

CERTIFICATE OF INSURANCE

A complete explanation of your plan

PPO (Plan 98Y)

Important benefit information – please read



Health Net®
LIFE INSURANCE COMPANY

C12801(CA 8/07)

PPO847LRG(1/07)

Dear Health Net Covered Person:

This is Your new Health Net PPO Certificate of Insurance.

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

Thank You for choosing Health Net.

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INTRODUCTION TO HEALTH NET PREFERRED PROVIDER ORGANIZATION (PPO)

Plan 98Y

HEALTH NET PPO CERTIFICATE OF INSURANCE

ISSUED IN CONNECTION WITH THE HEALTH NET PPO GROUP INSURANCE POLICY

UNDERWRITTEN
BY

HEALTH NET LIFE INSURANCE COMPANY

Los Angeles, California

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

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

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

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

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

HNL applies certain payment policies and rules to determine appropriate reimbursement that may affect Your responsibility (including, but not limited to, rules affecting reductions in reimbursement for charges for multiple procedures, services of an assistant surgeon, unbundled or duplicate items, and services covered by a global charge for the primary procedure). Additional information about HNL's reimbursement policies is available on the HNL website at www.healthnet.com or by contacting HNL's Member Services at the telephone number listed on Your Health Net PPO Identification Card.

Some Hospitals and other providers do not provide one or more of the following services that may be covered under this *Certificate* and that You might need: family planning; contraceptive services, including emergency contraception; sterilization,

including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. In order to determine from whom the above health care services may be available, HNL suggests You obtain this information prior to enrollment by calling prospective Physicians, Hospitals or clinics which contract with HNL or any other provider of choice. You may also obtain this information by calling HNL's Member Services at 1-800-676-6976.

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

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

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

Important Notice To California Certificateholders

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 10348
Van Nuys, CA 91049
1-800-676-6976**

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

**California Department of Insurance, Consumer Services Division
310 South Spring Street
South Tower
Los Angeles, CA 90013
1-800-927-HELP**

SCHEDULE OF BENEFITS

Health Net PPO Plan 98Y

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

Medical Benefits

Certification of Covered Expenses is required in some instances or benefits may be reduced. Please see the "Certification Requirement" portion of the "Plan Benefits" section of this *Certificate* for a list of services and supplies which require Certification.

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

Calendar Year Deductibles

Unless otherwise noted, the following Deductibles apply to Covered Expenses for Covered Services and Supplies provided by Preferred Providers and Out-of-Network Providers:

Combined Calendar Year Deductible (for Preferred Provider and Out-of-Network services, per Covered Person).....	\$250
Combined Family Calendar Year Deductible (all enrolled members of a family, for Preferred Provider and Out-of-Network services, during a Calendar Year)	\$750

Additional Deductibles

Emergency room Deductible	\$50
Urgent care Deductible	\$25
Noncertified inpatient services Deductible (for each inpatient admission)	\$250
Noncertified outpatient services Deductible (per visit)	\$250
Inpatient deductible per admission (Out-of-Network)	\$250
Outpatient services, per surgery (Out-of Network)	\$250
Skilled nursing facility deductible per admission (Out-of-Network)	\$250

Exceptions to the Deductibles:

- The emergency room or urgent care Deductible will not apply if the Covered Person is admitted to a Hospital directly from an emergency room or urgent care center.
- The Deductibles for noncertified inpatient and outpatient services will apply to services for which Certification was required but not obtained. Please see the "Certification Requirement" portion of the "Plan Benefits" section for a list of services that require Certification.

Out-of-Pocket Maximum

After an individual Covered Person has paid Deductibles, Copayments and Coinsurance equal to the Out-of-Pocket Maximum shown below, such Covered Person will have satisfied the Out-of-Pocket requirement and will not be required to pay further Copayments or Coinsurance for Covered Expenses incurred during the remainder of the Calendar Year except as otherwise stated. For most services, we will pay 100% of Covered Expenses for any additional services and supplies. The Covered Person will continue to be responsible for any charges billed in

excess of Covered Expenses (Customary and Reasonable Charges (C&R)) for the services of Out-of-Network Providers and will not be reimbursed for any amounts in excess of Customary and Reasonable Charges.

For services or supplies provided by a Preferred Provider	\$1500
For services or supplies provided by an Out-of-Network Provider	\$2000

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

In addition, if enrolled Covered Persons of the same family have paid Copayments and Coinsurance equal to the amounts shown below, the Out-of-Pocket Maximum will be considered to have been met for the entire family. No Copayment or Coinsurance for Covered Expenses shall be required from any enrolled Covered Person in that family for the remainder of that Calendar Year.

For services or supplies provided by a Preferred Provider	\$3000
For services or supplies provided by an Out-of-Network Provider	\$3000

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

Exceptions to the Out-of-Pocket Maximum:

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

- Covered Expenses used by the Covered Person to meet the Calendar Year Deductible;
- Covered Expenses for which the Coinsurance is 50%;
- Penalties paid for services for which Certification was required but not received;
- Expenses paid by the Covered Person for Mental Disorders or Chemical Dependency, except for Copayments paid for treatment of Severe Mental Illness or Serious Emotional Disturbances of a Child; and
- Expenses paid by the Covered Person for outpatient Prescription Drug benefits.
- Covered Expenses for visits to a physician, physician assistant or nurse practitioner (Preferred Provider)
- Covered Expenses for preventive care for a child or adult (Preferred Provider)
- Covered Expenses for specialist consultations (Preferred Provider)
- Covered Expenses for sterilization (male and female)

Lifetime Medical Benefit Maximums

For Hospice Care (Combined PPO and Out-of-Network)	\$10,000
For all medical benefits paid on behalf of each Covered Person during that Covered Person's lifetime (Combined PPO and Out-of-Network).....	\$5,000,000

Note: All calculations of benefit maximums (including the Lifetime Medical Benefit Maximum) for each Covered Person are based on the total aggregate amount of benefits paid under this plan and all other Health Net or HNL plans sponsored by the same employer.

Copayments and Coinsurance

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

Copayments: Copayments are fixed dollar amount charges, shown below, for which You are responsible. We will pay 100% of Covered Expenses for the services listed below after the Copayment is made. The Calendar Year Deductible does not apply. You will be responsible for paying Copayments until the amount paid during a Calendar Year is equal to the Out-of-Pocket Maximum shown above, except as otherwise stated.

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

Notes:

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

Services in an Emergency Room or Urgent Care Center

	Preferred Providers	Out-of-Network
Emergency room care professional services	20%	20%
Emergency room facility	20%	20%
Urgent care professional services	20%	20%
Urgent care facility	20%	20%

Note:

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

Authorized Hospital and Skilled Nursing Facility Services

	Preferred Providers	Out-of-Network
Unlimited days of care in a semi-private room or Special Care Unit including ancillary (additional) services (excluding non-Severe Mental Disorders and Chemical Dependency)	20%	30%

Unlimited days of care in a semi-private room or Special Care Unit including ancillary (additional) services for Severe Mental Illness and Serious Emotional Disturbances of a Child	20%	30%
Confinement in a Skilled Nursing Facility	20%	30%
<i>Maximum days per Calendar Year</i>	100	100
Inpatient detoxification	\$0	30%
<i>Maximum days per Calendar Year, combined with non-severe mental illness and chemical dependency</i>	No Maximum	Unlimited
<i>Maximum amount allowable per day</i>	\$175	Unlimited
<i>For Preferred Providers, You pay any amount in excess of \$175.</i>		
Outpatient surgery	20%	30%
Maximum amount payable by HNL per surgical session	No Maximum	\$350
Outpatient services other than surgery	20%	30%
Routine nursery care for newborns	20%	30%

Notes:

- Other professional services performed in the outpatient department of a Hospital, Outpatient Surgical Center or other licensed outpatient facility such as a visit to a Physician (office visit), laboratory and x-ray services, physical therapy, etc., may require a Copayment or Coinsurance when these services are performed.
- Diagnostic endoscopic procedures, such as diagnostic colonoscopy, performed in an outpatient facility require the Copayment or Coinsurance applicable for outpatient facility services. If, during the course of a diagnostic endoscopic procedure performed in a Hospital or Outpatient Surgical Center, a therapeutic (surgical) procedure is performed, then the Copayment or Coinsurance applicable for outpatient surgery will be required instead of the Copayment or Coinsurance for outpatient facility services.
- The Preferred Provider Coinsurance will apply if the Covered Person is admitted to a Hospital directly from an emergency room or urgent care center. The Covered Person will remain responsible for amounts billed in excess of Covered Expenses (Customary and Reasonable Charges) for the inpatient stay by an Out-of-Network Provider. You will not be reimbursed for any amounts in excess of Customary and Reasonable Charges billed by an Out-of-Network Provider.
- Look under the headings for the various services such as office visits, neuromuscular rehabilitation and other services to determine any additional Copayments or Coinsurances that may apply.

Treatment for Non-Severe Mental Disorders

	Preferred Providers	Out-of-Network
Treatment as an outpatient or in a Physician's office	\$0	30%
(Deductible waived for Preferred Providers)		
<i>Maximum visits per Calendar Year</i>	Unlimited	Unlimited
Treatment as an inpatient in a Hospital	\$0	30%
<i>Maximum days per Calendar Year</i>	Unlimited	Unlimited
<i>Maximum allowable per day</i>	\$175	Unlimited
<i>For Preferred Providers, You pay any amount in excess of \$175.</i>		
Physician visit to hospital or residential treatment facility	\$0	30%
(Deductible waived for Preferred Providers)		

Notes:

- The above Mental Disorders benefit maximums and limits will not apply to Severe Mental Illness or Serious Emotional Disturbances of a Child. Services for these mental conditions, as defined in the "Definitions" sec-

tion, are subject to whatever Copayment or Coinsurance would apply if the services were provided for a medical condition. Look under the headings for the various services such as office visits, outpatient services and inpatient Hospital services to determine the applicable Copayment or Coinsurance. All other Mental Disorders will be subject to the applicable Copayment or Coinsurance and limits shown above.

- All Calendar Year maximums for non-Severe Mental Disorders are combined with the Calendar Year maximums for Chemical Dependency.

Treatment for Chemical Dependency

	Preferred Providers	Out-of-Network
Treatment as an outpatient or in a Physician's office	\$0	30%
<i>Maximum visits per Calendar Year</i>	<i>50</i>	<i>No Limit</i>
<i>Maximum amount payable for each visit</i>	<i>\$25</i>	<i>30%</i>
<i>For Preferred Providers, You pay any amount in excess of \$25.</i>		
Treatment as an inpatient in a Hospital or residential treatment facility (Deductible waived for Preferred Providers).....	\$0	30%
<i>Maximum days per Calendar Year</i>	<i>30</i>	<i>Unlimited</i>
<i>Maximum amount allowable</i>	<i>\$175</i>	<i>No Limit</i>
<i>For Preferred Providers, You pay anything in excess of \$175.</i>		

Office Visits

	Preferred Providers	Out-of-Network
Visit to a Physician's office (for other than treatment of non-Severe Mental Disorders or conditions of Chemical Dependency) (Deductible waived for Preferred Providers)	20%	30%
Visit to a Physician's office for the treatment of Severe Mental Disorders or Serious Emotional Disturbances of a Child (Deductible waived for Preferred Providers).....	20%	30%
Preventive care services for children, including vision and hearing examinations, and immunizations (through age 16) (Deductible waived for Preferred Providers)	20%	30%
Maximum amount payable by HNL per visit	No Maximum	\$20
Preventive care services for adults (age 17 and older) (Deductible waived for Preferred Providers)	20%	30%
Annual routine physical examination (age 18 and older)	Not Covered	Not Covered
Physician visit to Covered Person's home (Deductible waived for Preferred Providers).....	20%	30%
Vision examinations (Deductible waived for Preferred Providers)	20%	Not Covered
Hearing examinations (Deductible waived for Preferred Providers)	20%	30%

Note:

Preventive care services for adults include mammograms, cervical cancer screening tests, pelvic exams, breast exams, colorectal cancer screening and screening and diagnosis of prostate cancer. Refer to the "Plan Benefits" section for additional details.

Allergy and Injection Services

	Preferred Providers	Out-of-Network
Allergy testing (Deductible waived for Preferred Providers).....	20%	30%
Allergy serum (Deductible waived for Preferred Providers)	20%	30%
Allergy injection services (serum not included)(Deductible waived)	\$15	\$15
All other injections (Deductible waived).....	\$15	\$15
Self-injectable drugs (copayment applies for each 30 day prescription) (Deductible waived).....	\$15	\$15
Office based injectable medications (Deductible waived)	\$15	\$15

Care for Conditions of Pregnancy

	Preferred Providers	Out-of-Network
Normal delivery, cesarean section, prenatal and postnatal care	20%	30%
Complications of pregnancy, including Medically Necessary terminations of pregnancy	20%	30%
Elective terminations of pregnancy.....	20%	30%
Genetic testing of fetus	20%	30%
Circumcision of newborn (birth through 30 days).....	20%	30%

Family Planning

	Preferred Providers	Out-of-Network
Infertility services	Not Covered	Not Covered
Sterilization of males.....	30%	50%
Sterilization of females.....	30%	50%
Intrauterine device (IUD)	20%	30%

Medical Supplies

	Preferred Providers	Out-of-Network
Durable Medical Equipment	20%	30%
Orthotics (such as bracing, supports and casts).....	20%	30%
Calendar Year maximum (Combined Preferred Provider and Out-of Network).....	\$5000	5000
Corrective footwear.....	20%	30%
Diabetic equipment.....	20%	30%
Diabetic footwear	20%	30%
Prostheses.....	20%	30%
Blood or blood products.....	20%	30%

Note:

- Diabetic equipment and orthotics which are covered under the medical benefit include blood glucose monitors, insulin pumps and corrective footwear.

Home Health Care Services

	Preferred Providers	Out-of-Network
Home Health Care Services	20%	30%
<i>Number of visits covered during a Calendar Year (combined Preferred Provider/Out-of-Network Provider)</i>	100	100

Hospice Care

	Preferred Providers	Out-of-Network
Hospice Care	20%	30%
(Combined Lifetime Maximum Preferred Providers/Out-of-Network Provider)	\$10,000	\$10,000

Acupuncture and Chiropractic Services

	Preferred Providers	Out-of-Network
Acupuncture	20%	30%
<i>Number of visits covered during a Calendar Year (Combined Preferred Providers/Out-of Network)</i>	12	12
<i>Maximum amount payable by HNL per visit</i>	\$25	\$25
Chiropractic services	20%	30%
<i>Number of visits covered during a Calendar Year (Combined Preferred Providers/Out-of Network)</i>	30	30
<i>Maximum amount payable by HNL per visit</i>	No Maximum	\$25

Ambulance

	Preferred Providers	Out-of-Network
Air Ambulance	20%	30%
Ground Ambulance	20%	30%

Other Professional Services

	Preferred Providers	Out-of-Network
Physician visit to Hospital or Skilled Nursing Facility	20%	30%
Surgery	20%	30%
Administration of anesthetics	20%	30%
Diagnostic imaging (including x-ray) and laboratory procedures	20%	30%
Chemotherapy	20%	30%
Nuclear medicine	20%	30%
Organ, bone marrow or tissue transplant (not Experimental or Investigational)* (Deductible waived for Preferred Providers)	20%	Not Covered
Renal dialysis	20%	30%
Physical therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy (Deductible waived for Preferred Providers)	20%	30%

Maximum amount payable by HNL.....	No Maximum.....	\$25
Maximum visits per calendar year (Combined Preferred Providers/Out of Network).....	30.....	30
Speech therapy (Deductible waived for Preferred Providers).....	20%.....	30%
Maximum amount payable by HNL.....	No Maximum.....	\$30
Maximum visits per Calendar Year (Combined Preferred Providers/Out of Network).....	24.....	24
Medical social services.....	20%.....	30%
Diabetes education.....	20%.....	30%
Outpatient infusion therapy.....	20%.....	30%
Maximum allowable each day.....	No Maximum.....	\$600

Note:

- Additional visits for physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy may be covered if precertified as Medically Necessary for rehabilitation services following neurological and orthopedic surgery, cerebral/cardiovascular accident, third degree burns, head trauma and spinal cord injury. Coverage for physical, occupational and speech rehabilitation therapy services is subject to certain limitations as described in the "General Limitations and Exclusions" section.
- *Transplant travel expenses (benefit limitations):
 - For transplant recipient and one companion per transplant episode (limited to 6 trips per episode)
 1. Transportation to transplant center: \$250 per trip for each person (round-trip coach airfare)
 2. Hotel accommodations: \$100 per day, for up to 21 days per trip, limited to one room (double occupancy)
 3. Meals & miscellaneous expenses: \$25 per day for each person, for up to 21 days per trip
 - For the donor per transplant episode (limited to one trip per episode)
 1. Transportation to transplant center: \$250 for round-trip coach airfare
 2. Hotel accommodations: \$100 per day, for up to 7 days
 3. Meals & miscellaneous expenses: \$25 per day, up to 7 days

Outpatient Prescription Drugs

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

Benefit Maximums

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

Notes:

- Except for insulin, diabetic supplies (blood glucose testing strips, lancets, disposable needles & syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (i.e. opened in order to dispense the product in quantities other than those packaged). When a prescription is dispensed, You will receive the size of package and/or number of packages required for You to test the number of times Your Physician has prescribed for a 30-day period.
- All benefits limited during a Covered Person's lifetime is the total amount of benefits offered under this plan, and shall apply to all Health Net or HNL plans sponsored by the same Group.
- Prescription Drug Orders that are combined or manufactured by the pharmacist and placed in ointment, capsule, tablet, solution, suppository, cream or other form using FDA approved drugs are covered at the Level III Drug Copayment. Coverage for Compounded Drugs is subject to Prior Authorization by HNL and Medical Necessity. Compounded Drugs are not covered if there is a similar proprietary product available.

Copayments and Coinsurance

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

Retail Pharmacy

	Participating Pharmacy	Nonparticipating Pharmacy
Level I Drugs (primarily generic) when listed in the Recommended Drug List	\$15	\$15 (see "Notes")
Level II Drugs (primarily brand), insulin and diabetic supplies when listed in the Recommended Drug List	\$30	\$30 (see "Notes")
Level III Drugs (drugs not listed in the Recommended Drug List or listed as Level III Drugs)	\$30	\$30 (see "Notes")
Sexual dysfunction drugs (including injections)	50%	50%

Maintenance Drugs through the Mail Order Program

	Mail Order Program
Level I Drugs (primarily generic) when listed in the Recommended Drug List	\$30
Level II Drugs (primarily brand), insulin and diabetic supplies when listed in the Recommended Drug List	\$60
Level III Drugs (drugs not listed in the Recommended Drug List or listed as Level III Drugs)	\$60

Notes:

- **In addition to the Copayments listed above for Nonparticipating Pharmacies, You must also pay 50% of the Prescription Drug Covered Expense.**
- If the pharmacy's usual and customary charge is less than the applicable Copayment or Coinsurance, You will pay the pharmacy's usual and customary charge.
- 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 shown above, unless the Physician has stated "Dispense As Written" or "Do Not Substitute" or words of similar meaning in the Physician's handwriting on the Prescription Drug Order.

- Some drugs may require Prior Authorization from HNL to be covered.
- In addition to the Copayments and Coinsurance shown above, You are responsible for charges billed in excess of the Prescription Drug Covered Expenses for all drugs dispensed by a Nonparticipating Pharmacy.
- Generic or Brand Name Drugs not listed in the Recommended Drug List which are prescribed by Your Physician and not excluded or limited from coverage are subject to the Level III Drug Copayment.
- Up to a 90-consecutive-calendar-day-supply of covered Maintenance Drugs will be dispensed at the applicable mail order Copayment or Coinsurance when ordered through HNL's contracted mail service vendor.
- Drugs (including injectable medications) when Medically Necessary for treating sexual dysfunction are limited to two doses per week or eight tablets per month. Sexual dysfunction drugs are not available through the mail order program.
- 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 for medical uses in the United States.

ELIGIBILITY, ENROLLMENT AND TERMINATION

Who Is Eligible For Coverage

The Covered Services and Supplies of this plan are available to the following people as long as they live in the United States, and meet the additional eligibility requirements of the Group:

- You: The principal Covered Person (employee);
- Spouse: Your lawful spouse as defined by California law. (The term "spouse" also includes the principal Covered Person's Domestic Partner as defined)
- Children: The unmarried dependent children of You or Your spouse (including legally adopted children and stepchildren); and
- Wards: Children for whom You or Your spouse is a court-appointed guardian.

Children of You or Your spouse who are the subject of a Medical Child Support Order, according to state or federal law, are also eligible.

Age Limit for Children

Each unmarried child is eligible until the age of 19 (the limiting age). Eligibility continues beyond the limiting age according to the following.

Eligibility continues until age 24 for a child who:

- Is enrolled as a full-time student, unmarried, and attends a certified school; and
- Depends on You for at least 50% of his or her economic support.

A child loses eligibility if he or she marries, ceases to be a full-time student, and stops being 50% financially dependent on You after age 19.

A full-time student is one taking at least twelve semester units (or equivalent hours) in a qualified college, university or vocational school.

Disabled Child

A child who reaches the age limit shown above is eligible to continue coverage if **all** of the following conditions apply:

- The child cannot hold a full-time job because of a mental or physical disability that began before the child reached the age limit; and
- The child has remained continuously dependent on You for at least 50% of his or her economic support since he or she became disabled.

If You are *enrolling* a disabled child for new coverage, You must provide HNL with proof of incapacity and dependency within 31 days of the date You apply for the child's coverage. The child must have been covered as a dependent of the principal Covered Person or spouse under a previous group health plan at the time the child reached the age limit.

If You are *continuing* coverage for a disabled child, You must provide HNL with proof of incapacity and dependency within 31 days of the date the child reaches the age limit.

You must provide the proof of incapacity and dependency at no cost to HNL.

A disabled child may remain covered by this plan for as long as he or she remains incapacitated and continues to meet the eligibility criteria described above.

How to Enroll for Coverage

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

Employee

Each new employee entering employment subsequent to the Effective Date of the Group's initial enrollment period shall be permitted, without proof of insurability, to apply for coverage for himself or herself and eligible Dependents within 31 days of becoming eligible, subject to the enrollment regulations in effect with the Group. Such enrollments, if accepted by HNL, become effective when any waiting or probationary period required by the Group is completed.

When the employee is not subject to a probationary period, the enrollment becomes effective, in accordance with established Group eligibility rules, either on the date of hire or on the first day of the Pay period following the date of meeting the County's eligibility requirements.

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

Newly Acquired Dependents

You are entitled to enroll newly acquired dependents as follows:

Spouse: If You marry while You are covered by this plan, You may enroll Your new spouse (and Your spouse's eligible children) within 31 days of the date of marriage. Coverage begins on the first day of the Pay Period following the date of meeting the County's eligibility requirements.

Domestic Partner: If You are the principal Covered Person and You enter into a domestic partnership while You are covered by this plan, You may enroll Your new Domestic Partner (and his or her eligible children) within 31 days of the date a Declaration of Domestic Partnership is filed with the Secretary of State or other recognized state or local agency, or within 31 days of the formation of the domestic partnership according to Your Group's eligibility rules. Coverage begins on the first day of the Pay Period following the date of meeting the County's eligibility requirements.

Newborn Child: Coverage for newborn children will be effective upon birth and during the first 31 days following birth. However, coverage after 31 days is contingent You enrolling the newborn within 31 days following birth.

Adopted Child: A newly adopted child or a child who is being adopted, becomes eligible on the date the birth parent or appropriate legal authority grants You or Your spouse, in writing, the right to control the child's health care.

Coverage begins automatically and will continue for 31 days from the date of eligibility. You must enroll the child before the 31st day for coverage to continue beyond the first 31 days. Your Employer will require written proof of the right to control the child's health care when such child is enrolled.

Legal Ward (Guardianship): If You or Your spouse become the legal guardian of a child, the child is eligible to enroll on the effective date of the court order, but coverage is not automatic. The child must be enrolled within 31 days of the effective date of the guardianship. Coverage will begin on the first day of the month after HNL receives the enrollment request.

Your Employer will require proof that You or Your spouse is the court-appointed legal guardian.

In Hospital at Time of Enrollment

If You are confined in a Hospital or Skilled Nursing Facility on the Effective Date of coverage, this plan will cover the remainder of that confinement only if You inform HNL's Member Services Department at the time of Your enrollment about the confinement.

Open Enrollment Period

An Open Enrollment Period shall be held annually, at which time potential Covered Persons may enroll under this *Certificate*. Upon receipt of enrollment changes and corresponding payment of dues for an enrollment, such enrollment changes shall, if accepted by 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 31 days of becoming eligible for coverage, he or she must wait until the next Open Enrollment Period to enroll. (Time limits for enrolling are explained in the "Employee" and "Newly Acquired Dependents" provision above.)

The term "form" within this section may include electronic enrollment forms or enrollment over the phone. Electronic or phone enrollments are deemed signed when You use Your employer's enrollment system to make or confirm changes to Your benefit enrollment.

A Late Enrollee may be excluded from coverage until the next Open Enrollment Period.

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

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

Exceptions to Late Enrollment Rule

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

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

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

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

2. You Did Not Enroll Because of Other Coverage and Later the Other Coverage is Lost

If You declined coverage in this plan, and You stated on the form the reason You were not enrolling was because of coverage through another group health plan, and the other coverage is or will be lost for any of the following reasons, the late enrollment exclusion will not apply to You:

- The principal enrollee of the other plan has ceased being covered by that other plan, (except for either failure to pay premium contributions, or a "for cause" termination, such as fraud or misrepresentation of an important fact);
- The other plan was terminated and not replaced with other Group coverage;
- The other Group stops making contributions toward employee's or dependent's coverage;
- The other principal enrollee or employee dies;
- The principal enrollee and spouse are divorced or legally separated and this causes loss of the Group coverage; or
- The other coverage was federal COBRA or Small Employer Cal-COBRA, and the period of coverage ends.

3. You Lose Eligibility for Healthy Families Program or No-Share-of-Cost Medi-Cal

If you declined coverage in this Plan because you or your Dependents were enrolled in the Healthy Families Program or no-share-of-cost Medi-Cal, and coverage was lost for the following reasons, the late enrollment rule will not apply to You:

- You or Your Dependents lose eligibility in the Healthy Families Program as a result of exceeding the Program's income or age limits.
- You or Your Dependents lose eligibility in no-share-of-cost Medi-Cal as a result of exceeding Medi-Cal's income limits.
- Late enrollment rules are waived only for the individual who lost coverage under Healthy Families Program or no-share-of-cost Medi-Cal.

4. Multiple Health Plans

If You are enrolled as a dependent in a health plan (not HNL), and the enrollee of that other plan, during open

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

5. Court Orders

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

If the exceptions in 2, 3 or 4 apply, You must enroll within 31 days of the loss of coverage. If You wait longer than 31 days to enroll, You will be a late enrollee and may not enroll until the next Open Enrollment Period. A court ordered dependent may be added without any regard to Open Enrollment restrictions.

Special Enrollment Rule For Newly Acquired Dependents

If an employee gains new dependents due to childbirth, adoption or marriage the following rules apply:

If the Employee Is Enrolled in this Plan

If You are covered by this plan as an employee of the Group, You can enroll a new dependent if You request enrollment within 31 days after childbirth, marriage or adoption. In addition, a court ordered dependent may be added without any regard to open enrollment restrictions.

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

If the Employee Declined Enrollment in this Plan

If You previously declined enrollment in this plan because of other Group coverage, and You gain a new dependent due to childbirth, marriage, adoption or placement for adoption, You can enroll yourself and the dependent within 31 days of childbirth, marriage, adoption or placement for adoption.

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

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

If You do not enroll yourself, the new dependent and any other family members within 31 days of acquiring the new dependent, You will have to wait until the next Open Enrollment Period to do so.

The Effective Date of coverage for You and all Dependents who enroll within 31 days of childbirth, marriage, adoption or placement for adoption will be the same as for the new dependent.

- In the case of childbirth, the Effective Date will be the moment of birth;
- For marriage, the Effective Date will be either on the date of marriage or the first day of the Pay Period following the date of marriage, according to the rules established by the Group;
- Regarding adoption, the Effective Date will be the date the birth parent or appropriate legal authority grants the employee or his or her spouse, in writing, the right to control the child's health care; and
- In the case of a Medical Child Support Order, the Effective Date will be the date the Group is notified of the court order.

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

While You have 31 days within which to enroll the child, until You and Your child are formally enrolled and recorded as Covered Persons in HNL's computer system, We cannot verify coverage to any inquiring medical provider.

Special Reinstatement Rule For Reservists Returning From Active Duty

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

Special Reinstatement Rule Under USERRA

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

Replacement Of Coverage Provision

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

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

Any covered medical charges used to satisfy Deductible or out-of-pocket requirements under the Prior Plan during the Calendar Year of the plan change, may be counted toward satisfying them under this Policy.

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

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

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

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

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

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

When Coverage Ends

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

All Covered Persons

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

Principal Covered Person and All Dependents

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

Individual Covered Persons

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

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

Notice Of Ineligibility

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

Coverage Options Following Termination

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

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

COBRA Continuation Coverage

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

Cal-COBRA Continuation Coverage

If You began receiving federal COBRA coverage on or after January 1, 2003, have exhausted federal COBRA coverage and have had less than 36 months of COBRA coverage, You have the opportunity to continue group coverage under this *Certificate* through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.

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

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

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

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

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

All subsequent payments must be made on the first day of each month. If the payment is late, the Covered Person will be allowed a grace period of 31 days. Fifteen days from the due date (the first of the month), HNL will send a letter warning that coverage will terminate 15 days from the date on the letter. If the Covered Person fails to make the payment within 15 days of the notice of termination, enrollment will be canceled by HNL. If the Covered Person makes the payment before the termination date, coverage will be continued with no break in coverage. Amounts received after the termination date will be refunded to the Covered Person by HNL within 20 business days.

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

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

The Covered Person may choose to continue to be covered by this plan for the balance of the period that he or she could have continued to be covered by the prior group plan. In order to continue Cal-COBRA coverage under the new plan, the Covered Person must request enrollment and pay the required premium within 31 days of receiving notice of the termination of the prior plan. If the Covered Person fails to request enrollment and pay the premium within the 31-day period, Cal-COBRA Continuation Coverage will terminate.

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

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

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

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

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

Additional COBRA-like Coverage (Senior-COBRA)

California law provides that an employee and his or her spouse who elected COBRA coverage following termination of employment may be entitled to additional COBRA-like coverage if the employee and spouse are eligible for Cal-COBRA prior to January 1, 2005.

If You were 60 years of age or older on the date of Your termination of employment and had worked for the Group for the previous five years, You and Your spouse may be eligible for additional coverage when the federal COBRA coverage expires. Additionally, a former spouse of an employee or former employee whose coverage under COBRA or Cal-COBRA expires may be entitled to additional COBRA-like coverage.

You may request additional information from HNL. If You wish to purchase this additional COBRA-like coverage, You must notify HNL in writing of Your wish to do so within 31 calendar days prior to the date continuation coverage under COBRA or Cal-COBRA is scheduled to end.

USERRA Coverage

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

Extension of Benefits

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

Conversion Coverage

Described below in the subsection titled "Conversion Coverage."

Continuation Of Coverage During A Labor Dispute

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

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

4. The premium due date on or after the date You ceased to be at work because of the labor dispute for 6 months; or
 5. The premium due date on or after the labor dispute is resolved.
- If You have Dependents insured on the date You cease work, You must also continue their coverage in order to continue coverage for You.

HIPAA

The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people covered under existing group health plans to maintain coverage regardless of pre-existing conditions when they change jobs or are unemployed for brief periods of time. California law provides similar and additional protections. Applicants who meet the following requirements are eligible to enroll in a guaranteed issue individual health plan from any health plan that offers individual coverage without medical underwriting. A health plan cannot reject Your application for guaranteed issue individual health coverage if You meet the following requirements, agree to pay the required premiums and live or work in the plan's service area. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance. To be considered an eligible individual:

- The applicant must have a total of 18 months of coverage (including COBRA, if applicable) without a significant break (excluding any employer-imposed waiting periods) in coverage of more than 63 days.
- The most recent coverage must have been under a group health plan. COBRA and Cal-COBRA coverage are considered group coverage.
- The applicant must not be eligible for coverage under any group health plan, Medicare or Medicaid, and must not have other health insurance coverage.
- The individual's most recent coverage could not have been terminated due to fraud or nonpayment of premiums.
- If COBRA or Cal-COBRA coverage was available, it must have been elected and such coverage must have been exhausted.

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

Extension of Benefits

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

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

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

For the purpose of this extension, You shall be considered totally disabled when, as a result of bodily injury or disease, You are unable to engage in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience and not, engaged in any employment or occupation for wage or

profit. A Dependent shall be considered totally disabled when he or she is prevented from performing all regular and customary activities usual for a person of that age and family status.

Conversion Coverage

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

Who Is Eligible For Conversion Coverage

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

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

Who Is Not Eligible For Conversion Coverage

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

How to Apply for Conversion Coverage

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

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

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

PLAN BENEFITS

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

In addition, many of the Covered Services and Supplies listed herein are subject to Certification in many instances, prior to the expenses being incurred. If Certification is not obtained, the available benefits will be reduced. Please refer to the "Certification Requirement" subsection for further details.

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

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

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

How Covered Expenses Are Determined

HNL will pay for Covered Expenses You incur under this plan. Covered Expenses are based on the maximum charge HNL will accept from each type of provider, not necessarily the amount a Physician or other health care provider ordinarily bills for the service or supply.

Preferred Providers

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

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

Out-of-Network Provider

The maximum amount HNL will pay for Covered Expenses when services or supplies are received from an Out-of-Network Provider is the lesser of the billed charge or the Customary and Reasonable Charge.

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

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

Deductibles

- After HNL determines the amount of Covered Expenses, HNL will subtract the applicable Deductible(s) and either the Copayment or the Coinsurance that applies to the covered service or supply. HNL will then pay up to the benefit limit shown in the "Schedule of Benefits" section.
- Only Covered Expenses will be applied to the satisfaction of the Deductible(s) shown in this *Certificate*.
- There may also be Deductibles in addition to the Calendar Year Deductible that You may need to pay, depending on the services or supplies received. Please check the "Deductibles" portion of the "Schedule of Benefits" section for details. Each Deductible is separate and distinct from the other, and Covered Expenses

applied to one Deductible will not be applied to any other Deductible of this plan, except that a Calendar Year Deductible will be applied toward the satisfaction of the family Deductible, as set forth below.

- Covered Expenses incurred under this plan in the last three months of a Calendar Year, used to satisfy this plan's Calendar Year Deductible for that year, may also be used to satisfy the Calendar Year Deductible for the following Calendar Year.
- Prior Deductible carryover credit applies if this Policy is replacing a similar policy that had been issued to the Group Policyholder. If a Covered Person has satisfied any portion of the Deductible under the prior carrier plan, the credit shall apply to the satisfaction of the Covered Person's initial Calendar Year Deductible under this *Certificate*. Proof of Deductible satisfaction under the prior carrier plan will be required upon submission of the initial claim for benefits to be payable under this *Certificate*.
- Expenses incurred under the Prescription Drug Benefit are not applied to the Calendar Year or additional Deductible(s).

Out-of-Pocket Maximum

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

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

Medical Lifetime Benefit Maximum

All medical benefits are limited to the maximum set forth in the "Schedule of Benefits" section during each Covered Person's lifetime. This amount applies to each Covered Person for all Health Net or HNL plans sponsored by the same Group.

Certification Requirement

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

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

Services Requiring Certification

- Inpatient admissions

Any type of facility, including but not limited to:

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

6. Hospice
- Surgical procedures including:
 1. Abdominal, ventral, umbilical, incisional hernia repair
 2. Bariatric procedures
 3. Blepharoplasty
 4. Breast reductions and augmentations
 5. Rhinoplasty
 6. Sclerotherapy
 7. Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
 - Organ, tissue and bone marrow transplant services, including pre-evaluation and pre-treatment services and the transplant procedure
 - Home Health Care Services including nursing, physical therapy, occupational therapy, speech therapy, home I.V. therapy and home uterine monitoring
 - Hospice Care
 - Outpatient Diagnostic Imaging:
 1. CT (Computerized Tomography)
 2. MRA (Magnetic Resonance Angiography)
 3. MRI (Magnetic Resonance Imaging)
 4. PET (Positron Emission Tomography)
 5. SPECT (Single Photon Emission Computed Tomography)
 - Durable Medical Equipment including power wheelchairs, scooters, Hospital beds and custom-made items
 - Prosthesis and orthotics over \$2,500
 - Air Ambulance
 - Tocolytic services (intravenous drugs used to decrease or stop uterine contractions in premature labor)
 - Orthognathic procedures (surgery performed to correct or straighten jaw and/or other facial bone misalignments to improve function), including TMJ treatment
 - Self-injectable drugs
 - Clinical trials
 - Bariatric-related services:
 1. Non-surgical bariatric-related consultations and services
 2. All bariatric-related surgical services

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

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

Exceptions

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

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

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

Certification Procedure

Certification must be requested by You within the following periods:

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

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

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

If Certification is denied for a covered service, HNL will send a written notice to You and to the provider of the service. However, HNL will not send written notice of the denial of Certification if the service or supply would not otherwise be covered by this plan.

Effect on Benefits

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

If Certification is not obtained, the payable percentage will be the reduced percentage as shown in the "Schedule of Benefits" section of this *Certificate*. Also, an additional Deductible will be applied to Covered Expenses as shown in the "Schedule of Benefits" section.

Resolution of Disputes

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

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

Medical Benefits

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

Hospital

Inpatient Services

Covered Expenses include:

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

Payment of benefits for hospitalizations will be reduced as set forth herein if Certification is not obtained for the hospitalization.

Outpatient Services

Covered Expenses include:

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

Certification may be required. Please refer to the "Certification Requirement" portion of this *Certificate* for details. Payment of benefits for outpatient services may be reduced as set forth herein if Certification is not obtained.

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

Ambulatory Surgical Center

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

Payment of benefits for outpatient surgery will be reduced as set forth herein if Certification is not obtained for the surgery.

Skilled Nursing Facility

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

Covered Expenses include:

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

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

Payment of benefits will be reduced as set forth herein if Certification is not obtained for the confinement.

Custodial Care is not covered.

Professional Services

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

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

When multiple procedures are performed at the same time, Covered Expenses include the Allowable Charge or Customary and Reasonable Charge (as applicable) for the first (or major) procedure and one-half the Allowable Charge or Customary and Reasonable Charge for each additional procedure. No benefit is payable for incidental surgical procedures, such as an appendectomy performed during gall bladder surgery.

Payment of benefits for surgical expenses will be reduced as set forth herein if Certification is not obtained for the surgery.

Diagnostic Imaging (Including X-Ray) and Laboratory Procedures

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

Home Health Care Services

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

services, medical social services, rehabilitation therapy (including physical, speech and occupational), pulmonary rehabilitation therapy and cardiac rehabilitation therapy.

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

- The skilled nursing care is appropriate for the medical treatment of a condition, illness, disease or injury;
- The Covered Person is 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);
- The Home Health Care Services are part-time and intermittent in nature; a visit lasts up to 4 hours in duration in every 24 hours; and
- The services are in place of a continued hospitalization, confinement in a Skilled Nursing Facility, or outpatient services provided outside of the Covered Person home.

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

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

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

Payment of benefits will be reduced as set forth herein if Certification is not obtained.

Self-Injectable Drugs

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

These drugs are not covered under any outpatient Prescription Drug program which may be described within this *Certificate*, but are covered only as described within this "Plan Benefits" section. (Note that insulin is only covered through an outpatient Prescription Drug program.)

When a self-injectable drug is prescribed, You must pay the copayment shown for Preferred Providers or Out-of-Network Providers (as applicable, depending on the provider who wrote the prescription) in the "Schedule of Benefits" section.

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

Outpatient Infusion Therapy

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

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

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

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

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

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

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

Payment of benefits will be reduced as set forth herein if Certification is not obtained for the therapy.

Ambulance Services

The following Ambulance services:

- **Ground Ambulance Transportation**, when it is Medically Necessary, as defined in the "Definitions" section. The following will be covered:

Charges for the base rate, mileage (up to the maximum number of miles stated in the "Schedule of Benefits" section), disposable supplies (supplies which can be used again are not covered), monitoring, electrocardiograms (EKGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR), and administration of oxygen and intravenous (IV) solutions in connection with Ambulance services when the transportation involves:

 1. A trip to a Hospital or Skilled Nursing Facility where You receive care which is covered under this *Certificate* as an inpatient, in the emergency room or in the outpatient department of a Hospital when the services could not have been performed in the home;
 2. A round trip from a Hospital or Skilled Nursing Facility where covered care is being provided, to some other medical treatment facility in order to obtain specialized diagnostic or therapeutic services (for example, a CT scan or radiation therapy) which are not available at the facility where You are an inpatient. The other medical treatment facility can be a Hospital, Skilled Nursing Facility, clinic, therapy center, diagnostic center or Physician's office; or
 3. A trip to Your home from a Hospital or Skilled Nursing Facility where You received covered services.
- **Air Ambulance Transportation**, when it is Medically Necessary, as defined in the "Definitions" section. The following will be covered:

Charges for the base rate, mileage, disposable supplies, monitoring, electrocardiograms (EKGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR), and administration of oxygen and intravenous (IV) solutions in connection with air Ambulance services when the transportation is from any location to a Hospital or a location nearby, such as an airport, for admission as an inpatient or treatment in an emergency room, and the Hospital services are themselves covered under this *Certificate*.

Payment of benefits for Air Ambulance Services will be reduced as set forth herein if Certification is not obtained.

All paramedic, 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.

Acupuncture

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

Diabetes Education

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

Hospice Care

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

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

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

Payment of benefits will be reduced as set forth herein if Certification is not obtained for the care.

Radiation Therapy, Chemotherapy and Renal Dialysis Treatment

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

Bariatric (Weight Loss) Surgery

Bariatric surgery provided for the treatment of morbid obesity is covered when Medically Necessary, authorized by HNL and performed at an HNL designated bariatric surgical center.

HNL has a designated network of bariatric surgical centers to perform weight loss surgery. Your Physician can provide You with information about these centers. You will be directed to an HNL designated bariatric surgical center at the time authorization is obtained.

If You live 50 miles or more from the nearest HNL designated bariatric surgical center, You are eligible to receive travel expense reimbursement. All requests for travel expense reimbursement must be prior approved by HNL. Approved travel-related expenses will be reimbursed as follows:

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

- Other reasonable expenses not to exceed \$25 per day, up to four (4) days per trip. Expenses for tobacco, alcohol, drugs, telephone, television, delivery, and recreation are specifically excluded.

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

Prostheses

Prostheses are covered as follows:

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

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

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

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

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

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

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

Certification may be required. Please refer to the "Certification Requirement" portion of this section for details. Payment of benefits will be reduced as set forth herein if Certification is required but not obtained.

Medically Necessary Corrective Footwear

Corrective footwear for conditions not related to diabetes is covered. Corrective footwear for the management and treatment of diabetes is covered as described under the "Diabetic Equipment" provision of this section.

Rental or Purchase of Durable Medical Equipment

Rental or purchase of Durable Medical Equipment which is ordered or prescribed by a Physician and is manufactured primarily for medical use. Durable Medical Equipment which is used for infusion therapy, corrective shoes or shoe inserts will be payable only as stated in the "Outpatient Infusion Therapy" or "Medically Necessary Corrective Footwear" provisions above. Durable Medical Equipment includes, but is not limited to, wheelchairs, crutches, bracing, supports, casts and Hospital beds. Some Durable Medical Equipment may have specific quantity limits or may not be covered as they are considered primarily for non-medical use. Orthotics are not subject to such quantity limits.

Certification may be required. Please refer to the "Certification Requirement" portion of this section for details. Payment of benefits will be reduced as set forth herein if Certification is required but not obtained.

Implanted Lens(es) Which Replace the Organic Eye Lens

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

Rehabilitative Services

Rehabilitative services (including physical, occupational and speech therapy,) when Medically Necessary and continuous functional improvement in response to the treatment plan is demonstrated by objective evidence, in accordance with the "Schedule of Benefits" section, except as stated in the "General Limitations and Exclusions" section. If approved by HNL prior to treatment, benefits for up to 12 additional visits may be covered when treatment follows post-neurological surgery, orthopedic surgery, cardiovascular or cerebral vascular accident, third degree burns, head trauma or spinal cord injury. Benefits for additional visits remain subject to all other benefit maximums and limitations.

Cardiac Rehabilitation Therapy

Cardiac rehabilitation therapy, when Medically Necessary and continuous functional improvement in response to the treatment plan is demonstrated by objective evidence, in accordance with the "Schedule of Benefits" section, except as stated in the "General Limitations and Exclusions" section. If approved by HNL prior to treatment, benefits for up to 12 additional visits may be covered when provided in connection with the treatment of heart disease.

Pulmonary Rehabilitation Therapy

Pulmonary rehabilitation therapy, when Medically Necessary and continuous functional improvement in response to the treatment plan is demonstrated by objective evidence, in accordance with the "Schedule of Benefits" section, except as stated in the "General Limitations and Exclusions" section. If approved by HNL prior to treatment, benefits for up to 12 additional visits may be covered when provided in connection with the treatment of chronic respiratory impairment.

Allergy Testing and Treatment

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

Reconstructive Surgery

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

Diabetic Equipment

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

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

* 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).
- Glucagon is provided through the self-injectables benefit (see the "Self-Injectable Drugs" provision of this section).
- Self-management training, education and medical nutrition therapy will be covered, only when provided by licensed health care professionals with expertise in the management or treatment of diabetes. Please refer to the "Diabetes Education" provision of this section for more information.

Preventive Care For Adults

Preventive care and diagnostic procedures for adults (age 17 and older) are covered at a Physician's direction. Covered services are limited to the following types of care and procedures:

- **Mammography:** For screening purposes in women at low risk of breast cancer. One baseline mammogram between the ages of 35 and 39; one mammogram every one to two Calendar Years for women between the ages of 40 and 49 and one mammogram every Calendar Year for women age 50 and above.
- **Cervical Cancer Screening Test:** One cervical cancer screening test per Calendar Year for women (includes the conventional Pap test, a human papillomavirus (HPV) screening test that is approved by the Food and Drug Administration (FDA) and the option of any cervical cancer screening test approved by the FDA).
- **Pelvic Exam and Breast Exam:** One normal exam and lab test per Calendar Year.
- **Colorectal Cancer Screening:** Once every three Calendar Years for men and women age 45 and above.
- **Screening and Diagnosis of Prostate Cancer:** Tests and procedures for the screening and diagnosis of prostate cancer, including but not limited to, prostate-specific antigen testing and digital rectal examinations, when Medically Necessary and consistent with good professional practice.

Preventive Care For Children

Preventive care and diagnostic procedures (including newborn pediatric care) for children through age 16, are covered and are limited to the following type of care or procedures:

- Office visits for the evaluation and management of the child's physical development for prevention of future medical problems;
- Vision and hearing exams
- Laboratory tests and x-rays; and
- Immunizations.

The above shall be consistent with the Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics (AAP) and the Recommended Childhood Immunization Schedule/United States jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices (ACIP) of the U.S. Public Health Service and the American Academy of Family Physicians.

Phenylketonuria (PKU)

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

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

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

Other specialized formulas and nutritional supplements are not covered.

Osteoporosis

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

Surgically Implanted Drugs

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

Dental Injury

Emergency Care of a Physician treating an Accidental Injury to the natural teeth which occurs while You are covered under this *Certificate*. You must receive services during the six months immediately following the date of injury and You must be covered under this *Certificate* at the time such services are rendered. Medically Necessary related Emergency Hospital services will also be covered. Damage to natural teeth due to chewing or biting is not Accidental Injury. Dental appliances are not a Covered Expense.

Care for Conditions of Pregnancy

*The coverage described below meets requirements for Hospital length of stay under the **Newborns' and Mothers' Health Protection Act of 1996**.*

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

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

Your Physician will not be required to obtain Certification for a Hospital stay that is equal to or less than 48 hours following vaginal delivery or 96 hours following cesarean section. Longer stays in the Hospital and scheduled cesarean section must be certified. If Certification is not obtained, payment of benefits will be reduced as set forth herein.

If You are discharged earlier than 24 hours after a vaginal delivery or 96 hours after a cesarean section, Your Physician may arrange a home visit during the first 48 hours following discharge by a licensed health care provider whose scope of practice includes postpartum care and newborn care. This home visit does not require Certification.

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

Please notify HNL upon confirmation of pregnancy.

Organ, Tissue and Bone Marrow Transplants

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

HNL has a specific network of transplant centers to perform organ, tissue and bone marrow transplants. Your Physician can provide You with information about those transplant centers. You will be directed to a designated HNL transplant center at the time Certification is obtained.

Medical services, in connection with organ, tissue or bone marrow 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.

If You receive services authorized by HNL for an organ, tissue or bone marrow transplant from an Out-of-Network Provider, Hospital or other health care provider, Covered Expenses will be the amount negotiated and agreed to by HNL and the Physician, Hospital or health care provider. Covered Person will be responsible for payment of any Deductibles and Coinsurance as stated in the "Schedule of Benefits" section of this *Certificate*.

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

- Transplant travel expenses (benefit limitations) are covered as follows:
 - For transplant recipient and one companion per transplant episode (limited to 6 trips per episodes)
 1. Transportation to transplant center: \$250 per trip for each person (round-trip coach airfare)
 2. Hotel accommodations: \$100 per day, for up to 21 days per trip, limited to one room (double occupancy)
 3. Meals & miscellaneous expenses: \$25 per day for each person, for up to 21 days per trip
 - For the donor per transplant episode (limited to one trip per episode)
 1. Transportation to transplant center: \$250 for round-trip coach airfare
 2. Hotel accommodations: \$100 per day, for up to 7 days
 3. Meals & miscellaneous expenses: \$25 per day, up to 7 days.

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

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

Organ, tissue and bone marrow transplants are not covered if provided by an Out-of-Network Provider.

Family Planning

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

Clinical Trials

Routine patient care costs for patients diagnosed with cancer who are accepted into phase I, II, III or IV clinical trials are covered when Medically Necessary, recommended by the Covered Person's treating Physician and authorized by HNL. The Physician must determine that participation has a meaningful potential to benefit the Covered Person and the trial has therapeutic intent. Clinical trial services performed by Out-of-Network Providers are covered only when the protocol for the trial is not available through Preferred Providers. Services rendered as part of a clinical trial subject to the reimbursement guidelines as specified in the law. The treatment shall be provided in a clinical trial that involves either a drug that is exempt from federal regulation in relation to a new drug application, or is approved by one of the following:

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

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

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

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

Chiropractic Services

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

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

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

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

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

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

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

Mental Health Care and Chemical Dependency Benefits

After Your Calendar Year Deductible has been met, the following benefits will be paid by HNL for expenses incurred by You for medical advice, treatment, counseling or testing for Mental Disorders or Chemical Dependency.

Payment of benefits for mental health and Chemical Dependency services will be reduced as set forth herein if Certification is not obtained for the services.

Services for Non-Severe Mental Disorders

You will be entitled to receive payment for the cost of covered inpatient Hospital Services and for the cost of outpatient visits to, and inpatient visits by, a Physician as shown in the "Schedule of Benefits" section.

Serious Emotional Disturbances of a Child

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

Severe Mental Illness

Treatment of Severe Mental Illness is covered as shown in the "Schedule of Benefits" section. Look under the headings for office visits, outpatient services and inpatient Hospital services to determine the applicable Copayment or Coinsurance.

Covered services include treatment of:

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

Chemical Dependency Services

You will be entitled to receive payment for the cost of covered inpatient Hospital services and for the cost of outpatient visits to, and inpatient visits by, a Physician, as shown in the "Schedule of Benefits" section.

Rehabilitation services in relation to Chemical Dependency shall be provided in a Hospital, residential Chemical Dependency care facility or outpatient Chemical Dependency care facility when the treatment program at the facility is approved by HNL and the services are authorized.

A Hospital is a facility as defined in the "Definitions" section. Some traditional Hospitals provide residential Chemical Dependency rehabilitation services.

A residential Chemical Dependency care facility is a 24-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 Chemical Dependency care facilities be appropriately licensed by their state in order to provide residential treatment services. Admissions that are not considered medically appropriate and are not covered include admissions for wilderness center training; for Custodial Care, for a situational or environmental change; or as an alternative to placement in a foster home or halfway house.

An outpatient Chemical Dependency care facility is a legally constituted facility that provides detoxification as well as rehabilitation services. The facility will be operated during designated hours and on certain specified days (usually Monday through Friday and occasionally half days on Saturday).

Residential Care

Care can be provided in either a Hospital which provides residential rehabilitation services for Chemical Dependency or a residential Chemical Dependency care facility which specializes in such care.

Covered Expenses

- Room and board, including nursing services
- Laboratory tests
- Drugs, biologicals and solutions dispensed by the facility and used while You are in the facility

- All services performed in the facility by professional and other trained staff members which are necessary for patient care and treatment
- Individual and group therapy or counseling
- Psychological testing
- Family counseling

Outpatient Care

Care can be provided in an outpatient Chemical Dependency care facility.

Covered Expenses

- Laboratory tests
- Drugs, biologicals and solutions dispensed by the facility in connection with treatment received at the facility and used while You are in the facility
- Drugs dispensed by the facility in connection with treatment received at the facility which are to be taken at home
- All services performed in the facility by professional and other trained staff members which are necessary for patient care and treatment
- Individual and group therapy or counseling
- Psychological testing
- Family counseling. Each session with one or more Covered Persons in a family will count as a visit which will be subtracted from the patient's total available visits

Chemical Dependency Rehabilitation Exclusions

The following services will not be covered:

- Use of personal or convenience items such as telephones, televisions or services of a hairdresser, etc.
- Health services rendered primarily in connection with disorders other than Chemical Dependency as classified in the edition of the International Classification of Diseases which is in effect as of the date of service
- Diversion therapy
- Unless You are fully participating in a rehabilitation program, the following procedures are not Covered Expenses: methadone, urine samples in relation to that drug, counseling and/or psychological testing

Outpatient Prescription Drug Benefits

The preceding sections of this *Certificate* provide coverage for Prescription Drugs obtained while an inpatient in a Hospital or Skilled Nursing Facility. This plan also includes coverage for Prescription Drugs outside a Hospital or Skilled Nursing Facility setting. This outpatient Prescription Drug benefit is subject to a specific set of terms and conditions documented in this *Certificate* which You must be informed about in order to obtain the highest level of coverage under this benefit. The provisions which follow are in addition to, and do not replace, any other provision under this *Certificate* which may apply to Prescription Drugs.

Covered Drugs and Supplies

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

Prescription Drugs must be dispensed for a condition, illness or injury that is covered by this Plan. Refer to the "General Limitations and Exclusions" section of this *Certificate* to find out if a particular condition is not covered.

Level I Drugs (Primarily Generic) and Level II Drugs (Primarily Brand)

Prescription Drugs listed in the Health Net Recommended Drug List are covered, when prescribed by a Physician, an authorized referral specialist or an emergent or urgent care Physician. Some Level I and Level II Drugs require Prior Authorization from HNL to be covered. The fact that a drug is listed in the Recommended Drug List does not guarantee that Your Physician will prescribe it for You for a particular medical condition.

Level III Drugs

Level III Drugs are Prescription Drugs that may be Generic Drugs or Brand Name Drugs, and are either:

- Specifically listed as Level III on the Recommended Drug List; or
- Not listed in the Health Net Recommended Drug List that are not excluded or limited from coverage.

Some Level III Drugs require Prior Authorization from HNL to be covered.

Please refer to the "Recommended Drug List" portion of this subsection for more details.

Generic Equivalents to Brand Name Drugs

You are financially responsible for the applicable Deductible, Copayment or Coinsurance for the Brand Name Drug plus an additional amount, as shown in the "Schedule of Benefits" section of this *Certificate*, if a Generic Drug equivalent is commercially available, but You:

- Receive a Brand Name Drug at a Participating Pharmacy or through the Mail Order Program; or
- Submit a claim for a Brand Name Drug from a Nonparticipating Pharmacy or due to Emergency Care.

However, if the Prescription Drug Order states "do not substitute" or "dispense as written" or words of similar meaning in the Physician's handwriting, You are only responsible for the applicable Deductible and Copayment.

Off-Label Drugs

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

- Approved by the Food and Drug Administration.
- Prescribed or administered by a licensed health care professional for the treatment of:
 1. A life-threatening condition, or
 2. A chronic and seriously debilitating condition in which the drug is determined to be Medically Necessary to treat such condition.
- Recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following:
 1. The American Medical Association Drug Evaluations
 2. The American Hospital Formulary Service Drug Information.
 3. The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional."
 4. 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.
- Otherwise Medically Necessary.

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

"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.

"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.

Diabetic Drugs and Supplies

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

Compounded Drugs

Prescription Drug Orders that are combined or manufactured by the pharmacist and placed in ointment, capsule, tablet, solution, suppository, cream or other form using FDA approved drugs are covered at the Level III Drug Copayment. Coverage for Compounded Drugs is subject to Prior Authorization by HNL and Medical Necessity. Compounded Drugs are not covered if there is a similar proprietary product available.

Contraceptives

Vaginal, oral contraceptives and emergency contraceptives are covered. Vaginal contraceptives include diaphragms and cervical caps, when a Physician performs a fitting examination and prescribes the device. Such devices are only available through a prescription from a pharmacy and limited to one fitting and prescription per Calendar Year unless additional fittings or devices are Medically Necessary. For a complete list of contraceptive products covered by HNL, please refer to the Recommended Drug List. Injectable contraceptives are covered as a medical benefit when administered by a Physician.

The Recommended Drug List

What is the Health Net Recommended Drug List?

HNL developed the Recommended Drug List to identify the safest and most effective medications for Health Net Life Covered Persons while attempting to maintain affordable pharmacy benefits. We specifically suggest to all Preferred Providers that they refer to this List when choosing drugs for patients who are Health Net Life Covered Persons. When Your Physician prescribes medications listed in the Recommended Drug List, it is ensured that You are receiving a high quality and high value prescription medication. In addition, the Recommended Drug List identifies whether a Generic version of a Brand Name Drug exists, and whether the drug requires Prior Authorization. If the Generic version exists, it will be dispensed instead of the Brand Name version.

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

How are Drugs Chosen for the Health Net Recommended Drug List?

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

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

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

Who is on the Health Net Pharmacy and Therapeutics Committee and How are Decisions Made?

The Committee is made up of actively practicing Physicians of various medical specialties from Health Net contracting Physician groups, as well as clinical pharmacists. Voting members are recruited from contracting Physician groups throughout California based on their experience, knowledge and expertise. In addition, the Pharmacy and Therapeutics Committee frequently consults with other medical experts to provide additional input to the Committee. A vote is taken before a drug is added to the Recommended Drug List. The voting members are not employees of HNL. This ensures that decisions are unbiased and without conflict of interest.

Prior Authorization Process

Prior Authorization status is included in the Recommended Drug List. The List identifies which drugs require Prior Authorization. A Physician must get approval from HNL before writing a Prescription Drug Order for a drug that is listed as requiring Prior Authorization, in order for the drug to be covered by HNL. If a drug is not on the List, Your Physician should call HNL to determine if the drug requires Prior Authorization.

Urgent requests from Physicians are handled in a timely fashion, not to exceed 72 hours, as appropriate and Medically Necessary, for the nature of the Covered Person's condition hours after HNL's receipt of the information reasonably necessary and requested by HNL to make the determination. Routine requests from Physicians are processed in a timely fashion, not to exceed five days, as appropriate and Medically Necessary for the nature of the Covered Person's condition after HNL's receipt of the information reasonably necessary and requested by HNL to make the determination. Requests may be submitted by telephone or facsimile. HNL will evaluate the submitted information upon receiving Your Physician's request for Prior Authorization and make a determination based on established clinical criteria for the particular medication. The criteria used for Prior Authorization are developed and based on input from the Health Net Pharmacy and Therapeutics Committee as well as Physician experts. Your Physician may contact HNL to obtain the usage guidelines for specific medications.

Retail Pharmacies and the Mail Order Program

Prescription Drugs Dispensed by a Participating Pharmacy

You must purchase covered drugs at a Participating Pharmacy to receive the highest available benefits for Prescription Drugs under this Plan.

HNL is contracted with many major pharmacy chains, supermarket based pharmacies and privately owned neighborhood pharmacies in California.

To find a conveniently located Participating Pharmacy, please visit Our website at www.healthnet.com or call the Member Services Department at the telephone number on Your HNL ID Card. Present the HNL ID Card and pay the appropriate Copayment when the drug is dispensed.

If refills are stipulated on the Prescription Drug Order, a Participating Pharmacy may dispense up to a 30-consecutive-calendar-day supply for each Prescription Drug Order or for each refill at the appropriate time interval.

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

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

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

Prescription Drugs Dispensed by a Nonparticipating Pharmacy

The maximum charge HNL will allow for a Prescription Drug Order is the Prescription Drug Covered Expense, as defined in the "Definitions" section. It is not necessarily the amount a Nonparticipating Pharmacy will charge. You are financially responsible for any amount charged by a Nonparticipating Pharmacy which exceeds the amount of Prescription Drug Covered Expense in addition to the appropriate Copayment or Coinsurance. If You present a

Prescription Drug Order for a Brand Name Drug, pharmacists will offer a Generic Drug equivalent if commercially available. At the time of the Emergency or Urgent Care visit, You should advise the treating Physician of any drug allergies or reactions, including to any Generic Drugs.

When Prescription Drugs are dispensed by a Nonparticipating Pharmacy, You will be required to:

- Pay the full cost of the Prescription Drug that is dispensed; and
- Submit a claim to HNL for possible reimbursement.

To receive the highest available benefits for Prescription Drugs under this *Certificate*, You must have the Prescription Drug Order dispensed by a Participating Pharmacy, and request that Generic Drugs be substituted for Brand Name Drugs.

Claim forms will be provided by HNL upon request.

Prescription Drugs Dispensed Through the Mail Service Prescription Drug Program

If Your prescription is for a Maintenance Drug, You shall be entitled to have a Prescription Drug Order filled through a mail delivery program selected by HNL. Through this program You can receive through the mail up to a 90-consecutive-calendar-day supply of a Maintenance Drug when so prescribed. In some cases a 90-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan, according to FDA or HNL usage guidelines. The lesser of the applicable mail order Copayments or Coinsurance or the mail order pharmacy's usual and customary charge will be required.

To use this program, You must place an order through the mail by completing a Prescription Mail Order Form. It must be accompanied by the original Prescription Drug Order, not a copy. The Prescription Mail Order Form and an explanation of how to use the program will be provided by HNL upon request. Please contact the Member Services Department at the telephone number on Your HNL ID Card.

Note: Schedule II narcotic drugs are not covered through the mail order program. Refer to the "Outpatient Prescription Drug Benefits" portion of the "General Limitations and Exclusions" section for more information.

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

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

GENERAL LIMITATIONS AND EXCLUSIONS

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

Medical Services and Supplies

Not Medically Necessary

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

Excess Charges

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

Clinical Trials

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

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

Cosmetic Services and Supplies

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

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

- Improve function, or
 - Create a normal appearance to the extent possible,
- then,
- Surgery to excise, enlarge, reduce or change the appearance of any part of the body;
 - Surgery to reform or reshape skin or bone; or
 - Surgery to excise or reduce skin or tissue are covered.

In addition, HNL will provide coverage for Medically Necessary breast reconstruction surgery if HNL determines that:

- The breast reconstructive surgery is performed subsequent to a Medically Necessary mastectomy; and

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

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

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

Contraceptives

Vaginal, oral and emergency contraceptives are covered as described in the "Outpatient Prescription Drug Benefits" portion of the "Plan Benefits" section of this *Certificate*. Vaginal contraceptives include diaphragms and cervical caps, and are only covered when a Physician performs a fitting examination and prescribes the device. Such devices are only available through a prescription from a pharmacy and limited to one fitting and prescription per Calendar Year unless additional fittings or devices are Medically Necessary. Injectable contraceptives (when administered by a Physician) and intrauterine devices (IUDs) are covered as a medical benefit. If Your Physician determines that none of the methods specified as covered by the Plan are medically appropriate, then the Plan will provide coverage for another FDA-approved prescription or contraceptive method as prescribed by Your Physician.

Dental Services

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

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

Care or treatment of teeth and supporting structures; extraction of teeth; treatment of dental abscess or granuloma; dental examinations and treatment of gingival tissues other than tumors are not covered, except as stated above. Spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, active splints or orthotics (whether custom fit or not), dental implants (materials implanted into or on bone or soft tissue), or other dental appliances, and related surgeries to treat dental conditions are not covered regardless of reason for such services.

Temporomandibular (Jaw) Joint Disorders

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

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

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

Dietary or Nutritional Supplements

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

Refractive Eye Surgery

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

Optometrics, Vision Therapy And Orthoptics

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

Outpatient Speech Therapy

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

Sex Change

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

Reconstruction of Prior Surgical Sterilization Procedures

Services to reverse voluntary surgically induced Infertility.

Conception by Medical Procedures

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

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

Genetic Testing and Diagnostic Procedures

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

Infertility Services

Services to diagnose, evaluate or treat Infertility are not covered.

Experimental Or Investigational Procedures

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

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

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

Routine Physical Examinations

For insurance, licensing, employment, school or camp. Any physical, vision or hearing exams which are not related to treatment of illness or injury, except as specifically stated in the "Plan Benefits" section of this *Certificate*.

Immunizations Or Inoculations

For adults or children, except as described in the "Plan Benefits" section of this *Certificate*.

Services Not Related To Covered Illness Or Injury

Any services not related to the diagnosis or treatment of a covered illness or injury.

Custodial Or Domiciliary Care

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

Inpatient Diagnostic Tests

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

Noneligible Hospital Confinements

Inpatient room and board charges in connection with a Hospital stay primarily for environmental change, physical therapy or treatment of chronic Pain.

Noneligible Institutions

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

Private Rooms

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

Private Duty Nursing

Inpatient and outpatient services (including incremental nursing) provided by a private duty nurse.

Chemical Dependency

Treatment of chronic alcoholism, drug addiction and other Chemical Dependency problems, including detoxification services are not covered, except as specifically stated in the "Plan Benefits" section of this *Certificate*.

Mental Disorders

Care as a condition of parole or probation and court ordered testing is not covered under this *Certificate*. All other treatment for Mental Disorders is also not covered, except as specifically stated in the "Plan Benefits" section of this *Certificate*.

Hyperkinetic Syndromes, Learning Disabilities, Behavioral Problems or Mental Retardation

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

Noncovered Items

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

- Alteration of Your residence to accommodate Your physical or medical condition, including the installation of elevators
- Disposable supplies for home use
- Exercise equipment, including treadmills and charges for activities or facilities normally intended or used for physical fitness
- Hygienic equipment, Jacuzzis and spas
- Corrective appliances, except prostheses, casts, splints. Surgical dressings, except when the dressing is a primary dressings, i.e., a therapeutic and protective covering applied directly to lesions either on the skin or opening to the skin required as a result of a surgical procedure performed by a Physician

- Support appliances and supplies such as stockings; arch supports
- Orthotics, unless custom made to fit the Covered Person's body. (Orthotics are supports or braces for weak or ineffective joints or muscles.)
- Orthodontic appliances to treat dental conditions related to the treatment of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders)
- Foot orthotics (whether or not custom fit) that are not incorporated into a cast, splint, brace or strapping of the foot, unless Your Group purchases a specific benefit for corrective footwear as shown in the "Medical Supplies" portion of the "Schedule of Benefits," section and the "Medically Necessary Corrective Footwear" provision of the "Plan Benefits" section
- Personal or comfort items
- Air purifiers, air conditioners and humidifiers
- Hearing aids
- Food supplements (except as specifically stated in the "Outpatient Infusion Therapy" provision of the "Plan Benefits" section of this *Certificate*)
- Educational services or nutritional counseling, except as specifically provided in the "Diabetes Education" or "Outpatient Infusion Therapy" provisions of the "Plan Benefits" section of this *Certificate*

However, the *Certificate* does cover Medically Necessary diabetic equipment as shown in the "Medical Supplies" portion of "Schedule of Benefits" and the "Diabetic Equipment" provision in the "Plan Benefits" section.

Treatment of Obesity

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

Transplants

Experimental or Investigational organ, bone marrow and tissue transplants.

Duplicate Coverage

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

Medicare

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

Workers' Compensation

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

Expenses Before Coverage Begins

Services received before the Covered Person's Effective Date.

Expenses After Termination of Coverage

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

Services For Which You Are Not Legally Obligated To Pay

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

Physician Self-Treatment

Self-treatment rendered in a non-emergency. Physician self-treatment occurs when Physicians provide their own medical services, including prescribing their own medication, ordering their own laboratory test and self-referring for their own services. Claims for emergency self-treatment are subject to review by HNL.

Services Provided by Immediate Family Members

Professional services received from a person who lives in Your home or who is related to You by blood, marriage or domestic partnership. Covered Persons who receive routine or ongoing care from a member of their immediate family may be reassigned to another Physician.

Acts of War

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

Crime

Conditions caused by Your commission (or attempted commission) of a felony.

Nuclear Energy

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

Governmental Agencies

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

Disabled or Hospitalized At The Time of Enrollment

If at the time of enrollment, You are totally disabled (or hospitalized) and You are entitled to a continuation of coverage from a prior group health plan or insurer, benefits of this *Certificate* shall not be provided for services rendered to treat the disabling condition (or the condition for which You are hospitalized), until the benefits available under the prior group plan have been exhausted.

Services Related To Pregnancy Induced Under A Surrogate Parenting Agreement

Services for conditions of pregnancy for a surrogate parent are covered, but when compensation is obtained for the surrogacy, We shall have a lien on such compensation to recover its medical expense. A surrogate parent is a woman who agrees to become pregnant with the intent of surrendering custody of the child to another person.

Outpatient Drugs and Medications

Any outpatient drugs, medications or other substances dispensed or administered in any outpatient setting, except as specifically stated in the "Plan Benefits" section of this *Certificate*. This includes any nonprescription (over-the-counter) drug 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 for a non-Prescription Drug.

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. Rehabilitative services, in excess of the number of visits stated in the "Schedule of Benefits" section, whether rendered in an inpatient or outpatient facility, are not covered. In addition, rehabilitation therapy services (physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy) are not covered when provided in connection with the treatment of the following conditions:

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

- Developmental articulation and language disorders

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

Foreign Travel Or Work Assignment

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

Telephone Consultations

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

Home Birth

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

Outpatient Prescription Drug Benefits

The exclusions and limitations in the "Medical Services and Supplies" portion of this section also apply to the coverage of Prescription Drugs.

Note: Services or supplies excluded under the Prescription Drug benefits may be covered under Your medical benefits portion of this *Certificate*. Please refer to the "Medical Benefits" portion of the "Plan Benefits" section for more information.

Additional exclusions and limitations:

Drugs Covered by Another Section

Prescription Drugs which are covered by any other benefits provided by this *Certificate*, including any drugs provided for outpatient infusion therapy, delivered or administered to the patient by the attending Physician, or billed by a Hospital or Skilled Nursing Facility, are not covered. This includes immunizing agents.

Noncovered Services

Drugs prescribed for a condition or treatment that is not covered by this *Certificate* are not covered. However, the *Certificate* does cover Medically Necessary drugs for a medical condition directly related to noncovered services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery).

No-Charge Items

Services or supplies for which You are not legally required to pay or for which no charge is made.

Nonprescription (Over-the-Counter) Drugs, Equipment and Supplies

Medical equipment and supplies (including insulin), that are available without a prescription, are covered only when prescribed by a Physician for the management and treatment of diabetes.

Any other non-Prescription Drugs, equipment or supplies which can be purchased without a Prescription Drug Order are not covered even if a Physician writes a prescription for such drug, equipment or supply unless specifically listed in the Recommended Drug List. These are commonly called over-the-counter drugs. Insulin is an exception to this limitation. However, if a higher dosage form of a non-Prescription Drug or over-the-counter drug is only available by prescription, that higher dosage drug will be covered.

If a drug that was previously available by prescription becomes available in an over-the-counter (OTC) form in the same prescription strength, then Prescription Drugs that are similar agents and have comparable clinical effect(s), will only be covered only when Medically Necessary and Prior Authorization is obtained from HNL.

Devices

Coverage is limited to vaginal contraceptive devices and those devices listed under the "Diabetic Supplies" provision of the "Outpatient Prescription Drug Benefits" portion of "Plan Benefits." No other devices are covered even if prescribed by a Physician.

Diagnostic Drugs

Drugs used for diagnostic purposes are not covered. Diagnostic drugs are covered under the medical benefit when Medically Necessary.

Drugs Prescribed for Cosmetic or Enhancement Purposes

Drugs that are prescribed for the following non-medical conditions are not covered: hair loss, sexual performance, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes and mental performance. Examples of drugs that are excluded when prescribed for such conditions include, but are not limited to, Penlac, Renova, Vaniqua, Propecia or Lustra. This exclusion does not exclude coverage for drugs when pre-authorized as Medically Necessary to treat a diagnosed medical condition affecting memory, including but not limited to, Alzheimer's dementia.

Appetite Suppressants or Drugs for Body Weight Reduction

Drugs for the treatment of obesity are not covered, unless Medically Necessary.

Dietary or Nutritional Supplements

Drugs used as dietary or nutritional supplements, including vitamins and herbal remedies, are limited to drugs that are listed in the Recommended Drug List. Phenylketonuria (PKU) is covered under the medical benefit (see the "Phenylketonuria" provision of the "Plan Benefits" section).

Drugs Prescribed for Common Cold

Drugs when prescribed to shorten the duration of the common cold are not covered.

Allergy Serum

Allergy desensitization products, whether administered by injection or drops placed in the nose or mouth (trans-mucosal absorption), to lessen or end the person's allergic reactions are not covered. These products are sometimes described as "allergy serum." Allergy serum is covered as a medical benefit. See the "Allergy and Injection Services" portion of the "Schedule of Benefits" section and the "Allergy Testing and Treatment" provision in the "Plan Benefits" section.

Nonapproved Uses, Investigational or Experimental Drugs

Medications limited by law to Investigational use, prescribed for Experimental purposes or prescribed for indications not approved by the Food and Drug Administration are excluded from coverage. However, Off-Label Drugs prescribed or administered by a licensed health care professional for the treatment of a life-threatening or chronic and seriously debilitating condition are covered as described in the "Outpatient Prescription Drug Benefits" portion of the "Plan Benefits" section or is otherwise Medically Necessary.

Injectable Drugs

Injectables (other than insulin when prescribed by a Physician) are not covered. Surgically implanted drugs are covered under the medical benefit (see the "Surgically Implanted Drugs" provision in the "Plan Benefits" section).

Irrigation Solutions

Irrigation solutions and saline solutions are not covered.

Contraceptives

Oral contraceptives and emergency contraceptives are covered, as described in the "Outpatient Prescription Drug Benefits" portion of the "Plan Benefits" section. Vaginal contraceptives include diaphragms and cervical caps, when a Physician performs a fitting examination and prescribes the device. Such devices are only available through a prescription from a pharmacy and limited to one fitting and prescription per Calendar Year unless additional fittings or devices are Medically Necessary. Injectable contraceptives are covered as a medical benefit when administered by a Physician.

If Your Physician determines that none of the methods specified as covered by the Plan are medically appropriate then the Plan will provide coverage for another FDA approved prescription or contraceptive method as prescribed by Your Physician.

Food and Drug Administration (FDA)

Supply amounts for prescriptions that exceed the FDA's or HNL's indicated usage recommendation are not covered unless Medically Necessary and Prior Authorization is obtained from HNL.

Quantity Limitations

Some drugs are subject to specific quantity limitations per Copayment or Coinsurance, whichever is applicable, based on recommendations for use by the FDA or HNL's usage guidelines. Medications taken on an "as-needed" basis may have a Copayment or Coinsurance based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If Medically Necessary, Your Physician may request a larger quantity from HNL.

Unit Dose or "Bubble" Packaging

Individual doses of medication dispensed in plastic, unit doses or foil packages and dosage forms used for convenience as determined by HNL are not covered, unless Medically Necessary or only available in that form.

Schedule II Narcotic Drugs

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 for medical uses in the United States.

Compounded Drugs

Prescription Drug Orders that are combined or manufactured by the pharmacist and placed in ointment, capsule, tablet, solution, suppository, cream or other form using FDA approved drugs are covered at the Level III Drug Copayment. Coverage for Compounded Drugs is subject to Prior Authorization by HNL and Medical Necessity. Compounded Drugs are not covered if there is a similar proprietary product available.

Smoking Cessation

Drugs used to reduce or cease smoking or for nicotine addiction are not covered.

Lost, Stolen or Damaged Drugs

Lost, stolen or damaged drugs are not covered. You will have to pay the retail price for replacing them.

Hypodermic Syringes and Needles

Hypodermic syringes and needles are limited to specific brands of disposable insulin needles, syringes, devices and specific brands of pen devices. Needles and syringes required to administer self-injected medications (other than insulin) will be provided when obtained through Our Specialty Pharmacy Vendor under the medical benefit. All other devices, syringes and needles are not covered.

Drugs Prescribed by a Dentist

Drugs prescribed for routine dental treatment are not covered.

GENERAL PROVISIONS

Term Of Certificate

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

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

Member Services Department Interpreter Services

HNL's Member Services Department has bilingual staff and a telephone interpreter service for additional languages to handle Member inquiries. Examples of interpretive services provided include explaining benefits and answering health plan questions in the Covered Person's preferred language. Call the Member Services number on your HNL ID card for this free service. HNL discourages the use of family members, friends and minors as interpreters.

Coordination of Benefits

Explanation

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

Purpose

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

Administration

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

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

- **COVERED EMPLOYEE:** HNL is the **Primary Plan** with responsibility for first payment, except when (a) You are covered by another group health plan or insurer as the employee and that plan has covered You longer than the HNL plan or (b) the group plan or insurer does not contain a "COB" provision similar to this one.
- **SPOUSE:** HNL is the **Primary Plan** with responsibility for first payment, except when (a) the spouse is covered under another group health plan or insurer as the employee or (b) the other group plan or insurer does not contain a "COB" provision similar to this one.

- **CHILD:** Determination of the **Primary Plan** will be based on the following:
 1. The insurer, under whom the child is covered as a principal Covered Person, employee or primary individual, shall be the **Primary Plan** for that child;
 2. If the child is not covered as specified above and is covered as a dependent under the insurers of both parents, then the insurer of the parent whose date of birth, but not year of birth, occurs earlier in a Calendar Year shall be the **Primary Plan** for dependent children covered under their group health plan. The insurer of the parent whose birthday occurs later in the Calendar Year shall be the **Secondary Plan** for dependent children covered under their group health plan;
 3. Group health plan as determined above is the **Primary Plan** with responsibility for first payment, unless the Rules Establishing the Order of Benefit Determination are affected because of a divorce and assignment of legal custody of the child. **If the Mother has legal custody**, her group plan or insurer pays first; the stepfather's (if any) group plan or insurer pays second; and the natural father's third. **If the Father has legal custody**, his group plan or insurer pays first; the stepmother's (if any) pays second and the natural mother's third; or
 4. However, if the child's parents are separated or divorced and there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses of that child, then the group health plan of the parent with such court-ordered financial responsibility shall be the **Primary Plan**. The group health plan of the other parent shall be the **Secondary Plan**.

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

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

Facility of Payment

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

Right to Receive and Release Necessary Information

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

Services Instead of Cash Payments

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

Right of Recovery

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

Medicare Coordination of Benefits (COB)

When You or Your spouse reaches age 65, You may become eligible for Medicare based on age. You may also become eligible for Medicare before reaching age 65 due to disability or end stage renal disease.

If You are enrolled in this Plan as well as in both Medicare Part A and Part B, and are not an active employee, then this plan coordinates benefits with Medicare. (Please note that You must enroll in Medicare Part A and Part B to be eligible for Medicare Coordination of Benefits.)

For services and supplies covered under Medicare Part A and Part B, claims are first submitted to the Medicare intermediary for determination and payment of allowable amounts. The Medicare intermediary then sends Your medical care provider a Medicare Summary Notice (MSN), (formerly an Explanation of Medicare Benefits (EOMB)). In most cases, the MSN will indicate that the Medicare intermediary has forwarded the claim to HNL for secondary coverage consideration. HNL will process secondary claims received from the Medicare intermediary. Secondary claims not received from the Medicare intermediary must be submitted to HNL by You or the provider of service, and must include a copy of the MSN. HNL and/or Your medical provider is responsible for paying the difference between the Medicare paid amount and the covered services outlined in this *Certificate*. This Plan will cover benefits as a supplemental payer only to the extent services are coordinated by Your Physician and authorized by HNL.

If either You or Your spouse is over the age of 65 and You are actively employed, neither You nor Your spouse is eligible for Medicare Coordination of Benefits. For answers to questions regarding Medicare, contact:

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

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

Grievance and Appeals Process

If You are not satisfied with efforts to solve a problem with HNL or a medical provider, You must first file a grievance or appeal against HNL by calling Member Services at **1-800-676-6976** or by submitting a Member Grievance Form through the HNL website at www.healthnet.com. You must file Your grievance or appeal with HNL within 365 calendar days following the date of the incident or action that caused Your grievance. You may also file a complaint in writing by sending information to:

Health Net Life Insurance Company
Member Services Appeals and Grievance Department
P.O. Box 10348
Van Nuys, CA 91049

Independent Medical Review of Grievances Involving a Disputed Health Care Service

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

The IMR process is in addition to any other procedures or remedies that may be available. You will not pay any application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. HNL will provide You with an IMR application form and HNL's grievance response letter that

states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause You to forfeit any statutory right to pursue legal action against HNL regarding the Disputed Health Care Service.

Eligibility

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

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

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

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

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

Independent Medical Review of Investigational or Experimental Therapies

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

Eligibility

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

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

Arbitration

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

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

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

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

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

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

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this *Certificate*, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the

arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that State or Federal law provide for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees.

Effective July 1, 2002, Covered Persons who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are *not* required to submit disputes about certain "adverse benefit determinations" made by HNL to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by HNL to deny, reduce, terminate or not pay for all or a part of a benefit. However, because your employer's plan is not subject to ERISA, the above described types of disputes will be subject to mandatory binding arbitration.

Medical Malpractice Disputes

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

SPECIFIC PROVISIONS

When a Third Party Causes a Covered Person's Injuries

If You are ever injured through the actions of another person (a third party), HNL will provide benefits for all Covered Services and Supplies that You receive through this plan. However, if You receive money because of Your injuries, You must reimburse HNL or the medical providers for the value of any services provided to You under this *Certificate*.

Examples of how an injury could be caused by the actions of another person:

- You were in a car accident and the other driver is at fault; or
- You slip and fall in a store because a wet spot was left on the floor.

Steps the Covered Person Must Take

HNL's legal right to reimbursement is called a lien.

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

- Telling HNL and the medical providers the name and address of the third party, if You know it, the name and address of his or her lawyer, if he or she is using a lawyer and describing how the injuries were caused;
- Completing any paperwork that HNL or the medical providers may reasonably require to assist in enforcing the lien;
- Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions;
- Notifying the lienholders immediately upon You or Your lawyer receiving any money from the third parties or their insurance companies; and
- Holding any money that You receive from the third parties or their insurance companies, in trust and reimbursing HNL and the medical providers for the amount of the lien as soon as You are paid by the third party.

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

Your reimbursement to HNL or the medical provider under this lien is based on the value of the services received and the costs of perfecting this lien. For the purposes of determining the lien amount, the value of the services depends on how the provider was paid and will be determined as permitted by law. Unless the money received came from a Workers' Compensation claim, the following applies:

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

Refund To HNL of Overpayment Of Benefits

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

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

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

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

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

Out-of-State Providers

Health Net PPO has created a program which allows Covered Persons access to participating providers outside their state of residence. This program is through the out-of-state provider network shown on Your HNL ID Card and is limited to Covered Persons traveling outside their state of residence for a period not exceeding six months. The program is not intended for Covered Persons traveling outside their state of residence solely to receive medical care.

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

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

Second Medical Opinion

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

- If the Covered Person questions the reasonableness or necessity of recommended surgical procedures.
- If the Covered Person questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious Chronic condition.
- If clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and the Covered Person requests an additional diagnosis.
- If the treatment plan in progress is not improving the medical condition of the Covered Person within an appropriate period of time given the diagnosis and plan of care, and Covered Person requests a second opinion regarding the diagnosis or continuance of the treatment.
- If the Covered Person has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

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

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

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

MISCELLANEOUS PROVISIONS

Form or Content of the Certificate

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

Benefits Not Transferable

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

Time Limit on Certain Defenses

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

Notice of Claim

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

Claim Forms

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

Proofs of Loss

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

Expenses for Copying Medical Records

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

Time of Payment of Claims

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

Cash Benefits

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

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

Payment to Providers or Covered Persons:

- **Direct Payment.** Benefit payment for Covered Expenses will be made directly to:
 1. **Contracting Hospitals:** Hospitals which have Provider Service Agreements with HNL to provide services to Covered Persons.

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

Payment When You Are Unable To Accept

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

Physical Examination

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

Foreign Travel or Work Assignment

Benefits will be provided for Emergency Care received in a foreign country. Determination of Covered Expenses will be based on the amount that is no greater than the maximum customary or reasonable charge (as determined by HNL) in the USA for the same or a comparable service. A Customary and Reasonable Charge is one that falls within the common range of fees billed by a majority of Physicians for a procedure in a given geographic region, or which is justified based on the complexity or the severity of treatment for a specific case.

Workers' Compensation Insurance

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

Notice

Any notice required of HNL shall be sufficient if mailed to the holder of the Group Policy at the address appearing on the records of HNL; if notice is required of You or the Group, it will be sufficient if mailed to the principal office of HNL in Woodland Hills, California.

Interpretation of Certificate

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

Legal Actions

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

Non-Regulation of Providers

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

Free Choice of Provider

This Health Net PPO plan does not interfere with Your right to select any properly licensed Hospital, Physician or other health care professional or facility that provides services or supplies covered by this plan. However, Your choice of provider may affect the amount of benefits payable.

Continuity of Care

If HNL's contract with a Preferred Provider is terminated, You may elect continued care by that provider if, at the time of termination, You were receiving care for an acute condition, serious chronic condition, pregnancy, new-

born, terminal illness or a scheduled surgery. For more information on how to request continued care, please contact the Member Services Department at the telephone number on Your HNL ID Card.

Providing of Care

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

Relationship of Parties

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

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

Confidentiality of Medical Records

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

Health Care Plan Fraud

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

Your Responsibility

As a Covered Person, You must:

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

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

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

If You are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if You know of or suspect any illegal activity, call Our toll-free hotline at **1-800-676-6976**. All calls are strictly confidential.

Privacy Statement

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

Information Security

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

Information We Collect

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

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

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

Disclosures

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

Additional Information about this Privacy Statement

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

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

NOTICE OF PRIVACY PRACTICES

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

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

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

How We May Use And Disclose Your Protected Health Information

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

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

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

Other Permitted Or Required Disclosures

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

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

Other Uses Or Disclosures With An Authorization

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

Your Rights Regarding Your Protected Health Information

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

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

If We deny Your request to amend, We will notify You in writing. You then have the right to submit to Us a written statement of disagreement with Our decision and We have the right to rebut that statement.

- **Right to an Accounting of Disclosures by the Plan.** You have the right to request an accounting of disclosures We have made of Your protected health information. The list will not include Our disclosures related to Your treatment, Our payment or health care operations, or disclosures made to You or with Your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

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

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

Health Information Security

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

Changes To This Notice

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

Complaints

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

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

Contact The Plan

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

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

You may also contact Us at:

Telephone: **1-800-676-6976**
Fax: **1-818-676-8981**
Email: Privacy@healthnet.com

DEFINITIONS

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

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

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

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.

Ambulatory Surgical Center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws, and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Average Wholesale Price for any Prescription Drug 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.

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

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

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

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

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

Compounded Drugs are Prescription Drug Orders that are combined or manufactured by the pharmacies and placed in an ointment, capsule, solution or cream using FDA approved drugs and used for a FDA approved indication.

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

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

Covered Expenses are the maximum charges for which HNL will pay benefits for each covered service or supply. The amount of Covered Expenses varies by whether You obtain services from a Preferred Provider or an Out-of-

Network Provider. Covered Expenses are the lesser of the billed charge or: (i) the Allowable Charge for the services or supplies provided by a Preferred Provider; (ii) the Customary and Reasonable Charge for the services or supplies provided by an Out-of-Network Provider.

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

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

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

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

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

Customary and Reasonable Charge, as determined by HNL, is a charge that falls within the common range of fees billed by a majority of Physicians for a procedure in a given geographic region, or that is justified based on the

complexity or the severity of the treatment for a specific case. Our determination of the Customary and Reasonable Charge is based upon data provided by Ingenix, Inc., calculated at the 85th percentile.

Deductible is a set amount you pay for specified Covered Services and Supplies before HNL pays any benefits for those Covered Services and Supplies.

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 a person eligible for coverage provided that the partnership with the principal Covered Person meets all domestic partnership requirements under California law or other recognized state or local agency.

The Domestic Partner and principal Covered Person must:

1. Have a common residence. It is not necessary that the legal right to possess the common residence be in both names.
2. Not be married or a member of another domestic partnership with someone else that has not been terminated, dissolved or judged a nullity.
3. Not be related by blood in a way that would prevent them from being married to each other in this state.
4. Be at least 18 years of age.
5. Be capable of consenting to the domestic partnership.
6. Be either of the following:
 - Members of the same sex; or
 - Members of the opposite sex and one or both be eligible for Social Security benefits and one or both be over the age of 62.
7. Both file a Declaration of Domestic Partnership with the Secretary of State or an equivalent document with another recognized state or local agency, or both are persons of the same sex who have validly formed a legal union other than marriage in a jurisdiction outside of California which is substantially equivalent to a Domestic Partnership as defined under California law.

(The requirements listed above are statutory eligibility requirements. Your Group's Domestic Partner eligibility requirements may be less restrictive.)

Durable Medical Equipment

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

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

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

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

Emergency Care also includes treatment of severe Pain or active labor. Active labor means labor at the time that

either of the following would occur:

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

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

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

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

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

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

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

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

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

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

Health Net Recommended Drug List (also known as Recommended Drug List or the List) is a list of the Prescription Drugs that are covered by this Plan. It is prepared and updated by HNL and distributed to Covered Persons, Member Physicians and Participating Pharmacies and posted on the HNL website at www.healthnet.com under the pharmacy information. Some Drugs in the Recommended Drug List require Prior Authorization from HNL in order to be covered.

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

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

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

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

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

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.

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

Level I Drugs are Prescription Drugs listed in the Health Net Recommended Drug List that are primarily Generic Drugs and are not excluded or limited from coverage.

Level II Drugs are Prescription Drugs listed in the Health Net Recommended Drug List that are primarily Brand Name Drugs and are not excluded or limited from coverage.

Level III Drugs are Prescription Drugs that are not listed in the Health Net Recommended Drug List or listed as Level III Drugs in the Recommended Drug List and are not excluded or limited from coverage. Some Level III Drugs require Prior Authorization from HNL in order to be covered.

Maintenance Drugs are Prescription Drugs taken continuously to manage chronic or long term conditions where Covered Persons respond positively to drug treatment.

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, and may be revised periodically, by HNL.

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

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

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

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

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

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

- It is a clinically significant behavioral or psychological syndrome or pattern;
- It is associated with a painful symptom, such as distress;

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

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

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

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

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

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

Out-of-Network Providers are Physicians, Hospitals or other providers of health care who are not part of the Health Net PPO Preferred Provider Organization (PPO) or otherwise contracted with HNL to provide health care at a special low rate (the Allowable Charge).

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

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

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

Participating Pharmacy is a facility authorized by HNL to dispense Prescription Drugs to persons eligible for benefits under the terms of this *Certificate*. A list of Participating Pharmacies and a detailed explanation of how the program operates has been provided or will be provided by HNL.

Physician means:

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

Dentist (D.D.S.)
 Optometrist (O.D.)
 Dispensing optician
 Podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
 Psychologist
 Chiropractor (D.C.)
 Nurse midwife
 Nurse Practitioner
 Physician Assistant
 Clinical social worker (M.S.W. or L.C.S.W.)
 Marriage, family and child counselor (M.F.C.C.)
 Physical therapist (P.T. or R.P.T.)
 Speech pathologist
 Audiologist

Occupational therapist (O.T.R.)
Psychiatric mental health nurse
Respiratory care practitioner
Acupuncturist (A.C.)

Preferred Provider Organization is a health care provider arrangement whereby HNL contracts with a group of Physicians or other medical care providers who agree to furnish services at the negotiated rate known as the Allowable Charge.

Preferred Providers are Physicians, Hospitals or other providers of health care who have a written agreement with HNL to participate in the Preferred Provider Organization (PPO) network and have agreed to provide You with Covered Services and Supplies at a contracted rate (the Allowable Charge). You must pay any Deductible(s), Copayment or Coinsurance required, but are not responsible for any amount charged in excess of the Allowable Charge. Preferred Providers are listed in the Preferred Provider Directory given to You upon enrollment and periodically updated. To insure the participation by a Preferred Provider, please contact the Member Services Department at the telephone number on Your HNL ID Card before services are received.

Prescription Drug is a drug or medicine that can be obtained only by a Prescription Drug Order. All Prescription Drugs are required to be labeled "Caution, Federal Law Prohibits Dispensing Without a Prescription." An exception is insulin and other diabetic supplies, which are considered to be covered Prescription Drugs.

Prescription Drug Covered Expenses are the maximum charges HNL will allow for each Prescription Drug Order. The amount of Prescription Drug Covered Expenses varies by whether a Participating or Nonparticipating Pharmacy dispenses the order. It is not necessarily the amount the pharmacy will bill. Any expense incurred which exceeds the following amounts is not a Prescription Drug Covered Expense: (a) for Prescription Drug Orders dispensed from a Participating Pharmacy, or through the mail service program, the Prescription Drug Allowable Charge; (b) for Prescription Drug Orders dispensed by a Nonparticipating Pharmacy, the lesser of the Maximum Allowable Cost or the Average Wholesale Price.

Prescription Drug Allowable Charge is the charge that Participating Pharmacies and the mail service program have agreed to charge Covered Persons, based on a contract between HNL and such provider.

Prescription Drug Order is a written or verbal order or refill notice for a specific drug, strength and dosage form (such as a tablet, liquid, syrup or capsule) directly related to the treatment of an illness 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 Level I, Level II and Level III Drugs. Physicians must obtain HNL's Prior Authorization before certain Level I, Level II and Level III Drugs will be covered.

Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a Hospital or Skilled Nursing Facility. 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."

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

- As a result of the Mental Disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either (i) the child is at risk of removal from home or already has been removed from the home or (ii) the Mental Disorder and impairment have been present for more than six months or are likely to continue for more than one year;
- The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a Mental Disorder; and/or

- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

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

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

Special Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Specialty Pharmacy Vendor is a pharmacy contracted with HNL specifically to provide injectable medications, needles and syringes.

Contact us

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

Customer Contact Center

Large Group:

1-800-676-6976

(for companies with 51 or
more employees)

Small Business Group:

1-800-361-3366

(for companies with 2-50 employees)

Individual & Family Plans:

1-800-839-2172

1-800-330-1777 (Spanish)

1-877-891-9053 (Mandarin)

1-877-891-9050 (Cantonese)

1-877-339-8596 (Korean)

1-877-891-9051 (Tagalog)

1-877-339-8621 (Vietnamese)

Telecommunications Device for the Hearing and Speech Impaired

1-800-995-0852

www.healthnet.com