on the basis that it is Experimental or Investigational, You may request an independent medical review (IMR) of HNL’s deci-

sion from the Department of Insurance. Please refer to the “Independent Medical Review of Grievances Involving a Disputed Health Care Service” in the “General Provisions” section for additional details.

Health Care Plan Fraud

Health care plan fraud is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by filing a claim that contains a false or deceptive statement is guilty of insurance fraud.

Your Responsibility

As a Covered Person, You must:

- File accurate claims. If someone else, such as Your spouse or another Dependent who is a Covered Person, files claims on Your behalf, You should review the form before You sign it;
- Review the explanation of benefits (EOB) form when it is returned to You. Make certain that benefits have been paid correctly based on Your knowledge of the expenses incurred and the services rendered;
- Never allow another person to seek medical treatment under Your identity. If Your ID Card is lost, You should report the loss to Us immediately; and
- Provide complete and accurate information on claims forms and any other information forms. Attempt to answer all questions to the best of Your knowledge.

To maintain the integrity of Your health plan, We encourage You to notify Us whenever a provider:

- bills You for services or treatments that You have never received;
- asks You to sign a blank claim form; or
- asks You to undergo tests that You feel are not needed.

If You are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if You know of or suspect any illegal activity, call Our toll-free hotline at the number shown on Your HNL ID card. All calls are strictly confidential.

Privacy Statement

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

Information Security

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

Information We Collect

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

- Information We receive from the Covered Person on applications or other forms (such as the Covered Person’s name, address, telephone number, social security number, account information, employment, health status and other personal information relevant to the Covered Person’s coverage); and
- Information about the Covered Person’s transactions with Us, Our affiliates or others (such as information about premium payment history, co-payments, claims payments, co-insurance).

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

Disclosures

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

Additional Information about this Privacy Statement

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

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

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION AND NONPUBLIC PERSONAL FINANCIAL INFORMATION* ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

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

How We May Use And Disclose Your Protected Health Information

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

- **Payment**. We use and disclose Your protected health information in order to pay for Your covered health coverage or expenses. For example, We may use Your protected health information to process claims to be reimbursed by another insurer that may be responsible for payment or for premium billing.
- **Health Care Operations**. We use and disclose Your protected health information in order to perform Our plan activities, such as quality assessment activities or administrative activities, including data management or customer service.
- **Treatment**. We may use and disclose Your protected health information to assist Your health care providers (doctors, pharmacies, Hospitals and others) in Your diagnosis and treatment. For example, We may disclose Your protected health information to providers to provide information about alternative treatments.
- **Plan Sponsor**. If You are enrolled through a group health plan, We may provide non-identifiable summaries of claims and expenses for enrollees in Your group health plan to the plan sponsor, which is usually the Group. If the plan sponsor provides plan administration services, We may also provide access to identifiable health information to support its performance of such services which may include but are not limited to claims audits or customer services functions. We will only share health information upon a certification from the plan sponsor representing there are restrictions in place to ensure that only plan sponsor employees with a legitimate need to know will have access to health information in order to provide plan administration functions.

  We may also disclose protected health information to a person, such as a family member, relative, or close personal friend, who is involved with Your care or payment. We may disclose the relevant protected health information to these persons if You do not object or we can reasonably infer from the circumstances that You do not object to the disclosure; however, when You are not present or are incapacitated, we can make the disclosure if, in the exercise of professional judgment, we believe the disclosure is in Your best interest.

Other Permitted Or Required Disclosures

- **As Required by Law.** We must disclose protected health information about You when required to do so by law.
- **Public Health Activities**. We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose protected health information to government agencies about abuse, neglect or domestic violence.
- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g., California Department of Health Services) for activities authorized by law.

- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about You in certain cases in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Coroners, Funeral Directors, Organ Donation.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
- **Research**. Under certain circumstances, We may disclose protected health information about You for research purposes, provided certain measures have been taken to protect Your privacy.
- **To Avert a Serious Threat to Health or Safety**. We may disclose protected health information about You, with some limitations, when necessary to prevent a serious threat to Your health and safety or the health and safety of the public or another person.
- **Special Government Functions**. We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation**. We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

Other Uses Or Disclosures With An Authorization

Other uses or disclosures of Your protected health information will be made only with Your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that We have already taken action on the information disclosed or if We are permitted by law to use the information to contest a claim or coverage under the Plan.

Your Rights Regarding Your Protected Health Information

You have certain rights regarding protected health information that the Plan maintains about You.

- **Right To Access Your Protected Health Information**. You have the right to review or obtain copies of Your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of Your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing Your requested information, but We will tell You the cost in advance.
- **Right To Amend Your Protected Health Information**. If You feel that protected health information maintained by the Plan is incorrect or incomplete, You may request that We amend the information. Your request must be made in writing and must include the reason You are seeking a change. We may deny Your request if, for example, You ask Us to amend information that was not created by the Plan, as is often the case for health information in Our records, or You ask to amend a record that is already accurate and complete.

  If We deny Your request to amend, We will notify You in writing. You then have the right to submit to Us a written statement of disagreement with Our decision and We have the right to rebut that statement.
- **Right to an Accounting of Disclosures by the Plan**. You have the right to request an accounting of disclosures We have made of Your protected health information. The list will not include Our disclosures related to Your treatment, Our payment or health care operations, or disclosures made to You or with Your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

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

- **Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information**. You have the right to request that We restrict or limit how We use or disclose Your protected health information for treatment, payment or health care operations. **We may not agree to Your request.** If We do agree, We will comply with Your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In Your request, You must tell Us (1) what information You want to limit; (2) whether You want to limit how We use or disclose Your information, or both; and (3) to whom You want the restrictions to apply.
- **Right To Receive Confidential Communications**. You have the right to request that We use a certain method to communicate with You about the Plan or that We send Plan information to a certain location if the communication could endanger You. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from Us could endanger You. We will accommodate all reasonable requests. Your request must specify how or where You wish to be contacted.
- **Right to a Paper Copy of This Notice**. You have a right at any time to request a paper copy of this Notice, even if You had previously agreed to receive an electronic copy.
- **Contact Information for Exercising Your Rights**. You may exercise any of the rights described above by contacting Our Privacy Office. See the end of this Notice for the contact information.

Health Information Security

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

Changes To This Notice

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

Complaints

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

We support Your right to protect the privacy of Your protected health information***. We will not retaliate against You or penalize You for filing a complaint.***

Contact The Plan

If You have any complaints or questions about this Notice or You want to submit a written request to the Plan as required in any of the previous sections of this Notice, You may send it in writing to:

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

You may also contact Us at:

Telephone: **1-888-893-1572**
Fax: **1-818-676-8314**
Email: Privacy@healthnet.com

* *Nonpublic personal financial information includes personally identifiable financial information that You provided to us to obtain health plan coverage or we obtained in providing benefits to You. Examples include Social Se-*

curity numbers, account balances and payment history. We do not disclose any nonpublic personal information about You to anyone, except as permitted by law.

DEFINITIONS

This section defines words that will help You understand Your Plan. These words appear throughout this *Certificate* with the initial letter of the word in capital letters.

Accidental Injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental Injury does not include illness, infection (except infection of a cut or nonsurgical wound) or damage to the teeth or dental prosthesis caused by chewing.

Ambulance means an automobile or airplane (fixed wing or helicopter), which is specifically designed and equipped for transporting the sick or injured. It must have patient care equipment, including at least a stretcher, clean linens, first aid supplies and oxygen equipment. It must be staffed by at least two persons who are responsible for the care and handling of patients. One of these persons must be trained in advanced first aid. The vehicle must be operated by a business or agency which holds a license issued by a local, state or national governmental authority authorizing it to operate Ambulances.

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

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

Calendar Year is the twelve-month period that begins at 12:01 a.m. Pacific Time on January 1 of each year.

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

Chemical Dependency is alcoholism, drug addiction or other Chemical Dependency problems.

Coinsurance is the percentage of the Covered Expenses for which You are responsible, as specified in the "Schedule of Benefits" section.

Contracted Chiropractor is a doctor of chiropractic (D.C.), licensed by the state of California, who has a contract in effect with American Specialty Health Plans (ASH Plans) to provide the chiropractic benefits of this Plan.

Contracted Rate is the rate that Preferred Providers are allowed to charge You, based on a contract between HNL and such provider. Covered Expenses for services provided by a Preferred Provider will be based on the Contracted Rate.

Copayment is a fixed dollar fee charged to You for Covered Services and Supplies when You receive them. The amount of each Copayment is indicated in the "Schedule of Benefits" section.

Corrective Footwear includes specialized shoes, arch supports and inserts and is custom made for Covered Persons who suffer from foot disfigurement. Foot disfigurement includes, but is not limited to, disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by accident or developmental disability.

Covered Expenses are the maximum charges for which HNL will pay benefits for each covered service or supply (including covered services related to Mental Disorders and Chemical Dependency). The amount of Covered Expenses varies by whether You obtain services from a Preferred Provider or an Out-of-Network Provider. Covered Expenses are the lesser of the billed charge or: (i) the Contracted Rate for the services or supplies provided by a Preferred Provider; (ii) the Maximum Allowable Amount for the services or supplies provided by an Out-of-Network Provider

Covered Person is the enrolled employee (referred to as "You" or "Your" or the "principal Covered Person") or his or her Dependent who is covered under this *Certificate.*

Covered Services and Supplies means Medically Necessary services and supplies that are payable or eligible for reimbursement, subject to Copayments, Coinsurance, benefit limitations or maximums, under the *Certificate*.

Creditable Coverage means coverage under any individual or group policy, contract or program, that is written or administered by a disability insurance company, healthcare service plan, fraternal benefits society, self-insured Group plan or any other entity, in this state or elsewhere, that arranges or provides medical, Hospital, and surgical coverage not designed to supplement other private or governmental plans. Any such coverage must not be interrupted by a lapse of more than 180 days (in cases where the coverage ended as a result of loss of employment or action taken by an employer) or by a lapse of more than 62 days (for any other reason), from the Effective Date of coverage under this plan in order to qualify as Creditable Coverage. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance:

- The federal Medicare program pursuant to Title XVIII of the Social Security Act;
- The Medicaid program pursuant to Title XIX of the Social Security Act;
- Any other publicly sponsored program, provided in this state or elsewhere, of medical, Hospital and surgical care;
- 10 U.S.C.A. Chapter 55 (commencing with section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS));
- A medical care program of the Indian Health Service or of a tribal organization;
- A state health benefits risk pool;
- A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP));
- A public health plan as defined in federal regulations authorized by Section 2701 (c)(1)(i) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996;
- A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. Sec. 2504(e)); or
- Any other Creditable Coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

Custodial Care is care that is rendered to a patient to assist in support of the essentials of daily living such as help in walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets and supervision of medications which are ordinarily self-administered, and for which the patient:

- Is disabled mentally or physically and such disability is expected to continue and be prolonged;
- Requires a protected, monitored or controlled environment whether in an institution or in the home; and
- Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

Dependents are individuals who meet the eligibility requirements for coverage under this *Certificate* and have been enrolled by the principal Covered Person (employee).

Domestic Partner is, for the purposes of this *Certificate*, the principal Covered Person’s same-sex spouse if the principal Covered Person and spouse are a couple who meet all of the requirements of Section 308(c) of the California Family Code, or are registered domestic partners who meets all domestic partnership requirements specified by section 297 or 299.2 of the California Family Code.

Durable Medical Equipment

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

Effective Date is the date on which You become covered or entitled to benefits under this *Certificate*.

Emergency Care is any otherwise covered service for an acute illness, a new injury or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or, if a minor, to the minor's parent or guardian that a reasonable person with an average knowledge of health and medicine, (a prudent layperson) would seek if he or she was having serious symptoms (including symptoms of Severe Mental Illness and Serious Emotional Disturbances of a Child), and believed that without immediate treatment, any of the following would occur:

- His or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger);
- His or her bodily functions, organs or parts would become seriously damaged; or
- His or her bodily organs or parts would seriously malfunction.

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

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

Emergency Care includes air and ground Ambulance transport services provided through the "**911**" emergency response system, if the request was made for Emergency Care.

Emergency Care will also include additional screening, examination and evaluation by a Physician (or other health care provider acting within the scope of his or her license) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate such condition, within the capability of the facility.

HNL will make any final decisions about Emergency Care. See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" under "General Provisions" for the procedure to request an Independent Medical Review of a Plan denial of coverage for Emergency Care.

Experimental is any procedure, treatment, therapy, drug, biological product, equipment, device or supply which HNL has not determined to have been demonstrated as safe, effective or medically appropriate and which the United States Food and Drug Administration (FDA) or Department of Health and Human Services (HHS) has determined to be Experimental or Investigational or is the subject of a clinical trial.

Please refer to "Independent Medical Review of Investigational or Experimental Therapies" in the "General Provisions" section as well as the "Medical Benefits" portion of the "Plan Benefits" section of this *Certificate* for additional information.

Group is the business organization (usually an employer or trust) to which HNL has issued the Policy to provide the benefits of this Plan.

Health Net Life Insurance Company (HNL) is a life and disability insurance company regulated by the California Department of Insurance. The term "We," "Our" or "Us" when they appear in this *Certificate* refer to HNL.

Health Net PPO is the Preferred Provider Organization (PPO) plan described in this *Certificate*, which allows You to obtain medical benefits from either a network of Preferred Providers with whom HNL has contracted to provide services at the Contracted Rate; or else any Out-of-Network Provider. Health Net PPO is underwritten by HNL.

Health Net PPO Service Area is the United States.

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

Home Health Care Services are services, including skilled nursing services, provided by a licensed Home Health Care Agency to a Covered Person in his or her place of residence that is prescribed by the Covered Person's attending Physician as part of a written plan. Home Health Care Services are covered if the Covered Person is homebound, under the care of a contracting Physician, and requires Medically Necessary skilled nursing services, physical, speech, occupational therapy, or respiratory therapy or medical social services. Only Intermittent Skilled Nursing Services (not to exceed 4 hours a day) are covered benefits under this plan. Private Duty Nursing or shift care (including any portion of shift care services) is not covered under this plan. See also "Intermittent Skilled Nursing Services" and "Private Duty Nursing."

Hospice is a facility or program that provides a caring environment for meeting the physical and emotional needs of the terminally ill. The Hospice and its employees must be licensed according to applicable state and local laws and certified by Medicare.

Hospice Care is care that is designed to provide medical and supporting care to the terminally ill and their families. Hospice Care is designed to be provided primarily in Your home.

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

Infertility exists when any of the following apply to a female Covered Person who has not yet gone through menopause:

- The Covered Person has had regular heterosexual relations for one year or more without use of contraception or other birth control methods and has not become pregnant, or if she became pregnant, could not achieve a live birth; or
- The Covered Person has been unable to achieve conception after six cycles of artificial insemination; or
- The Physician has diagnosed a medical condition that prevents conception or live birth.

Intermittent Skilled Nursing Services are services requiring the skilled services of a registered nurse or LVN, which do not exceed 4 hours in every 24 hours.

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

- Maximum Allowable Amount for physician services is determined by applying a designated percentile from the database of physician charges from the Ingenix MDR Payment System (MDR) or a similar type of database of physician charges.
- For hospital services, Maximum Allowable Amount is calculated using a method developed by Viant, Inc., a data service that applies a hospital profit margin factor for hospitals, to the estimated costs of the services rendered by the Out-of-Network hospital or a similar type of hospital data service.
- For other types of services, Maximum Allowable Amount is determined by applying a designated percentile from the database of applicable professional or ancillary provider charges from the MDR or a similar type of database of applicable professional or ancillary provider charges. Payments to providers other than physicians may be reduced based upon their licensed scope of practice.
- In the event the applicable service or database does not include an amount for the service or supply provided, Maximum Allowable Amount shall be deemed to be 75% of the amount normally charged by the provider for the same services or supplies. The Maximum Allowable Amount determined under the databases described above may be more or less than 75% of the amount normally charged by the provider for the same services or supplies.

- The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses. See "Schedule of Benefits," "Plan Benefits" and "General Limitations and Exclusions" sections for specific benefit limitations, maximums, pre-certification requirements and surgery payment policies that limit the amount HNL pays for certain Covered Services and Supplies.

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

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

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

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

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

Investigational approaches to treatment are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective procedures within the organized medical community. HNL will decide whether a service or supply is considered Investigational.

Medical Child Support Order is a court judgment or order that, according to state or federal law, requires group health plans that are affected by that law to provide coverage to a child or children who is the subject of such an order. HNL will honor such orders.

Medically Necessary (or Medical Necessity) means health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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

Mental Disorders are a nervous or mental condition that meets all of the following conditions:

- It is a clinically significant behavioral or psychological syndrome or pattern;

- It is associated with a painful symptom, such as distress;
- It impairs a patient's ability to function in one or more major life activities; or
- It is a condition listed as an Axis I Disorder (excluding V Codes) in the most recent edition of the DSM by the American Psychiatric Association.

Neuro-Musculoskeletal Disorder is a misalignment of the skeletal structure, muscular weakness, osteopathic imbalance or any disorder related to the spinal cord, neck or joints.

Open Enrollment Period is a period of time each Calendar Year, during which individuals who are eligible for coverage in this Plan may enroll for the first time, or if You were enrolled previously, may add Your eligible Dependents.

The Group decides the exact dates for the Open Enrollment Period.

Changes requested during the Open Enrollment Period become effective on the first day of the calendar month following the date the request is submitted, or on any date approved by Us.

Orthotics (such as bracing, supports and casts) are rigid or semi-rigid devices that are externally affixed to the body and designed to be used as a support or brace to assist the Covered Person with the following:

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

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

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

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

Pain means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder or condition.

Physician means:

- A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
- One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for whom benefits are specified in this *Certificate*, and when benefits would be payable if the services were provided by a Physician as defined above:

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

Clinical social worker (M.S.W. or L.C.S.W.)
Marriage, family and child counselor (M.F.C.C.)
Physical therapist (P.T. or R.P.T.)
Speech pathologist
Audiologist
Occupational therapist (O.T.R.)
Psychiatric mental health nurse
Respiratory care practitioner
Acupuncturist (A.C.)

Preferred Provider Organization is a health care provider arrangement whereby HNL contracts with a group of Physicians or other medical care providers who have contracted to furnish services at the rate known as the Contracted Rate.

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

Preventive Care Services are services and supplies that are covered under the “Preventive Care Services” heading as shown in the “Schedule of Benefits” and "Plan Benefits" section. These services and supplies are provided to individuals who do not have the symptom of disease or illness, and generally do one or more of the following:

- Maintain good health
- Prevent or lower the risk of diseases or illnesses
- Detect disease or illness in early stages before symptoms develop
- Monitor the physical and mental development in children

Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a Hospital or Skilled Nursing Facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of four hours in any 24-hour period. Private Duty Nursing may be provided in an inpatient or outpatient setting, or in a non-institutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care" and includes any portion of shift care services.

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

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

- A qualified autism service professional is a behavioral service provider that has training and experience in providing services for pervasive developmental disorder or autism and is approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Man-

agement Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations.

- A qualified autism service paraprofessional is an unlicensed and uncertified individual who has adequate education, training, and experience as certified by the Qualified Autism Service Provider, and who meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code.

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

Serious Emotional Disturbances Of A Child is when a child under the age of 18 has one or more Mental Disorders identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance use disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following:

- As a result of the Mental Disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either (i) the child is at risk of removal from home or already has been removed from the home or (ii) the Mental Disorder and impairment have been present for more than six months or are likely to continue for more than one year;
- The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a Mental Disorder; and/or
- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

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

Skilled Nursing Facility is an institution that is licensed by the appropriate state and local authorities to provide skilled nursing services. In addition, Medicare must approve the facility as a participating Skilled Nursing Facility.

Special Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for the care of inpatients with acute conditions that require constant treatment and monitoring including, but not limited to, an intensive care, cardiac intensive care, and cardiac surgery intensive care unit, and a neonatal intensive or intermediate care newborn nursery.

Specialist is a Physician who delivers specialized services and supplies to the Covered Person.

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

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

NOTICE OF LANGUAGE SERVICES

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or please call 800-522-0088. PPO members: for more help call the CA Dept. of Insurance at 1-800-927-4357. HMO members: call the DMHC Helpline at 1-888-HMO-2219. **English**

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o llame al 800-522-0088. Afiliados a PPO: para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Afiliados a HMO: llame a la Línea de Ayuda del Departamento de Atención Médica Administrada de California (DMHC, por sus siglas en inglés) al 1-888-HMO-2219. **Spanish**

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，部分文件可以翻譯成您的語言並寄送給您。如需協助，請撥您會員卡所列的電話號碼或撥 800-522-0088 與我們聯絡。PPO 會員：如需其他協助，請致電 CA 保險局，電話 1-800-927-4357。HMO 會員：請撥 DMHC 協助專線 1-888-HMO-2219。 **Chinese**

Dịch vụ ngôn ngữ miễn phí. Quý vị có thể được cấp thông dịch viên. Quý vị có thể được cấp người đọc văn bản cho quý vị hoặc nhận tài liệu, văn bản bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi cho chúng tôi tại số điện thoại trên thẻ hội viên của quý vị hoặc gọi số 800-522-0088. Hội viên chương trình PPO: Để được trợ giúp thêm, vui lòng gọi cho Sở Bảo hiểm CA tại số 1-800-927-4357. Hội viên chương trình HMO: xin gọi Đường dây trợ giúp của Sở DMHC tại 1-888-HMO-2219. **Vietnamese**

무료 언어 지원 서비스. 귀하는 통역사 서비스를 받으실 수 있습니다. 본인에게 편한 언어로 서류 낭독 서비스 및 번역 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상의 안내번호로 전화하시거나 800-522-0088 번으로 연락해 주십시오. PPO 가입자: 더 많은 도움이 필요하신 분은 캘리포니아 보험 담당국, 안내번호 1-800-927-4357 번으로 문의하십시오. HMO 가입자: DMHC 헬프라인, 안내번호 1-888-HMO-2219 번으로 문의해 주십시오. **Korean**

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin. Maaari mong ipabasa sa iyo ang mga dokumento, at maaaring ipadala sa iyo ang ilan sa mga ito sa iyong wika. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o kaya mangyaring tumawag sa 800-522-0088. Para sa PPO members: para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Para sa HMO members: tawagan ang DMHC Helpline sa 1-888-HMO-2219. **Tagalog**

Անվճար Լեզվական Ծառայություններ: Կարող եք թարգմանիչ ստանալ: Փաստաթղթերը կարող են ձեզ համար ընթերցվել կամ ձեզ ուղարկվել ձեր լեզվով: Օգնության համար զանգահարեք մեզ ձեր ինքնության (ID) տոմսի վրա նշված համարով կամ խնդրում ենք զանգահարել 800-522-0088 համարով: PPO անդամներ՝ լրացուցիչ օգնության համար զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք (CA Dept. of Insurance) 1-800-927-4357 համարով: HMO անդամներ՝ զանգահարեք DMHC-ի Օգնության գծին՝ 1-888-HMO-2219 համարով: **Armenian**

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика. Вам могут прочесть ваши документы, а также выслать вам некоторые из них на вашем языке. Для получения помощи звоните нам по номеру телефона, указанному в вашей карточке-удостоверении, или по номеру 800-522-0088. Просим участников плана PPO для получения дополнительной помощи звонить в Министерство страхования (Department of Insurance) штата Калифорния по номеру 1-800-927-4357. Участников организаций медицинского обслуживания (HMO) просим обращаться в телефонную службу помощи Департамента организованного медицинского обслуживания (DMHC) по телефону 1-888-HMO-2219. **Russian**

無料の言語サービス。通訳がご利用になれ、書類を日本語でお読みします。また、書類によっては日本語版をお届けできるものもあります。サービスをご希望の方は、IDカード記載の番号または 800-522-0088 までご連絡ください。PPO加入者: その他のお問い合わせはカリフォルニア州保険庁、1-800-927-4357 までご連絡ください。HMO加入者: DMHCヘルプライン、1-888-HMO-2219 までご連絡ください。 **Japanese**

خدمات بی هزینه مربوط به زبان. می توانید از خدمات یک مترجم شفاهی برخوردار شوید. می توانید بگوئید تا نوشته ها به زبان خودتان برایتان خوانده شده و بعضی از آنها به زبان خودتان برایتان ارسال شوند. برای دریافت کمک بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. اعضاء HMO: با خط تلفنی کمکی DMHC به شماره 1-888-HMO-2219 تماس بگیرید. **Farsi**

ਭਾਸ਼ਾ ਦੀਆਂ ਮੁਫਤ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ। ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ ਅਤੇ ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਕਿਸੇ ਵੀ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ ਕਿਰਪਾ ਕਰਕੇ 800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। PPO ਮੈਂਬਰ: ਹੋਰ ਸਹਾਇਤਾ ਲਈ CA ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। HMO ਮੈਂਬਰ: DMHC ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। **Punjabi**

ការបកប្រែភាសាដោយឥតអស់ថ្លៃ។ អ្នកអាចទទួលជំនួយពីអ្នកបកប្រែបាន។ អ្នកអាចឲ្យគេអានឯកសារជូនអ្នក និងផ្ញើឯកសារខ្លះ ទៅឲ្យអ្នក ជាភាសាខ្មែរបាន។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខដែលមានតាត់នៅលើប័ណ្ណ ID របស់អ្នក ឬសូមទូរស័ព្ទ ទៅលេខ 800-522-0088។ សមាជិក PPO: សំរាប់ជំនួយបន្ថែម សូមទូរស័ព្ទទៅក្រសួង ធានារ៉ាប់រងរដ្ឋកាលីហ្វ័ញ៉ា តាមលេខ 1-800-927-4357។ សមាជិក HMO: សូមទូរស័ព្ទទៅខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219។ **Khmer**

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم. يمكنك طلب قراءة وثائق وإرسال بعضها إليك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك (ID) أو رجاء الاتصال بالرقم 800-522-0088. أعضاء PPO: للحصول على المساعدة الإضافية يمكنهم الاتصال بـ CA Dept. of Insurance على الرقم 1-800-927-4357. أعضاء برنامج HMO: يمكنهم الاتصال بخط المساعدة التابع لـ DMHC بواسطة الرقم 1-888-HMO-2219. **Arabic**

Kev Pab Lus Tsis Muaj Nqi Them. Koj txais tau tus neeg txhais lus. Koj muab tau cov ntawv nyeem rau koj thiab ib co xa tuaj rau koj ua koj hom lus. Kom tau kev pab, hu rau peb ntawm tus xovtooj sau rau koj daim npav ID lossis thov hu 800-522-0088. Cov tswv cuab PPO: kom tau kev pab ntxiv hu rau lub CA Dept. of Insurance ntawm 1-800-927-4357. Cov tswv cuab HMO: hu rau lub DMHC Helpline ntawm 1-888-HMO-2219. **Hmong**

Doo bąąh hiliní da hazaad bee haká'adoowołgo. Ata' halne'é ła' áka'adoolwołígíí jóki'. Naaltsoos binahjį' éé dahózinígíí hach'į' yíidooltah áádóó ła' hach'į' adoolyiił t'áá hó hazaad k'ehjí. Aká'adoowoł biniiyé, nihich'į' hódíilnih béésh bee hane'é binumber bee néé hó'dolzin biniiyé nanitinígíí bikáá' éí doodaií kojį' hodíilnih 800-522-0088. PPO atah jilíigo: t'áá náás bee shiká'anáá'doowoł ninizingo kojį' hodíilnih CA Dept of Insurancejį' éí 1-800-927-4357. HMO atah jilíigo: kojį' hodíilnih DMHC béésh bee hane'é bee aká'a'áyeedjį' éí 1-888-HMO-2219. **Navajo**

Contact us

Health Net PPO
Post Office Box 10196
Van Nuys, California 91410-0196

Customer Contact Center
Large Group:
1-888-893-1572
(for companies with 51 or
more employees)

Small Business Group:
1-800-361-3366
(for companies with 2-50 employees)

Individual & Family Plans:
1-800-839-2172

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

www.healthnet.com

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