Certificate of Insurance

A complete explanation of your plan

Flex Med (Plan JDG)

Important benefit information – please read

Notice of Right to Examination for individuals age 65 and older: The Policyholder or certificate holder has the right to return the Policy or Certificate, by mail or other delivery method, within 30 days after its receipt, and to have the full premium and any policy or membership fee paid refunded.

This Certificate is not a Medicare Supplement Certificate. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

C11401 (CA 1/22)

Dear Health Net Life Insurance Company Covered Person:

This is your new Health Net Life Insurance Company *Certificate*.

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 Life Insurance Company.

Table of Contents

PLAN JDG

FLEX NET BENEFIT CERTIFICATE

ISSUED IN CONNECTION WITH THE FLEX NET INSURANCE POLICY

UNDERWRITTEN
BY

HEALTH NET LIFE INSURANCE COMPANY

Los Angeles, California

HEALTH NET LIFE INSURANCE COMPANY (herein called HNL or Health Net) agrees to provide benefits as described in this *Certificate* to the principal Covered Person and eligible Dependents, subject to the terms and conditions of the Flex Net Insurance Policy (the Policy) which is incorporated herein and issued to the Group. All benefits described within this *Certificate* will be administered by Health Net Life Insurance Company.

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

THE BENEFITS OF THIS *CERTIFICATE* ARE PROVIDED ONLY FOR SERVICES THAT ARE CONSIDERED MEDICALLY NECESSARY BY HNL AND MEDICARE. THE FACT THAT A PHYSICIAN OR OTHER PROVIDER MAY PERFORM, PRESCRIBE, ORDER, RECOMMEND OR APPROVE A SERVICE, SUPPLY OR HOSPITALIZATION DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY, OR MAKE IT A COVERED SERVICE.

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

HNL applies certain payment policies and rules to determine appropriate reimbursement that may affect the Covered Person's 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 "Professional Services" portion of the "Medical Benefits" section for additional details. Additional information about HNL's reimbursement policies is available on the HNL website at www.healthnet.com or by contacting HNL's Customer Contact Center at the telephone number listed on your Flex Net identification card.

When the Medicare Hospital Deductible changes each year, the benefits will automatically change to reflect the new Medicare benefits. The Subscription Charges may also be adjusted to reflect such changes.

Important Notice to California Certificate Holders

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

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

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

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

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 prostheses 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.

Calendar Year is the continuous, twelve-month period beginning January 1 of each year at 12:01 a.m., Pacific Time.

Coinsurance means the portion of the Covered Expenses for which the Covered Person is responsible, as specified in the "Schedule of Benefits" section.

Copayment is a fee charged to the Covered Person for Covered Services and Supplies when he or she receives them. The Copayment is due and payable to the provider of care at the time the service is received. The Copayment for each Covered Service or Supply is shown 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 allowable for each Covered Service or Supply as provided by that type of provider (including covered services related to Mental Health and Substance Use Disorders). It is not necessarily the amount a physician or provider bills for a service. Any expense incurred which exceeds the Maximum Allowable Amount is not a Covered Expense.

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

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

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

- Is disabled mentally or physically and such disability is expected to continue and be prolonged;
- Requires a protected, monitored, or controlled environment whether in an institution or in the home; and

- Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

Deductible is the amount of payment which must be incurred by the Covered Person each Calendar Year and for which the Covered Person has payment responsibility before benefits become payable by HNL.

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 is registered as domestic partners and 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, it is not for convenience and/or comfort and it is not useful to anyone in the absence of illness or injury);
- Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities.
- Withstands repeated use; and
- Is appropriate for use in a home setting

Effective Date is the date on which the Covered Person becomes covered or entitled to benefits under this *Certificate*. Enrolled Dependents may have a different Effective Date than the principal Covered Person if they are added later to the plan.

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

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

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

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

Emergency Care is available and accessible to all Covered Persons in the Service Area 24 hours a day, seven days a week. Emergency Care includes air and ground Ambulance transport services provided through the **911** emergency response system, if the request was made for Emergency Care. Ambulance

services will transport the Covered Person to the nearest 24-hour emergency facility with physician coverage.

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

A "psychiatric emergency medical condition" means a Mental Health or Substance Use Disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the Mental Health or Substance Use Disorder.

See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" under "Coverage Decisions and Disputes Resolutions" for the procedure to request an Independent Medical Review of a Plan denial of coverage for Emergency Care.

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

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

- It is currently the subject of active and credible evaluation (e.g., clinical trials or research) to determine:
  - clinical efficacy,
  - therapeutic value or beneficial effects on health outcomes, or
  - benefits beyond any established medical based alternative.
- It is the subject of an active and credible evaluation and does not have final clearance from applicable governmental regulatory bodies (such as the US Food and Drug Administration "FDA") and unrestricted market approval for use in the treatment of a specified medical condition or the condition for which authorization of the service is requested.
- The most recent peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals do not conclude, or are inconclusive in finding, that the service is safe and effective for the treatment of the condition for which authorization of the service is requested.

Flex Net is the name of the insurance policy, evidenced by an Insurance Policy issued to the Group, of which this *Certificate* is a part. It is underwritten by HNL.

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

Group Open Enrollment Period is a period of no less than 10 days, to be determined by the Group, and occurring at least once annually, during which any eligible employee of the Group may join or transfer from one health plan provided by the Group to another, without providing proof of insurability.

Health Net Of California, Inc. (herein referred to as Health Net) is a federally qualified health maintenance organization (HMO) and a California health care service plan licensed by the California Department of Managed Health Care.

Health Net Life Insurance Company (HNL or Health Net) is a life and disability insurance company regulated by the California Department of Insurance.

Health Net HMO Service Area is the enrollment area in the continental United States established by Health Net and approved by the California Department of Managed Health Care.

Home Health Care Agency is an organization licensed by the state in which it is located to provide Home Health Care Services, certified by Medicare or accredited by Joint Commission on the Accreditation of Healthcare Organizations.

Home Health Care Services are services, including skilled nursing services, provided by a licensed Home Health Care Agency to a Covered Person in his or her place of residence that is prescribed by the Covered Person's attending physician as part of a written plan. Home Health Care Services are covered if the Covered Person is homebound, under the care of a contracting physician, and requires Medically Necessary skilled nursing services, physical, speech, occupational therapy, or respiratory therapy or medical social services. Only Intermittent Skilled Nursing Services, (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."

Home Infusion Therapy is infusion therapy that involves the administration of medications, nutrients, or other solutions through intravenous, subcutaneously by pump, enterally or epidural route (into the bloodstream, under the skin, into the digestive system, or into the membranes surrounding the spinal cord) to a patient who can be safely treated at home. Home Infusion Therapy always originates with a prescription from a qualified physician who oversees patient care and is designed to achieve physician-defined therapeutic end points.

Hospice is a program provided by a public agency or private organization, or a part of either, that is primarily engaged in providing certain services to terminally ill persons. The Hospice and its employees must be licensed in accordance with applicable state and local laws and certified by Medicare.

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

Hospital is a place that maintains and operates organized facilities licensed by the state in which they are located for the diagnosis, care, and treatment of human illnesses to which persons may be admitted for overnight stay, but which does not include Skilled Nursing Facility or Hospice, and which is accredited or certified either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by Medicare.

Infertility means either (1) the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Intermittent Skilled Nursing Services are services requiring the skilled services of a registered nurse or LVN, which do not exceed 4 hours in every 24 hours, provided either continuously or intermittently, in a 24-hour period. Home health aide services are covered under the Home Health Care benefit if the

Covered Person's condition requires the services of a nurse, physical therapist, occupational therapist, or speech therapist.

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

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

- It is currently the subject of active and credible evaluation (e.g., clinical trials or research) to determine:
  - clinical efficacy,
  - therapeutic value or beneficial effects on health outcomes, or
  - benefits beyond any established medical based alternative.
- It is the subject of an active and credible evaluation and does not have final clearance from applicable governmental regulatory bodies (such as the US Food and Drug Administration "FDA") and unrestricted market approval for use in the treatment of a specified medical condition or the condition for which authorization of the service is requested.
- The most recent peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals do not conclude, or are inconclusive in finding, that the service is safe and effective for the treatment of the condition for which authorization of the service is requested.

Maximum Allowable Amount (MAA) is the amount on which HNL bases its reimbursement for Covered Expenses for inpatient Hospital care (beyond lifetime reserve days), care in a Skilled Nursing Facility (days 101-365) and for care received during Foreign Travel or Work Assignment, provided by a health care 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 health care provider or the amount determined as set forth below. Maximum Allowable Amount is not the amount that HNL pays for a Covered Service; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles and other applicable amounts set forth in this *Certificate*.

- ***Maximum Allowable Amount for Covered Services and Supplies, excluding Emergency Care, and outpatient pharmaceuticals,*** received from a health care provider is a percentage of what Medicare would pay, known as the Medicare Allowable Amount, as defined in this *Certificate*.

For illustration purposes only, health care provider: 70% Plan Payment / 30% Coinsurance:
Provider's billed charge for extended office visit.....$128.00
MAA allowable for extended office visit (example only; does not mean
that MAA always equals this amount).....$102.40
Your Coinsurance is 30% of MAA: 30% x $102.40 (assumes
Deductible has already been satisfied).....$30.72
You are also responsible for the difference between the billed charge ($128.00)
and the MAA amount ($102.40).....$25.60
Total amount of $128.00 charge that is your responsibility.....$56.32

The Maximum Allowable Amount for facility services, including but not limited to Hospital, Skilled Nursing Facility, and Outpatient Surgery, is determined by applying 150% of the Medicare Allowable Amount.

Maximum Allowable Amount for physician and all other types of services and supplies is the lesser of the billed charge or 100% of the Medicare Allowable Amount.

In the event there is no Medicare Allowable Amount for a billed service or supply code:

- Maximum Allowable Amount for professional and ancillary services shall be 100% of FAIR Health's Medicare gapfilling methodology. Services or supplies not priced by gapfilling methodology shall be the lesser of: (1) the average amount negotiated with HNL contracted providers within the geographic region for the same Covered Services or Supplies provided; (2) the 50th percentile of FAIR Health database of professional and ancillary services not included in FAIR Health Medicare gapfilling methodology (3) 100% of the Medicare Allowable Amount for the same Covered Services or Supplies under alternative billing codes published by Medicare; or (4) 50% of the provider's billed charges for Covered Services. A similar type of database or valuation service will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination.
- Maximum Allowable Amount for facility services shall be the lesser of: (1) the average amount negotiated with HNL contracted providers within the geographic region for the same Covered Services or Supplies provided; (2) 100% of the derived amount using a method developed by Data iSight for facility services (a data service that applies a profit margin factor to the estimated costs of the services rendered), or a similar type of database or valuation service, which will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination; (3) 150% of the Medicare Allowable Amount for the same Covered Services or Supplies under alternative billing codes published by Medicare; or (4) 50% of the provider's billed charges for Covered Services.
- ***Maximum Allowable Amount for Emergency* Care** will be the greater of: (1) the median of the amounts calculated using the same method HNL generally uses to determine payments for health care providers, excluding any Copayment or Coinsurance; or (2) the amount paid under Medicare Part A or B, excluding any Copayment or Coinsurance.
- ***Maximum Allowable Amount for covered outpatient pharmaceuticals*** (including but not limited to injectable medications) dispensed and administered to the patient in an outpatient setting, including, but not limited to, physician office, outpatient Hospital facilities, and services in the patient's home, will be the lesser of billed charges or the Average Wholesale Price for the drug or medication.
- The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses. See "Schedule of Benefits," "Medical Benefits" and "General Limitations" sections for specific benefit limitations, maximums and payment policies that limit the amount HNL pays for certain Covered Services and Supplies. HNL uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement.

In addition to the above, from time to time, HNL also contracts with vendors that have contracted fee arrangements with providers ("Third Party Networks"). In the event HNL contracts with a Third Party Network that has a contract with the health care provider, HNL may, at its option, refer a claim for

services to a fee negotiation service to negotiate the Maximum Allowable Amount for the service or supply provided directly with the health care provider. In either of these two circumstances, you will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance.

NOTE: When the Centers for Medicare and Medicaid Services (CMS) adjust the Medicare Allowable Amount, HNL will adjust, without notice, the Maximum Allowable Amount based on the CMS schedule currently in effect. Claims payment will be determined according to the schedule in effect at the time the charges are incurred. Claims payment will also never exceed the amount the health care provider charges for the service or supply. You should contact the Customer Contact Center if You wish to confirm the Covered Expenses for any treatment or procedure You are considering.

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

Medicaid (identified as "Medi-Cal" in California) is the program of medical coverage provided by the states under Title XIX of the Social Security Act, as amended by Public Law 89-97, including any amendments which may be enacted in the future.

Medically Necessary (or Medical Necessity)

For services other than Mental Health or Substance Use Disorders: Medically Necessary (or Medical Necessity) means health care services and outpatient Prescription Drug benefits that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

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

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

For Treatment of Mental Health or Substance Use Disorders: Medically Necessary (or Medical Necessity) means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of Mental Health and Substance Use Disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.

- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

For these purposes:

- "Generally accepted standards of Mental Health and Substance Use Disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of Mental Health and Substance Use Disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.
- "Health care provider" means any of the following:
    - A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
    - An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.
    - A qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 10144.51 of the Insurance Code and Section 1374.73.
    - An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.
    - An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.
    - A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.
    - A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.
    - A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

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

Medicare Allowable Amount HNL uses available guidelines of Medicare to assist in its determination as to which services and procedures are eligible for reimbursement. HNL will, to the extent applicable, apply Medicare claim processing rules to claims submitted. HNL will use these rules to evaluate the claim information and determine accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying Medicare rules may affect the Maximum Allowable Amount if it is determined the procedure and/or diagnosis codes used were inconsistent with Medicare procedure coding rules or reimbursement policies.
Medicare pays 100% of the Medicare Allowable Amount. The Medicare Allowable Amount is subject to automatic adjustment by the Centers for Medicare and Medicaid Services (CMS), an agency of the federal government which regulates Medicare.

Mental Health and Substance Use Disorders means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this definition as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

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-Pocket Maximum is the maximum dollar amount of Covered Expenses for which the Covered Person is responsible in a Calendar Year. After that maximum is reached, this plan will pay 100% of Covered Expenses incurred during the remainder of that Calendar Year, as shown in the "Schedule of Benefits" section. Expenses the Covered Person incurs which are not Covered Expenses under this *Certificate* will not count towards meeting the Out-of-Pocket Maximum.

Preventive Care Services (including services for the detection of asymptomatic diseases) are services provided under a physician's supervision and which include the following:

- Reasonable health appraisal examinations on a periodic basis
- A variety of family planning services
- Preventive prenatal and postnatal care in accordance with the guidelines of the Health Resources and Services Administration (HRSA)
- Vision and hearing testing for Covered Persons
- Immunizations for children in accordance with the recommendations of the American Academy of Pediatrics and immunizations for adults as recommended by the U.S. Public Health Service
- Venereal disease tests
- Cytology examinations on a reasonable periodic basis
- Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided through HNL.

Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or

is normally and routinely provided by the nursing staff of a Hospital or Skilled Nursing Facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of four hours in any 24-hour period. Private Duty Nursing may be provided in an inpatient or outpatient setting, or in a non-institutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care" and includes any portion of shift care services.

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

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

- A qualified autism service professional: (1) provides behavioral health treatment which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider; (2) is supervised by a Qualified Autism Service Provider; (3) provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (4) is a behavioral service provider that has training and experience in providing services for pervasive developmental disorder or autism and who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program; (5) has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code; and (6) is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.
- A qualified autism service paraprofessional is an unlicensed and uncertified individual who: (1) is supervised by a Qualified Autism Service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice; (2) provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (3) meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations; (4) has adequate education, training, and experience as certified by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers, and (5) is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

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

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

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

Specialty Drugs are specific Prescription Drugs used to treat complex or chronic conditions and usually require close monitoring. These drugs may require special handling, special manufacturing processes, and may have limited pharmacy availability. Specialty Drugs include drugs that have a significantly higher cost than traditional pharmacy benefit drugs and may be self-administered orally, topically, by inhalation, or by injection (either subcutaneously or intramuscularly). A list of Specialty Drugs can be found in the Health Net Formulary. Specialty Drugs require Prior Authorization from HNL and must be dispensed through the Specialty Pharmacy Vendor to be covered.

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

Telehealth Services means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the provider for telehealth is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers. For the purposes of this definition the following apply:

- “Asynchronous store and forward” means the transmission of a patient's medical information from an originating site to the health care provider for telehealth at a distant site without the presence of the patient.
- “Distant site” means a site where a health care provider for telehealth who provides health care services is located while providing these services via a telecommunications system.
- “Originating site” means a site where a patient is located at the time health care services are provided via telecommunications system or where the asynchronous store and forward service originates.
- “Synchronous interaction” means a real-time interaction between a patient and a health care provider for telehealth located at a distant site.

Transplant Performance Center is a provider in HNL’s designated network in California for solid organ, tissue and stem cell transplants and transplant-related services, including evaluation and follow-up care. For purposes of determining coverage for transplants and transplant-related services, HNL’s

network of Transplant Performance Centers includes any providers in HNL's designated supplemental resource network.

Urgent Care is any otherwise Covered Service for medical care or treatment with respect to which the application of the time periods for making non-Urgent Care determinations could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability of the claimant to regain maximum function; or, in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment in question.

SCHEDULE OF BENEFITS

The following is only a brief summary of the amounts and percentages of Covered Expenses. The full description of the Covered Expenses appears within the "Medical Benefits" section. All provisions, including all limitations appearing elsewhere within this *Certificate*, apply in full to the following.

Covered Services for medical conditions and Mental Health and Substance Use Disorders provided appropriately as Telehealth Services are covered on the same basis and to the same extent as Covered Services delivered in-person.

COVID-19 Screening and Testing: All Medically Necessary screening and testing (including items or services furnished in person or via Telehealth Services) for COVID-19 will be covered without cost-sharing or balance billing as long as required pursuant to a state or federal requirement. Upon expiration of the state or federal requirements, screening and testing for COVID-19 may be subject to cost-shares and/or balance billing. You will be notified by HNL prior to the expiration of this requirement.

COVID-19 Preventive Service: Any qualifying preventive service, including immunization, that is intended to prevent or mitigate COVID-19 disease, will be covered without cost-sharing or balance billing as long as required pursuant to a state or federal requirement. Upon expiration of the state or federal requirements, screening and testing for COVID-19 may be subject to cost-shares and/or balance billing. You will be notified by HNL prior to the expiration of this requirement.

For additional information, please visit www.healthnet.com **and select "COVID-19 Updates."**

Medical Out-of-Pocket Maximum

For each Covered Person $6350
For each covered family $12700
Percentage payable after Out-of-Pocket Maximum is reached (until the end of the Calendar Year) 100%

In accumulating the Out-of-Pocket Maximum, the following expenses will not be counted:

(a) Any expense not specifically listed as a Covered Expense within this *Certificate*;

Once the Out-of-Pocket Maximum is reached, the expenses listed in (a) shall not become payable at 100%.

Percentage amounts below represent HNL's payment level. Benefits are payable based on the Maximum Allowable Amount. The Covered Person is responsible for charges in excess of the Maximum Allowable Amount.

All benefits are coordinated with Medicare to cover your expenses up to the Medicare Allowable amount, including the Medicare Parts A and B Deductibles.

Authorized Hospital and Skilled Nursing Facility Services [1,4,5]

Unlimited days of care in a Hospital's semiprivate room with ancillary services including maternity care
Days 1-60 ..... Medicare Part A Deductible
Days 61-90 ..... 100%

Beyond 90 days (to lifetime reserve days)..... 100%
Beyond lifetime reserve days (to a maximum of 365 days) ..... 90% of Maximum Allowable Amount
Confinement in a Skilled Nursing Facility
Days 1-20.....Not Covered
Days 21-100..... 100%
Days 101-365..... 80% of Maximum Allowable Amount
Outpatient surgery 100%
Outpatient services 100%

Note(s):

- 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 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 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 above Coinsurance for inpatient Hospital or Special Care Unit services is applicable for each admission for the hospitalization of an adult, pediatric or newborn patient. For an inpatient stay for the delivery of a newborn, the newborn will not be subject to a separate Deductible and Coinsurance for inpatient Hospital services unless the newborn patient requires admission to a Special Care Unit or requires a length of stay greater than 48 hours for vaginal delivery or 96 hours for caesarean section.

Emergency Services (for Medical Care other than Mental Health and Substance Use Disorders)[1,4,5]

Within the United States:

Emergency room care (professional and facility charges)..... 100%
Urgent Care center (professional and facility charges)..... 100%
Ambulance (ground or air)..... 100%
Outside the United States:

Hospital care (inpatient or outpatient) 100%
Professional medical care 80%

Note(s):

- HNL uses a prudent layperson standard to determine whether the criteria for Emergency Care have been met. HNL applies the prudent layperson standard to evaluate the necessity of medical services which a Covered Person accesses in connection with a condition that the Covered Person perceives to be an emergency situation. Please refer to "Emergency Care" in the "Definitions" section to see how the prudent layperson standard applies to the definition of "Emergency Care."
- The emergency room Coinsurance will not apply if the Covered Person is admitted to a Hospital directly from an emergency room or Urgent Care center. See "Authorized Hospital and Skilled Nursing Facility Services" above for applicable Coinsurance.

Emergency Services (for Mental Health and Substance Use Disorders)[1,4,5]

Within the United States:

Emergency room care (professional and facility charges)..... 100%
Urgent Care center (professional and facility charges)..... 100%
Ambulance (ground or air)..... 100%

Outside the United States:

Hospital care (inpatient or outpatient) 100%
Professional medical care 80%

Note(s):

- HNL uses a prudent layperson standard to determine whether the criteria for Emergency Care have been met. HNL applies the prudent layperson standard to evaluate the necessity of medical services which a Covered Person accesses in connection with a condition that the Covered Person perceives to be an emergency situation. Please refer to “Emergency Care” in the "Definitions" section to see how the prudent layperson standard applies to the definition of "Emergency Care."
- The emergency room Coinsurance will not apply if the Covered Person is admitted to a Hospital directly from an emergency room or Urgent Care center. See “Authorized Hospital and Skilled Nursing Facility Services” above for applicable Coinsurance.

Mental Health and Substance Use Disorders [1,4,5]

Mental Health[1,4,5]

Outpatient office visits (psychological evaluation or therapeutic session in an office or other outpatient setting, including individual and group therapy sessions, gender dysphoria, medication management and drug therapy monitoring) 100%

Outpatient services other than office visits (psychological and neuropsychological testing, gender dysphoria, intensive outpatient care program, day treatment, partial hospitalization and other outpatient procedures including behavioral health treatment for pervasive developmental disorder or autism)..... 100%

Physician visit to Hospital, Behavioral Health Facility or Residential Treatment Center 100%
Inpatient facility[1]
Days 1-60 .....Medicare Part A Deductible
Days 61-90 ..... 100%
Beyond 90 days (to lifetime reserve days)..... 100%
Beyond lifetime reserve days (to a maximum of 365 days) ..... 90% of Maximum Allowable Amount

Substance Use Disorders

Outpatient office visits (psychological evaluation or therapeutic session in an office or other outpatient setting, including individual and group therapy sessions, medication management and drug therapy monitoring) 100%
Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care and program, day treatment, partial hospitalization, medical treatment for withdrawal symptoms, outpatient detoxification and other outpatient services)*..... 100%
Inpatient facility[1]
Days 1-60 .....Medicare Part A Deductible
Days 61-90 ..... 100%
Beyond 90 days (to lifetime reserve days)..... 100%
Beyond lifetime reserve days (to a maximum of 365 days) ..... 90% of Maximum Allowable Amount
Inpatient detoxification (acute care for Substance Use Disorder) 100%

Note(s):

If two or more Covered Persons in the same family attend the same treatment session, only one Coinsurance will be applied.

Care For Conditions Of Pregnancy[1,4,5]

Prenatal care..... 100%
Normal delivery, cesarean section and postnatal care 100%
Complications of pregnancy ..... See note below
Genetic testing of fetus 100%
Circumcision of newborn*..... 100%
California Prenatal Screening Program administered by the California State Department of Public Health 100%

Note(s):

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

Prenatal, postnatal and newborn care that are Preventive Care Services are covered in full. See "Preventive Care Services" below. If other non-Preventive Care Services are received during the same office visit, the above Copayment or Coinsurance will apply for the Non-Preventive Care

Services. Refer to “Care for Conditions of Pregnancy” in the “Medical Benefits” section and the "Preventive Care List of Services" section for more details.

* 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.

Ambulance (for Medical Care other than Mental Health and Substance Use Disorders)

Ambulance (ground or air) 100%

Ambulance (for Mental Health and Substance Use Disorders)

Ambulance (ground or air) 100%

Other Professional Services[1,4,5]

Visit to a physician's office 100%
Physician’s visit to a Covered Person’s home 100%
Allergy testing 100%
Allergy serum ..... Not Covered
Allergy injection services (serum not included) 100%
Injections (except for Infertility) 100%
Routine vision and hearing examinations (for diagnosis or treatment, including refractive eye examinations) 100%
Annual physical examinations ..... Not Covered
Surgery in Hospital[2] 100%
Chemotherapy or radiation therapy 100%
Administration of anesthetics 100%
Diagnostic imaging (including x-ray) and laboratory procedures 100%
Durable Medical Equipment 100%
Orthotics (such as bracing, supports and casts) 100%
Diabetic equipment (includes blood glucose monitors and insulin pumps) 100%
Diabetic footwear 100%
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy: inpatient treatment and outpatient treatment[3] 100%
Physician visits to Hospital or Skilled Nursing Facility 100%
Home Health Care Services (limited to part-time or intermittent skilled nursing care (to a maximum of 8 hours per day and 21 days), physical therapy or speech therapy) 100%
Respite care services (Hospice Only) (maximum of 5 consecutive days per stay) 100%
Blood or blood products (except for drugs used to treat hemophilia, including blood factors) 100%
Nuclear Medicine 100%
Organ, stem cell or tissue transplants (not Experimental or Investigational) 100%

Prostheses (replacing body parts) 100%
Hearing aids ..... Not Covered
Renal dialysis 100%
Hospice Care 100%
Immunosuppressive drugs[6] 80%
Epoetin (EPO) 100%
Osteoporosis drugs 100%
Oral cancer drugs 100%
Female Sterilization 100%
Male Sterilization 100%
Medical social services 100%
Patient education 100%
Chiropractic care 100%
Acupuncture services ..... Not Covered

Note(s):

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

Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under "Preventive Care Services" in this section. For additional information, please refer to the "Preventive Care List of Services" section.

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

Immunizations that are considered Preventive Care Services are covered under "Preventive Care Services" in this section.

Preventive Care Services

Preventive Care Services 100%

Note(s):

Preventive Care Services are covered at no cost to you and are not subject to any Deductible.

Covered Services and Supplies include, but are not limited to, annual preventive physical examinations, immunizations, well-woman examinations, and preventive services for pregnancy, other women's preventive services as supported by the Health Resources and Services Administration (HRSA), breast feeding support, weight management intervention services, tobacco cessation intervention services and supplies and preventive vision and hearing screening examinations. Refer to the "Preventive Care List of Services" section for details.

If you receive any other Covered Services and Supplies in addition to Preventive Care Services during the same visit, You will also pay the applicable Copayment or Coinsurance for those services.

Infertility Services

Infertility services ..... Not Covered

Footnotes:

[1] The percentages that appear in this chart are based on the Maximum Allowable Amount. The Covered Person is responsible for charges in excess of the Maximum Allowable Amount in addition to the Coinsurance shown.

[2] Surgery includes surgical reconstruction of a breast, incident to a mastectomy, including surgery to restore symmetry; it also includes prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema.

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

[4] Reimbursement for professional services will be based on the Maximum Allowable Amount.

[5] Reimbursement for Medicare –approved inpatient services will be calculated according to the Maximum Allowable Amount and payment limited to Medicare allowable amount per day as follows:

- For Days 1-90 Health Net Life is responsible for the Medicare allowable amount not paid by Medicare.
- For Days 91-150, Health Net Life is responsible for 100% of the Medicare allowable amount.
- For Days 151 and beyond, Health Net Life is responsible for 90% of Maximum Allowable Amount, up to a lifetime maximum of 365 days (lifetime reserve days must be exhausted before benefits are payable).

[6] Immunosuppressive drugs are covered at 80% of Medicare approved charges following a covered transplant in accordance with Medicare guidelines. Immunosuppressive drugs are only covered through the medical benefit and are not available through the “Prescription Drug Benefits” shown below.

Prescription Drug Benefits

Deductibles, per Calendar Year

Outpatient Prescription Drugs, per Covered Person $75

Percentage amounts below represent HNL's payment level

Outpatient Prescription Drugs 80%
Preventive drugs and women’s contraceptives $0

Retail pharmacy (up to a 30-day supply)

Generic Drugs 80%
Brand Name Drugs and diabetic supplies 80%
Outpatient Prescription Drugs 80%
Preventive drugs and women’s contraceptives $0

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

Outpatient Prescription Drugs..... 80%

Notes and Exceptions:

- Orally administered anti-cancer drugs will have a Copayment and Coinsurance maximum of $200 for an individual prescription of up to a 30-day supply.
- Prescription Drugs will have a Copayment and Coinsurance maximum of $250 for an individual prescription of up to a 30-day supply.
- If the pharmacy's retail price is less than the applicable Copayment or Coinsurance, the Covered Person will pay the pharmacy's retail price. What the Covered Person pays will accrue to the Deductible and Out-of-Pocket Maximum.
- If there is a generic equivalent available and the Covered Person requests a Brand Name Drug, the Covered Person will be required to pay the difference in cost between the Generic Drug and Brand Name Drug in addition to the Copayment shown above.
- Preventive drugs and all women's contraceptives that are approved by the Food and Drug Administration are covered as shown above. Please see the "Preventive Drugs and Women' Contraceptives" provision in the "Outpatient Prescription Drug Benefit" portion of the "Medical Benefits" section for additional details.
- If a Brand Name Drug is dispensed, and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the Generic and Brand Name Drug. However, if a Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from HNL, then the Brand Name Drug will be dispensed at no charge.
- Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order.
- Insulin and diabetic supplies listed on the Formulary are subject to the Tier 2 Drug Copayment. Insulin and diabetic supplies not listed on the Formulary require the Tier 3 Drug Coinsurance.
- Except for insulin, diabetic supplies (blood glucose testing strips, lancets, specific brands of needles & syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (i.e., opened in order to dispense the product in quantities other than those packaged).
- Schedule II narcotic Drugs are not covered through mail order. Schedule II Drugs are Drugs classified by the Federal Drug Enforcement Administration as having a high abuse risk but also safe and accepted medical uses in the United States. A partial prescription fill, which is of a quantity less than the entire prescription, can be requested by you or your Physician. Partial prescription fills are subject to a prorated Copayment or Coinsurance based on the amount of the prescription that is filled by the pharmacy.
- When a prescription is dispensed, the Covered Person will receive the size of package and/or number of packages required for the Covered Person to test the number of times his or her physician has prescribed for a 30-day period. The Copayment or Coinsurance will be applicable for each prescription dispensed for insulin and diabetic supplies.

- “Split-fill” Program: For certain high cost orally-administered Drugs, including anti-cancer Drugs, HNL provides a free 14-day trial. Drugs under the Split-fill program are indicated in the Formulary with “SF” in the comment section. Health Net will approve the initial fill for a 14-day supply at no cost to You. If, after the initial fill, You are free of adverse effects and wish to continue on the Drug, the subsequent fills will be dispensed for the full quantity as written by your Physician. You will be charged the applicable Copayment or Coinsurance for each subsequent fill up to the Copayment and Coinsurance maximum for orally-administered anti-cancer Drugs described above
- For a complete description of Prescription Drug benefits and exclusions and limitations, please refer to the "Outpatient Prescription Drug Benefit" portion of the "Medical Benefits" section.

TERM OF CERTIFICATE

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

Covered Persons who are totally disabled on the date coverage under this *Certificate* ends may be eligible for continuation of coverage. See the "Extension of Benefits" section.

ELIGIBILITY, ENROLLMENT AND TERMINATION

Who is Eligible for Coverage

The Covered Services and Supplies of this plan are available to the following individual retirees as long as they live in the United States and meet any additional eligibility requirements of the Group, as mutually agreed upon with HNL. Please contact your Group administrator to discuss additional eligibility requirements.

- The principal **Covered Person** who
  1. Is entitled to Medicare due to either being 65 years of age or older or being totally disabled;
  2. Is presently, and will continue to be covered under both Parts A and B of Medicare; and
  3. Is not enrolled in a Medicare Risk Program through any Health Care Service Plan.
- **Spouse**, who must be listed on the enrollment form completed by the principal Covered Person and meets the same qualifications as the principal Covered Person.
- **Domestic Partner:** The registered Domestic Partner, as defined by California law, who must be listed on the enrollment form completed by the principal Covered Person and meets the same qualifications as the principal Covered Person.

Who is Ineligible for Coverage

A spouse or Domestic Partner under age 65 at the time application for coverage is made is not eligible under this plan. The spouse or Domestic Partner may apply for coverage under the Flex Net Conversion Plan.

WHEN THE COVERED PERSON BECOMES INELIGIBLE

The Covered Person and his or her spouse or Domestic Partner will become ineligible for coverage under this *Certificate* under the following conditions:

THE PRINCIPAL COVERED PERSON (RETIRED EMPLOYEE)

- Upon termination of the Group Policy between the employer and HNL, including termination for nonpayment of premiums by the Group, fraud or intentional misrepresentation of material fact, violation of participation or contribution rules, HNL's withdrawal of this type of health insurance policy from the market, or HNL ceases to issue group health insurance policies in California, as described in the Group Policy;
- When the eligibility requirements established by the employer and HNL are not met; or
- On the date the principal Covered Person no longer has coverage under both Medicare Part A and Part B.

A SPOUSE OR DOMESTIC PARTNER

- On the date the principal Covered Person becomes ineligible, as stated above;
- On the first of the month following entry of a final decree of divorce, annulment or dissolution of marriage or domestic partnership from the principal Covered Person;

- Upon the death of the principal Covered Person.

The Policy specifies the date and time such termination is effective.

Group Open Enrollment Period

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

Late Enrollment Rule

HNL's late enrollment rule requires that if an individual does not enroll within 30 days of becoming eligible for coverage, he or she must wait until the next Group Open Enrollment Period to enroll.

The term "form" within this section may include electronic enrollment forms or enrollment over the phone. Electronic or phone enrollments are deemed signed when the principal Covered Person uses his or her employer's enrollment system to make or confirm changes to the principal Covered Person's benefit enrollment.

A Late Enrollee may be excluded from coverage for 12 months or until the next Open Enrollment Period.

The employee may have decided not to enroll upon first becoming eligible. At that time, the Group should have given the employee a form to review and sign. It would have contained information that there are circumstances when an employee is not considered a late enrollee.

If the employee later changes his/her mind and decides to enroll, HNL can impose its late enrollment rule. This means that individuals identified on the form the employee signed will not be allowed to enroll before the next Open Enrollment Period. There are, however, exceptions to this rule.

Exceptions to Late Enrollment Rule

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

1. **The employee did not receive a form to sign, or a signed form cannot be produced**
   If the employee chose not to enroll when first eligible, the late enrollment rule will not apply if:
   - The employee never received from the Group, or signed a form explaining the consequences of his or her decision; or
   - The signed form exists but cannot be produced as evidence of the retiree's informed decision.
2. **The employee or his or her Dependents did not enroll because of other coverage, and later the other coverage is lost**
   If the employee or his or her Dependents declined coverage in this Plan, and stated on the form the reason the employee or his or her Dependents was not enrolling was because of coverage through another group health plan, and the other coverage is or will be lost, the late enrollment exclusion will not apply. The reasons for loss of coverage include, but are not limited to:
   - Loss of coverage because of termination of employment or reduction in the number of hours of employment;

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

3. **The Employee or his or her Dependents Loses Eligibility from a Medi-Cal Plan**
   If the principal Covered Person or his or her Dependents becomes ineligible and loses coverage under Medi-Cal, the principal Covered Person and his or her Dependents will be eligible to enroll in this plan upon submitting a completed application form within 60 days of losing such coverage. If the principal Covered Person and his or her Dependents wait longer than 60 days to enroll, the principal Covered Person and his or her Dependents may not enroll until the next Open Enrollment period.
4. **Multiple Health Plans**
   If an eligible person is enrolled as a dependent in a health plan (not HNL), and the principal enrollee of that other plan, during open enrollment, chooses a different plan (such as moving from an HMO plan to a fee-for-service plan), and the eligible person does not wish to continue to be covered by the original plan in which he or she had been a dependent, the eligible person will not be considered a late enrollee, should that person decide to enroll in this plan.
5. **Court Orders**
   If a court orders the principal Covered Person to provide coverage for a current spouse or Domestic Partner or minor child, or orders an enrolled spouse or Domestic Partner to provide coverage to a minor child, through HNL, that spouse or Domestic Partner or child will not be treated as a late enrollee.

If the exceptions in 2 or 4 apply, the Employee must enroll within 30 days of the loss of coverage. If the Employee waits longer than 30 days to enroll, the Employee will be a late enrollee and may not

enroll until the next Group Open Enrollment Period. A court ordered dependent may be added without any regard to Open Enrollment restrictions.

Special Enrollment Rule

If an employee gains a new dependent due to marriage or domestic partnership the following rule applies:

- **If the Employee or Retiree Is Enrolled in this Plan**

  If the Covered Person is covered by this plan as a Principal Covered Person, the Covered Person can enroll his or her spouse or Domestic Partner, over age 65, if the Covered Person requests enrollment within 31 days after marriage or domestic partnership. In addition, a court ordered dependent may be added without any regard to open enrollment restrictions.

  The Effective Date of coverage will be on the first of the month following the date the application for coverage is received.

If any of the above exceptions apply, the retiree must enroll within 30 days of either the loss of coverage or the date of the court order. If the retiree waits longer than 30 days to enroll, the retiree will be a late enrollee.

Notice of Ineligibility

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

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.

- **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 18 months. Please check with the Group to determine if the Covered Person is eligible.
- **Extension of Benefits Due to Total Disability:** Described in the "Extension of Benefits" section.
- **Continuation of Coverage During a Labor Dispute:** If the principal Covered Person ceases to work because of a labor dispute and his or her employer is paying all or a portion of the premium for the Covered Person’s coverage pursuant to the terms of a collective bargaining agreement, the Covered Person may continue his or her coverage subject to the following terms and conditions:
  1. Continuation of coverage requires:
     a. The Covered Person’s payment to the union which represents him or her of the monthly premium required for this coverage;

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

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

2. If any premium due is unpaid on the date work ceases, there will be no continuation unless such premium is paid by the Employer or the union prior to the next premium due date.

3. The amount of the Covered Person's 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.

4. 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. HNL still has the right to increase the premium rates before, during and after the date work ceases, if HNL would have had the right to increase rates under the Policy, had work not ceased.

5. The continued coverage under this provision will cease on the earliest of:
   a. The end of the period of time for which the union has made payment for the Covered Person's coverage, if the next premium due is not made;

   b. 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;

   c. The premium due date on or following the date that the Covered Person start full-time work with another Employer;

   d. The premium due date on or after the date the Covered Person ceased to be at work because of the labor dispute for 6 months; or

   e. The premium due date on or after the labor dispute is resolved.

6. If the Covered Person has Dependents insured on the date he or she ceases work, he or she must also continue their coverage in order to continue coverage for the Covered Person.

Special Reinstatement Rule for Reservists Returning from Active Duty

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

Special Reinstatement Rule under USERRA

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

GENERAL LIMITATIONS

HNL does not cover the services or supplies listed below. Also services or supplies that are excluded from coverage in this *Certificate*, exceed *Certificate* limitations, are follow-up care (or related to follow-up care) to Certificate limitations, or are related in any way to *Certificate* limitations will not be covered.

Not Medically Necessary

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

Excess Charges

Amounts charged for covered medical services and treatment that are in excess of the Maximum Allowable Amount, as defined in the "Definitions" section.

Ambulance Services

Paramedic and air or ground Ambulance services that are not Emergency Care will not be covered unless services are Medically Necessary. Non-emergency paramedic and air or ground Ambulance services which do not result in a patient's transportation will not be covered.

Cosmetic Services and Supplies

Cosmetic surgery or services and supplies performed to alter or reshape normal structures of the body solely to improve the physical appearance of a Covered Person are not covered. However, the *Certificate* does cover Medically Necessary services and supplies for complications which exceed routine follow-up care that is directly related to cosmetic surgery (such as life-threatening complications).

In addition, hair analysis, hairpieces and wigs, hair/cranial prostheses, chemical face peels, abrasive procedures of the skin or epilation are not covered.

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

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

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

In 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.

*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 "Medical Benefits" section and in the following situations:

- General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the Covered Person requires that an ordinarily non-covered dental service which would normally be treated in a dentist's office and without general anesthesia must instead be treated in a Hospital or Outpatient Surgical Center. The general anesthesia and associated facility services must be Medically Necessary are subject to the other exclusions and limitations of this *Certificate* and will only be covered under the following circumstances (a) Covered Persons who are under eight 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 for dental injury under the "Medical Benefits" section.
- 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.

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 HNL.

Optometrics, Vision Therapy and Orthoptics

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

Reconstruction of Prior Surgical Sterilization Procedures

Services to reverse voluntary surgically induced Infertility.

Fertility Preservation

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

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

Prenatal Genetic Testing and Diagnostic Procedures

Prenatal genetic testing is covered for specific genetic disorders for which genetic counseling is available when Medically Necessary. 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, please refer to the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "Coverage Decisions and Disputes Resolution" section for more information; or
- Clinical trials for patients with cancer or life-threatening diseases or conditions are deemed appropriate according to the "Covered Expenses" portion of the "Medical Benefits" section.

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

Clinical Trials

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

- The Investigational drug, item, device or service itself;
- Services other than health care services, including but not limited to cost of travel, or costs of other nonclinical 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.

Non-preventive Physical Examinations

Physical examinations (including psychological examinations or drug screening) that are not medically indicated or physician directed and are obtained for the purposes of checking the Covered Person’s 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 the “Preventive Care List of Services” section of this *Certificate*.

Immunizations or Inoculations

For foreign travel or occupational purposes.

Injectable Drugs

Self-administered injectable drugs as described in the Formulary are covered. All other injectable drugs are not covered under the Prescription Drug benefit. Surgically implanted drugs are covered under the medical benefit (see the "Surgically Implanted Drugs" provision in the "Medical Benefits" section).

Custodial or Domiciliary Care

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

Noneligible Hospital Confinements

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

Noneligible Institutions

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

Nonlicensed Provider

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

Sober Living Facilities

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

Private Rooms

For registered bed patients in a Hospital or long-term care facility, unless determined to be Medically Necessary.

Private Duty Nursing

Inpatient and outpatient services (including incremental nursing) provided by a private duty nurse, except as Medically Necessary and not in excess of the visit maximum for Home Health Care Services. Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home healthcare visit or is normally and routinely provided by the nursing staff of a Hospital or Skilled nursing Facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of six hours in any 24-hour period. Private Duty Nursing may be provided in an Inpatient or Outpatient setting, or in a non-institutional setting, such as home or at school. Private Duty Nursing may also be referred to as "shift care" and includes any portion of shift care services. Private Duty Nursing provided as Home Health Care Services may not exceed a maximum of 3 visits per day, up to 2 hours per visit.

Noncovered Items

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

- Alteration of the Covered Person's residence to accommodate his or her physical or medical condition, including the installation of elevators;
- Disposable supplies for home use. However, diabetes supplies, disposable devices that are Medically Necessary for the administration of a covered outpatient Prescription Drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs, and syringes for self-injectable outpatient Prescription Drugs that are not dispensed in pre-filled syringes are covered.
- Exercise equipment, including treadmills and charges for activities or facilities normally intended or used for physical fitness;
- Hygienic equipment or supplies;
- Orthodontic appliances, to treat dental conditions related to the treatment of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders);
- Support appliances such as stockings, over the counter support devices or Orthotics, and devices or Orthotics for improving athletic performance or sports-related activities;
- Orthotics and Corrective Footwear except as described in the "Durable Medical Equipment" and "Diabetic Equipment" provisions of the "Medical Benefits" section;
- Other Orthotics, including Corrective Footwear, not mentioned above, that are not Medically Necessary and custom made for the Covered Person. Corrective Footwear must also be permanently attached to an Orthotic device meeting coverage requirements under this *Certificate*;
- Durable Medical Equipment not prescribed by a physician;
- Personal or comfort items;
- Hearing aids; except for implanted hearing aids;

- Food supplements; or
- Educational services or nutritional counseling, except as specifically provided in the "Diabetic Equipment", “Phenylketonuria (PKU)” and “Mental Health or Substance Use Disorder Benefits” provisions of the "Medical Benefits" section of this *Certificate*.

Treatment of Obesity

Treatment or surgery for obesity, weight reduction or weight control is limited to the treatment of morbid obesity or as a Preventive Care Service.

Transplants

Experimental or Investigational organ, stem cell and tissue transplants are only covered when independent review deems them appropriate as described in the “Independent Medical Review of Investigational or Experimental Therapies” portion of the “Specific Provisions” section of this *Certificate*.

Duplicate Coverage

If the Covered Person is covered by more than one plan, benefits will be determined by applying provisions of the "Coordination of Benefits" section.

Medicare

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

Workers' Compensation

If the Covered Person requires 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 the Covered Person is entitled and then obtain reimbursement from the Workers' Compensation carrier liable for the cost of medical treatment related to the 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" section.

Services for Which the Covered Person is Not Legally Obligated to Pay

Services for which no charge is made to the Covered Person in the absence of insurance coverage, except services received at a charitable research Hospital which is not operated by a governmental agency.

Physician Self-Treatment

This plan does not cover physician 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 tests 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 the Covered Person's home or who is related to the Covered Person by blood, marriage or domestic partnership. Covered Persons who receive routine or ongoing care from a member of their immediate family may need to change to another physician.

Governmental Agencies

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

Totally Disabled on the Covered Person's Effective Date

Generally, under the federal Health Insurance Portability and Accountability Act, HNL cannot deny a Covered Person’s benefits due to the fact that he or she is totally disabled on his or her Effective Date. However, if on the Effective Date, a Covered Person is totally disabled and pursuant to state law he or she is entitled to an extension of benefits from the insurance carrier providing coverage to his or her prior group health plan, benefits of this *Certificate* will be coordinated with benefits payable by the insurance carrier providing coverage to a Covered Person 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 a Covered Person is entitled to an extension of benefits from the insurance carrier providing coverage to his or her prior group health plan, and state law permits such arrangements, the insurance carrier providing coverage to a Covered Person 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.

Home Alterations

Any expenses related to the alteration of the Covered Persons residence, whether authorized by a physician or not, to accommodate the Covered Person’s particular medical or physical condition.

Routine Foot Care

This Plan does not cover services for treatment of corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes or if the routine foot care is Medically Necessary.

Surrogate Pregnancy

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

to recover its medical expense. A surrogate pregnancy is one in which a woman has agreed to become pregnant with the intention of surrendering custody of the child to another person. The benefits that are payable under this provision are subject to HNL's right to recovery as described in "Surrogacy Arrangements" in the "Specific Provisions" section of this *Certificate*.

Outpatient Prescription Drugs

Any outpatient drugs, medications or other substances dispensed or administered in any outpatient setting, except as specifically stated in the "Medical Benefits" section. Except for over-the counter preventive drugs and women's contraceptives, nonprescription (over-the-counter) drugs that can be purchased without a prescription (including a drug requiring a prescription but for which there is a non-prescription equivalent), even if a physician writes a Prescription Drug Order for a non-prescription drug are not covered.

Visits to the Covered Person's Home

Physician's visits to the Covered Person's home are 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 and occupational 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; or
- 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 and continuous functional improvement in response to the treatment plan is demonstrated by objective evidence.

Rehabilitation therapy for physical impairments in Covered Persons with Mental Health and Substance Use Disorders, 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

The Covered Person receives services or obtains supplies in a foreign country, (a) in the case of foreign travel, more than six months beyond the departure date from the USA in relation to a particular trip, and (b) when the principal Covered Person is on temporary work assignment outside the USA and is not being paid in US dollars by the employer, and the services or supplies would have been covered had they been obtained in the USA. Determination of Covered Expenses will be based on the Maximum

Allowable Amount in the USA for the same or a comparable service. Please refer to "Maximum Allowable Amount" in the "Definitions" section.

Crime

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

Nuclear Energy

Conditions caused by release of nuclear energy, when government coverage is in effect.

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.

Infertility Services

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

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

For Medically Necessary fertility preservation services in connection with iatrogenic Infertility, refer to the "Fertility Preservation" section of the "Medical Benefits" section for more details.

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 Medically Necessary services related to behavioral health covered as shown in the "Medical Benefits" section, all other services related to educational and professional purposes are not covered. Examples of excluded services include education and training for non-medical purposes such as:

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

- Academic education during residential treatment.
- Behavioral training

However, services related to behavioral health treatment for a pervasive development disorder or autism are covered as shown in the "Medical Benefits" section.

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 Mental Health and Substance Use Disorders, and as otherwise preauthorized by HNL), hypnotherapy, crystal healing therapy yoga, hiking, rock climbing and any other type of sports activity 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 Health condition for purposes of developing a mental health treatment plan or when Medically Necessary to treat a Mental Health or Substance Use Disorder.

State Hospital Treatment

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

MEDICAL BENEFITS

The benefits described below will be provided for Covered Expenses incurred for treatment of a covered illness, injury or condition. An expense is incurred on the date the Covered Person receives the service or supply for which the charge is made. These benefits are subject to all provisions of this *Certificate*, which may limit benefits or result in benefits not being payable, and to any specific limitations set forth in this section. The fact that a physician or other provider may prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary, or make it a Covered Service.

All benefits are coordinated with Medicare to cover your expenses up to the Medicare Allowable amount, including the Medicare Parts A and B Deductibles.

Telephone Triage and Screening

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

Deductibles

Medicare Part A Inpatient Hospital Deductible

The Medicare Part A inpatient Hospital Deductible is the amount not paid by Medicare during the first 60 days of inpatient Hospital care during a benefit period. A benefit period is a period of time determined by Medicare which begins on the day the Covered Person enters a Hospital as an inpatient and ends after he or she has been out of a Hospital or Skilled Nursing Facility for 60 consecutive days. HNL covers the Medicare Part A Deductible.

Medicare Part B Medical Insurance Deductible

The Medicare Part B Medical Deductible is the amount due annually to Medicare in relation to Covered Services and Supplies before any service or supply becomes a Covered Expense. HNL covers the Medicare Part B Deductible.

Basis of Payment

Payment by HNL will be provided as set forth in the "Schedule of Benefits" for Covered Expenses set forth below, which are incurred by that Covered Person. Payment by HNL shall not exceed the Medicare Allowable amount, the Maximum Allowable Amount, where specified, or any visit or daily amount limitations set forth in the "Schedule of Benefits" section. Other limitations on Covered Expenses may apply. See "Schedule of Benefits," "Medical Benefits" and "General Limitations" sections for specific benefit limitations, maximums and payment policies that limit the amount HNL pays for certain Covered Services and Supplies.

When the Covered Person's total medical Coinsurance amounts for Covered Expenses exceed in any Calendar Year the amount set forth in the "Schedule of Benefits" as the Out-of-Pocket Maximum, HNL will pay the remainder of Covered Expenses incurred by that Covered Person in the same Calendar Year at 100 percent (100%) of the Maximum Allowable Amount. However, this will not apply to certain expenses as shown in the "Schedule of Benefits" Section.

In addition, if the Covered Persons of an enrolled family together incur an amount equal to the family Out-of-Pocket Maximum shown in the "Schedule of Benefits" during any Calendar Year, no further Coinsurance will be required for any Dependents during the remainder of that Calendar Year, other than as specified in the "Schedule of Benefits" Section.

Covered Expenses

Hospital

Inpatient Services

- Accommodations as an inpatient in a room of two or more beds, at the Hospital's most common semi-private room rate. Accommodations in a private room are not considered a Covered Expense unless determined to be Medically Necessary by HNL.
- 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, speech therapy, occupational therapy, pulmonary rehabilitation therapy and cardiac rehabilitation 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 the Covered Person's stay (but not take home drugs).
- Blood transfusions, including blood processing, the cost of blood and unreplaced blood and blood products. The collection and storage of the Covered Person's own blood for autologous blood transfusions are covered only for a scheduled surgery. 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 "Coverage Decisions and Disputes Resolution" section for additional information.)

  Autologous or designated donor blood transfusions will be paid at the community donor rate determined by the specific licensed blood bank providing the service.

Outpatient

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 (but not take-home drugs).
- Use of the facilities of an Outpatient Surgical Center including operating and recovery rooms, supplies, ancillary services, laboratory and x-ray services, drugs and medicines administered by the Outpatient Surgical Center (but not take-home drugs).

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

Skilled Nursing Facility

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

- 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, pulmonary rehabilitation therapy and cardiac rehabilitation therapy;
- Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Skilled Nursing Facility for use during the Covered Person's stay; and
- Blood transfusions, including blood processing, the cost of blood and unreplaced blood and blood products. The collection and storage of the Covered Person's own blood for autologous blood transfusions are covered only for a scheduled surgery. 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 "Coverage Decisions and Disputes Resolution" section for additional information.)

  Autologous or designated donor blood transfusions will be paid at the community donor rate determined by the specific licensed blood bank providing the service.

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

Custodial Care is not covered.

Professional Services

- Necessary services of a physician, including office visits and consultations, Hospital and Skilled Nursing Facility visits.
- 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 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 available Medicare guidelines to determine the circumstances under which claims for assistant surgeon services and co-surgeon and team surgeon services will be eligible for reimbursement, in accordance with HNL's normal claims filing requirements.
- When adjudicating claims for Covered Services for the postoperative global period for surgical procedures, HNL applies Medicare's global surgery periods to the American Medical Association defined Surgical Package. The Surgical Package includes typical postoperative care. These criteria include consideration of the time period for recovery following surgery and the need for any subsequent services or procedures which are part of routine postoperative care.

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

Additional Services and Supplies

- **All prescribed diagnostic imaging (including x-ray) and laboratory procedures**, services and materials, including cancer screening tests.
- **Home Health Care Services** 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 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:

  1. The skilled nursing care is appropriate for the medical treatment of a condition, illness, disease or injury;
  2. The Covered Person is home bound 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);

3. The Home Health Care Services are part-time and intermittent in nature; a visit lasts up to 8 hours in duration in every 24 hours; and
4. The services are in place of a continued hospitalization, confinement in a Skilled Nursing Facility, or outpatient services provided outside of the Covered Person's home.

Additionally, Home Infusion Therapy is also covered. A provider of infusion therapy must be a licensed pharmacy. Home nursing services are also provided to ensure proper patient education, training, and monitoring of the administration of prescribed home treatments. Home treatments may be provided directly by infusion pharmacy nursing staff or by a qualified home health agency. The patient does not need to be homebound to be eligible to receive Home Infusion Therapy. See the "Definitions" section. Note: Diabetic Supplies are covered under medical supplies include blood glucose monitors and insulin pumps.

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 at 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.

- **Air and Ground Ambulance and Ambulance Transport Services** provided 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 will be covered only if the services are Medically Necessary.

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

- **Hospice Care** is care that is reasonable and necessary to control or manage terminal illness or related conditions. Hospice Care benefits are designed to be provided primarily in the Covered Person's home. A terminal illness is when a Covered Person has been given a medical prognosis of one year or less to live.

  Covered Persons to receive Hospice Care benefits are entitled to the following:

  a. All Medically Necessary services and supplies furnished by the Hospice. This includes doctors' and nurses' services, homemaker services and drugs.
  b. Up to five consecutive days of respite care. Respite care is furnished to a person in an inpatient setting in order to provide relief for Dependents or others caring for that person.
  c. All of these services and supplies will be provided or arranged by the Hospice.

- **Radiation Therapy, Nuclear Medicine, Chemotherapy and Renal Dialysis Treatment** are covered when determined to be Medically Necessary.

- **Prostheses** - Corrective appliances, such as internally implanted devices, and prosthetic devices are covered as follows:

a. Internally implanted devices, such as pacemakers 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;

b. External prostheses and the fitting and adjustment of these devices. Repair or replacement is covered unless necessitated by misuse or loss. HNL may, at its option, pay for replacement rather than the repair of an item.

c. 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:

1. Affixed to the body externally, and

2. Required to replace all or any part of any body organ or extremity, or

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.

DENTAL APPLIANCES AND CORRECTIVE SHOE INSERTS ARE NOT A COVERED EXPENSE.

Prostheses will also be covered and are replaceable when no longer functional.

- **Reconstructive Surgery** – HNL will provide coverage for Medically Necessary breast reconstruction surgery if HNL determines that:

a. The breast reconstruction surgery is performed subsequent to a Medically Necessary mastectomy (including lumpectomy), and

b. The surgery is performed on either breast to achieve or restore symmetry (balanced proportions) in the breasts.

Reconstructive surgery also includes 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. Reconstructive surgery 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 "Dental Services" and "Temporomandibular (Jaw) Joint Disorders" portions of the "General Limitations" section.

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

- **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. Rental charges that exceed the reasonable purchase price of the equipment are not covered.

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.

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

- The Corrective Footwear is Medically Necessary
- The Corrective Footwear is custom made for the Covered Person, and
- The Corrective Footwear is permanently attached to a Medically Necessary Orthotic device that is also a covered benefit under this plan.
- Corrective Footwear for the management and treatment of diabetes-related medical conditions is covered under the “Diabetic Equipment” benefit as Medically Necessary.

Covered Durable Medical Equipment will be repaired or replaced when necessary. However, repair or replacement for loss or misuse is not covered.

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

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

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

Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered as Preventive Care Services. For additional information, please refer to the "Preventive Care List of Services" section. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor. For additional information, please refer to the "Preventive Care List of Services" section.

- **Diabetic Equipment and Services**

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

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

- Specific brands of disposable insulin needles and syringes*
- Glucagon*

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

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

- Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin are provided through the prostheses benefit (see the Prostheses provision of this section).
- Diabetic daycare self-management education programs means instruction which will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy thereby avoiding frequent hospitalizations and complications.
- Diabetic daycare self-management training, education and medical nutrition therapy will be covered, only when provided by registered or certified health care professionals knowledgeable in the management or treatment of diabetes, under the direction and supervision of a licensed physician who is board certified in internal medicine or pediatrics.

- **Implanted Lens Which Replaces the Organic Eye Lens** are covered when Medically Necessary.
- **Blood Transfusions**, including blood processing and the cost of unreplaced blood and blood products. The collection and storage of the Covered Person's own blood for autologous blood transfusion are also covered.

  The amount on which HNL bases its reimbursement for Covered Services associated with blood transfusions, autologous and designated donor transfusions will be the rate charged by a licensed blood bank in the local community where the service is performed.
- **Rehabilitation Therapy** (including physical therapy, occupational therapy and speech therapy) is covered when Medically Necessary in accordance with the "Schedule of Benefits" section except as stated in the "General Limitations" section.
- **Cardiac Rehabilitation Therapy**, provided in connection with the treatment of heart disease is covered when Medically Necessary in accordance with the "Schedule of Benefits" section except as stated in the "General Limitations" section.
- **Pulmonary Rehabilitation Therapy**, provided in connection with the treatment of chronic respiratory impairment is covered when Medically Necessary, in accordance with the "Schedule of Benefits" section except as stated in the "General Limitations" section.
- **Allergy Testing and Treatments**, excluding allergy serum
- **Preventive Care Services**

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

Preventive Care Services are covered as directed by your physician, and in accordance with the following:

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

Your physician will evaluate your health status (including, but not limited to, your risk factors, family history, gender and/or age) to determine the appropriate Preventive Care Services and frequency. Additional information regarding Preventive Care Services may be accessed through (https://www.healthcare.gov/coverage/preventive-care-benefits/).

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

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

- **Breast Cancer:** Services related to the diagnosis and treatment of breast cancer is 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.
- **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.
- **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 Services of a physician while the Covered Person is covered under this *Certificate*, treating an Accidental Injury to the natural teeth. The Covered Person 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 an Accidental Injury.

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, except as excluded under the "Dental Services" provision of the "General Limitations and Exclusions" section.

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

Used for the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw or associated bone joints are covered, except as excluded under the "Dental Services" provision of the "General Limitations and Exclusions" section.

Telehealth Services

Medically Necessary services, including consultation, diagnosis and treatment, for medical conditions and Mental Health or Substance Use Disorders provided appropriately as Telehealth Services are covered on the same basis and to the same extent as Covered Services delivered in-person. Please refer to the "Telehealth Services" definitions in the "Definitions" section for more information.

Care for Conditions of Pregnancy

Hospital and professional services will be covered, including prenatal and postnatal care, delivery, and circumcision of newborns. Covered Expenses include prenatal diagnostic procedures in the case of high-risk pregnancies. Prenatal testing administered by the State Department of Health Services through the California Prenatal Screening Program is also covered.

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

Preventive services for pregnancy, as listed in the U.S. Preventive Services Task Force A&B recommendations and Health Resources and Services Administration's ("HRSA") Women's Preventive Service are covered as Preventive Care Services.

When the Covered Person gives birth to a child in the Hospital, the Covered Person is entitled to coverage of at least 48 hours of care following a vaginal delivery, or at least 96 hours following a cesarean section delivery.

The Covered Person may be discharged earlier only if the Covered Person and her physician agree to it.

The Covered Person's physician, in consultation with the Covered person, may decide to discharge the Covered person earlier than 48 hours after a vaginal delivery or 96 hours after a cesarean section. If the Covered Person is discharged earlier, then this Policy covers a post discharge follow-up visit. The follow-up visit will be either an in-home visit, physician office visit, or visit to a facility under contract with HNL. The location of the visit will be determined by the Covered Person's physician, in consultation with the Covered Person.

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, in consultation 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).

Family Planning

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

Counseling, planning and other services for problems of fertility and Infertility, when determined to be Medically Necessary by a physician are covered in accordance with the "Schedule of Benefits" section. Preventive sterilization of females and women's contraception methods and counseling on contraceptive methods, as supported by the HRSA guidelines, are covered as Preventive Care Services. Contraceptive counseling includes, but is not limited to, follow-up and management of side effects of contraceptives, counseling for continued adherence and contraceptive device placement and removal.

As part of Preventive Care Services, HNL provides coverage of all FDA-approved contraceptive drugs, devices, and other products for women, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by Your (or the Covered Person's) provider; voluntary sterilization procedures; patient education and counseling on contraception; and follow-up services related to the drugs, devices, products and procedures, including, but not limited to, management of side effects of contraceptives, counseling for continued adherence and contraceptive device placement and removal. Contraceptives that are covered under the medical benefit include intrauterine devices (IUDs), injectable contraceptives and implantable contraceptives (including, but not limited to, intrauterine devices (IUDs), injectable contraceptives and implantable contraceptives and prescribed over-the-counter contraceptives); and contraceptive counseling (including, but not limited to, follow-up and management of side effects of contraceptives, counseling for continued adherence and contraceptive device placement and removal). Prescribed contraceptives for women, as shown under "Preventive Care Services" in the "Schedule of Benefits" section, are covered as described in the "Outpatient Prescription Drug Benefits" portion of this "Medical Benefits" section of this *Certificate*.

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

Sterilizations are covered in accordance with the "Schedule of Benefits" section.

Fertility Preservation

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

Organ, Tissue, and Stem Cell Transplants

Organ, tissue and stem cell transplants that are not Experimental or Investigational are covered.

HNL has a specified network of designated Transplant Performance Centers to perform organ, tissue and stem cell transplants. The physician can provide information about this network. The Covered Person will be directed to a designated HNL transplant center.

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

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

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

If the Covered Person receives services authorized by HNL for an organ, tissue or stem cell transplant from a Transplant Performance Center, Covered Services will be reimbursed at the amount contracted and agreed to by HNL and the Transplant Performance Center. The Covered Person will be responsible for payment of any Deductibles and Coinsurance as stated in the "Schedule of Benefits" section.

Organ, tissue and stem cell transplants will be covered regardless of the Covered Person's human immunodeficiency virus (HIV) status.

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

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

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

Reconstructive Surgery

Reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, disease, or gender dysphoria to do either of the following:

- Improve function
- Create a normal appearance to the extent possible, unless the surgery offers only a minimal improvement in the appearance of the Covered Person.

This does not include cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

Includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

Reconstructive surgery includes 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.

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, authorized by HNL, and either recommended by the Covered Person's treating physician or the Covered Person provides medical and scientific information establishing eligibility for the trial, and authorized by HNL. Services rendered as part of a clinical trial subject to the reimbursement guidelines as specified in the law.

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

"Routine patient care costs" are the costs associated with the requirements 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 "General Limitations" section for more information.

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

Outpatient Prescription Drug Benefit

The preceding descriptions under this "Medical Benefits" section provide for coverage for Prescription Drugs obtained while an inpatient in a Hospital. This section provides coverage for Prescription Drugs obtained otherwise. The provisions which follow are in addition to, and do not replace any other provision under this section which may apply to Prescription Drugs. In addition, coverage is subject to exclusions and limitations as shown in the "Limitations and Exclusions" subsection below.

DEFINITIONS

The following definitions apply to the coverage provided under this section. Other Definitions appearing within this *Certificate* also apply to the coverage provided under this section.

Average Wholesale Price (AWP) is the amount listed in a national pharmaceutical pricing publication, and accepted as the standard price for that Drug by HNL.

Brand Name Drug is a Prescription Drug or medicine that has been registered under a brand or trade name by its manufacturer and is advertised and sold under that name, and indicated as a brand in the Medi-Span or similar national Database.

Drug Discount or Coupon or Copay Card means cards or Coupons typically provided by a Drug manufacturer to discount the Copayment and/or Coinsurance or Your other out-of-pocket costs (e.g. Deductible or Out-of-Pocket Maximum).

Drugs are: (1) FDA-approved medications that require a prescription either by California or Federal law; (2) insulin, and disposable hypodermic insulin needles and syringes; (3) pen delivery systems for the administration of insulin, as Medically Necessary; (4) diabetic testing supplies (including lancets, lancet puncture devices, blood and urine testing strips, and test tablets); (5) over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B; (6) contraceptive drugs and devices, including oral contraceptives, contraceptive rings, patches, diaphragms, cervical caps, female OTC contraceptive products when ordered by a physician or Health Care Provider, and emergency contraceptives; or (7) inhalers and inhaler spacers for the management and treatment of asthma.

Formulary (also known as the Drug List) is a list of the Prescription Drugs that are covered by this Plan. It is prepared and updated by Health Net and distributed to Covered Persons, Member physicians and Participating Pharmacies and posted on the HNL website at www.healthnet.com. The Formulary is also referred to as "2-Tier Formulary". Some Drugs in the Formulary require Prior Authorization from HNL in order to be covered.

Generic Drug is a pharmaceutical equivalent of one or more Brand Name Drugs, whose patent has expired and is available from multiple manufacturers as set out in the Medi-Span or similar third-party database used by HNL, and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength, and effectiveness as the Brand Name Drug.

Maintenance Drugs are Prescription Drugs (excluding Specialty Drugs) taken continuously to manage chronic or long-term conditions where Covered Persons respond positively to a Drug treatment plan with a specific medication at a constant dosage requirement.

Maximum Allowable Cost for any Prescription Drug is the maximum charge HNL will allow for Generic Drugs or for Brand Name Drugs which have a generic equivalent. A list of Maximum Allowable Costs is maintained on our pharmacy claims processor's website. The Maximum Allowable Cost refers to the upper limit or maximum amount that HNL will pay the pharmacy for Generic Drugs and Brand Name Drugs that have generic versions available ("multi-source brands").

Nonparticipating Pharmacy is a facility not authorized by HNL to be a Participating Pharmacy.

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

1. The Drug is approved by the Food and Drug Administration; and
2. The Drug meets one of the following conditions:

A. The Drug is prescribed or administered by a licensed health care professional for the treatment of a life threatening condition; or

B. The Drug is prescribed by a licensed health care professional for the treatment of a chronic and seriously debilitating condition the Drug is Medically Necessary to treat such condition and Prior Authorization by HNL has been obtained; and

3. The Drug is recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following:

   A. The American Hospital Formulary Service Drug Information; or

   B. One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer therapeutic regimen:

      i. The Elsevier Gold Standard's Clinical Pharmacology;

      ii. The National Comprehensive Cancer Network Drug and Biologics Compendium;

      iii. The Thomson Micromedex DrugDex; or

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

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

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

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

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

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

Participating Pharmacy is a facility that is authorized by HNL to dispense Prescription Drugs to persons eligible for benefits under the terms of this *Certificate*. A list of Participating Pharmacies and a detailed explanation of how the program operates are available from HNL upon request.

Prescription Drug is a Drug or medicine which, according to federal law, can be obtained only by a Prescription Drug Order and is required to bear a label which says "Caution, Federal Law Prohibits Dispensing Without a Prescription" or is restricted to prescription dispensing by State law. Insulin is also included.

Prescription Drug Order is a written or verbal order or refill notice for a specific Drug, strength and dosage form (such as a tablet, liquid, syrup or capsule) related to the treatment of an illness or injury and which is issued by the attending physician within the scope of his or her professional license.

Prior Authorization is HNL's approval process for certain Drugs. Physicians must obtain HNL's Prior Authorization before certain Drugs will be covered. You may obtain a list of Drugs requiring Prior Authorization by visiting our website at www.healthnet.com.

Requests for Prior Authorization, including step therapy exceptions, may be submitted electronically or by telephone or facsimile. Urgent requests from physicians for authorization are processed, and

prescribing providers notified of HNL's determination as soon as possible, not to exceed 24 hours after HNL’s receipt of the request. A Prior Authorization request is urgent when a Covered Person is suffering from a health condition that may seriously jeopardize the insured’s life, health, or ability to regain maximum function. Routine requests from physicians are processed, and prescribing providers notified of HNL's determination in a timely fashion, not to exceed 72 hours after HNL's receipt of the request. For both urgent and routine requests, HNL must also notify the insured or his or her designee of its decision. If HNL fails to respond within the required time limit, the Prior Authorization request is deemed granted.

If a Drug is not on the Formulary, your physician can ask for an exception. To request an exception, your physician can submit a Prior Authorization request along with a statement supporting the request. Requests for Prior Authorization may be submitted electronically or by telephone or facsimile. If we approve an exception for a Drug that is not on the Formulary, the non-preferred Brand Name Drug tier (Tier 3) or Specialty Copayment applies. If You are suffering from a condition that may seriously jeopardize Your life, health, or ability to regain maximum function, or if You are undergoing a current course of treatment using a Drug that is not on the Formulary, then the Covered Person, his or her designee or the physician can request an expedited review. Expedited requests for an exception will be processed, and the Covered Person, his or her designee and the prescribing providers will be notified, within 24 hours after HNL’s receipt of the request. Standard requests for an exception will be processed, and the Covered Person, his or her designee and the prescribing provider will be notified within 72 hours after HNL’s receipt of the request. Exceptions based on the Covered Person’s medical condition will be for the duration of the Covered Persons’ medical condition.

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

You may use the Prior Authorization process to obtain coverage at no cost for a prescription contraceptive that is not on the Formulary or the brand name equivalent of a covered generic contraceptive that is unavailable. HNL will cover the contraceptive if Your physician submits a Prior Authorization request when Medically Necessary. This request is not subject to denial by HNL.

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

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

Contraceptive Drugs, devices and outpatient contraceptive services that are being prescribed for a medical condition other than contraceptive purposes are covered but will require Prior Authorization.

BENEFITS

Each Covered Person must pay the Copayments as set forth in the "Schedule of Benefits" section for covered Prescription Drug expenses incurred during any Calendar Year if prescribed by a physician and which are purchased according to the provisions specified within this section. Injectable insulin

prescribed by a physician is covered. The Drug or medicine must be dispensed by a licensed pharmacist. Drugs and medicines must be dispensed by a Participating Pharmacy, as set forth below, in order to be eligible for coverage.

Expenses incurred for outpatient Prescription Drug purchases are not included in the calculations of Out-of-Pocket Maximums.

Cost sharing and any accrual of amounts from all Drug Coupons paid on Your behalf for any Prescription Drugs obtained by You through the use of a Drug Discount, Coupon, or Copay Card provided by a Prescription Drug manufacturer will not apply toward Your plan Deductible or Out-of-Pocket Maximum.

Diabetic Drugs and Supplies

Prescription Drugs for the treatment of diabetes are covered. Diabetic supplies are also covered including, but not limited to, insulin needles and syringes, specific brands of pen delivery systems, specific brands of disposable insulin needles and syringes, specific brands of disposable insulin pen needles, specific brands of blood glucose monitors and test strips, Ketone test strips specific brands of lancet puncture devices and specific brands of lancets used in monitoring blood glucose levels. Refer to the "Schedule of Benefits" section for details about the supply amounts that are covered.

Preventive Drugs and Women’s Contraceptives

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

Covered contraceptives are all FDA-approved contraceptives for women that are either available over-the-counter or are only available with a Prescription Drug Order, including, but not limited to, diaphragms, sponges, female condoms, cervical caps and spermicide. Women’s contraceptives that are covered under this Prescription Drug benefit include vaginal, oral, transdermal and emergency contraceptives.

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

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

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

Smoking Cessation Coverage

Drugs on the Formulary that require a prescription in order to be dispensed by a retail pharmacy for the relief of nicotine withdrawal symptoms are covered. In addition, all FDA-approved smoking cessation medications, including prescription and over the counter medications, are covered without Prior

Authorization when prescribed by a physician. Over-the-counter smoking cessation Drugs that are covered under this Plan require a Prescription Drug Order. You must present the Prescription Drug Order at a Health Net Participating Pharmacy to obtain such Drugs.

Smoking cessation programs are covered by HNL. For information regarding smoking cessation behavioral modification support programs available through HNL, contact the Customer Contact Center at the telephone number on Your HNL ID card or visit Our website at www.healthnet.com (see "Wellsite"). For all FDA-approved tobacco cessation medications, no limits will be imposed on the number of days that are covered, regardless of whether the medications are taken alone or in combination.

Schedule II Narcotic Drugs

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

Specialty Drugs

Specialty Drugs listed in the Health Net Formulary are covered when Prior Authorization is obtained from HNL and the Drugs are dispensed through HNL's Specialty Pharmacy Vendor. These include Drugs that are made using biotechnology; Drugs that require special training for self-administration; Drugs that require regular monitoring of care by a pharmacy; and Drugs that cost more than six hundred dollars for a one-month supply.

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

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

"Split-fill" Program

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

Compounded Drugs

Compounded Drugs are prescription orders that have at least one ingredient that is Federal Legend or state restricted in a therapeutic amount as Medically Necessary and are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form and require a prescription order for dispensing. Coverage for Compounded Drugs is subject to Prior Authorization by HNL and Medical Necessity. Refer to the “Off-Label Drugs” provision in the “Outpatient Prescription Drugs Benefits” portion of this "Medical Benefits" section for information about FDA approved Drugs for off-label use. HNL covers compounded medication(s) when:

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

Step Therapy

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

Covered Persons Residing within the State of California

- **Prescription Drugs Dispensed by a Participating Pharmacy**

  The Covered Person must purchase covered Drugs at a Participating Pharmacy to receive the highest available benefits for Prescription Drugs under this *Certificate*. HNL is contracted with many major pharmacy chains, supermarket based pharmacies and privately owned neighborhood pharmacies in California. For a complete and up-to-date list of Participating Pharmacies, please visit Our website at www.healthnet.com or call the Customer Contact Center the telephone number on the HNL ID card.

  If the Covered Person presents a Prescription Drug Order for a Brand Name Drug, pharmacists will offer a Generic Drug equivalent if commercially available. At the time of an emergency or Urgent Care visit, the Covered Person should advise the treating physician of any Drug allergies or reactions, including any Generic Drugs.

  The Covered Person, upon presentation of a valid Flex Net identification card which indicates coverage for Prescription Drugs, shall be entitled to have a Prescription Drug Order filled by a Participating Pharmacy, subject to the following. If refills are stipulated on the Prescription, a Participating Pharmacy may dispense up to a 30-day supply for each Prescription Drug Order or for each refill at the appropriate time interval.

  Except as described below in “When the Flex Net identification card is not in Your Possession”, if you elect to pay out-of-pocket and submit a prescription claim directly to HNL instead of having the

Participating Pharmacy submit to HNL, you will be reimbursed based on the Prescription Drug Covered Expense, less any applicable Copayment, Coinsurance or Deductible.

IF THE FLEX NET IDENTIFICATION CARD HAS NOT BEEN RECEIVED OR IF IT HAS BEEN LOST, REFER TO THE "WHEN THE FLEX NET IDENTIFICATION CARD IS NOT IN THE COVERED PERSON'S POSSESSION" PROVISION BELOW.

1. **GENERIC DRUGS WILL BE DISPENSED** by Participating Pharmacies when the Prescription Drug Order specifies a Generic Drug. Also, when a Brand Name Drug is specified, but a Generic Drug equivalent is commercially available, the Generic Drug may be substituted. In such event, the Covered Person must pay the Participating Pharmacy, based on the HNL discounted pharmacy rate charge for the Drugs purchased, and the applicable Coinsurance for each Drug prescribed which is filled with a Generic Drug. Refer to the "Schedule of Benefits" section. (Exceptions are described immediately below.)

2. **IF A BRAND NAME DRUG IS DISPENSED** and there is an equivalent Generic Drug commercially available, You will be required to pay the difference in cost between the Generic Drug and Brand Name Drug in addition to the Copayment or Coinsurance shown above.

3. **IF A COVERED PERSON RECEIVES A BRAND NAME DRUG** and a Generic Drug equivalent is commercially available, the Prescription Drug Order must indicate "do not substitute" or "dispense as written" or words of similar meaning, or the Covered Person will be financially responsible for an additional amount, as shown in the "Schedule of Benefits" section.

- **Prescription Drugs Dispensed by a Nonparticipating Pharmacy**

  There are NO BENEFITS for Prescription Drugs that are dispensed by Nonparticipating Pharmacies. (Exceptions are described below.)

- **Prescription Drugs Dispensed through the Mail Service Prescription Drug Program**

  If a Maintenance Drug is prescribed, the Covered Person shall be entitled to have a Prescription Drug Order filled through a mail delivery program selected by HNL. Through this program, a Covered Person can receive, through the mail, up to a 90-consecutive-calendar day supply of a Maintenance Drug when appropriate.

  Even when a prescription is dispensed (in increments of 30-day supplies), the lesser of 2 Copayments, or the mail order pharmacy’s retail price, will be required.

  In some cases, a 90-consecutive-calendar-day supply of medication may not be an appropriate Drug treatment plan, according to FDA or HNL usage guidelines, and may be less than a 90-consecutive-calendar-day supply.

  In addition, if a Brand Name Drug is dispensed, and a Generic Drug equivalent is commercially available, the Prescription Drug Order must indicate "do not substitute" or "dispense as written", or the Covered Person will be financially responsible for an additional amount, as shown in the "Schedule of Benefits" section.

  To use this program, the Covered Person must place an order through the mail by completing a prescription mail order form. It must be accompanied by the original Prescription Drug Order, written for a 90-consecutive-calendar-day-supply, when appropriate, not a copy. The prescription mail order form and an explanation of how to use this program will be provided by HNL upon request. Please call the Customer Contact Center at the number on your HNL ID card.

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

- **When the Flex Net Identification Card is Not in the Covered Person's Possession**

If the Covered Person needs to have a Prescription Drug Order filled and has not received a Flex Net identification card, or it has been lost, the Covered Person must pay for the Drug(s). The Covered Person may then be entitled to partial reimbursement. After the Flex Net identification card has been received, the Covered Person must file a claim. Claim forms will be provided by HNL upon request.

Reimbursement will be according to the following:

PARTICIPATING PHARMACY

1. **FOR PURCHASES DURING THE FIRST 60 DAYS OF COVERAGE**, payment will be the amount of the retail charge to the Covered Person less either the Coinsurance or Copayment (whichever is applicable) specified in the "Schedule of Benefits" section.
2. **FOR PURCHASES AFTER 60 DAYS OF COVERAGE**, payment will be at the level HNL would reimburse a Participating Pharmacy for the identical Prescription Drug Order less either the Coinsurance or Copayment (whichever is applicable) specified in the "Schedule of Benefits" section. Payment will be reduced further if a Brand Name Drug is purchased, and a Generic Drug equivalent is commercially available. The additional reduction in payment will be the amount of the difference between the equivalent Generic Drug and the Brand Name Drug.

   If a Brand Name Drug is dispensed and a Generic Drug equivalent is commercially available, the Prescription Drug Order must indicate "do not substitute" or "dispense as written", or the Covered Person will be financially responsible for an additional amount, as shown in the "Schedule of Benefits" section.

NONPARTICIPATING PHARMACY

1. **IF THE DRUG IS PURCHASED IN CALIFORNIA:**
   a. **FOR PURCHASES DURING THE FIRST 30 DAYS OF COVERAGE**, payment will be the retail charge to the Covered Person less the Coinsurance or Copayment specified in the "Schedule of Benefits" section.
   b. **FOR PURCHASES AFTER 30 DAYS OF COVERAGE**, there are NO BENEFITS.

1. **IF THE DRUG IS PURCHASED OUTSIDE CALIFORNIA:**
   a. **FOR PURCHASES DURING THE FIRST 60 DAYS OF COVERAGE,** payment will be the retail charge to the Covered Person less the Coinsurance or Copayment specified in the "Schedule of Benefits" section.

      Note: The "Exclusions and Limitations" portion of this subsection still apply when Prescription Drugs are dispensed by a Nonparticipating Pharmacy.

   b. **FOR PURCHASES AFTER 60 DAYS OF COVERAGE, there are NO BENEFITS.**

Covered Persons Residing outside the State of California

- **GENERIC DRUGS** will be a Covered Expense when the Prescription Drug Order specifies a Generic Drug.

- If a **BRAND NAME DRUG** is dispensed and a Generic Drug equivalent is commercially available, the Prescription Drug Order must indicate "do not substitute" or "dispense as written", or the Covered Person will be financially responsible for an additional amount, as shown in the "Schedule of Benefits" section.
- **CLAIM FORM** must be filed by the Covered Person with HNL in order to obtain reimbursement. Payment will be made, minus either the Coinsurance or Copayment (whichever is applicable) after review of the form.
- **IF THE COVERED PERSON** prefers to receive a Brand Name Drug, even though the Prescription Drug Order specified a Generic Drug, or even if a Brand Name Drug was prescribed, but the Prescription Drug Order did not state "dispense as written" or "do not substitute" in the physician's handwriting, and a Generic equivalent is commercially available, then the Covered Person will be financially responsible for an additional amount, as shown in the "Schedule of Benefits" section.

GENERAL PROVISIONS

The following General Provisions apply to the coverage provided under this section. Other "General Provisions" appearing within this *Certificate* also apply to the coverage provided under this section.

- Expense must be incurred on or after the Covered Person's Effective Date of coverage under this *Certificate* and prior to termination of such coverage. An expense will be considered to have been incurred on the date that the Prescription Drug is dispensed.
- Benefits for Prescription Drugs for Covered Persons residing within California shall be provided only when dispensed at a Participating Pharmacy or facility authorized by HNL.
- In some cases a 30-consecutive-day-supply of medication may not be an appropriate Drug treatment plan according to the Food and Drug Administration (FDA) or HNL's usage recommendation. If this is the case, the amount of medication dispensed may be less than a 30-day supply.
- Up to a 90-consecutive-calendar-day supply of Maintenance Drugs (see "Definitions" above) may be dispensed through the Mail Service Prescription Drug Program. Prescription Drugs that are not Maintenance Drugs will also be dispensed by the mail order program, but the quantity dispensed may be less than a 90-day quantity.
- Any Participating Pharmacy or Nonparticipating Pharmacy furnishing benefits to the Covered Person does so as an independent contractor, and HNL shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by the Covered Person.
- HNL shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with the manufacturing, compounding, dispensing, or use of any Prescription Drug covered under this *Certificate*.
- HNL retains the right to replace any administrator through which Covered Persons may be required to obtain Prescription Drugs. If HNL should replace any such administrator, the principal Covered Person would be notified of all new procedures. HNL also retains the right to modify the program with due notice to Covered Persons.
- Blood Glucose strips and lancets will be dispensed in 50-unit or 100-unit packages for each 30-day period. The Covered Person must pay one Copayment for each.

- Oral contraceptives are covered.

LIMITATIONS AND EXCLUSIONS
All exclusions and limitations which appear elsewhere in this *Certificate* also will apply to coverage provided under this section.

Note: Services or supplies excluded under the Outpatient Prescription Drug Benefit may be covered under the "Medical Benefits" section. Please refer to the "Covered Expenses" portion of the "Medical Benefits" section for more information.

In addition, the following Drugs and medicines are NOT COVERED for any Covered Persons.

- Medical equipment and supplies (including insulin), that are available without a prescription, are covered only when prescribed by a physician for the management and treatment of diabetes or for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations or for female contraception. In addition, disposable devices that are Medically Necessary for the administration of a covered outpatient Prescription Drug are covered. Any other nonprescription Drugs, equipment or supplies which can be purchased without a Prescription Drug Order are not covered even if a physician writes a prescription for such Drug, equipment or supply or a Drug where there is a non-prescription equivalent available unless specifically listed in the Formulary. These are commonly called over-the-counter Drugs. Insulin is an exception to this limitation. However, if a higher dosage form of a nonprescription Drug or over-the-counter Drug is only available by prescription, that higher dosage Drug will be covered.
- Supply amount for prescriptions which exceeds the Food and Drug Administration's or HNL's indicated usage recommendation unless Medically Necessary and Prior Authorization is obtained from HNL. However, Drugs that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S., but are not approved by the FDA, may be covered when Medically Necessary. If a Covered Person has a life-threatening or seriously debilitating condition and requests coverage of a non-FDA approved Drug for an Experimental or Investigational purpose, he or she is entitled to IMR if Health Net delays, denies, or modifies the coverage. For more information, please refer to the "Independent Medical Review of Investigational or Experimental Therapies" provision in the "Coverage Decisions and Disputes Resolution" section in this *Certificate*.
- Some Drugs are subject to specific quantity limitations per Copayment or Coinsurance, whichever is applicable, based on recommendations for use by the FDA or HNL's usage guidelines. Medications taken on an "as-needed" basis may have a Copayment or Coinsurance based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If Medically Necessary, the physician may request a larger quantity from HNL.
- Schedule II Drugs are Drugs classified by the Federal Drug Enforcement Administration as having a high abuse risk but also safe and accepted for medical uses in the United States. Schedule II narcotic analgesics, sexual dysfunction and smoking cessation Drugs and Specialty Drugs are not covered through mail order.
- Drugs prescribed for a condition or treatment that is not covered by this *Certificate*. However, the *Certificate* does cover Medically Necessary Drugs for a medical condition directly related to noncovered services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery).

- Devices are limited to vaginal contraceptive devices; no other devices are covered, even if prescribed by a physician.

Exceptions:

Medical equipment and supplies which are prescribed by a physician for the management and treatment of diabetes will be covered, even if available without a prescription.

- Drugs or supplies prescribed for cosmetic or enhancement purposes as determined by HNL, including, but not limited to, those intended to treat wrinkles, baldness or conditions of hair loss, sexual performance, athletic performance, anti-aging and cognitive performance are not covered. Examples of Drugs that are excluded when prescribed for such conditions include, but are not limited to, Latisse, Renova, Vaniqa, Propecia or Lustra. This exclusion does not exclude coverage for Drugs when pre-authorized as Medically Necessary to treat a diagnosed medical condition affecting memory, including but not limited to Alzheimer's or dementia.
- Cosmetics and health or beauty aids
- Drugs for the treatment of obesity are not covered, unless Medically Necessary
- Non preventive immunizing agents
- Allergy desensitization products, whether administered by injection or drops placed in the nose or mouth (transmucosal absorption) for the purpose of treating allergies by desensitization (to lessen or end the person's allergic reactions). These products are sometimes described as allergy serum. Allergy serum is covered as a medical benefit. See the "Other Services" portion of the "Schedule of Benefits" section and the "Allergy Testing and Treatment" provision in this "Medical Benefits" section.
- Medications limited by law to Investigational use.
- Medications prescribed for Experimental purposes or indications not approved by the Food and Drug Administration (unless the Drug is being prescribed or administered by a licensed health care professional for the treatment of a life-threatening or chronic and seriously debilitating condition and the Off-Label use of the Drug for that purpose has generally been recognized as safe and effective as described in this section).
- Injectables (except insulin) and pharmaceutical agents purchased for surgical implantation. Surgically implanted Drugs are covered under the medical benefit (see the "Surgically Implanted Drugs" provision in this "Medical Benefits" section).
- Drugs prescribed to remove or lessen wrinkles in the skin.
- Specific brands of disposable insulin needles, syringes and specific brands of pen devices are covered. In addition, disposable devices that are Medically Necessary for the administration of a covered outpatient Prescription Drug are covered. Needles and syringes required to administer self-injected medications will be provided through HNL’s contracted Specialty Pharmacy Vendor. All other syringes and needles are not covered.
- Any medication which is to be taken by or administered to an individual, in whole or in part, while a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

- Drugs used as dietary or nutritional supplements, including vitamins and herbal remedies, including when in combination with a Prescription Drug product, are subject to Prior Authorization from HNL. Phenylketonuria (PKU) is covered under the medical benefit (see the "Phenylketonuria" provision of the "Medical Benefits" section).
- Unit dose, or "bubble" packaging (an individual dose of medication dispensed in plastic or foil packages) and dosage forms used for convenience, unless Medically Necessary or only available in that form.
- Prescription Drug Orders that are combined or manufactured by the pharmacist and placed in an ointment, capsule, solution, or cream using FDA approved Drugs, when the primary Drug being used for an FDA approved indication.
- Once You have taken possession of Drugs, replacement of lost, stolen or damaged Drugs is not covered. The Covered Person will have to pay the retail price for replacing them. However, if a state of emergency is declared by the Governor and You are displaced by the disaster, this exclusion will not apply.
- Devices (other than diaphragms or cervical caps) even if prescribed by a physician.
- Drug used for diagnostic purposes. Diagnostic Drugs are covered under the medical benefit when Medically Necessary.
- Irrigation solutions and saline solutions.
- Drugs (including injectable medications) prescribed for sexual dysfunction are not covered. This includes Drugs that establish, maintain, or enhance sexual function, libido or satisfaction.
- Drugs prescribed by a dentist, including drugs for routine dental treatment, are not covered.

Mental Health or Substance Use Disorder Benefits

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

The following benefits will be paid by HNL for Medically Necessary expenses incurred by the Covered Person for medical advice, treatment, counseling or testing for a Mental Health or Substance Use.

Telehealth services for Mental Health or Substance Use Disorders are covered. See the "Telehealth Services" provision in this "Medical Benefits" section for more details.

Gender Affirming Procedures

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

Outpatient Services

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

Covered services include:

- Outpatient office visits for the treatment of Mental Health or Substance Use Disorders, including gender dysphoria, by physicians and other licensed providers, as described in this *Certificate.* Services include:
  - outpatient crisis intervention
  - assessment and treatment services
  - specialized therapy
  - including individual and group mental health evaluation and treatment
  - medication management,
  - drug therapy monitoring, and
  - in connection with gender dysphoria: physician office visits for hormone therapy (including hormone injections).
- Outpatient services other than office visits for Mental Health or Substance Use Disorders, including gender dysphoria, as ordered by a physician (defined in this *Certificate*). Services include:
  - psychological and neuropsychological testing when necessary to evaluate Mental Health or Substance Use Disorders
  - neurofeedback (biofeedback),
  - intensive outpatient care program, day treatment programs
  - partial hospitalization programs
  - medical treatment for withdrawal symptoms
  - electroconvulsive therapy, transcranial magnetic stimulation,
  - other outpatient procedures, and
  - in connection with gender dysphoria: fertility preservation, speech therapy, and surgical services (such as hysterectomy, ovariectomy and orchiectomy, breast surgery, genital surgery, mastectomy, and reconstructive surgery i.e. facial reconstruction).
- Intensive outpatient care program is a treatment program that is utilized when a patient’s condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week.
- Partial hospitalization/day treatment program is a treatment program that may be free-standing or Hospital-based and provides services at least four (4) hours per day and at least four (4) days per week.

- Behavioral Health Treatment (BHT) 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 pervasive developmental disorder or autism, are covered as shown in the "Schedule of Benefits" section under "Mental Health or Substance Use Disorders."
    - A licensed physician or licensed psychologist must establish the diagnosis of pervasive developmental disorder or autism.
    - The treatment must be prescribed by a licensed physician, or developed by a licensed psychologist, and must be provided under a documented treatment plan prescribed, developed and approved by a Qualified Autism Service Provider providing treatment to the Covered Person for whom the treatment plan was developed. The treatment must be administered by the Qualified Autism Service Provider, by qualified autism service professionals who are supervised by the treating Qualified Autism Service Provider or by qualified autism service paraprofessionals who are supervised by the treating Qualified Autism Service Provider or a qualified autism service professional.
    - The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated, and must be reviewed by the Qualified Autism Service Provider at least once every six months and modified whenever appropriate. The treatment plan must not be used for purposes of providing or for the reimbursement of respite, day care or educational services, or to reimburse a parent for participating in a treatment program.
    - HNL may deny coverage for continued treatment if the ongoing Medical Necessity is not demonstrated. HNL will not deny or delay coverage for Medically Necessary BHT for lack of cognitive, developmental, or IQ testing; or because services are available from a California Regional Center or on the grounds that behavioral health treatment is Experimental, Investigational, or educational; or on the grounds that behavioral health treatment is not being, will not be, or was not, provided or supervised by a licensed person, entity or group when the provider or supervisor in question is certified by a national entity that is accredited by the National Commission for Certifying Agencies.

Inpatient Services

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

Covered Services and Supplies include:

- Accommodations in a room of two or more beds, including special treatment units, such as intensive care units and psychiatric care units, unless a private room is Medically Necessary.
- Supplies and ancillary services normally provided by the facility, including 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 Limitations" section.

Detoxification

Inpatient services for acute detoxification and treatment of acute medical conditions relating to Mental Health or Substance Use Disorders are covered.

COORDINATION OF BENEFITS

HNL will coordinate all benefits of this Certificate with Medicare, with Medicare as the Primary Plan. HNL is considered the Secondary Plan.

Medicare Coordination of Benefits (COB)

For services and supplies covered under Medicare Part A and Part B, claims are first submitted to the Medicare administrative contractor for determination and payment of allowable amounts. The Medicare administrative contractor then sends the Covered Person's 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 intermediary must be submitted to HNL by the Covered Person or the provider of service, and must include a copy of the MSN. HNL and/or the Covered Person's medical provider is responsible for paying the difference between the Medicare paid amount and the Covered Services outlined in this *Certificate*, subject to any limitations established by law. This plan will cover benefits as a secondary payer only to the extent services are coordinated by the Covered Person's physician and authorized by HNL as required under this *Certificate*.

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 shall determine 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 coordination of benefits with respect to any person claiming benefits under this *Certificate* without consent of, or notice to, the Covered Person 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 a Covered Person covered under this *Certificate*.

Services Instead of Cash Payments

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

Right of Recovery

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

COVERAGE DECISIONS AND DISPUTES RESOLUTION

Notification of HNL's Initial Benefit Determination

Timing of notice:

HNL shall notify the Covered Person of the initial benefit determination within the timeframes described below.

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

For concurrent care decisions: If the treatment involves Urgent Care, the request by the Covered Person or the Covered Person's physician to extend the course of treatment beyond the period of time or number of treatments shall be decided as soon as possible, taking in to account the medical exigencies. The Covered Person will be notified of Our decision within 24 hours of the receipt of the review request, provided that such a request is made to HNL at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

If concurrent review results in an adverse benefit determination, the Covered Person will be notified sufficiently in advance of the reduction or termination to allow time to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

For all other claims:

Benefit determinations that are not based on Medical Necessity are subject to the time frames that are described herein.

In the case of a pre-service claim, HNL shall notify the Covered Person of Our decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the receipt of the request. HNL may extend this time period for up to 15 additional days if an extension is necessary due to matters beyond HNL's control. HNL will notify the Covered Person, prior to the end of the initial 15-day period, of the circumstances requiring the extension of time and the date by which HNL expects to render a decision. In the case in which HNL requires additional information that is necessary to make Our determination, the notice of extension shall describe the required information and the time frame (that is at least 45 days from the Covered Person's receipt of the notice) to provide the specified information.

In the case of a post-service claim, the Covered Person shall be notified of relevant decisions within a reasonable period of time, but no later than 30 calendar days following the receipt of the claim by HNL. HNL may extend this time period for up to 15 additional days if an extension is necessary due to matters beyond HNL's control. HNL will notify the Covered Person, prior to the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which HNL expects to render a decision. In the case in which HNL requires additional information that is necessary to make Our

determination, the notice of extension shall describe the required information and the time frame (that is at least 45 days from the Covered Person's receipt of the notice) to provide the specified information.

Manner and content of notice of an adverse benefit determination:

If Our determination results in an adverse benefit determination, HNL shall send a written or electronic notice to the Covered Person and to the provider of the service that shall include a clear and concise explanation of the reasons for Our decision, a description of the criteria or guidelines used and the clinical reasons for the decisions regarding Medical Necessity, and a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary. The explanation will also include the specific plan provisions on which determination is based. The Medical Necessity decisions communicated to the medical providers will include the name and telephone number of the health care professional responsible for the denial, delay or modification.

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

HNL will provide the following upon request:

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

Grievance, Appeals Process, Independent Medical Review and Arbitration 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 including on the basis of:

- A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review; or
- Any reduction or termination of an approved ongoing course of treatment to be provided over a period of time or number of treatments before the end of such period of time or number of treatments. If there is an adverse benefit determination, the Covered Person will be notified sufficiently in advance of the reduction or termination to allow time to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
- Rescission of coverage, even if it does not have an adverse effect on a particular benefit at that time; or

- Determination of an individual's eligibility to participate in this HNL plan; or
- Determination that a benefit is not covered; or
- An exclusion or limitation of an otherwise covered benefit based on a source-of-injury exclusion; or
- Determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

If the Covered Person is not satisfied with efforts to solve a problem with HNL or a provider before filing an arbitration proceeding, the Covered Person must file a grievance or appeal against HNL by contacting HNL's Customer Contact Center at the telephone number on your HNL ID card or by submitting a Member Grievance Form through HNL's website at www.healthnet.com. The Covered Person must file a grievance or appeal with HNL within 365 calendar days following the date of the incident or action that caused your grievance. The Covered Person 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

A "Claim Involving Urgent Care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-Urgent Care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. In the case of Claims Involving Urgent Care, HNL will provide notification of determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

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

A Covered Person must participate in HNL's grievance or appeals process before requesting Independent Medical Review (IMR) for denials unless there is an imminent and serious threat to the Covered Person's health. However, You will not be required to participate in the HNL's grievance or appeals process for more than 30 days. In the case of a grievance that requires expedited review, You will not be required to participate in HNL's grievance process for more than three days. In such cases, the Covered Person may contact the California Department of Insurance (CDI) to request an IMR of the denial. The CDI may be contacted at **1-800-927-4357** or www.insurance.ca.gov.

Upon request, HNL will provide:

- The process HNL, its contracting provider groups, or any entity with which it contracts for services that include utilization review or utilization management functions, uses to authorize, delay, modify, or deny health care services under the benefits provided by the insurance contract; and
- The criteria or guidelines used by HNL, or an entity with which HNL contracts for utilization review or utilization management functions, to determine whether to authorize, modify, delay, or deny health care services.

For a grievance or appeal of HNL's benefit determination, HNL shall notify the Covered Person of Our decision in writing or electronically within the following time frames:

Urgent Care claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours from the time the initial request was received by HNL, until the close of the case with the Covered Person.

Non-Urgent Care services that have not been rendered (pre-service claims): Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days from the time the initial request was received by HNL, until the close of the case with the Covered Person.

Non-Urgent Care services that have already been rendered (post-service claims): Within a reasonable period of time, but not later than 60 days from the time the initial request was received by HNL, until the close of the case with the Covered Person.

If Our decision is to uphold the adverse benefit determination, the notice of Our decision shall include the specific reason or reasons for the adverse determination and reference to the specific plan provisions on which the determination is based. HNL will provide the following upon request:

- Copies of, all documents, records, and other information relevant to the claim;
- An internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination;
- If the adverse benefit determination is based on a Medical Necessity or Experimental treatment or similar exclusion or limitation, an explanation of the scientific or clinical judgment used for the determination.

Independent Medical Review of Grievances Involving a Disputed Health Care Service

The Covered Person may request an independent medical review ("IMR") of disputed health care services from the California Department of Insurance ("CDI") at 1-800-927-4357 or on their website at www.insurance.ca.gov if he or she believes that health care services eligible for coverage and payment under his or her HNL plan have been improperly denied, modified, or delayed by HNL. A "Disputed Health Care Service" is any health care service eligible for coverage and payment under the Covered Person's HNL plan that has been denied, modified, or delayed by HNL, in whole or in part because the service is not Medically Necessary. The Department may be contacted at **1-800-927-4357** or www.insurance.ca.gov.

The IMR process is in addition to any other procedures or remedies that may be available. The Covered Person pays no application or processing fees of any kind for IMR. The Covered Person has the right to provide information in support of the request for IMR. HNL will provide the Covered Person with an IMR application form and HNL's grievance response letter that states its position on the Disputed

Health Care Service. A decision not to participate in the IMR process may cause the Covered Person to forfeit any statutory right to pursue legal action against HNL regarding the Disputed Health Care Service.

Eligibility

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

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

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

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

2. The Disputed Health Care Service has been denied, modified, or delayed by HNL, based in whole or in part on a decision that the health care service is not Medically Necessary; and

3. The Covered Person has filed a grievance with HNL and the disputed decision is upheld by HNL or the grievance remains unresolved after 30 days. Within the next six months, the Covered Person may apply to the Department for IMR, or later, if the Department agrees to extend the application deadline. If the Covered Person's grievance requires expedited review he or she may bring it immediately to the Department's attention. The Department may waive the requirement that the Covered Person follow HNL's grievance process in extraordinary and compelling cases.

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

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

If there is an imminent and serious threat to the health of the Covered Person, including, but not limited to, serious Pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the Covered Person's health, all necessary information and documents shall be delivered to an independent medical review organization within 24 hours of approval of the request for review. In reviewing a request for review, the Department of Insurance may waive the requirement that the Covered Person follow the insurer's grievance process in extraordinary and compelling cases, where the commissioner finds that the Covered Person has acted reasonably.

For more information regarding the IMR process, or to request an application form, please contact HNL's Customer Contact Center at **1-800-522-0088**.

Independent Medical Review of Investigational or Experimental Therapies

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

Eligibility

1. The Covered Person must have a life-threatening or seriously debilitating condition.
2. The Covered Person's physician must certify to HNL that he or she has a life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving the Covered Person's condition or are otherwise medically inappropriate, and there is no more beneficial therapy covered by HNL.

- Either (a) Your contracting physician has recommended a drug, device, procedure, or other therapy that the physician certifies in writing is likely to be more beneficial to You than any available standard therapies, or (b) You, or the Your physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat Your condition, has requested a therapy that, based on two documents from the medical and scientific evidence, as defined below, is likely to be more beneficial for You than any available standard therapy. The physician certification shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation. Nothing in this provision shall be construed to require HNL to pay for the services of a noncontracting physician that are not otherwise covered pursuant to the contract.

3. The Covered Person has been denied coverage by HNL for the recommended or requested therapy.
4. If not for HNL's determination that the recommended or requested treatment is Experimental or Investigational, it would be covered.

For purposes of this provision, "life-threatening" means either or both of the following:

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

For purposes of this provision, "seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

For purposes of this provision, "medical and scientific evidence" means the following sources:

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

2. Peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database of Health Services Technology Assessment Research (HSTAR).
3. Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act.
4. Either of the following reference compendia:
   a. The American Hospital Formulary Service's Drug Information.
   b. The American Dental Association Accepted Dental Therapeutics.
5. Any of the following reference compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
   a. The Elsevier Gold Standard's Clinical Pharmacology.
   b. The National Comprehensive Cancer Network Drug and Biologics Compendium.
   c. The Thomson Micromedex DrugDex.
6. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.
7. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

If there is an imminent and serious threat to the health of the Covered Person, including, but not limited to, serious Pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the Covered Person's health, all necessary information and documents shall be delivered to an independent medical review organization within 24 hours of approval of the request for review. In reviewing a request for review, the Department of Insurance may waive the requirement that the Covered Person follow the insurer's grievance process in extraordinary and compelling cases, where the commissioner finds that the Covered Person has acted reasonably.

If HNL denies coverage of the recommended or requested therapy and the Covered Person meets the eligibility requirements, HNL will notify the Covered Person within five business days of its decision and his or her opportunity to request an external review of HNL's decision through IMR. HNL will provide the Covered Person with an application form to request an IMR of HNL's decision. The IMR process is in addition to any other procedures or remedies that may be available. The Covered Person pays no application or processing fees of any kind for IMR. The Covered Person has the right to provide information in support of his or her request for IMR. If the Covered Person's physician determines that the proposed therapy should begin promptly, he or she may request expedited review and the experts on the IMR panel will render a decision within seven days of the request. If the IMR panel recommends that HNL cover the recommended or requested therapy, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which the Covered Person is entitled. A decision not to participate in the IMR process may cause the Covered Person to forfeit any statutory right to pursue legal action against HNL regarding the denial of the recommended or requested therapy. For more information, please contact the Customer Contact Center at **1-800-522-0088**.

Arbitration

As a condition to becoming an HNL Covered Person, **THE COVERED PERSON AGREES TO SUBMIT ALL DISPUTES RELATING TO OR ARISING OUT OF HIS OR HER HNL MEMBERSHIP TO INDIVIDUAL FINAL BINDING ARBITRATION, EXCEPT DISPUTES CONCERNING ADVERSE BENEFIT DETERMINATIONS AS DEFINED IN 45 CFR 147.136, AND YOU AGREE NOT TO PURSUE CLASS ARBITRATION. Likewise, HNL agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both the Covered Person and HNL are bound to use binding bilateral arbitration as the final means of resolving disputes that may arise between the parties, and thereby both parties agree to forego any right they may have to a jury trial on such disputes.** However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by HNL's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Sometimes disputes or disagreements may arise between the Covered Person (including his or her 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 the Covered Person's HNL membership. Typically such disputes are handled and resolved through the HNL Grievance, Appeal and Independent Medical Review process described above, and you must attempt to resolve your dispute by utilizing that process before instituting arbitration. However, in the event that a dispute is not resolved in that process, HNL uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with HNL involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

HNL's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is $500,000 or less ($50,000 or less with respect to disputes with HNL involving alleged professional liability or medical malpractice), the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $500,000 or $50,000, whichever is applicable. In the event that total amount of damages is over $500,000 or $50,000, whichever is applicable, the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then in accordance with California Insurance Code 10123.19(b), either party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter. When a petition is made to the court to appoint a neutral arbitrator, the court shall nominate five persons from lists of persons supplied jointly by the parties to the arbitration or obtained from a governmental agency concerned with arbitration or private disinterested association concerned with arbitration. The parties to the agreement who seek arbitration and against whom arbitration is sought may within five days of receipt of notice of the nominees from the court jointly select the arbitrator whether or not the arbitrator is among the nominees.

If the parties fail to select an arbitrator within the five-day period, the court shall appoint the arbitrator from the nominees.

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

Health Net Life Insurance Company
Attention: Legal Department
P.O. Box 4504
Woodland Hills, CA 91365-4504

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

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

Covered Persons who are enrolled in a 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, the Covered Person 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 the Covered Person 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 a Covered Person is ever injured through the actions of another person or his or herself (responsible party), HNL will provide benefits for all Covered Services and Supplies that the Covered Person receives under this *Certificate*. However, if the Covered Person receives money or is entitled to receive money because of his or her injuries, HNL or the medical providers retain the right to recover the value of any services provided to the Covered Person 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 a Covered Person could be injured through the actions of a responsible party are:

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

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

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

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

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

By accepting benefits under this Plan, the Covered Person also grants HNL an assignment of his or her right to recover medical expenses from any medical payment coverage available to the extent of the full cost of all covered services provided by HNL and the Covered Person specifically directs such medical payments carriers to directly reimburse HNL on the Covered Person's behalf.

Steps the Covered Person Must Take

If the Covered Person is injured because of a responsible party, he or she must cooperate with HNL's and the medical providers' efforts to obtain reimbursement, including:

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

How the Amount of the Covered Person'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.*

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

- The amount of the reimbursement owed to HNL or the medical provider will be reduced by the percentage that the recovery is reduced if a judge, jury or arbitrator determines that the Covered Person was responsible for some portion of his or her injuries.
- The amount of the reimbursement owed HNL or the medical provider will also be reduced by a pro rata share for any legal fees or costs paid from money the Covered Person received.

- The amount the Covered Person will be required to reimburse HNL or the medical provider for services received under this plan will not exceed one-third of the money the Covered Person received if he or she engages a lawyer, or one-half of the money received if a lawyer is not engaged.
- For health care services not provided on a capitated basis, the amount actually paid by the licensee, medical group, or independent practice association pursuant to that contract or policy to any treating medical provider.
- For health care services provided on a capitated basis, the amount equal to 80 percent of the usual and customary charge for the same services by medical providers that provide health care services on a noncapitated basis in the geographic region in which the services were rendered.

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

Surrogacy Arrangements

A Surrogacy Arrangement is an arrangement in which a woman agrees to become pregnant and to carry the child for another person or persons who intend to raise the child.

Your Responsibility for Payment to HNL

If a Covered Person enters into a surrogacy arrangement, the Covered Person must pay HNL for Covered Services and Supplies the Covered Person receives related to conception, pregnancy, or delivery in connection with that arrangement ("Surrogacy Health Services"), except that the amount the Covered Person must pay will not exceed the payments the Covered Person and/or any family members are entitled to receive under the surrogacy arrangement. The Covered Person also agrees to pay HNL for the Covered Services and Supplies that any child born pursuant to the surrogacy arrangement receives at the time of birth or in the initial Hospital stay, except that if the Covered Person provides proof of valid insurance coverage for the child in advance of delivery or if the intended parents make payment arrangements acceptable to HNL in advance of delivery, the Covered Person will not be responsible for the payment of the child's medical expenses.

Assignment of Your Surrogacy Payments

By accepting Surrogacy Health Services, the Covered Person automatically assigns to HNL the Covered Person's right to receive payments that are payable to the Covered Person or the chosen payee under the surrogacy arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, HNL will also have a lien on those payments and/or any escrow account or trust established to hold those payments. Those payments shall first be applied to satisfy HNL's lien. The assignment and HNL's lien will not exceed the total amount of the Covered Person's obligation to HNL under the preceding paragraph.

Duty to Cooperate

Within 30 days after entering into a surrogacy arrangement, the Covered Person must send written notice of the arrangement, including the names and addresses of the other parties to the arrangement to

include any escrow agent or trustee, and a copy of any contracts or other documents explaining the arrangement as well as the account number for any escrow account or trust, to:

Surrogacy Third Party Liability – Product Support
The Rawlings Company
One Eden Parkway
LaGrange, KY 40031-8100

The Covered Person must complete and send HNL all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for HNL to determine the existence of any rights HNL may have under this "Surrogacy Arrangements" provision and/or to determine the existence of (or accounting for funds contained in) any escrow account or trust established pursuant to the Covered Person's surrogacy arrangement and to satisfy HNL's rights.

The Covered Person must do nothing to prejudice the health plan's recovery rights.

The Covered Person must also provide HNL the contact and insurance information for the persons who intend to raise the child and whose insurance will cover the child at birth.

The Covered Person may not agree to waive, release, or reduce HNL's rights under this provision without HNL's prior, written consent. If the Covered Person's estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, the Covered Person's estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to HNL's liens and other rights to the same extent as if the Covered Person had asserted the claim against the third party. HNL may assign our rights to enforce HNL's liens and other rights.

Non-Assignment

The right of the Covered Person and his or her Dependents to receive benefits under this Certificate is personal to the Covered Person and/or Dependents and is not assignable in whole or in part to any Hospital, Provider, person or other entity. This provision does not prohibit direct payment to any provider, but any decision by HNL to pay a provider directly for services is made solely for the convenience of HNL and not an acceptance or endorsement of any assignment.

EXTENSION OF BENEFITS

When an enrolled Covered Person's coverage ends due to termination of the Group Policy between HNL and the Group, benefits of this *Certificate* will be extended for the disabling illness, subject to all of the following:

When Benefits Will Be Extended Due to Total Disability

BENEFITS WILL BE EXTENDED WHEN:

- The Covered Person lost coverage due to the fact that the Group Policy between HNL and the Group was terminated, regardless of the reason for the termination, whether such termination is initiated by the Group or HNL, and
- The Covered Person is totally disabled. For the purpose of this benefit, the term “total disability” is defined as a disability that renders You unable to perform with reasonable continuity the substantial and material acts necessary to pursue Your usual occupation in the usual or customary way or to engage with reasonable continuity in another occupation in which You could reasonably be expected to perform satisfactorily in light of Your age, education, training, experience, station in life, physical and mental capacity.

Obtaining an Extension of Benefits Due to Total Disability

The principal Covered Person must submit a written request to HNL that benefits be extended. HNL must receive the request within 90 days of termination of the Group Policy. The request must include written certification by the attending physician that the Covered Person is totally disabled.

Ongoing Proof of Total Disability

At least once every 90 days while services and benefits are being extended, HNL must receive proof that the Covered Person's total disability is continuing. The principal Covered Person shall be responsible for ensuring that HNL receives this proof prior to the required 90-day intervals.

Duration of Extension Due to Total Disability

Benefits are provided until whichever of the following occurs first:

- The Covered Person is no longer totally disabled;
- The maximum benefits of this *Certificate* are paid;
- 12 months pass from the date coverage ended; or
- The Covered Person becomes covered by a replacement group health policy or plan obtained by the Group which does not contain a limitation regarding the disabling condition.

Scope of Benefits During Extension Due to Total Disability

All benefits of this *Certificat*e will be provided but only for the disabling condition.

Covered Person Responsibility during the Extension Due to Total Disability

The Covered Person will be responsible for any unpaid Deductible and/or Coinsurance required by this *Certificate* during the extension of benefits. The Covered Person will not be required to pay premiums during this period.

GENERAL PROVISIONS

Government Coverage

Covered Person's and Dependents must be enrolled in Medicare to be eligible for this HNL Medicare COB Plan. For answers to questions regarding Medicare, contact:

- The 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
  6325 Security Blvd.
  Baltimore, MD 21207

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 the Covered Person 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 the Covered Person's eligibility under this *Certificate* and appropriate legal action**.

Transfer of Medical Records

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

Notice of Claim

Written notice of claim must be given to HNL within 20 days after the occurrence or commencement of any covered loss, or as soon thereafter as reasonably possible. Notice may be given to HNL at 21281 Burbank Blvd., Woodland Hills, CA 91367, or to any of HNL's authorized agents or mailed to HNL at P.O. Box 9040, Farmington, MO 63640-9040. Notice should include information sufficient for HNL to identify the Covered Person.

Claim Forms

When HNL receives notice of a claim, it will furnish the Covered Person with HNL's usual forms for filing proof of loss. If HNL does not do so within 15 days, the Covered Person can comply with the requirements for furnishing proof of loss by submitting written proof within the time fixed in this

Certificate for filing such proofs of loss. Such written proof must cover the occurrence, the character and the extent of the loss.

Proofs of Loss

Written proof of loss must be furnished to HNL at P.O. Box 9040, Farmington, MO 63640-9040, in case of claim for loss for which this *Certificate* provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the insurer is liable; 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, HNL is not required to accept proofs more than one year from the time proof is otherwise required.

Expenses for Copying Medical Records

HNL will reimburse the Covered Person or provider for reasonable expenses incurred in copying medical records requested by HNL.

Time of Payment of Claims

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

Within 30 working days after receipt of the complete claim by HNL, HNL may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied. The notice will identify the contested or denied portion(s) of the claim, and the specific reasons for such contention or denial, as supported by the factual and legal bases known to HNL at that time.

In the event HNL requires additional time to affirm or deny the claim, HNL shall notify the claimant in writing. This written notice shall specify any additional information HNL requires in order to make a determination and shall state any continuing reasons for HNL’s inability to make a determination. This notice shall be given within thirty calendar days of the notice that the claim is being contested and every thirty calendar days thereafter until a determination is made or legal action is served. If the determination cannot be made until some future event occurs, HNL shall comply with this continuing notice requirement by advising the claimant of the situation and providing an estimate as to when the determination can be made.

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

Payment of Life Claim

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Covered Person. Any other accrued indemnities unpaid at the Covered Person's death may,

at the option of HNL, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Covered Person.

If any indemnity of this *Certificate* shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, HNL may pay such indemnity, up to an amount not exceeding $1,000 to any relative by blood or connection by marriage or domestic partnership of the insured or beneficiary who is deemed by HNL to be equitably entitled thereto. Any payment made by HNL in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the Covered Person in the application or otherwise all or a portion of any indemnities provided by this *Certificate* on account of Hospital, nursing, medical, or surgical services may, at the HNL's option and unless the Covered Person requests otherwise in writing not later than the time of filing proofs of that loss, be paid directly to the person or persons having paid for the hospitalization or medical or surgical aid, or to the Hospital or person rendering those services; but it is not required that the service be rendered by a particular Hospital or person.

Cash Benefits

HNL will reimburse you for the amount you paid for Covered Expenses, less any applicable Deductible, Copayment or Coinsurance. You must provide proof of any amounts that you have paid. If you signed an assignment of benefits and the provider presents it to us, we will send the payment directly to the provider.

Claims Denial

1. **DENIAL**: If the Covered Person submits a fully completed claim to HNL, and it is partially or totally denied, he or she will be notified in writing of the denial within 30 working days from the date the claim was submitted. The Covered Person will be given the specific reasons and sections of the *Certificate* on which the denial is based. If the claim might be paid with more information, the Covered Person will be told what additional information is necessary and why.
2. **APPEAL**: The Covered Person or his or her authorized representative has the right to appeal the denial or partial denial of any claim made under the *Certificate* by requesting a review of the claim. The request must be made in writing to HNL within 365 days of the date that appears on the claims denial.

   If the request is not made within the 365 day period, the Covered Person waives the right to a review.

   This request must include the Covered Person’s name, address, date of denial and the reasons upon which the request for review is based. Any facts that support these reasons and any issues or comment the Covered Person or the representative deems relevant should be included. In addition, the Covered Person or the representative may examine pertinent documents that relate to the denial of the claim.
3. **REVIEW AND DECISION**: Upon receipt of the request for review, HNL will make full and fair review of the claim and its denial.

   HNL has a period of 60 days (after the receipt of the request for review of an adverse benefit determination) in which to make a decision and notify the Covered Person.

The decision on the request for review will be in writing and will include the specific reasons supporting it and specific references to the pertinent *Certificate* provisions on which the decision is based. If HNL upholds the denial, the Covered Person may request an independent medical review or initiate binding arbitration. A Covered Person must participate in HNL's grievance or appeals process before requesting independent medical review for denials unless there is an imminent and serious threat to the Covered Person's health. However, You will not be required to participate in the HNL's grievance or appeals process for more than 30 days. In the case of a grievance that requires expedited review, You will not be required to participate in HNL's grievance process for more than three days. See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" and "Arbitration" under "Coverage Decisions and Disputes Resolution" for the procedure to request an Independent Medical Review or arbitration of a Plan denial of coverage.

Payment to Providers or Principal Covered Persons:

1. **Direct Payment.** Benefit payment for Covered Expenses will be made directly to:
   a. Contracting Hospitals - Hospitals which have Provider Service Agreements with HNL to provide services to Covered Persons.
   b. Providers of Ambulance transportation, nurse practitioners, midwives for perinatal care and certified nurse midwives. As required by the California Insurance Code, this must occur. But, if the submitted provider's statement or bill indicates that the charges have been paid in full, payment will be made to the principal Covered Person.
   c. Other providers of service not mentioned in a. and b. above, Hospital and professional, when required by law or at HNL's election if you agree, in writing.
2. **Joint Payment.** Benefit payment for Covered Expenses will be made jointly to other providers and the principal Covered Person when a written assignment stipulates joint payment:
3. **Direct Payment to principal Covered Person.** In situations not described above, payment will made to the principal Covered Person. HNL reserves the right to recover an overpayment if all or some of the payment made by HNL exceeded the benefits under the *Certificate*. If an overpayment is discovered, we will notify the principal Covered Person within 6 months of the date of the error. In the case of an error prompted by representations or nondisclosure of claimants or third parties, HNL will notify the principal Covered Person within fifteen (15) calendar days after the date of discovery of such error. The notice will include the cause of the error and the amount of the overpayment.

Payment When Covered Person Is Unable to Accept

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

Physical Examination and Autopsy

HNL, at its expense, has the right and opportunity to examine or request an examination of any Covered Person whose injury or sickness is the basis of a claim as often as is reasonably required while the claim is pended and to make an autopsy in case of death where it is not forbidden by law.

Change of Beneficiary

Unless the Covered Person makes an irrevocable designation or beneficiary, the right to change of beneficiary is reserved to the Covered Person and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this *Certificate* or to any change of beneficiary or beneficiaries, or to any other changes in this *Certificate*.

Foreign Travel or Work Assignment

Benefits will be provided for Covered Expenses incurred in a foreign country, as long as the Covered Person has been outside the USA for less than six months in relation to a particular foreign trip, or the principal Covered Person is on temporary work assignment outside the USA and is being paid in US dollars by the employer, and the services or supplies would have been covered had they been obtained in the USA. Determination of a Allowable Amount will be based on an amount that is no greater than the Maximum Allowable Amount paid in the USA for the same or a comparable service.

Workers' Compensation Insurance

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

Diethylstilbestrol

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

Notice

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

If notice is required of the principal Covered Person 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 provision of this section.

Misstatement of Age

If the age of any Covered Person covered under this *Certificate* has been misstated, there shall be an adjustment of the premium for this *Certificate* so that there shall be paid to the insurer the premium for

the coverage of such Covered Person at his correct age, and the amount of the insurance coverage shall not be affected.

Clerical Error

No clerical error on the part of the Group applying for coverage shall affect the insurance, or amount thereof, of any Covered Person, provided proper premium adjustment is made upon discovery of such error.

Non-Regulation of Providers

This HNL plan does not regulate the amounts charged by providers of medical care.

Free Choice of Provider

As a Covered Person in this HNL plan, you are not required to select a primary care physician. This HNL plan does not interfere with the Covered Person's right to select any properly licensed Hospital, physician (including specialists and behavioral health care providers), laboratory or other health care professional or facility that provides services or supplies covered by this plan.

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 the Covered Person 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.

Technology Assessment

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

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

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

condition requires expert evaluation. If HNL denies, modifies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational, you may request an independent medical review (IMR) of HNL's decision from the Department of Insurance. Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" in the "Coverage Decisions and Disputes Resolution" section for additional details.

Confidentiality of Medical Records

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

Health Care Plan Fraud

Health care plan fraud is a felony that can be prosecuted. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Covered Person's Responsibility

As a Covered Person, you must:

- File accurate claims. If someone else, such as your spouse or Domestic Partner or another dependent who is a Covered Person, files claims on your behalf, you should review the form before you sign it;
- Review the explanation of benefits (EOB) form when it is returned to you. Make certain that benefits have been paid correctly based on your knowledge of the expenses incurred and the services rendered;
- Never allow another person to seek medical treatment under your identity. If your ID card is lost, you should report the loss to HNL 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, HNL encourages you to notify HNL 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 HNL's toll-free hotline at the number shown on the HNL ID card. All calls are strictly confidential

PREVENTIVE CARE LIST OF SERVICES

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

Preventive Care Services are covered as shown in the "Schedule of Benefits" section. Please consult with Your physician to determine whether a specific service is preventive or diagnostic. When Preventive Care Services, as described in this section, are received from a Participating Provider, they are covered at no cost share to You. If the primary purpose of the office visit is unrelated to a Preventive Care Service or if other non-Preventive Care Services are received during the same office visit, the non-Preventive Care Services are payable at benefit levels indicated in the "Schedule of Benefits" section.

Preventive Care Services are covered for children and adults, as directed by Your physician, and in accordance with the following:

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

Your physician will evaluate Your health status (including, but not limited to, Your risk factors, family history, gender and/or age) to determine the appropriate Preventive Care Services and frequency. HNL will not make its own determinations as to risk and will defer to the physician's decision. Additional information regarding Preventive Care Services may be accessed through (https://www.healthcare.gov/coverage/preventive-care-benefits/).

Preventive Care Services for children include:

- For the screening of alcohol, tobacco, and drug use for school-aged children and adolescents: Services include a physician interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents. Limited to one (1) screening per year.
- Autism Spectrum Disorder Screening for children: Limited to one (1) screening at the age of 18 month and one (1) at the age of 24 months, as recommended by the American Academy of Pediatrics.
- Psychosocial/Behavioral Assessments for children ages 0 to 17 years: This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. Please refer to the Bright Futures Periodicity Schedule for frequency information.

- Bilirubin Concentration Screening for the detection of genetic disorders in newborns: Please refer to the Bright Futures Periodicity Schedule for frequency information as recommended by the American Academy of Pediatrics.
- Blood Pressure Screening for children ages 0 to 17 years: Screening should occur per general clinical practice guidelines for screening and management of high blood pressure in children and adolescents. Limited to one (1) at every medical visit.
- Blood screening for newborns: Preventive coverage includes screening pursuant to the Recommended Uniform Screening Panel (RUSP) for newborns, verifying results, and follow up, as appropriate.
- Depression Screening for adolescents beginning routinely at age 7-18 years: For the detection of Major Depressive Disorder (MDD) in children and adolescents. Limited to one (1) screening per year.
- Developmental Screening for children under age 3 to diagnose and assess potential developmental delays: Using a surveillance algorithm as a strategy to support health care professionals in developing a pattern and practice for addressing developmental concerns in children from birth through 3 years of age. Limited to one (1) surveillance per year.
- Dyslipidemia Screening for all children. Please refer to the Bright Futures Periodicity Schedule for frequency information.
- Fluoride chemoprevention rinse or supplements for children ages 6 months to 17 years of age with a fluoride deficiency in their water source.
- Fluoride varnish for all infants at age 6 months, as soon as teeth are present, to children up to 5 years of age. A topical application administered in a pediatrician or dentist office. Limited to every 3-6 months for treatment.
- Gonorrhea preventive medication for the eyes of all newborns. Erythromycin ophthalmic ointment application to the eyes: Limited to one (1) treatment within 24 hours of birth.
- Hearing screening for all newborns and for children. Please refer to the Bright Futures Periodicity Schedule for frequency information.
- Height, weight and body mass index (BMI) measurements for children and adolescents ages: 0– 17 years. Limited to one (1) screening at the time of birth before discharge of Hospital stay and at yearly wellness visit, as recommended by the American Academy of Pediatrics.
- Hepatitis B screening for adolescents at high risk for infection. Testing for antibodies to HBsAg (anti-HBs) and Hepatitis B core antigen (anti-HBc) is also done as part of a screening panel to help distinguish between infection and immunity. Periodic screening may be useful in patients with ongoing risk for HBV transmission who do not receive a vaccination. Screenings provided at the discretion of your physician.
- HIV screening test for children and adolescents. Services include counseling and screening test for HIV. preventive coverage for at least a one-time screening between the ages of 15 and 18 regardless of risk, and additional screening based on risk for children and adolescents, including those under the age of 15, up to every 3 to 6 months in high-risk cases. Please refer to the Bright Futures Periodicity Schedule for frequency information.

- Immunization vaccines for children from birth to age 18. (Note: doses, recommended ages and recommended populations vary). Coverage will be pursuant to the Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, United States, 2018 (available at https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html).
  - Diphtheria, Tetanus, Pertussis (Whooping Cough) vaccination
  - Haemophilus influenza type b vaccination
  - Hepatitis A vaccination
  - Hepatitis B vaccination
  - Human Papillomavirus (HPV) vaccination
  - Inactivated Poliovirus vaccination
  - Influenza (flu shot) vaccination
  - Measles vaccination
  - Meningococcal meningitis vaccination
  - Pneumococcal vaccination
  - Rotavirus vaccination:
    - RotaTeq® (RV5)
    - Rotarix® (RV1)
  - Varicella (Chickenpox) Vaccination
- Iron screening for children. Anemia is a condition in which the amount of red blood cells in the body is decreased below normal for your child's age. Please refer to the Bright Futures Periodicity Schedule for frequency information.
- Lead screening (screening for blood lead levels) for children at risk of lead poisoning as determined by a health care provider in accordance with standards adopted by the California Department of Public Health. Screenings provided at the discretion of your physician.
- Medical history for all children throughout development. Growth and development includes not only the physical changes that will occur from infancy to adolescence, but also some of the changes in emotions, personality, behavior, thinking and speech that children develop as they begin to understand and interact with the world around them. Please refer to the Bright Futures Periodicity Schedule for frequency information.
- Obesity screening and counseling in children and adolescents (when necessary, clinicians should offer or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status). Please refer to the Bright Futures Periodicity Schedule for frequency information.

- Oral health risk assessment for young children. When an oral examination by a dentist is not possible, an infant should receive an oral health risk assessment by age 6 months by a pediatrician or other qualified oral health professional (e.g., dental hygienist) or other health professional. Infants within one of the following risk groups should be referred to a dentist as soon as possible: mother or other primary caregiver has active caries, parent or other caregiver has low socioeconomic status, child receives more than three between meal foods or beverages containing sugar per day, child is put to bed with a bottle or a sippy cup with beverage containing sugar, child has special health care needs, child is a recent immigrant, child has white spot lesions or enamel defects, child has visible cavities or fillings, child has plaque on teeth. Please refer to the Bright Futures Periodicity Schedule for frequency information.
- Regular well-baby and well-child visits. Please refer to the Bright Futures Periodicity Schedule for frequency information.
- Sexually transmitted infection prevention counseling, screening, and behavioral counseling for all sexually active adolescents, as well as adults who are at increased risk for Sexually Transmitted Infections (STIs). Screenings provided at the discretion of your physician for Sexually Transmitted Diseases (STD) for sexually active patients. Screenings for sexually transmitted diseases include, Chlamydia, Gonorrhea, HIV, Genital Herpes, Syphilis, Trichomoniasis, HPV, genital warts and cervical cancer.
- Skin cancer. Behavioral counseling intervention to help minimize exposure to ultraviolet (UV) radiation. Behavioral counseling interventions target sun-protection behaviors to reduce UV radiation exposure, including use of broad-spectrum sunscreen with a sun-protection factor of 15 or greater; wearing hats, sunglasses, or sun-protective clothing; avoiding sun exposure; seeking shade during midday hours (10 am to 4 pm); and avoiding indoor tanning bed use to reduce the risk of skin cancer for persons aged 6 months to 24 years. Limited to one (1) counseling intervention per year.
- Tuberculin testing for children at higher risk of tuberculosis ages: 0 months – 17 years. The Tuberculin skin test is performed by injecting a small amount of fluid (called tuberculin) into the skin on the lower part of the arm. Please refer to the Bright Futures Periodicity Schedule for frequency information.
- Vision screening for all newborns, children and adolescents (0-21). Vision screening can be performed by primary care providers, trained laypersons (e.g., school-based screenings), and eye care providers. Vision screening techniques are either provider-based (e.g., traditional acuity testing, inspection, red reflex testing) or instrument-based. Instrument-based screening can often be performed at an earlier age than provider-based acuity testing and allows earlier screening for risk factors that are likely to lead to amblyopia and poor vision. Please refer to the Bright Futures Periodicity Schedule for frequency information.

Preventive Care Services for women include:

- Anemia screening on a routine basis for pregnant women or women who may become pregnant. Several factors have been identified that may increase a pregnant woman’s risk for iron deficiency anemia, including a diet lacking in iron-rich foods, gastrointestinal disease and/or medications that can decrease iron absorption, and a short interval between pregnancies. Limited to one (1) screening for anemia during the first prenatal visit. Limited to one (1) screening in high-risk pregnant women during each trimester and at 4 to 6 weeks postpartum.

- Anxiety screening for adolescent and adult women, including those who are pregnant or postpartum. Adolescent and adult women, including those who are pregnant and postpartum, should be assessed for anxiety as a routine preventive health service. Screenings provided at the discretion of your physician.
- Breast cancer chemoprevention counseling and medications for women at higher risk. Women at high risk of breast cancer may be able to improve the odds of staying cancer-free by taking certain medicines, an approach known as chemoprevention or preventive therapy. Taking medicines to help lower the risk of getting a disease is called chemoprevention. The most commonly used medicine options to lower breast cancer risk are tamoxifen and raloxifene. Counseling and medication treatments at the discretion of your physician.
- Breast cancer genetic counseling and testing (BRCA) for women at high risk. Genetic testing gives people the chance to learn if their breast cancer or family history of breast cancer is due to an inherited gene mutation. Genetic testing for hereditary breast and ovarian cancer looks for mutations in the BRCA1 and BRCA2 genes. Your physician might suggest testing using a multigene panel, which looks for mutations in several genes at the same time, including BRCA1 and BRCA2. Counseling and testing are provided at the discretion of your physician.
- Breast cancer mammography screenings (once annually for average risk women beginning at the age of 40). A mammogram is an x-ray picture of the breast. Doctors use a mammogram to look for early signs of breast cancer. Regular mammograms are the best tests doctors have to find breast cancer early, sometimes up to three years before it can be felt. A monthly self-exam should be performed. Limited to one (1) mammogram screening every year if not considered high risk. Limited to two (2) mammogram screenings for high risk Covered Members.
- Breastfeeding comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and the postpartum period to ensure the successful initiation and maintenance of breastfeeding for pregnant and nursing women as prescribed by Your physician. We will determine the type of equipment, whether to rent or purchase the equipment, and the vendor. You can find out how to obtain a breast pump by calling the Customer Contact Center at the phone number on Your Health Net Life ID card.
- Cervical dysplasia screening for females at ages 21 - 65: For the early detection of abnormal changes in cells. Limited to one (1) screening per year or every 5 years screening with high-risk Human Papillomavirus (hrHPV) testing alone or every 5 years with hrHPV testing in combination with Pap (cotesting).
- Cervical cancer screening. These tests can help find cervical cells that are infected with HPV or other abnormal cells before they turn into cervical cancer. Limited to one (1) screening per year as part of annual well visit.
    - Pap test (also referred to as a Pap smear) for women 21 – 65 and
    - Human Papillomavirus (HPV) DNA test with the combination of a Pap smear every year for women 30 – 65 who don’t want a more frequent Pap smear.
- Chlamydia infection screening for women age 24 and younger, and older women at increased risk. Generally performed as a urinalysis or a swab test. Limited to one (1) screening per year as part or annual well visit.

- Contraception (all FDA-approved contraceptive Drugs, devices, sterilization, and other products for women). Preventative contraception includes all FDA-approved contraceptive Drugs and devices, (including, but not limited to, IUDs, injectable and implantable contraceptives). Coverage also includes contraceptive counseling, contraceptive education, (including, but not limited to, follow-up and management of side effects of contraceptives, counseling for continued adherence) and contraceptive device placement and removal.
- Depression screening for pregnant and postpartum women. Screening for the presence of prenatal mood and anxiety disorders, using an evidence-based tool such as the Edinburgh Postnatal Depression Screen (EPDS) or Patient Health Questionnaire (PHQ-9). Screenings are provided at the discretion of your physician.
- Depression interventions for pregnant and postpartum women. Pregnant and postpartum individuals who are at increased risk of perinatal depression will be provided with or referred to counseling interventions. Preventive intervention in this case applies to a pregnant woman and up to 1 year postpartum.
- Diabetes screening for women with a history of gestational diabetes who are not currently pregnant and who have not been diagnosed with type 2 diabetes before. Physicians may use blood tests to diagnose gestational diabetes. Patients may have the glucose challenge test, the oral glucose tolerance test, or both. Limited to one (1) screening per year as part of annual well visit.
- Domestic and interpersonal violence screening and counseling for all women (screening women of reproductive age for interpersonal and domestic violence is recommended, at least annually, and, when needed, providing or referring to ongoing support services). Limited to one (1) screening and counseling per year as part of annual well visit. However, additional treatment will be provided as needed, at the discretion of your physician.
- Folic acid supplement counseling and testing (daily supplement containing 0.4 to 0.8 mg of folic acid) for women who may become pregnant. A folic acid test measures the amount of folic acid in the blood. Folic acid is one of many B vitamins. The body needs folic acid to make Red Blood Cells (RBC), White Blood Cells (WBC) and platelets, and for normal growth. Folic acid also is important for the normal development of a baby (fetus). Limited to one (1) testing and counseling per year as part of annual well visit.
- Gestational diabetes screening for women 24 to 28 weeks pregnant, as well as those at high risk of developing gestational diabetes. Testing can be performed one of two ways. There is formal systematic testing with a 75g, 2-hour OGTT for GDM between 24 and 28 weeks of gestation. There is also the one step approach, in the 1-step approach, a 75-g glucose load is administered after fasting and plasma glucose levels are evaluated after 1 and 2 hours. GDM is diagnosed if 1 glucose value fails at or one above the specified glucose threshold. Screenings are provided at the discretion of your physician.
- Gonorrhea screening for all sexually active women. All pregnant women aged 25 years and older women at increased risk for gonorrhea (e.g., those with a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection) should be screened for gonorrhea at the first prenatal visit. Screenings are provided at the discretion of your physician.
- Healthy weight gain counseling for pregnant women. Behavioral health counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.

- Hepatitis B screening for pregnant women at their first prenatal visit, as well as additional screening will be covered under preventive care at the time of admission for delivery if:
  - The patient's HBsAg status is unknown (e.g., the woman did not obtain prenatal care or if she is admitted to a Hospital other than the one that performed the screening at the first prenatal visit) or
  - She has new or continuing risk factors for Hepatitis B virus (HBV) infection.

  Screenings are provided at the discretion of your physician.
- HIV screening and counseling for women. Services include counseling and screening for HIV. Screenings limited to every 3 or 6 months, depending on risk factors.
- Human Papillomavirus (HPV) screening test. The HPV test is primarily used to screen for cervical cancer and/or determine whether you may be at increased risk of cervical cancer if you are a woman between the ages of 30 and 65. The test determines whether your cervical cells are infected with a high-risk type of Human Papillomavirus (hrHPV). Limited to one (1) screening per year.
- Osteoporosis screening for postmenopausal women to prevent osteoporotic fractures is recommended with bone measurement testing, as follows:
  - For postmenopausal women younger than 65 years at increased risk (as determined by a formal clinical risk assessment tool) and
  - For postmenopausal women 65 years and older.

  Limited to one (1) screening and counseling per year as part of annual well visit.
- Preeclampsia prevention. Low-dose aspirin is recommended as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia. Counseling is provided at the discretion of your physician.
- Preeclampsia (PE) screening for pregnant women. All pregnant women should be screened for preterm PE. Biomarkers offer a potential for early diagnosis and effective treatments. Screenings are provided at each prenatal care visit and repeated as needed at the discretion of your physician.
- Rh incompatibility screening follow-up testing for women. This test often is done at the first prenatal visit. The results from this test also can suggest how severe the baby's hemolytic anemia has become. Screenings are at the discretion of your physician. Rh (D) immunoglobulin is a medication used to prevent RhD isoimmunization in mothers who are RhD negative and to treat idiopathic thrombocytopenic purpura in people who are Rh positive. It is often given both during and following pregnancy. It may also be used when RhD negative people are given RhD positive blood. If an Rh(D)-positive or weakly Rh(D)-positive (e.g., Du-positive) infant is delivered, a dose of Rh(D) immunoglobulin should be repeated postpartum, preferably within 72 hours after delivery or at the discretion of your physician.
- Sexually transmitted infections counseling and screenings for women. Screenings and counseling for sexually transmitted diseases include: Chlamydia, Gonorrhea, HIV, Genital Herpes, Syphilis, Trichomoniasis, HPV, genital warts and cervical cancer, as recommended at the discretion of your physician.

- Syphilis screening for all pregnant women (pregnant women should be screened as early as possible in the pregnancy) or women who may become pregnant, as well as for any woman at increased risk. All women should be screened serologically for syphilis early in pregnancy. A Rapid Plasma Reagin (RPR) test screening and treatment (if the RPR test is reactive) should be performed at the time pregnancy is confirmed. Screenings are at the discretion of your physician. Urinary incontinence screening for women yearly. Screening should ideally assess whether women experience urinary incontinence and whether it impacts their activities and quality of life. Screenings are at the discretion of your physician.
- Tobacco use screening, counseling and cessation advice is recommended for all pregnant individuals. Physicians should ask all pregnant individuals about tobacco use, advise cessation and provide behavioral interventions for cessation.
- Urinary tract or other infection screening, antibiotic therapy and monitoring for pregnant women or women who may become pregnant. Urinary tract infections are diagnosed by performing a urinalysis, which looks for evidence of infection, such as bacteria and white blood cells in a sample of urine. Screenings, therapy and monitoring are at the discretion of your physician.
- Weight gain counseling for pregnant women. Behavioral health counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.
- Well-woman visits. Well-woman visits include a full checkup, separate from any other visit for sickness or injury. These visits focus on preventive care for women, which may include: services, like shots, that improve your health by preventing diseases and other health problems. Preventive coverage for as many well-woman visits as are determined by your physician to be necessary

Preventive Care Services for adults include:

- Abdominal aortic aneurysm one-time screening for men of specified ages (65 to 75 years) who have ever smoked or who have smoked at least 100 cigarettes in their lifetime. Limited to one (1) screening and counseling per year as part of annual well visit.
- Alcohol misuse screening, interventions, and counseling is recommended for adults 18 years or older, including pregnant women (persons engaged in risky or hazardous drinking will be provided behavioral counseling interventions to reduce unhealthy alcohol use). Screenings, interventions, and counseling will be at the discretion of your physician.
- Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk. The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10 year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years. Aspirin interferes with your blood's clotting action. When you bleed, your blood's clotting cells, called platelets, build up at the site of your wound. The platelets help form a plug that seals the opening in your blood vessel to stop bleeding. Medication treatment is at the discretion of your physician.
- Blood pressure screening. Screening should occur per general clinical practice guidelines for screening and management of high blood pressure. Limited to one (1) screening and counseling per year as part of annual well visit.

- Cholesterol screening for adults of certain ages or at higher risk. Adults age 20 or older should have their cholesterol and other traditional risk factors checked every four to six years. After age 40, your health care provider will also want to use an equation to calculate your 10-year risk of experiencing cardiovascular disease or stroke. Limited to one (1) screening and counseling per year as part of annual well visit.
- Colorectal Cancer: Screening for men and women age 45-75 for colorectal cancer. Fecal occult blood test/fecal immunochemical test annually; or fecal DNA testing (Cologuard) every 3 years; or flexible sigmoidoscopy every 5 years; or CT colonography every 5 years; or colonoscopy every 10 years. All surgical procedures such as polyp removal, anesthesia, consultations, readings/results of polyp biopsy as well as preparation associated with screening will be included as part of the screening in conjunction with frequency recommendations by the United States Preventive Services Task Force.
- Depression screening: For the detection of Major Depressive Disorder (MDD) in adults. When initial screening is positive, preventive coverage also includes additional assessment that considers severity of depression and comorbid psychological problems (e.g., anxiety, panic attacks, or substance abuse), alternate diagnoses, and medical conditions. Screenings, interventions, medications, and counseling will be at the discretion of your physician.
- Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese. Coverage includes intensive behavioral counseling interventions for patients with abnormal blood glucose to promote a healthful diet and physical activity. Screenings are at the discretion of your physician.
- Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting and at increased risk for falls. This screening consists of asking patients whether they have fallen 2 or more times in the past year or sought medical attention for a fall, or, if they have not fallen, whether they feel unsteady when walking. Effective exercise interventions include supervised individual and group classes and physical therapy, although most studies reviewed by the USPSTF included group exercise. The most common frequency and duration for exercise interventions was 3 sessions per week for 12 months, although duration of exercise interventions ranged from 2 to 42 months.
- Healthy diet and physical activity counseling to prevent Cardiovascular Disease (CVD): adults 18 years or older with known hypertension or elevated blood pressure, those with dyslipidemia, or those who have mixed or multiple risk factors, such as metabolic syndrome or an estimated 10-year CVD risk of 7.5% or greater will be offered/referred to behavioral counseling interventions to promote a healthy diet and physical activity. HNL will cover any intervention prescribed by a Physician as Preventive Care Services. Counseling frequencies and interventions are at the discretion of your Physician.
- Hearing screening: Hearing screening is a test to tell if people might have hearing loss. Limited to one (1) screening per year.
- Hepatitis B screening for people at high risk of infection. Testing for antibodies to HBsAg (anti-HBs) and Hepatitis B core antigen (anti-HBc) is also done as part of a screening panel to help distinguish between infection and immunity. Periodic screening may be useful in patients with ongoing risk for HBV transmission who do not receive vaccination. Screenings are at the discretion of your physician.

- Hepatitis C screening for adults at increased risk, as well as offering a one-time screening for adults aged 18 to 79 years without known liver disease, with periodic rescreening for those with continued risk for HCV infection. Screening for hepatitis C is performed by measuring antibody to HCV (anti-HCV) in a person's serum. A positive test (detection of the antibody) is not a diagnosis of the disease; it only indicates that a person was previously exposed to hepatitis C. Screenings are at the discretion of your physician.
- HIV preexposure prophylaxis for the prevention of HIV infection (clinicians should offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition). Pre-Exposure Prophylaxis (or PrEP) is a way for people who do not have HIV but who are at very high risk of getting HIV to prevent HIV infection by taking a pill every day. Screenings are at the discretion of your physician. Preventive coverage without cost sharing for all of the following:
  - HIV and other testing to initiate PrEP
  - PrEP medication:
    - Truvada (or TE);
    - Descovy; and
    - tenofovir disoproxil fumarate
  - Follow-up and monitoring, including but not limited to:
    - HIV testing every 3 months
    - Office visits to a primary care provider or Specialist
    - Additional lab tests to monitor the effects of the PrEP medication
    - STI screening
- HIV screening for everyone ages 15 to 65, as well as other ages if at increased risk. An antibody-antigen blood test checks for levels of both HIV antibodies and the p24 antigen. Limited to one (1) screening every 3 or 6 months in high risk cases. Screenings are at the discretion of your physician.
- Immunization vaccines for adults ages 18 and up. (note: doses, recommended ages and recommended populations vary): https://www.cdc.gov/vaccines/schedules/hcp/adult.html
  - Diphtheria
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster
  - Human Papillomavirus (HPV)
  - Influenza (flu shot) vaccination
  - Measles
  - Meningococcal
  - Mumps
  - Pertussis

  - Pneumococcal
  - Rubella
  - Tetanus
  - Varicella (Chickenpox)

- Lung cancer screening with low-dose computed tomography for adults aged 50 – 80 at high risk for lung cancer (they are heavy smokers or have quit in the past 15 years). During an LDCT scan, you lie on a table and an X-ray machine uses a low dose (amount) of radiation to make detailed images of your lungs. Screenings are at the discretion of your physician.
- Nutritional counseling for adults at higher risk for chronic disease. A healthy diet helps properly manage and reduce their risks of chronic diseases, including obesity. Adults who eat a healthy diet live longer and have a lower risk of obesity, heart disease, type 2 diabetes, and certain cancers. Limited to one (1) counseling session per year.
- Obesity screening and counseling (those with a body mass index of 30 or higher should be offered or referred to intensive, multicomponent behavioral interventions). Screening are at the discretion of your physician for BMI and behavioral therapy sessions that include a dietary assessment and counseling to help you lose weight by focusing on diet and exercise.
- Periodic health evaluations. A periodic health examination is an evaluation of your overall health status during which your doctor will evaluate your body, organs, and their functioning. Limited to one (1) annual screening.
- Screening and diagnosis of prostate cancer (including prostate-specific antigen testing and digital rectal examinations). One test is the digital rectal exam (DRE). The doctor or nurse inserts a lubricated, gloved finger into your rectum to feel the prostate for lumps or anything unusual. Another test is the prostate-specific antigen (PSA) blood test. Your PSA level may be high if you have prostate cancer. Limited to one (1) annual screening.
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
- Skin cancer. Behavioral counseling intervention to help minimize exposure to ultraviolet (UV) radiation and reduce the risk of skin cancer for persons aged 6 months to 24 years. The screening checks the skin for moles, birthmarks, or other marks that are unusual in color, size, shape, or texture. Certain unusual marks may be signs of skin cancer. Behavioral counseling interventions target sun-protection behaviors to reduce UV radiation exposure, including use of broad-spectrum sunscreen with a sun-protection factor of 15 or greater; wearing hats, sunglasses, or sun-protective clothing; avoiding sun exposure; seeking shade during midday hours (10 am to 4 pm); and avoiding indoor tanning bed use and reduce the risk of skin cancer. Limited to one (1) annual screening.
- Smoking cessation intervention services, including behavioral management activities, tailored self-help materials, and tobacco cessation counseling sessions. We provide coverage for 4 in-person, 10-minute long individual or group counseling sessions, as well as 3 telephone counseling sessions. Services related to pharmacotherapy and behavioral interventions, and all combinations thereof, are covered as preventive care. Screenings are at the discretion of your physician.

- Statin preventive medication for adults ages 40 to 75 years with no history of Cardiovascular Disease (CVD), 1 or more CVD risk factors, and a calculated 10 year CVD event risk of 10% or greater. Statins are a group of medicines that can help lower the level of Low-Density Lipoprotein (LDL) cholesterol in the blood. LDL cholesterol is often referred to as "bad cholesterol," and statins reduce the production of it inside the liver. Medication treatment coverage is for daily use of low-to moderate-dose statin without limit on duration. Screenings and medication treatments are at the discretion of your physician.
- Syphilis screening for adults at higher risk. Screenings are at the discretion of your physician.
- Tobacco use screening, counseling and cessation advice is recommended for all adults. Physicians should ask about tobacco use, advise cessation and provide behavioral interventions and US Food and Drug Administration (FDA)-approved pharmacotherapy for cessation
- Tuberculosis screening for adults without symptoms at high risk. The Tuberculin skin test is performed by injecting a small amount of fluid (called tuberculin) into the skin on the lower part of the arm. Limited to one (1) screening during annual well visit.
- Unhealthy drug use screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)

IMPORTANT NOTICES

Covered Persons' Rights, Responsibilities and Obligations Statement

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

Covered Persons have the right to:

- Receive information about HNL, its services, its practitioners and providers and Covered Persons' rights and responsibilities;
- Be treated with respect and recognition of their dignity and right to privacy;
- Participate with practitioners in making decisions about their health care;
- A candid discussion of appropriate or Medically Necessary treatment options for their conditions, regardless of cost or benefit coverage;
- Request an interpreter at no charge to you;
- Use interpreters who are not your family members or friends;
- File a grievance in your preferred language by using the interpreter service or by completing the translated grievance for 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 Health Net's member rights and responsibilities policies.

Covered Persons have the responsibility and obligation to:

- Supply information (to the extent possible) that the health care practitioners and providers need in order to provide care;
- Follow plans and instructions for care that they have agreed-upon with their practitioners; and
- Be aware of their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- Refrain from intentionally submitting materially false or fraudulent claims or information to HNL.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Covered Entities Duties:

Health Net Life** (referred to as “We “or “the Plan") is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Health Net Life is required by law to maintain the privacy of Your protected health information (PHI), provide You with this Notice of Our legal duties and privacy practices related to Your PHI, abide by the terms of the Notice that is currently in affect and notify You in the event of a breach of Your unsecured PHI. PHI is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

This Notice describes how We may use and disclose Your PHI. It also describes Your rights to access, amend and manage Your PHI and how to exercise those rights. All other uses and disclosures of Your PHI not described in this Notice will be made only with Your written authorization.

Health Net Life reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for Your PHI We already have as well as any of Your PHI We receive in the future. Health Net Life will promptly revise and distribute this Notice whenever there is a material change to:

- The uses or disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice.

We will make any revised Notices available on our website and in our Member Handbook.

C11401(CA 1/22)

***This Notice of Privacy Practices applies to enrollees in any of the following Health Net entities:** Health Net of California, Inc., Health Net Community Solutions, Inc., Managed Health Network, LLC and Health Net Life Insurance Company, which are subsidiaries of Health Net, LLC. and Centene Corporation.

Internal Protections of Oral, Written and Electronic PHI:

Health Net Life protects your PHI. We have privacy and security processes to help.

These are some of the ways we protect your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how We may use or disclose Your PHI without Your permission or authorization:

- ***Treatment*** - We may use or disclose Your PHI to a physician or other health care provider providing treatment to You, to coordinate Your treatment among providers, or to assist us in making prior authorization decisions related to Your benefits.
- ***Payment*** - We may use and disclose Your PHI to make benefit payments for the health care services provided to You. We may disclose Your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:
  - processing claims
  - determining eligibility or coverage for claims
  - issuing premium billings
  - reviewing services for Medical Necessity
  - performing utilization review of claims.
- ***Health Care Operations*** - We may use and disclose Your PHI to perform Our health care operations. These activities may include:
  - providing customer services
  - responding to complaints and appeals
  - providing case management and care coordination
  - conducting medical review of claims and other quality assessment and improvement activities.

  In Our health care operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of Your PHI with these associates. We may disclose Your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with You for its health care operations. This includes the following:

- quality assessment and improvement activities
- reviewing the competence or qualifications of health care professionals
- case management and care coordination
- detecting or preventing health care fraud and abuse.

- ***Group Health Plan/Plan Sponsor Disclosures*** – We may disclose Your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to You, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

- ***Fundraising Activities*** – We may use or disclose Your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If We do contact You for fundraising activities, We will give You the opportunity to opt-out, or stop, receiving such communications in the future.
- ***Underwriting Purposes*** – We may use or disclose Your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If We do use or disclose Your PHI for underwriting purposes, We are prohibited from using or disclosing Your PHI that is genetic information in the underwriting process.
- ***Appointment Reminders/Treatment Alternatives*** - We may use and disclose Your PHI to remind You of an appointment for treatment and medical care with us or to provide You with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.
- ***As Required by Law*** - If federal, state, and/or local law requires a use or disclosure of Your PHI, We may use or disclose Your PHI to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, We will comply with the more restrictive laws or regulations.
- ***Public Health Activities*** - We may disclose Your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclosure Your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness of products or services under the jurisdiction of the FDA.
- ***Victims of Abuse and Neglect*** - We may disclose Your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law authorized by law to receive such reports if We have a reasonable belief of abuse, neglect or domestic violence.
- ***Judicial and Administrative Proceedings*** - We may disclose Your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:
  - an order of a court
  - administrative tribunal
  - subpoena

- summons
- warrant
- discovery request
- similar legal request.

- ***Law Enforcement*** - We may disclose Your relevant PHI to law enforcement when required to do so, For example, in response to a:
  - court order
  - court-ordered warrant
  - subpoena
  - summons issued by a judicial officer
  - grand jury subpoena.

  We may also disclose Your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.
- ***Coroners, Medical Examiners and Funeral Directors*** - We may disclose Your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose Your PHI to funeral directors, as necessary, to carry out their duties.
- ***Organ, Eye and Tissue Donation*** - We may disclose Your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:
  - cadaveric organs
  - eyes
  - tissues
- ***Threats to Health and Safety*** - We may use or disclose Your PHI if We believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
- ***Specialized Government Functions*** - If You are a member of U.S. Armed Forces, We may disclose Your PHI as required by military command authorities. We may also disclose Your PHI:
  - to authorized federal officials for national security and intelligence activities
  - the Department of State for medical suitability determinations
  - for protective services of the President or other authorized persons.
- ***Workers' Compensation*** - We may disclose Your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

- ***Emergency Situations*** – We may disclose Your PHI in an emergency situation, or if You are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by You. We will use professional judgment and experience to determine if the disclosure is in Your best interests. If the disclosure is in Your best interest, We will only disclose the PHI that is directly relevant to the person's involvement in Your care.
- ***Inmates*** - If You are an inmate of a correctional institution or under the custody of a law enforcement official, We may release Your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide You with health care; to protect Your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.
- ***Research*** - Under certain circumstances, We may disclose Your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of Your PHI.

Uses and Disclosures of Your PHI that Require Your Written Authorization

We are required to obtain Your written authorization to use or disclose Your PHI, with limited exceptions, for the following reasons:

Sale of PHI – We will request Your written authorization before We make any disclosure that is deemed a sale of Your PHI, meaning that We are receiving compensation for disclosing the PHI in this manner.

Marketing – We will request Your written authorization to use or disclose Your PHI for marketing purposes with limited exceptions, such as when We have face-to-face marketing communications with You or when We provide promotional gifts of nominal value.

Psychotherapy Notes – We will request Your written authorization to use or disclose any of Your psychotherapy notes that We may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Individuals Rights

The following are Your rights concerning Your PHI. If You would like to use any of the following rights, please contact us using the information at the end of this Notice.

- ***Right to Revoke an Authorization*** - You may revoke Your authorization at any time, the revocation of Your authorization must be in writing. The revocation will be effective immediately, except to the extent that We have already taken actions in reliance of the authorization and before We received Your written revocation.

- ***Right to Request Restrictions*** - You have the right to request restrictions on the use and disclosure of Your PHI for treatment, payment or health care operations, as well as disclosures to persons involved in Your care or payment of Your care, such as family members or close friends. Your request should state the restrictions You are requesting and state to whom the restriction applies. We are not required to agree to this request. If We agree, We will comply with Your restriction request unless the information is needed to provide You with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when You have paid for the service or item out of pocket in full.
- ***Right to Request Confidential Communications*** - You have the right to request that We communicate with You about Your PHI by alternative means or to alternative locations. This right only applies in the following circumstances: (1) the communication discloses PHI including all or part of the medical information or provider name and address relating to receipt of sensitive services, or (2) disclosure of PHI including all or part of the medical information or provider name and address could endanger You if it is not communicated by the alternative means or to the alternative location You want. You do not have to explain the reason for Your request, but Your request must clearly state that either the communication discloses PHI including all or part of the medical information or provider name and address relating to receipt of sensitive services or that disclosure of PHI including all or part of the medical information or provider name and address could endanger You if the communication means or location is not changed. We must accommodate Your request if it is reasonable and specifies the alternative means or location where Your PHI should be delivered.
- ***Right to Access and Receive Copy of Your PHI*** - You have the right, with limited exceptions, to look at or get copies of Your PHI contained in a designated record set. You may request that We provide copies in a format other than photocopies. We will use the format You request unless We cannot practicably do so. You must make a request in writing to obtain access to Your PHI. If We deny Your request, We will provide You a written explanation and will tell You if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.
- ***Right to Amend Your PHI*** - You have the right to request that We amend, or change, Your PHI if You believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny Your request for certain reasons, for example if We did not create the information You want amended and the creator of the PHI is able to perform the amendment. If We deny Your request, We will provide You a written explanation. You may respond with a statement that You disagree with Our decision and We will attach Your statement to the PHI You request that We amend. If We accept Your request to amend the information, We will make reasonable efforts to inform others, including people You name, of the amendment and to include the changes in any future disclosures of that information.
- ***Right to Receive an Accounting of Disclosures*** - You have the right to receive a list of instances within the last 6 years period in which We or Our business associates disclosed Your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures You authorized and certain other activities. If You request this accounting more than once in a 12-month period, We may charge You a reasonable, cost-based fee for responding to these additional requests. We will provide You with more information on Our fees at the time of Your request.

- ***Right to File a Complaint*** - If You feel Your privacy rights have been violated or that We have violated Our own privacy practices, You can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-800-368-1019, (TTY: 1-866-788-4989) or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

- ***Right to Receive a Copy of this Notice*** - You may request a copy of Our Notice at any time by using the contact information list at the end of the Notice. If You receive this Notice on Our web site or by electronic mail (e-mail), You are also entitled to request a paper copy of the Notice.

Contact Information

If You have any questions about this Notice, Our privacy practices related to Your PHI or how to exercise Your rights You can contact us in writing or by phone using the contact information listed below.

Health Net Life Privacy Office
Attn: Privacy Official
P.O. Box 9103
Van Nuys, CA 91409

Telephone: 1-800-522-0088
Fax: 1-818-676-8314
Email: Privacy@healthnet.com

FINANCIAL INFORMATION PRIVACY NOTICE

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

We are committed to maintaining the confidentiality of Your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect: We collect personal financial information about You from the following sources:

- Information We receive from You on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about Your transactions with us, Our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information: We do not disclose personal financial information about Our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of Our general business practices, We may, as permitted by law, disclose any of the personal financial information that We collect about You, without Your authorization, to the following types of institutions:

- To Our corporate affiliates, such as other insurers;
- To nonaffiliated companies for Our everyday business purposes, such as to process Your transactions, maintain Your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on Our behalf.

Confidentiality and Security: We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect Your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access Your personal financial information.

Questions about this Notice:

If You have any questions about this notice:

Please **call the toll-free phone number on the back of Your ID card** or contact Health Net Life at 1-800-522-0088.

NONDISCRIMINATION NOTICE

Health Net Life Insurance Company (Health Net) complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at:

Group Plans through Health Net 1-800-522-0088 (TTY: 711)

If you believe that Health Net has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Health Net's Customer Contact Center at the number above and telling them you need help filing a grievance. Health Net's Customer Contact Center is available to help you file a grievance. You can also file a grievance by mail, fax or email at:

Health Net Life Insurance Company Appeals & Grievances
P.O. Box 10348
Van Nuys, CA 91410-0348
Fax: 1-877-831-6019

Email: Member.Discrimination.Complaints@healthnet.com (Covered Persons) or

Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

You may submit a complaint by calling the California Department of Insurance at 1-800-927-4357 or online at:

https://www.insurance.ca.gov/01-consumers/101-help/index.cfm.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

LANGUAGE ASSISTANCE SERVICES

HNL provides free language assistance services, such as oral interpretation, sign language interpretation, translated written materials and appropriate auxiliary aids for individuals with disabilities. HNL's Customer Contact Center has bilingual staff and interpreter services for additional languages to support the Covered Person's language needs. Oral interpretation services in Your language can be used for, but not limited to explaining benefits, filing a grievance and answering questions related to Your health plan. Also, Our Customer Contact Center staff can help You find a health care provider who speaks Your language. Call the Customer Contact Center number on Your HNL ID card for this free service and to schedule an interpreter. Providers may not request that a Covered Person bring his or her own interpreter to an appointment. There are limitations on the use of family and friends as interpreters. Minors can only be used as interpreters if there is an imminent threat to the patient's safety and no qualified interpreter is available. Language assistance is available 24 hours a day, 7 days a week at all points of contact where a covered benefit or service is accessed. If You cannot locate a health care provider who meets Your language needs, You can request to have an interpreter available at no charge. Interpreter services shall be coordinated with scheduled appointments for health care services in such a manner that ensures the provision of interpreter services at the time of the appointment.

NOTICE OF LANGUAGE SERVICES

English
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call the Customer Contact Center at the number on your ID card or call Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). For California marketplace, call IFP On Exchange 1-888-926-4988 (TTY: 711) or Small Business 1-888-926-5133 (TTY: 711). For Group Plans through Health Net, call 1-800-522-0088 (TTY: 711).

Arabic
خدمات لغوية مجانية. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة اللازمة، يرجى التواصل مع مركز خدمة العملاء عبر الرقم المبين على بطاقتك أو الاتصال بالرقم الفرعي لخطة الأفراد والعائلة: 1-800-839-2172 (TTY: 711). للتواصل في كاليفورنيا، يرجى الاتصال بالرقم الفرعي لخطة الأفراد والعائلة عبر الرقم: 1-888-926-4988 (TTY: 711) أو المشروعات الصغيرة 1-888-926-5133 (TTY: 711). لخطط المجموعة عبر Health Net، يرجى الاتصال بالرقم 1-800-522-0088 (TTY: 711).

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Օգնության համար զանգահարեք Հաճախորդների սպասարկման կենտրոն ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք Individual & Family Plan (IFP) Off Exchange՝ 1-800-839-2172 հեռախոսահամարով (TTY՝ 711): Կալիֆորնիայի համար զանգահարեք IFP On Exchange՝ 1-888-926-4988 հեռախոսահամարով (TTY՝ 711) կամ Փոքր բիզնեսի համար՝ 1-888-926-5133 հեռախոսահամարով (TTY՝ 711): Health Net-ի Խմբային ծրագրերի համար զանգահարեք 1-800-522-0088 հեռախոսահամարով (TTY՝ 711):

Chinese
免費語言服務。您可使用口譯員服務。您可請人將文件唸給您聽並請我們將某些文件翻譯成您的語言寄給您。如需協助，請撥打您會員卡上的電話號碼與客戶聯絡中心聯絡或者撥打健康保險交易市場外的 Individual & Family Plan (IFP) 專線：1-800-839-2172（聽障專線：711）。如為加州保險交易市場，請撥打健康保險交易市場的 IFP 專線 1-888-926-4988（聽障專線：711），小型企業則請撥打 1-888-926-5133（聽障專線：711）。如為透過 Health Net 取得的團保計畫，請撥打 1-800-522-0088（聽障專線：711）。

Hindi
बिना शुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, अपने आईडी कार्ड में दिए गए नंबर पर ग्राहक सेवा केंद्र को कॉल करें या व्यक्तिगत और फैमिली प्लान (आईएफपी) ऑफ एक्सचेंज: 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफोर्निया बाजारों के लिए, आईएफपी ऑन एक्सचेंज 1-888-926-4988 (TTY: 711) या स्मॉल बिजनेस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के माध्यम से ग्रुप प्लान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Tsis Muaj Tus Nqi Pab Txhais Lus. Koj tuaj yeem tau txais ib tus kws pab txhais lus. Koj tuaj yeem muaj ib tus neeg nyeem cov ntaub ntawv rau koj ua koj hom lus hais. Txhawm rau pab, hu xovtooj rau Neeg Qhua Lub Chaw Tiv Toj ntawm tus npawb nyob ntawm koj daim npav ID lossis hu rau Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) Ntawm Kev Sib Hloov Pauv: 1-800-839-2172 (TTY: 711). Rau California qhov chaw kiab khw, hu rau IFP Ntawm Qhov Sib Hloov Pauv 1-888-926-4988 (TTY: 711) lossis Lag Luam Me 1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hu rau 1-800-522-0088 (TTY: 711).

Japanese
無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプが必要な場合は、IDカードに記載されている番号で顧客連絡センターまでお問い合わせいただくか、Individual & Family Plan（IFP）（個人・家族向けプラン）Off Exchange：1-800-839-2172（TTY：711）までお電話ください。カリフォルニア州のマーケットプレイスについては、IFP On Exchange 1-888-926-4988（TTY：711）または Small Business 1-888-926-5133（TTY：711）までお電話ください。Health Netによるグループプランについては、1-800-522-0088（TTY：711）までお電話ください。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជនតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក ឬហៅទូរស័ព្ទទៅកាន់កម្មវិធី Off Exchange របស់គម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) តាមរយៈលេខ៖ 1-800-839-2172 (TTY: 711)។ សម្រាប់ទីផ្សាររដ្ឋ California សូមហៅទូរស័ព្ទទៅកាន់កម្មវិធី On Exchange របស់គម្រោង IFP តាមរយៈលេខ 1-888-926-4988 (TTY: 711) ឬក្រុមហ៊ុនអាជីវកម្មខ្នាតតូចតាមរយៈលេខ 1-888-926-5133 (TTY: 711)។ សម្រាប់គម្រោងជាក្រុមតាមរយៈ Health Net សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-522-0088 (TTY: 711)។

Korean
무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 고객서비스 센터에 연락하시거나 개인 및 가족 플랜(IFP)의 경우 Off Exchange: 1-800-839-2172(TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스의 경우 IFP On Exchange 1-888-926-4988(TTY: 711), 소규모 비즈니스의 경우 1-888-926-5133(TTY: 711)번으로 전화해 주십시오. Health Net을 통한 그룹 플랜의 경우 1-800-522-0088(TTY: 711)번으로 전화해 주십시오.

Navajo
Doo bą́ą́h ílínígóó saad bee háká ada'iiyeed. Ata' halne'ígíí da ła' ná hádídóot'įįł. Naaltsoos da t'áá shí shizaad k'ehjí shichį' yídooltah nínízingo t'áá ná ákódoolníił. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíjį' hodíílnih ninaaltsoos nanitingo bee néého'dolzinígíí hodoonihjį' bikáá' éí doodago kojį' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojį' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí kojį' hólne' 1-888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí kojį' hólne' 1-800-522-0088 (TTY: 711).

Persian (Farsi)
خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای دریافت کمک، با مرکز تماس مشتریان به شماره روی کارت شناسایی یا طرح فردی و خانوادگی (IFP) Off Exchange به شماره: 1-800-839-2172 (TTY:711) تماس بگیرید. برای بازار کالیفرنیا، با IFP On Exchange شماره 1-888-926-4988 (TTY:711) یا کسب و کار کوچک 1-888-926-5133 (TTY:711) تماس بگیرید. برای طرح های گروهی از طریق Health Net، با 1-800-522-0088 (TTY:711) تماس بگیرید.

Panjabi (Punjabi)
ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਔਫ਼ ਐਕਸਚੇਂਜ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਔਨ ਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੌਲ ਬਿਜ਼ਨੇਸ ਨੂੰ 1-888-926-5133 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਹੈਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਹਿਕ ਪਲੈਨਾਂ ਲਈ, 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь, звоните по телефону Центра помощи клиентам, указанному на вашей карте участника плана. Вы также можете позвонить в отдел помощи участникам не представленных на федеральном рынке планов для частных лиц и семей (IFP) Off Exchange 1-800-839-2172 (TTY: 711). Участники планов от California marketplace: звоните в отдел помощи участникам представленных на федеральном рынке планов IFP (On Exchange) по телефону 1-888-926-4988 (TTY: 711) или в отдел планов для малого бизнеса (Small Business) по телефону 1-888-926-5133 (TTY: 711). Участники коллективных планов, предоставляемых через Health Net: звоните по телефону 1-800-522-0088 (TTY: 711).

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete, obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, comuníquese con el Centro de Comunicación con el Cliente al número que figura en su tarjeta de identificación o llame al plan individual y familiar que no pertenece al Mercado de Seguros de Salud al 1-800-839-2172 (TTY: 711). Para planes del mercado de seguros de salud de California, llame al plan individual y familiar que pertenece al Mercado de Seguros de Salud al 1-888-926-4988 (TTY: 711); para los planes de pequeñas empresas, llame al 1-888-926-5133 (TTY: 711). Para planes grupales a través de Health Net, llame al 1-800-522-0088 (TTY: 711).

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, tumawag sa Customer Contact Center sa numerong nasa ID card ninyo o tumawag sa Off Exchange ng Planong Pang-indibidwal at Pampamilya (Individual & Family Plan, IFP): 1-800-839-2172 (TTY: 711). Para sa California marketplace, tumawag sa IFP On Exchange 1-888-926-4988 (TTY: 711) o Maliliit na Negosyo 1-888-926-5133 (TTY: 711). Para sa mga Planong Pang-grupo sa pamamagitan ng Health Net, tumawag sa 1-800-522-0088 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โทรหาศูนย์ลูกค้าสัมพันธ์ได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือโทรหาฝ่ายแผนบุคคลและครอบครัวของเอกชน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โหมด TTY: 711) สำหรับเขตแคลิฟอร์เนีย โทรหาฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โหมด TTY: 711) หรือ ฝ่ายธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โหมด TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โหมด TTY: 711)

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu c ầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi Trung Tâm Liên Lạc Khách Hàng theo số điện thoại ghi trên thẻ ID của quý vị hoặc gọi Chương Trình Bảo Hiểm Cá Nhân & Gia Đình (IFP) Phi Tập Trung: 1-800-839-2172 (TTY: 711). Đối với thị trường California, vui lòng gọi IFP Tập Trung 1-888-926-4988 (TTY: 711) hoặc Doanh Nghiệp Nhỏ 1-888-926-5133 (TTY: 711). Đối với các Chương Trình Bảo Hiểm Nhóm qua Health Net, vui lòng gọi 1-800-522-0088 (TTY: 711).

CA Commercial On and Off-Exchange Member Notice of Language Assistance

FLY017549EH00 (12/17)

Contact us

FLEX MED
Post Office Box 9103
Van Nuys, California 91409-9103

Customer Contact Center
Large Group:
1-800-522-0088 TTY: 711
(for companies with 101 or
more employees)

Small Business Group:
1-800-361-3366 TTY: 711
(for companies with 2-100 employees)
1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)
www.healthnet.com

C11401 (CA 1/22)

Group Number:	10914A
Service Representative:	JUDY BLAESI
Region:	STK