



Health Net
Life Insurance Company

A COMPLETE

explanation of your insurance plan

Individual and Family Plan Policy
SimpleChoice HSA

INSURANCE PLAN 193 0WDK
EOCID:117077



**HEALTH NET PPO INSURANCE POLICY
(the Policy)**

ISSUED BY

**HEALTH NET LIFE INSURANCE COMPANY
(HNL)**

LOS ANGELES, CALIFORNIA

Upon payment of premium charges in the amount and manner provided in this Policy. Health Net Life Insurance Company

HEREBY AGREES

to provide benefits as defined in this Policy to the Policyholder and their eligible Dependents according to the terms and conditions of this Policy. Payment of Premium by the Policyholder in the amount and manner provided for in the Policy shall constitute the Policyholder's acceptance of the terms and conditions of the Policy. This Health Net Life Insurance Company Policy, the Application for Individual and Family Policy and the enrollment forms of Policyholder's Dependents, inclusively shall constitute the entire agreement between the parties.

HEALTH NET LIFE INSURANCE COMPANY

A handwritten signature in cursive script that reads 'Franklin Tom'.

Franklin Tom
Secretary

A handwritten signature in cursive script that reads 'Gerald V. Coil'.

Gerald V. Coil
President

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

Participating or 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 the Covered Persons under this Policy with Covered Services and Supplies as explained in this Policy and accept a special contracted rate, called the "Allowable Charge" as payment in full. The Covered Person's share of costs is based on that contracted rate. Preferred Providers are listed on the HNL website at www.healthnet.com or one can contact the Member Services Department at the telephone number on the 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 COVERED PERSONS USE OUT-OF-NETWORK PROVIDERS, BENEFITS ARE SUBSTANTIALLY REDUCED. COVERED PERSONS WHO USE OUT-OF-NETWORK PROVIDERS WILL INCUR SIGNIFICANTLY HIGHER OUT-OF-POCKET EXPENSE. The Covered Person's out-of-pocket expense is greater because: (1) the Covered Person is responsible for a higher percentage of the benefits than for the services of Participating or Preferred Providers; (2) HNL's benefit for Out-of-Network Providers is based on the Customary and Reasonable Charge; and (3) the Covered Person is financially responsible for any amounts Out-of-Network providers charge in excess of those benefits. Certain deductibles may also apply to the services of Out-of-Network Providers but not to those of Participating or Preferred Providers.

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.

To maximize the benefits received under this Health Net PPO insurance plan, Covered Persons must use Participating or Preferred Providers.

Some Hospitals and other providers do not provide one or more of the following services that may be covered under this Policy and that the Covered Person might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. The Covered Person should obtain more information before enrollment by calling his or her prospective doctor, Participating or Preferred Provider, or clinic, or call HNL's Member Services Department at the telephone number on his or her HNL ID card, to ensure that the health care services needed can be obtained.

Notice of Right to Examination: If You are not satisfied with Your coverage under this Policy, You may return it within 10 days of receipt. The Policy must be mailed or delivered to HNL. If the Policy is returned to HNL within 10 days of receipt, HNL will refund any Premium paid and the Policy will be considered void from the beginning as if it had never been issued.

PLEASE CONTACT OUR MEMBER SERVICE DEPARTMENT BEFORE SERVICES ARE RECEIVED WITH QUESTIONS ABOUT THE COVERAGE.

THE TERMS "YOU" OR "YOUR" WHEN THEY APPEAR IN THIS POLICY, REFER TO THE POLICYHOLDER. THE TERMS "WE" "OUR" OR "US" WHEN THEY APPEAR IN THIS POLICY, REFER TO HNL. PLEASE REFER TO "POLICYHOLDER" AND "HNL" IN THE "DEFINITIONS" SECTION FOR MORE INFORMATION.

Important Notice To California Policyholders

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
1-800-638-3678**

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

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

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DEFINITIONS

This section defines words that will help you understand your plan. These words appear throughout the *Policy* with the initial letter of the word in capital letters. Definitions do not imply coverage and are subject to eligibility rules, coverage limitations and exclusions specified elsewhere in this *Policy*.

- A. ALLOWABLE CHARGE** is the charge that Participating or Preferred Providers are allowed to charge a Covered Person, based on a contract between HNL and such provider. Covered Expenses for services provided by a Participating or Preferred Provider will be based on the Allowable Charge.
- B. 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.
- C. AMBULATORY SURGICAL CENTER** is a health care facility which primarily provides outpatient surgery. The facility must be licensed by the state and accredited by a recognized accreditation body, or certified by Medicare.
- D. CALENDAR YEAR** is the continuous, twelve-month period commencing January 1 of each year at 12:01 a.m., Pacific Time.
- E. CALENDAR YEAR DEDUCTIBLE** is the amount of medical and outpatient Prescription Drug Covered Expenses which must be incurred by You, or Your family, each Calendar Year and for which You or Your family has payment responsibility before benefits become payable by HNL.
- F. CERTIFICATION** refers to the requirement that certain Covered Expenses require review and approval, frequently prior to the expenses being incurred. The "Schedule of Benefits" shows the penalties applicable to those expenses which are authorized in accordance with the provisions of this Policy, and those expenses which are not so certified. The requirements for Certification are described in the "Certification Requirement" section.
- H. CHIROPRACTIC TREATMENT PLAN** is a proposed course of treatment for Neuro-musculoskeletal Disorders. The plan will be submitted by a Participating Chiropractor, and will include the type and amount of chiropractic manipulations, adjustments, therapies, radiology and laboratory services appropriate for the condition.
- I. COINSURANCE** is the percentage of the Covered Expenses, for which the Covered Person is responsible, as specified in the "Schedule of Benefits."
- J. COPAYMENT** is a fixed dollar fee charged to a Covered Person for Covered Services and Supplies. The amount of each Copayment is indicated in "Schedule of Benefits" and is due and payable by the Covered Person to the provider of care at the time services are rendered.
- K. 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 the Covered Person obtains services from a Participating or Preferred Provider, or an Out-of-Network Provider. Covered Expenses are the lesser of the billed charge or: (i) the Allowable Charge, for the cost of services or supplies provided by a Participating or Preferred Provider; or (ii) the Customary and Reasonable Charge or for the cost of services or supplies provided by an Out-of-Network Provider.
- L. COVERED PERSON** means You and Your Dependents who are covered under this *Policy*.
- M. 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 Policy.
- N. CREDITABLE COVERAGE** means:
 - (1) 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 employer plan, or any other entity, in

this state or elsewhere, and that arranges or provides medical, Hospital and surgical coverage not designed to supplement other private or governmental plans. 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.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The Medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, Hospital and surgical care.

(5) 10 U.S.C.A. Chapter 55 (commencing with section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).

(9) 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.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. Sec. 2504(e)).

(11) 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)).

O. 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.

P. CUSTOMARY AND REASONABLE CHARGE, as determined by HNL, is a charge which 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.

Q. DEPENDENT includes:

1. a Policyholder's legally married spouse or domestic partner as defined by California law;
2. a Policyholder's unmarried child who is
 - (a) under the age of 19; or
 - (b) claimed as a dependent on the Policyholder's federal income tax return consistent with requirements of the United States Internal Revenue Service, is enrolled in an accredited school as a full-time student as defined by the rules of such school, and who has not yet reached age 24; or
 - (c) over 19 and incapable of earning his or her own living by reason of physical disability incurred prior to the limiting age and who is chiefly dependent upon the Policyholder or Policyholder's spouse or domestic partner for support and who was insured under this Policy on the date just prior to the day his or her insurance would have ended due to age;

The term "child" includes a stepchild, a legally adopted child from the moment of placement in Your home, and any other child who is entirely supported by You or Your spouse or domestic partner, permanently

resides in the Your household and for whom the You or Your spouse or domestic partner is a court-appointed guardian.

In order for a child to remain insured after age 19, You must provide such proof that the child continues to qualify as a Dependent as We reasonably request. Proof of a child's incapacity and dependency must be furnished to Us within 31 days of the child becoming 19 years of age or becoming incapacitated.

R. 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.

S. EFFECTIVE DATE is the date on which the Policyholder becomes covered by the benefits under this Policy. The precise Effective Date can be found on the Notice of Acceptance.

T. EMERGENCY CARE is any otherwise Covered Service that a reasonable person with an average knowledge of health and medicine would seek if he or she was having serious symptoms, and believed that without immediate treatment, any of the following would occur:

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

HNL will make any final decisions about Emergency Care.

U. EXPERIMENTAL is any procedure, treatment, therapy, drug, biological product, equipment, device or supply which HNL has determined not 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 "Specific Provisions" section for additional information.

V. GRACE PERIOD is the 10-day period which begins on the day following the due date of any Premium due, other than the first Premium.

W. HEALTH NET LIFE INSURANCE COMPANY or HNL (also referred to as "We", "Our" and "Us") is a life and disability insurance company regulated by the California Department of Insurance.

X. HEALTH NET PPO is the Preferred Provider Organization (PPO) insurance plan described in this Policy, which allows Covered Persons to obtain medical benefits from either a network of Preferred or Participating Providers with whom HNL has contracted to provide services at a controlled rate; or else any Out-of-Network Provider. HNL underwrites the benefits of Health Net PPO.

Y. HEALTH NET RECOMMENDED DRUG LIST (also known as Recommended Drug List or the List) is the approved list of drugs which are covered. It was developed to identify the safest and most effective medications for Health Net Life Covered Persons while attempting to maintain affordable pharmacy benefits. We specifically suggest to all 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 Recom-

mended 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 Prior Authorization is required.

- Z. 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 Agency Services under the terms and conditions of this Policy and certified by Medicare.
- AA. HOME HEALTH CARE AGENCY SERVICES** are provided through personal contact at a Covered Person's residence made by a Home Health Care Agency which are determined to be Medically Necessary and which are described in the "Medical Benefits" section of this Policy.
- BB. HOSPICE** is a program provided by a public agency or private organization, or a part of either, that is primarily engaged in providing certain services to terminally ill persons. The Hospice and its employees must be licensed in accordance with applicable state and local laws and certified by Medicare.
- CC. HOSPICE CARE** is care that is designed to provide medical and supporting care to the terminally ill and their families. Hospice Care is designed to be provided primarily in the Covered Person's home.
- DD. HOSPITAL** is a legally operated facility defined as a Hospital and an institution licensed by the state and approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by Medicare.
- EE. INPATIENT** means being confined as a bed patient in a Hospital, Hospice or Skilled Nursing Facility.
- FF. 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 as determined by HNL. HNL will decide whether a service or supply is considered Investigational. This includes any services or supplies that are out-moded or are not efficacious, such as those defined by the federal Medicare and state Medicaid programs, or drugs or devices not approved by the U.S. Food and Drug Administration.
- GG. MEDICALLY NECESSARY (or MEDICAL NECESSITY):** A Medically Necessary service or supply is one that meets the following criteria: it is an otherwise covered category of services and not specifically excluded and is recommended by the treating Physician and determined by HNL's Medical Director or Physician designee to be:

Purpose

- For the purpose of treating a medical condition;

Scope

- The most appropriate supply or level of service, considering potential benefits and harm to the patient; not furnished primarily for the convenience of the Covered Person or provider; not required solely for custodial, comfort or maintenance reasons; consistent with HNL medical guidelines and furnished in the most economically efficient manner that may be provided safely and effectively for the Covered Person; and

Evidence

- Known to be effective and safe in improving health outcomes. For new treatments, services or supplies, effectiveness is determined by scientific evidence. For existing treatments, services or supplies, effectiveness is determined first by one or more of the following scientific evidence, then by professional standards, or then by expert opinion.

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

HH. 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.

II. MENTAL DISORDERS is 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 *Diagnostic and Statistical Manual of Mental Disorders* (DMS) by the American Psychiatric Association.

JJ. NEURO-MUSCULOSKELETAL DISORDERS are misalignment of the skeletal structure and muscular weakness, osteopathic imbalances and disorders related to the spinal cord, neck and joints.

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

LL. OUT-OF-POCKET MAXIMUM is the maximum dollar amount of deductibles, Copayments and Coinsurance for which You or Your family must pay for medical and outpatient Prescription Drug Covered Expenses 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." Certain expenses, as described in the "Schedule of Benefits" 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.

MM. 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.

NN. PARTICIPATING CHIROPRACTOR is a duly licensed chiropractor who practices in the state of California and who has a service contract in effect to furnish specific chiropractic care to Covered Persons eligible under the terms and provisions of this Policy. Participating Chiropractors are listed in the Participating Provider Directory.

OO. PARTICIPATING OR 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 Covered Persons with health care at a contracted rate (the Allowable Charge). The Covered Person must pay any deductible(s), Copayment or Coinsurance required, but is not responsible for any amount charged in excess of the Allowable Charge. Participating or Preferred Providers are listed in the Preferred Provider Directory given to each Covered Person upon enrollment. The Preferred Provider Directory is periodically updated. To insure the participation by any Participating or Preferred Provider, please contact Our Member Services Department at the telephone number on the HNL ID card before services are received.

PP. 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 which benefits are specified in this Policy, and when benefits would be payable if the services were provided by a Physician as defined in 1., above:
 - a. Dentist (D.D.S.)
 - b. Optometrist (O.D.)
 - c. Dispensing optician
 - d. Podiatrist, or Chiropodist (D.P.M., D.S.P. or D.S.C.)
 - e. Psychologist
 - f. Chiropractor (D.C.)
 - g. Nurse midwife
 - h. Nurse practitioner
 - i. Physician assistant

- j. Clinical social worker (M.S.W. or L.C.S.W.)
- k. Marriage, family and child counselor (M.F.C.C.)
- l. Physical therapist (P.T. or R.P.T.)*
- m. Speech pathologist*
- n. Audiologist*
- o. Occupational therapist (O.T.R.)*
- p. Psychiatric mental health nurse.*
- q. Respiratory therapist*
- r. Acupuncturist (A.C.)

NOTE: Services by providers who have an asterisk by their title may be covered only when a medical doctor (M.D.) or doctor of osteopathy (D.O.) referred the Covered Person to them.

- QQ. POLICYHOLDER** is the person enrolled under this Policy who is responsible for payment of Premiums to HNL and whose status is the basis for Dependent eligibility under this Policy.
- RR. 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 Covered Services and Supplies at the negotiated rate known as the Allowable Charge.
- SS. PRE-EXISTING CONDITION** means an illness, injury or condition which existed during the six-month period immediately prior to the Covered Person's Effective Date. An illness, injury, or condition is considered to have existed when the Covered Person: (1) sought or received professional advice for that illness, injury, or condition; or (2) received medical care or treatment for that illness, injury or condition.
- TT. PREMIUM** is the amount the Policyholder pays HNL for the insurance provided under this Policy.
- UU. 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 chemical dependency 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: (a) 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; (b) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a Mental Disorder and/or (c) 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.
- VV. SEVERE MENTAL ILLNESS** 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.
- WW. SERVICE AREA** is the geographically area within which HNL markets and sells Individual PPO insurance plans, and is defined as the following counties in the state of California: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo and Yuba.

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

SCHEDULE OF BENEFITS

Health Net PPO Plan 193

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

Plan Deductibles and Out-of-Pocket Maximums

Calendar Year Deductibles

The following Calendar Year Deductibles apply to both the medical and outpatient Prescription Drug benefits. Once Your payment for medical and Prescription Drug Covered Expenses equals the amount shown below, the medical and outpatient Prescription Drug benefits will become payable by Us (subject to any additional deductible, Copayment or Coinsurance as described herein).

Individual Calendar Year Deductible (Policyholder-only coverage)	\$4,000
Family Calendar Year Deductible (family coverage – Policyholder and one or more Dependents).....	\$8,000

Notes:

- **Individual Calendar Year Deductible** applies to the principal Covered Person who enrolled in this plan without any Dependent enrollment. It does not apply to family coverage.
- **Family Calendar Year Deductible** applies to family coverage, which includes the principal Covered Person and his or her Dependent(s). When the Covered Persons have collectively paid the amount equal to the Family Calendar Year Deductible, the Calendar Year Deductible will be considered to have been met for the entire family.
- If the principal Covered Person has Policyholder-only coverage and changes to family coverage (that is, adds Dependents), any amounts applied to the Individual Calendar Year Deductible will be applied to the Family Calendar Year Deductible.
- If the principal Covered Person has family coverage and changes to Policyholder-only coverage (that is, removes all Dependents), any amounts applied to the Family Calendar Year Deductible will be applied to the Individual Calendar Year Deductible.

Exceptions:

- Preventive care services and annual routine physical examinations are not subject to the Calendar Year Deductibles.

Out-of-Pocket Maximums

The following Out-of-Pocket Maximums apply to both the medical and Outpatient Prescription Drug benefits. Deductibles, Coinsurances and Copayments paid for Covered Services and Supplies under the medical and outpatient Prescription Drug benefits will be applied to the Out-of-Pocket Maximums. Once You meet the Out-of-Pocket Maximum, You will not be required to pay further Copayments or Coinsurances for covered services, supplies or Prescription Drugs obtained during the remainder of the Calendar Year. We will pay 100% of Covered Expenses for any additional services and supplies (including Prescription Drug Covered Expenses). You will continue to pay any charges billed in excess of Covered Expenses for the services of Out-of-Network Providers.

Individual Out-of-Pocket Maximum (Policyholder-only coverage for services or supplies provided by a Preferred Provider).....	\$4,000
Family Out-of-Pocket Maximum (family coverage – Policyholder and one or more Dependents for services or supplies provided by a Preferred Provider).....	\$8,000
Individual Out-of-Pocket Maximum (Policyholder-only coverage for services or supplies provided by an Out-of-Network Provider).....	\$5,000

Family Out-of-Pocket Maximum (family coverage – Policyholder and one or more Dependents for services or supplies provided by an Out-of-Network Provider)\$10,000

Notes:

- **Individual Out-of-Pocket Maximum** applies to the principal Covered Person who enrolled in this plan without any Dependent enrollment. It does not apply to family coverage.
- **Family Out-of-Pocket Maximum** applies to family coverage, which includes the principal Covered Person and his or her Dependent(s). When the Covered Persons have collectively paid deductibles, Coinsurances and Copayments equal to the Family Out-of-Pocket Maximum, the Out-of-Pocket Maximum will be considered to have been met for the entire family. No deductible, Copayment or Coinsurance for Covered Services and Supplies shall be required from any Covered Person in that family for the remainder of that Calendar Year.
- If the principal Covered Person has Policyholder-only coverage and changes to family coverage (that is, adds Dependents), any amounts applied to the Individual Out-of-Pocket Maximum will be applied to the Family Out-of-Pocket Maximum.
- If the principal Covered Person has family coverage and changes to Policyholder-only coverage (that is, removes all Dependents), any amounts applied to the Family Out-of-Pocket Maximum will be applied to the Individual Out-of-Pocket Maximum.

Exceptions:

- Penalties paid for services for which Certification was required but not received will not be applied to the Individual or Family Out-of-Pocket Maximum.

A. MEDICAL BENEFITS

The medical benefits are subject to the Calendar Year Deductible and Out-of-Pocket Maximum as described at the beginning of this section.

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

The Covered Person 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.

For information on the Outpatient Prescription Drug Copayment and Coinsurance, see the "Outpatient Prescription Drugs" portion of this section.

1. LIFETIME MEDICAL BENEFIT MAXIMUMS

For all medical benefits paid on behalf of each Covered Person during that Covered Person's lifetime \$6,000,000

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 HNL Individual and Family PPO plans for such Covered Person.

2. COPAYMENTS AND COINSURANCE

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

Copayments: Copayments are fixed dollar amounts, shown below, for which the Covered Person is responsible. HNL will pay 100% of covered Expenses of the services listed below after the Copayment is made. The Covered Person will be responsible for paying Copayments until the amount paid during a Calendar Year is equal to the Out-of-Pocket Maximum shown above.

Coinsurance: Coinsurance is the percentage, shown below, of Covered Expenses (as defined) for which the Covered Person is responsible. After the deductible(s) have been satisfied, the Covered Person will

be responsible for paying Coinsurance until the amount paid during a Calendar Year is equal to the Out-of-Pocket Maximum.

Notes:

- Any Copayments or Coinsurance paid for the services of a Preferred Provider will apply toward the Out-of-Pocket Maximum for Out-of-Network Providers. In addition, Coinsurance paid for the services of an Out-of-Network Provider will apply toward the Out-of-Pocket Maximum for Preferred Providers.
- The Covered Person will also be required to pay any charges billed by an Out-of-Network Provider that exceed 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.**

Noncertification Penalties

	Preferred Providers	Out-of-Network
Services for which Certification was required but not obtained will be reduced by.....	50%	50%

Services in an Emergency Room or Urgent Care Center

	Preferred Providers	Out-of-Network
Emergency room care professional services	\$0	\$0
Emergency room facility	\$0	\$0
Urgent care professional services	\$0	\$0
Urgent care facility.....	\$0	\$0

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

Authorized Hospital and Skilled Nursing Facility Services

	Preferred Providers	Out-of-Network
Unlimited days of care in a semi-private room or Special Care Unit including ancillary (additional) services (excluding non-Severe Mental Disorders and Chemical Dependency)	\$0	50%
<i>Maximum amount per day</i>	<i>No Maximum</i>	\$600
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	\$0	50%
<i>Maximum amount allowable per day</i>	<i>No Maximum</i>	\$600
Confinement in a Skilled Nursing Facility.....	\$0	50%
<i>Maximum combined days per Calendar Year</i>	100	100
<i>Maximum amount allowable per day</i>	<i>No Maximum</i>	\$600
Inpatient detoxification.....	\$0	50%
<i>Maximum days per Calendar Year</i>	3	3
<i>Maximum amount per day</i>	<i>No Maximum</i>	\$600
Outpatient surgery (Hospital or Outpatient Surgical Center charges only).....	\$0	50%

Maximum amount per surgical session.....	No Maximum.....	\$600
Outpatient facility services (other than surgery).....	\$0.....	50%
Maximum amount per day	No Maximum.....	\$600

Treatment for Non-Severe Mental Disorders

	Preferred Providers	Out-of-Network
Treatment as an outpatient or in a Physician's office	\$0.....	Not Covered
Maximum amount payable per visit.....	\$30.....	N/A
Maximum visits per Calendar Year.....	20.....	N/A
Treatment as an inpatient in a Hospital.....	\$0.....	50%
Maximum amount allowable per day.....	\$300.....	\$300
Maximum days per Calendar Year	30.....	30

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" section, 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 Copayments or Coinsurance and limits shown above.

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)	\$0.....	50%
Visit to a Physician's office for the treatment of Severe Mental Disorders or Serious Emotional Disturbances of a Child	\$0.....	50%
Preventive care services for children include vision and hearing examinations and immunizations (through age 18).....	\$40.....	Not Covered
Preventive care services for adults (age 18 and older).....	\$40.....	Not covered
Immunizations for foreign travel or occupational purposes	\$0.....	Not covered
Annual routine physical examination (age 19 and older)	\$0.....	Not Covered
Calendar Year maximum.....	\$200.....	Not Applicable

Allergy and Injection Services

	Preferred Providers	Out-of-Network
Allergy testing.....	\$0.....	50%
Allergy serum	\$0.....	50%
Allergy injection services (serum not included)	\$0.....	50%
All other injections (per dose).....	\$0.....	50%
Self-injectable drugs per prescription (maximum of 30 days per prescription).....	\$0.....	50%

Care for Conditions of Pregnancy

	Preferred Providers	Out-of-Network
Complications of pregnancy, including Medically Necessary terminations of pregnancy	\$0	50%
Elective terminations of pregnancy.....	\$0	50%

Family Planning

	Preferred Providers	Out-of-Network
Sterilization of males	\$0	Not covered
Sterilization of females	\$0	Not covered
Intrauterine device (IUD).....	\$0	50%

Medical Supplies

	Preferred Providers	Out-of-Network
Durable Medical Equipment and orthotics.....	50%	Not Covered
<i>Calendar Year maximum</i>	\$2000	N/A
Corrective footwear.....	50%	Not Covered
<i>Calendar Year maximum</i>	\$200	N/A
Diabetic equipment	20%	Not Covered
Prosthetics	\$0	50%
Blood or blood products	\$0	\$0

Note

Coverage for orthotics may be limited. Refer to the "General Exclusions and Limitations" section for limitations on covered orthotics. Diabetic equipment and orthotics which are covered under the medical benefit include blood glucose monitors, insulin pumps and podiatric devices.

Home Health Care Agency Services

	Preferred Providers	Out-of-Network
Home Health Care Agency Services	\$0	50%
<i>Maximum amount per day</i>	N/A	\$75
<i>Number of combined visits covered during a Calendar Year</i>	90	90

Hospice Care

	Preferred Providers	Out-of-Network
Hospice Care.....	\$0	50%

Acupuncture and Chiropractic Services

	Preferred Providers	Out-of-Network
Acupuncture.....	\$0.....	Not Covered
<i>Maximum amount payable by HNL per day.....</i>	<i>\$20.....</i>	<i>N/A</i>
<i>Number of visits covered during a Calendar Year.....</i>	<i>12.....</i>	<i>N/A</i>
Chiropractic Services	\$0.....	Not Covered
<i>Maximum amount per day</i>	<i>\$20.....</i>	<i>N/A</i>
<i>Number of visits covered during a Calendar Year.....</i>	<i>12.....</i>	<i>N/A</i>

Other Services

	Preferred Providers	Out-of-Network
Surgery	\$0.....	50%
Administration of anesthetics.....	\$0.....	50%
X-ray and laboratory procedures.....	\$0.....	50%
Chemotherapy	\$0.....	50%
Nuclear medicine	\$0.....	50%
Organ, bone marrow or tissue transplants (not Experimental or Investigational)	\$0.....	Not Covered
Renal dialysis	\$0.....	50%
Physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy	\$0.....	Not Covered
<i>Maximum combined visits per Calendar Year.....</i>	<i>20.....</i>	<i>N/A</i>
Diabetes education	\$0.....	50%
Air Ambulance.....	\$0.....	\$0
Ground Ambulance.....	\$0.....	\$0
Outpatient infusion therapy	\$0.....	50%
<i>Number of days for each supply of injectable Prescription</i>		
<i>Drugs and other substances, for each delivery.....</i>	<i>14.....</i>	<i>14</i>
<i>Maximum amount per day</i>	<i>No Maximum.....</i>	<i>\$600</i>

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.

B. OUTPATIENT PRESCRIPTION DRUG BENEFITS

The outpatient Prescription Drug benefits are subject to the Calendar Year Deductible and Out-of-Pocket Maximum as described at the beginning of this section

The Covered Person's 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 "Medical Benefits" and "General Limitations and Exclusions" sections for more information about what benefits are provided.

1. BENEFIT MAXIMUMS

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

Notes:

- Diabetic supplies (blood glucose testing strips, lancets, 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, the Covered Person will receive the size of package and/or number of packages required for the Covered Person to test the number of times your Physician has prescribed for a 30-day period. The Level II Drug Copayment will be applicable for each prescription dispensed for insulin and diabetic supplies listed on the Recommended Drug List. Insulin and diabetic supplies not listed on the Recommended Drug List require the Level III Drug Copayment.
- All benefits limited during a Covered Person's lifetime is the total amount of benefits offered under this plan.

2. COPAYMENTS AND COINSURANCE

Retail Pharmacy

	Participating Pharmacy	Nonparticipating Pharmacy
Level I Drugs (primarily generic) when listed in the Recommended Drug List	\$0.....	Not Covered
Level II Drugs (primarily brand), insulin and diabetic supplies when listed in the Recommended Drug List	\$0.....	Not Covered
Level III Drugs (drugs not listed in the Recommended Drug List)	\$0.....	Not Covered
Contraceptive devices	\$0.....	Not Covered

Maintenance Drugs through the Mail Order Program

Mail Order Program

Level I (primarily generic) when listed in the Recommended Drug List	\$0
Level II (primarily brand), insulin and diabetic supplies when listed in the Recommended Drug List	\$0
Level III Drugs (drugs not listed in the Recommended Drug List)	\$0

Notes

- If the pharmacy's usual and customary charge is less than the applicable Copayment or Coinsurance, the Covered Person will pay the pharmacy's usual and customary charge.
- If a Brand Name Drug is dispensed at the Covered Person's request, and there is an equivalent Generic Drug commercially available, the Covered Person will be required to pay the difference in cost between the Generic Drug and Brand Name Drug in addition to the Copayment shown above.
- Some drugs may require Prior Authorization from HNL to be covered.
- Insulin and diabetic supplies listed on the Recommended Drug List are subject to the Copayments or Coinsurance (whichever is applicable), shown above for Level II Drugs. Insulin and diabetic supplies not listed on the Recommended Drug List require the Level III Drug Copayment. When a prescription is dispensed, the Covered Person will receive the size of package and/or number of packages required for the Covered Person to test the number of times your Physician has prescribed for a 30-day period.
- 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.

TERM OF POLICY AND PREMIUMS

A. TERM OF POLICY AND TERMINATION

Coverage for this *Policy* will commence on the date set forth in the Notice of Acceptance. This Policy shall remain in effect subject to the payment of Premiums as required, and subject to the right of HNL and the Policyholder to terminate it in accordance with the terms of the Policy.

The following describes the termination provisions of this Policy:

Coverage under this Policy will automatically terminate on the earliest to occur of the following dates:

- If any Premium as specified in the Notice of Acceptance is not paid before the end of the Grace Period, this Policy will terminate effective on midnight of the last day of the month for which full Premiums have last been paid. If the Policyholder brings current the delinquent amount during this Grace Period, this Policy will be reinstated. HNL may collect from the Policyholder or enrolled Dependents the amount expended by HNL for health care services provided to the Policyholder and any enrolled Dependents after the Effective Date of termination of coverage.
- If the Policyholder ceases to be eligible according to the eligibility provisions of this Policy, coverage will be terminated for the Policyholder and any enrolled Dependents effective on midnight of the last day of the month in which loss of eligibility occurred.
- If a Dependent ceases to be eligible according to the eligibility provisions of this Policy, coverage will be terminated only for that person effective on midnight of the last day of the month in which loss of eligibility occurred.
- Coverage may be continued for any Dependent who is a registered, full-time student at an accredited college or university outside the Service Area as long as the Policyholder maintains a permanent residence within the Service Area and the child qualifies as the Policyholder's Dependent under Internal Revenue Service standards.
- On midnight of the last day of the month in which entry of the final decree of dissolution of marriage annulment or termination of domestic partnership occurs, a spouse or domestic partner shall cease to be an eligible Dependent. Children of the spouse or domestic partner who are not also the natural or legally adopted children of the Policyholder shall cease to be eligible Dependents at the same time.
- If a Policyholder makes a false statement or omission as to the Policyholder's health status or history or that of any of the Policyholder's Dependents in applying for this insurance plan, or obtains or attempts to obtain Covered Services by means of deception or false, misleading or fraudulent information, acts or omissions, HNL may terminate coverage immediately upon notice.

Termination of the Policyholder's coverage automatically terminates coverage for any enrolled Dependents.

B. TERMINATION UPON NOTICE

The Policyholder may terminate this Policy by sending a written notice to Health Net Individual Products, P.O. Box 1150, Rancho Cordova, CA 95741-1150. The Policy will end at 12:01 a.m. on the first day of the month following Our receipt of your written notice to cancel. Except as prohibited by law, HNL may cancel this Policy together with all like Policies, upon 31 days written notice delivered to or mailed to the Policyholder at his/her last address as shown on Our records, if HNL discontinues or suspends active business operations, or changes the nature of business, or no longer exists because of dissolution, merger, or otherwise.

C. RENEWAL PROVISIONS

Subject to the termination provisions described in this Policy, coverage will remain in effect for each month Premium fees are received and accepted by HNL.

D. CHANGES IN PREMIUMS

Premiums may be changed by HNL on at least 30 days written notice to the Policyholder prior to the date of such change. Any change in Premium shall take effect on the first day of the next month following the expiration of the notice period.

If this Policy is terminated for any reason, the Policyholder shall be liable for all Premiums for any time this Policy is in force during a grace period and any notice period.

E. GRACE PERIODS

A grace period of 10 days will be allowed for payment of any premium due, except the first one. During this period the Policy will remain in force (subject to the right of the Health Net Life to cancel in accordance with the termination provision above).

F. REINSTATEMENT

Once this Policy lapses, HNL may or may not put it back in force (reinstate) at its option. HNL's acceptance of a late premium without requiring an application for reinstatement will reinstate this Policy. If HNL requires an application for reinstatement, the Policyholder will be given a conditional receipt for the premium. If HNL approves the application, this Policy will be reinstated on the approval date. If HNL does not give the Policyholder prior written notice of disapproval, this Policy will be reinstated on the 45th day after the date of the conditional receipt.

After reinstatement, this Policy will cover only losses that result from an injury sustained after the date of reinstatement or an illness that begins more than 10 days after such date. In all other respects, the Policyholder's rights and HNL's rights will stay the same, subject to any provisions that are endorsed on or attached to this Policy at the time of reinstatement.

ELIGIBILITY AND ENROLLMENT

HNL establishes the conditions of eligibility that must be met in order to be eligible for coverage and continuing coverage under this Policy. In order to receive coverage under this Policy, the Policyholder and each of the Policyholder's Dependents that apply for coverage must continually reside in Our Service Area. Persons age 65 and older and persons who are eligible for Medicare benefits are not eligible to receive coverage under this insurance plan. The Notice of Acceptance indicates the names of applicants who have been accepted for coverage, the Effective Date thereof and the Deductible selected.

Policyholders covered under this Policy may also enroll Dependents who satisfy the eligibility requirements for enrollment. **Except as otherwise indicated below, We reserve the right to reject any Policyholder's or Dependent's application for coverage.** The following types of Dependents describe those who may enroll in this Policy:

- Spouse: The legal spouse, as defined by California law, (excluding common law marriages) of the Policyholder.
- Domestic Partners: The domestic partner and Policyholder must:
 1. Have a common residence.
 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 either of the following:
 - a) Members of the same sex; or
 - b) 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.
 6. Be capable of consenting to the domestic partnership.

Both file a Declaration of Domestic Partnership with the Secretary of State.
- Children: An unmarried, natural born or legally adopted child of the Policyholder, the Policyholder's spouse or domestic partner, under 19 years of age.

Students 19 years of age and older. An unmarried, natural born or legally adopted child of the Policyholder or the Policyholder's spouse or domestic partner who has reached 19 years of age may continue to be covered until the end of the month in which the child's 24th birthday occurs provided the child is a full-time student and is claimed as a Dependent on the Policyholder's federal tax return in accordance with the requirements of the U.S. Internal Revenue Code. For the purposes of this Policy, a full-time student must take 9 semester units or equivalent hours at a qualified college, university or vocational school, as determined by HNL. **Continued coverage for these persons is guaranteed if they are enrolled under this Policy prior to 19 years of age (We may decline such persons at the time of the Policyholder's application).**

Disabled children 19 years of age and older. An unmarried, natural born or legally adopted child of the Policyholder or his or her spouse or domestic partner who has been enrolled under this Policy prior to reaching 19 years of age, or 24 years of age in the case of a full-time student described above, and who is incapable of self-support because of or physical disability that commenced prior to the limiting age may continue enrollment as a Dependent after reaching such age. Coverage may be continued as long as the child continues to meet the eligibility criteria described above. Proof of the child's disability and dependency must be furnished at no cost to HNL. **Continued coverage for these persons is guaranteed if they are enrolled under this Policy prior to 19 years of age. (We may decline such persons at the time of the Policyholder's application.)**

A. APPLICATION FOR COVERAGE (ENROLLMENT) AND EFFECTIVE DATES

1. NEWLY ELIGIBLE DEPENDENTS

- An application to add coverage for a newly married spouse or domestic partner will only be considered if We receive a completed application within thirty (30) days of marriage or Declaration of Domestic Partnership. Evidence of Insurability will be required at the time of the new spouse's or domestic partner's enrollment. Coverage shall begin on the date indicated on the Notice of Acceptance for the new enrollee.
- A newly adopted child, or a child who is being adopted, becomes eligible on the date the birth parent or appropriate legal authority grants the Policyholder or his or her spouse or domestic partner, in writing, the right to control the child's health care.

Coverage begins automatically and will continue for 30 days from the date of eligibility. The Policyholder must enroll the child before the 30th day for coverage to continue beyond the first 30 days.

- Coverage for newborn children will be effective upon birth and during the first thirty (30) days following birth. However, coverage after thirty (30) days is contingent upon the Policyholder enrolling the newborn within thirty (30) days following birth.
- If a court has ordered the Policyholder to provide coverage for an eligible Dependent, coverage will be effective for the first thirty (30) days following the date of the court order. To continue coverage after thirty (30) days, the Policyholder must enroll the eligible Dependent within thirty (30) days of the date of the court order and pay any required premiums

MEDICAL 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 Policy.

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

In addition, many of the Covered Services or 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" section of this Policy for further details.

An expense is incurred on the date the Covered Person receives 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 benefits maximum described in the "Schedule of Benefits" section or elsewhere in the Policy, nor for any service or supply excluded herein.

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.

This Plan provides benefits required by the Newborns' and Mothers' Health Protection Act of 1996 and the Women's Health and Cancer Rights Act of 1998.

A. HOW COVERED EXPENSES ARE DETERMINED

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

- **PARTICIPATING OR PREFERRED PROVIDERS**

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

Since the Participating or Preferred Provider has agreed to accept the Allowable Charge as payment in full, the Covered Person will not be responsible for any amount billed in excess of the Allowable Charge. However, he or she is responsible for any applicable deductible(s), Copayments or Coinsurance payment required. The Covered Person is always responsible for services or supplies not covered by this plan.

- **OUT-OF-NETWORK PROVIDERS**

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. The Covered Person will need to pay that excess amount, in addition to any applicable deductible(s), Copayments or Coinsurance payment required. The Covered Person is always responsible for services or supplies not covered by this plan.

Important Note: Even if a Hospital is a Participating or Preferred Provider, the Covered Person should not assume that all Physicians and other individual providers of health care are Participating or Preferred Providers. Covered Persons should request that all provider services be performed by Participating or Preferred Providers whenever the Covered Person enters a Hospital.

B. 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 Policy.

- There may also be deductibles in addition to the Individual or Family Calendar Year Deductible that the Covered Person may need to pay, depending on the services or supplies received. Please check the "Additional or Benefit Deductible" section 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.
- Covered Expenses incurred under this Policy in the last three months of a Calendar Year, used to satisfy this insurance Policy's Calendar Year Deductible for that year, may also be used to satisfy the Calendar Year Deductible for the following Calendar Year.
- Covered Expenses incurred under the Prescription Drug Benefit will be applied to the Calendar Year Deductible, but will not be applied to any additional deductible(s) or any benefit deductible.

C. OUT-OF-POCKET MAXIMUMS

When the Covered Person's total medical and Prescription Drug Copayments, Coinsurance, additional or benefit deductible, and Calendar Year Deductible 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 that Covered Person for the remainder of that Calendar Year. (See the "Schedule of Benefits" section for exceptions.)

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

D. MEDICAL BENEFIT MAXIMUMS

HNL will not make benefit payments for any Covered Person that exceed any of the benefit limits shown in the "Schedule of Benefits" section.

E. INSURANCE PLAN BENEFITS

NOTE: Please read this description of plan benefits carefully. Please, also read the "Schedule of Benefits" section regarding the Covered Person's out of pocket expenses and "General Limitations and Exclusions" for details of any restrictions placed on the benefits.

• HOSPITAL

a. Inpatient Services

- i. Accommodations as an Inpatient in a room of two or more beds, at the Hospital's most common semi-private room rate.
- ii. Services in Special Care Units.
- iii. Operating, delivery and special treatment rooms.
- iv. Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services.
- v. Physical therapy.
- vi. Radiation therapy, chemotherapy and renal dialysis treatment.
- vii. Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Hospital for use during the Covered Person's stay.
- viii. 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.

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

b. Outpatient Services

- i. 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.
- ii. 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.
- iii. 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" section of this *Policy* for details. Payment of benefits for outpatient services will 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 the Covered Person's health if the dental services are not performed and when use of the Hospital setting has been ordered by both a medical doctor and a dentist. 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.

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

- **SKILLED NURSING FACILITY**

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

- a. 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.
- b. Special treatment rooms.
- c. Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services.
- d. Physical, occupational and speech therapy.
- e. Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Skilled Nursing Facility for use during the Covered Person's stay.
- f. 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.

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

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

Custodial care is not covered.

- **PROFESSIONAL SERVICES**

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

- b. All covered surgical procedures, including the services of the surgeon or specialist, assistant surgeon if Medically Necessary 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.
- c. All covered mental illnesses, including schizophrenia, schizoaffective disorder, Bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia nervosa, bulimia nervosa and Serious Emotional Disturbances of a Child (to include disorders identified by the Diagnostic and Statistical Manual of Mental Disorders).

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

- **ADDITIONAL SERVICES AND SUPPLIES**

- a. **Routine Physical Examinations:** One routine physical examination (for Covered Persons age 19 and older) is covered during a Calendar Year, if performed by a Participating or Preferred Provider, up to the maximum amount shown in the "Schedule of Benefits." Routine physical examinations are not covered if performed by an Out-of-Network Provider.

- b. **X-Ray and Laboratory Procedures**

All prescribed x-ray and laboratory procedures, services and materials.

- c. **Home Health Care Agency Services**

Home Health Care Agency Services include professional nursing care, infusion services, short-term physical therapy, short-term respiratory therapy, short-term occupational therapy, short-term speech therapy and skilled medical social services in accordance with a Physician's treatment plan and rendered by a Home Health Care Agency. Only part-time or intermittent care is covered (generally less than 28 hours per week). However, Custodial Care services, as described in the "Definitions" section of this *Policy*, are not covered. The maximum number of covered visits per Calendar Year is set forth in the "Schedule of Benefits."

In addition, in accordance with an approved treatment plan, coverage will be provided for therapies in the home, 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 benefit.

Payment of benefits for Home Health Care Agency Services will be reduced as set forth herein if Certification is not obtained for the services.

- d. **Outpatient Infusion Therapy**

Outpatient infusion therapy to administer covered drugs and other substances by injection or aerosol is covered when appropriate for the Covered Person's illness, injury or condition 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 and local laws. Only a 14-day supply will be dispensed per delivery.

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

- i. Non-Prescription Drugs or medications
- ii. Any drug labeled "Caution, limited by Federal Law to Investigational use" or Investigational drugs not approved by the FDA
- iii. Drugs or other substances obtained outside of the United States
- iv. Homeopathic or other herbal medications not approved by the FDA
- v. FDA approved drugs or medications prescribed for indications that are not approved by the FDA, or which do not meet medical community standards (except that non-Investigational FDA approved drugs used for off-label indications when the conditions of state law have been met)
- vi. Growth hormone treatment

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

e. Ambulance Services

The following Ambulance services:

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

Charges for the base rate, mileage, 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 is:

- (a) To a Hospital or Skilled Nursing Facility where the Covered Person receives care which is covered under this Policy 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;
- (b) 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 the Covered Person is an Inpatient.

The other medical treatment facility can be a Hospital, Skilled Nursing Facility, clinic, therapy center, diagnostic center or Physician's office;

- (c) To the Covered Person's home from a Hospital or Skilled Nursing Facility where the Covered Person received Covered Services.

- ii. **Air Ambulance Transportation**, when it is Medically Necessary, as defined in Part I, "Definitions" of this Policy. 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 Policy.

Payment of benefits for non-emergent transport and air Ambulance will be reduced as set forth herein if Certification is required but 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 Policy, has been met.

f. **Acupuncture**

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

g. **Diabetes Education**

HNL will pay for a diabetes instruction program supervised by a Physician. A diabetes instruction program is a program designed to teach the Covered Person (the diabetic) and Covered Persons of the diabetic's family about the disease process and the daily management of diabetic therapy.

h. **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 the Covered Person's home.

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

- i. All Medically Necessary services and supplies furnished by the Hospice. This includes doctors' and nurses' services, homemaker services and drugs.
- ii. Up to five consecutive days of respite care. Respite care is furnished to a person in an Inpatient setting in order to provide relief for Dependents or others caring for that person.
- iii. 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."

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

i. **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.

Please notify HNL upon initiation of renal dialysis treatment.

j. **Prosthetics and Corrective Appliances**

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

- i. Internally implanted devices, such as pacemakers and hip joints, which are medically indicated and consistent with accepted medical practice and approved for general use by the Federal Food and Drug Administration;
- ii. External prosthetic devices and the fitting and adjustment of these devices.

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

- (a) Affixed to the body externally, and
 - (b) Required to replace all or any part of any body organ or extremity, or
 - (c) In the event that more than one type of prosthetic device or corrective appliance is available, benefits will be provided only for the device or appliance which is medically and reasonably indicated in accordance with accepted medical practice.
- iii. Visual aids (excluding eyewear) to assist the visually impair with proper dosing of insulin.
 - iv. In addition, the following prosthetics are covered:
 - (a) If all or part of a breast is surgically removed for Medically Necessary reasons, reconstructive surgery and a prosthetic device incident to the mastectomy are covered.
 - (b) Prosthetic devices for restoring a method of speaking (but not including electronic voice boxes) following a laryngectomy are covered.

Repair or replacement of prosthetic devices 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.

DENTAL APPLIANCES ARE NOT A COVERED EXPENSE.

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

- k. **Medically Necessary Corrective Footwear** is covered for Covered Persons who suffer from foot disfigurement, including disfigurement resulting from cerebral palsy, arthritis, polio, spina bifida, diabetes, accidental injury or developmental disability.

Corrective footwear is not covered if provided by an Out-of-Network provider

- l. **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 in 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 and Hospital beds.

Payment of benefits for rental or purchase of Durable Medical Equipment will be reduced as set forth herein if Certification is required but not obtained.

Durable Medical Equipment is not covered if provided by an Out-of-Network provider

- m. **Implanted Lens Which Replaces the Organic Eye Lens**

- n. **Rehabilitative Services**, including physical therapy, acupressure, occupational therapy, speech therapy, cardiac therapy and inhalation therapy, are covered, 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" except as stated in the "General Exclusions and Limitations" section.

Cardiac Rehabilitation Therapy provided in connection with the treatment of heart disease is covered, 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" 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.

- o. **Pulmonary Rehabilitation Therapy** provided in connection with the treatment of chronic respiratory impairment is covered, 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" 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.

- p. **Allergy Testing and Treatment**

- q. **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 *Policy*, but are covered only as described within this "Medical Benefits" section. (Note that insulin is only covered through an outpatient Prescription Drug program.)

When a self-injectable drug is prescribed, the Covered Person must pay the full cost of the prescription to the pharmacist at the time the drug is dispensed. Then the Covered Person must file a claim for reimbursement. HNL will first subtract any charges billed in excess of the Covered Expense. Then HNL will subtract the applicable deductible(s), and the Copayment or Coinsurance shown for Preferred Providers or Out-of-Network Providers (as applicable, depending on the provider who wrote the

prescription) in the "Schedule of Benefits" section. The Covered Person will be reimbursed for the remainder.

The Covered Person has the option of having their prescription filled through HNL's contracted Specialty Pharmacy Vendor. If the Covered Person has met their Calendar Year Deductible (if applicable), the Specialty Pharmacy Vendor will only charge the Covered Person for the appropriate Copayment or Coinsurance shown in the "Schedule of Benefits" section. HNL will reimburse the Specialty Pharmacy Vendor directly.

- r. **Surgically Implanted Drugs** are covered under the medical benefit when Medically Necessary, and may be provided in an inpatient or outpatient setting.

- s. **Allergy Serum**

- t. **Sterilizations for male and female** are only covered when provided by a Participating or Preferred Provider.

- u. **Diabetic Equipment** is covered and may include (but are not limited to) blood glucose monitors, insulin pumps and related supplies, podiatric devices. In addition, diabetic supplies may be covered.

Self-management training and education will be covered, if provided by licensed health care professionals with expertise in the management or treatment of diabetes.

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

Diabetic equipment is not covered if provided by an Out-of-Network Provider.

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

- w. **Preventive Care** and diagnostic procedures for adults (age 19 and older) are covered only if provided by a Participating or Preferred Provider, and at a Physician's direction. Covered services are limited to the following types of care and procedures:

- i. **Mammography:** For screening purposes in women at low risk of breast cancer. One baseline low dose mammogram between the ages of thirty- five (35) and thirty-nine (39), one baseline low dose mammogram every two Calendar Years between the ages of forty (40) and forty-nine (49) (or more frequently if recommended by a Physician) and one baseline low dose mammogram every Calendar Year when age fifty (50) and above.

- ii. **Pap Smears, Pelvic Exam and Breast Exam:** One normal exam and lab test per Calendar Year.

- iii. **Sigmoidoscopy:** Once every three Calendar Years for men and women age forty-five (45) and above.

- iv. **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 is not covered if provided by an Out-of-Network Provider.

- x. **Preventive Care** and diagnostic procedures (including newborn pediatric care) for children through age eighteen (18), are covered only if provided by a Participating or Preferred Provider, and are limited to the following type of care or procedures:

- i. Office visits for the evaluation and management of the child's physical development for prevention of future medical problems,
- ii. Laboratory tests and x-rays, and
- iii. Immunizations.

The above shall be consistent with the guidelines published by the American Academy of Pediatrics (AAP) or the Advisory Committee on Immunization Practices (ACP).

Newborn pediatric care is the routine care of a newborn child, including periodic physical examinations and standard immunizations administered by or under the immediate direction of a Physician. Newborn pediatric care shall be covered for the first thirty (30) days of life if the mother is the Policyholder or Policyholder's spouse or domestic partner. After thirty (30) days, benefits will be extended only if the child is properly enrolled in Health Net PPO.

Preventive care is not covered if provided by an Out-of-Network Provider.

- **DENTAL INJURY**

Emergency Care of a Physician treating an accidental injury to the natural teeth which occurs while the Covered person is covered under this Policy. Services must be received during the six months immediately following the date of injury and the Covered Person must be covered under this Policy 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.

- **PHENYLKETONURIA (PKU)**

Coverage for phenylketonuria testing and treatment 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.

- **CARE FOR CONDITIONS OF PREGNANCY**

Only Hospital and Professional Services incurred as the result of complications of pregnancy will be covered under this Policy.

Terminations of pregnancy (Medically Necessary [and elective]) are covered.

- **ORGAN, TISSUE AND BONE MARROW TRANSPLANTS**

Medically Necessary services provided in connection with organ, tissue or bone marrow transplants that are not Experimental or Investigational, are covered only when performed at a facility approved by HNL:

- a. For the Covered Person who receives the transplant, and
- b. For the donor (whether or not a Covered Person). Benefits are reduced by any amounts paid or payable by the donor's own coverage.

In order to receive the maximum benefits of this plan, HNL requires that all organ, tissue and bone marrow transplants be Certified. Physicians and other health care professionals providing covered services in connection with the transplant also need to be Certified.

Transplant procedures performed at a facility not approved by HNL for organ, tissue and bone marrow transplant procedures will not be covered. Not all Participating or Preferred Providers are approved by HNL for performing transplant procedures. The Covered Person will be directed to a transplant center at the time Certification is obtained.

Organ donation extends and enhances lives and is an option that a Covered Person may want to consider. For more information on organ donations, including how to elect to be an organ donor, please con-

tact the Member Services Department at the telephone number on the HNL ID Card, or visit the Department of Health and Human Services organ donation website at www.organdonor.gov.

If a Covered Person receives services not Certified by HNL for an organ, tissue or bone marrow transplant, he or she will incur the Non-Certification 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.

- **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 are 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 *Policy*, 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 BENEFITS**

For chiropractic care, a Covered Person must go to a Participating Chiropractor or Chiropractic Care is covered in accordance with the "Schedule of Benefits" section.

a. For the services of a Participating Chiropractor, the following provisions apply:

- i. An initial examination is covered to determine the nature of the Covered Person's problem. If during this examination the chiropractor determines that additional services are warranted, he or she must submit a Chiropractic Treatment Plan. If the Chiropractic Treatment Plan is not submitted, or the plan is not approved, then additional visits are not covered.

However, the Covered Person will not be financially responsible (other than for the appropriate Coinsurance) for the cost of any visits provided while the Treatment Plan was being reviewed.

- ii. Subsequent visits are covered up to the maximum number of visits stated in the "Schedule of Benefits" 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.

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

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

b. For the services of a Participating Chiropractor, the following services or supplies are not covered under this benefit:

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

- **MENTAL HEALTH CARE AND CHEMICAL DEPENDENCY BENEFITS**

After the Covered Person's Calendar Year Deductible has been met, the following benefits will be paid by HNL for expenses incurred by the Covered Person for medical advice, treatment, counseling or testing for Mental Disorders or chemical dependency.

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

- a. **SERVICES FOR MENTAL DISORDERS**

The Covered Person 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."

Outpatient services for non-severe Mental Disorders are not covered if provided by and Out-of-Network provider.

- b. **SERIOUS EMOTIONAL DISTURBANCES OF A CHILD (SED)**

The treatment and diagnosis of serious emotional disturbances of a child under the age of 18 is covered as shown in "Schedule of Benefits" section.

- c. **SEVERE MENTAL ILLNESS**

Treatment of severe mental illness is covered as shown in "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

d. **CHEMICAL DEPENDENCY SERVICES**

The Covered Person will be entitled to receive payment for Covered Expenses for acute detoxification limited to a maximum of 3 days per Calendar Year.

F. LIFETIME MEDICAL BENEFIT MAXIMUM

All medical benefits are limited to the maximum set forth in the "Schedule of Benefits" during each Covered Person's lifetime.

GENERAL EXCLUSIONS AND LIMITATIONS

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

- A. 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 provided under the "Certification Requirement" section of this Policy, will be reduced. However, the *Policy* 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).
- B. 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.
- C. PRE-EXISTING CONDITIONS:** Services or supplies received for the treatment of a Pre-Existing Condition during the first six consecutive months during which the Covered Person is covered. Except that:
1. This exclusion shall not apply to a child newly born to, or newly adopted by, an enrolled Policyholder or his or her spouse or domestic partner.
 2. This exclusion shall not apply to conditions of pregnancy.
 3. If a Covered Person becomes eligible for coverage under this Policy within 63 days of the termination of any Creditable Coverage, that Covered Person will be given credit toward the 6 month waiting period for time covered by the Creditable Coverage.

This exclusion shall apply only to the medical benefits which are described in the "Medical Benefits" section. Payment of any other type of benefit described in this Policy for a Pre-Existing Condition shall not constitute waiver of this exclusion for other services the Covered Person may receive for that condition.

D. 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 *Policy* 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 reconstruction surgery is performed subsequent to a Medically Necessary mastectomy.
- the surgery is performed on either breast to achieve or restore symmetry (balanced proportions) in the breasts subsequent to a Medically Necessary mastectomy.

Breast reconstruction surgery will be subject to the Certification requirements described in the "Certification Requirements" section. 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.

E. CONTRACEPTIVES: Oral contraceptives and emergency contraceptives are covered. Vaginal contraceptives are limited to 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 (which are administered by a Physician) and intrauterine devices (IUDs) are covered as a medical benefit. Oral contraceptives are covered, as described in the "Outpatient Prescription Drug Benefits" section. If the Covered Person's 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.

F. DENTAL SERVICES: Except as specifically stated elsewhere in this *Policy* dental services are limited to the services stated in "Dental Injury" under the "Medical Benefits" section of this *Policy* 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. Such services, including general anesthesia and associated facility services, must be Medically Necessary and subject to the other limitations and exclusions of this *Policy* and will be covered for Covered Persons under any of the following circumstances (a) Covered Person s who are under seven years of age, (b) developmentally disabled or (c) 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, crowns, orthodontia (braces), bridge work or other restorations, mechanical devices and dental implants (materials implanted into or on bone or soft tissue), or any associated procedure as part of the implantation or removal of implants are not covered regardless of reason for such services.

G. TEMPOROMANDIBULAR (JAW) JOINT DISORDERS: Temporomandibular Joint (TMJ) Disorder is a condition of the jaw joint which commonly causes headaches, tenderness of the jaw muscles, or dull aching facial pain. These symptoms often result when chewing muscles and jaw joints do not work together correctly. Surgical procedures and medical appliances (including custom-made TMJ appliances) to correct a TMJ disorder are covered when determined to be Medically Necessary and require Certification. However, spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, active splints or orthotics (whether custom fit or not), dental implants and other dental appliances to treat dental conditions related to TMJ disorders are not covered.

H. SURGERY AND RELATED SERVICES (OFTEN REFERRED TO AS "ORTHOGNATHIC SURGERY" OR "MAXILLARY AND MANDIBULAR OSTEOTOMY") for the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw, except when such surgery is required due to recent trauma or the existence of tumors or neoplasms, or when otherwise Medically Necessary. However, spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, active splints or orthotics (whether custom fit or not), dental implants and other dental appliances are not covered under any circumstances.

I. REFRACTIVE EYE SURGERY: Any eye surgery for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism, unless Medically Necessary, recommended by the Covered Person's treating Physician and authorized by Us.

J. OPTOMETRICS AND ORTHOPTICS: Optometric services, eye exercises including orthoptics, except as specifically stated elsewhere in this *Policy*. Contact or corrective lenses (except an implanted lens which replaces the organic eye lens), and eyeglasses unless specifically provided elsewhere in this *Policy*.

K. 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.

L. RECONSTRUCTION OF PRIOR SURGICAL STERILIZATION PROCEDURES: Services to reverse voluntary surgically induced infertility.

- M. CONCEPTION BY MEDICAL PROCEDURE:** 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 and supplies (including injections and injectable medications) which prepare the Covered Person to receive these services.
 - Collection, storage or purchase of sperm or ova.
 - Services and supplies for the purpose of diagnosing the cause of infertility.
- N. GENETIC TESTING AND DIAGNOSTIC PROCEDURES:** Genetic testing is not covered except 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.
- O. EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES:** Experimental or Investigational drugs, devices, procedures or other therapies are only covered when:
- Independent review deems them appropriate (please refer to the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "Specific Provisions" section for more information);
 - Clinical trials for cancer patients are deemed appropriate according to the "Medical Benefits" portion of the "Plan Benefits" section.
- In addition, benefit will also be provided for services and supplies to treat medical complications caused by Experimental or Investigational services or supplies.
- Certification may be required. Please refer to the "Certification Requirement" section for details. Payment of benefits will be reduced as set forth herein if Certification is required but not obtained.
- P. ROUTINE PHYSICAL EXAMINATIONS:** For insurance, licensing, employment, school, or camp. Any physical, vision or hearing exams which are not related to diagnosis or treatment of illness or injury, except as specifically stated in the "Medical Benefits" section.
- Q. IMMUNIZATIONS OR INOCULATIONS:** For adults or children, except as described in the "Medical Benefits" section.
- R. SERVICES NOT RELATED TO COVERED ILLNESS OR INJURY:** Any services not related to the diagnosis or treatment of a covered illness or injury.
- S. CUSTODIAL OR DOMICILIARY CARE OR REST CURES:** 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.
- T. INPATIENT DIAGNOSTIC TESTS:** Inpatient room and board charges incurred in connection for an admission to a Hospital or other Inpatient treatment facility primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- U. NON-ELIGIBLE HOSPITAL CONFINEMENTS:** Inpatient room and board charges in connection with a Hospital stay primarily for environmental change, physical therapy or treatment of chronic pain.
- V. NON-ELIGIBLE INSTITUTIONS:** Any services or supplies furnished by a non-eligible institution, which is 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.
- W. PRIVATE ROOMS:** Expenses in excess of a Hospital's (or other Inpatient facility's) most common semi-private room rate.
- X. INFERTILITY:** Services to diagnose, evaluate or treat infertility are not covered.
- Y. PRIVATE DUTY NURSING:** Inpatient and outpatient services (including incremental nursing) provided by a private duty nurse, except as specifically provided through a Home Health Care Agency.

Z. CHEMICAL DEPENDENCY: This Plan does not cover treatment of chronic alcoholism, drug addiction, or other Chemical Dependency problems, except detoxification. Also not covered are nonmedical ancillary services and rehabilitation services, including inpatient, residential and outpatient chemical dependency programs, psychological counseling and aversion therapy unless specifically provided under the "Mental Health and Chemical Dependency Benefits" section.

AA. MENTAL DISORDERS: This Plan does not cover treatment of Mental Disorders except as specifically described. This Plan does not cover care for, mental health care as a condition of parole or probation, or court-ordered testing for Mental Disorders. Services and supplies for treating Mental Disorders are covered only as specified in the "Mental Disorders and Chemical Dependency" portion of the "Schedule of Benefits" section.

BB. 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, 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."

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

- Alteration of the Covered Person's residence, to accommodate the Covered Person's 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 prosthetics, 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
- Personal or comfort items
- Air purifiers, air conditioners and humidifiers
- Hearing aids
- Educational services or nutritional counseling, except as specifically provided in the "Diabetes Education Program" or "Outpatient Infusion Therapy" provisions of the "Medical Benefits" section.
- Orthotics, unless custom made to fit the Covered Person's body. (Orthotics are supports or braces for weak or ineffective joints or muscles.)
- Orthotics, whether or not custom fit, to treat dental conditions related to TMJ disorders

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

DD. TREATMENT OF OBESITY: Treatment or surgery for obesity, weight reduction or weight control, except as specifically stated in the "Medical Benefits" section and when provided for morbid obesity.

EE. MEDICARE: All benefits provided under this Policy shall be reduced by any amounts to which a Covered Person is entitled under the program commonly referred to as Medicare when federal law permits Medicare to pay before an individual health plan.

FF. EXPENSES BEFORE COVERAGE BEGINS: Services received before the Covered Person's Effective Date.

GG. EXPENSES AFTER TERMINATION OF COVERAGE: Services received after coverage under this Policy ends regardless of when the illness, disease, injury or course of treatment began.

HH. SERVICES FOR WHICH THE COVERED PERSON IS NOT LEGALLY OBLIGATED TO PAY: Services for which no charge is made to the Covered Person in the absence of insurance coverage, except services received at a charitable research Hospital which is not operated by a governmental agency.

- II. 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 Health Net Life.
- JJ. SERVICES PROVIDED BY IMMEDIATE FAMILY MEMBERS:** Professional services received from a person who lives in the Covered Person's home or who is related to the Covered Person by blood or marriage. Covered Persons who receive routine or ongoing care from a Covered Person of their immediate family may be reassigned to another Physician.
- KK. CRIME:** Conditions caused by the Covered Person's commission (or attempted commission) of a felony.
- LL. NUCLEAR ENERGY:** Conditions caused by release of nuclear energy, when government funds are available.
- MM. GOVERNMENTAL AGENCIES:** Any services provided by or for which payment is made by, a local, state or federal government agency. This limitation does not apply to MediCal, Medicaid or Medicare.
- NN. 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.
- OO. OUTPATIENT DRUGS AND MEDICATIONS:** Any outpatient drugs, medications or other substances dispensed or administered in any outpatient setting, except as specifically stated in the "Medical Benefits" or "Outpatient Prescription Drug Benefits" sections of this Policy. This includes any non-prescription (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.
- PP. UNLISTED SERVICES:** ANY SERVICE OR SUPPLIES NOT SPECIFICALLY LISTED IN THIS POLICY AS COVERED EXPENSES.
- QQ. 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.
- RR. OUTPATIENT SPEECH THERAPY:** Therapy which is not provided in relation to surgery, injury or disease.
- SS. FOREIGN TRAVEL OR WORK ASSIGNMENT:** If the Covered Person receives services or obtains supplies in a foreign country, benefits will be payable for Emergency Care only.
- TT. HOME BIRTH:** A birth which takes place at home will be covered when the criteria for Emergency Care, as defined in this *Policy*, have been met.
- UU. VISITS TO THE COVERED PERSON'S HOME:** Physician's visits to the Covered Person's home are not covered.

CERTIFICATION REQUIREMENTS

Some of the Covered Expenses under this insurance plan are subject to a requirement of Certification, or treatment review, before services are received, in order for full benefits to be available.

Certification and any further Certifications are performed by HNL or an authorized designee. The telephone number which the Covered Person can use to obtain Certification is listed on the Health Net PPO Identification Card issued 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.

A. SERVICES REQUIRING PRIOR CERTIFICATION

Services requiring Certification include:

1. Inpatient admissions

Any type of facility, including but not limited to:

- Hospital
- Skilled Nursing Facility
- Mental health facility
- Chemical dependency facility
- Acute rehabilitation center
- Hospice

2. Ambulance

- Air Ambulance
- Non-emergent transport

3. Ambulatory services

- Home Health Care Agency Services including nursing, physical therapy, occupational therapy, speech therapy, home I.V. therapy and home uterine monitoring
- Prosthesis for major limbs
- Durable Medical Equipment

4. Experimental services, new technology and evolutionary changes in proven technology

5. Orthognatic procedures (surgery performed to correct or straighten jaw and/or other facial bone misalignments to improve function.)

6. Outpatient Diagnostic imaging:

- CT Scans
- MRA (Magnetic Resonance Angiography)
- MRI (Magnetic Resonance Imaging)
- MUGA - Cardiac Scan (Multiple Gated Acquisition)
- PET (Positron-Emission Tomography)
- SPECT (Single Photon Emission Computed Tomography)

7. Surgical procedures including:

- Abdominal, ventral, umbilical, incisional hernia repair

- Blepharoplasty
 - Breast reductions and augmentations
 - Mastectomy for gynecomastia
 - Rhinoplasty
 - Sclerotherapy
 - Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
8. Temporomandibular Joint (TMJ) Disorder treatment
 9. Transplant-related services including pre-evaluation and pre-treatment services, and the transplant procedure

HNL will consider the Medical Necessity for the proposed treatment, the proposed level of care (Inpatient or Outpatient) and the duration of the proposed treatment, with the exception of reconstructive surgery incident to a mastectomy.

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 may be authorized by HNL.

Additional services not indicated in the above list may require Certification. Please consult the "Schedule of Benefits" section of this Policy to see additional services that may require Certification.

Exceptions

HNL does not require Certification for dialysis services. However, please notify HNL upon initiation of dialysis services.

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.

B. CERTIFICATION PROCEDURE

Certification must be requested, by you, within the following periods:

- Five (5) 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 non-Emergency Care; within forty-eight (48) hours or as soon as reasonably possible.
- Before admission to a Skilled Nursing Facility or Hospice Care program or before Home Health Care Agency Services are scheduled to begin.

In order to obtain Certification, the Covered Person or the Covered Person's Physician is responsible for contacting HNL as shown on the Health Net PPO Identification Card before receiving any service requiring Certification. If the Covered Person receives any such service and does not follow the procedures set forth in this "Certification Requirement" section, the Noncertification Penalties stated in the "Schedule of Benefits" will be applied.

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

If Certification is denied for a covered service, HNL will send a written notice to the patient 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 insurance plan.

C. 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 Part VII, "Medical Benefits" of this Policy.

If Certification is not obtained, but the Covered Person receives the services anyway, the Noncertification Penalties shown in "Schedule of Benefits" will be applied.

D. 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 the Covered Person or the Covered Person's 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.
- If you still remain dissatisfied with the reconsideration decision following review by HNL, the Covered Person may request an independent review or go through the binding arbitration remedy set forth in the "Specific Provisions" section of this *Policy*.

SPECIFIC PROVISIONS

Grievance and Appeals Process

If the Covered Person is not satisfied with efforts to solve a problem with HNL or a medical provider, the Covered Person must first file a grievance or appeal against HNL by calling the Member Services Department at the telephone number on your HNL ID card or by submitting a Member Grievance Form through the HNL website at www.healthnet.com. The Covered Person 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 91410-0348

Independent Medical Review of Grievances Involving a Disputed Health Care Service

The Covered Person may request an independent medical review ("IMR") of disputed health care services from the Department of Insurance ("Department") if he or she believes that health care services eligible for coverage and payment under his or her HNL plan have been improperly denied, modified, or delayed by HNL. A "Disputed Health Care Service" is any health care service eligible for coverage and payment under the Covered Person's HNL plan that has been denied, modified, or delayed by HNL, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available. The Covered Person pays no application or processing fees of any kind for IMR. The Covered Person has the right to provide information in support of the request for IMR. HNL will provide the Covered Person with an IMR application form and HNL's grievance response letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause the Covered Person to forfeit any statutory right to pursue legal action against HNL regarding the Disputed Health Care Service.

Eligibility

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

- 1.(A) The Covered Person's provider has recommended a health care service as Medically Necessary, or
 - (B) The Covered Person has received urgent or Emergency Care that a provider determined to have been Medically Necessary
 - (C) In the absence of the provider recommendation described in 1.(A) above, or the receipt of urgent or Emergency Care described in 1.(B) above, the Covered Person has been seen by a Physician for the diagnosis or treatment of the medical condition for which he or she seeks IMR;
2. The Disputed Health Care Service has been denied, modified, or delayed by HNL, based in whole or in part on a decision that the health care service is not Medically Necessary; and
3. The Covered Person has filed a grievance with HNL and the disputed decision is upheld by HNL or the grievance remains unresolved after 30 days. Within the next six months, the Covered Person may apply to the Department for IMR, or later, if the Department agrees to extend the application deadline. If the Covered Person's grievance requires expedited review he or she may bring it immediately to the Department's attention. The Department may waive the requirement that the Covered Person follow HNL's grievance process in extraordinary and compelling cases.

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

For non-urgent cases, the IMR organization designated by the Department must provide its determination within 30 days of receipt of the application for review and the supporting documents. For urgent cases involving an imminent and serious threat to the Covered Person's health, including, but not limited to, serious pain, the

potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the Covered Person's health, the IMR organization must provide its determination within three business days.

For more information regarding the IMR process, or to request an application form, please call HNL's 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 the Covered Person meets the eligibility criteria set out below, the Covered Person may request an independent medical review ("IMR") of HNL's decision from the Department of Insurance.

Eligibility

- The Covered Person must have a life-threatening or seriously debilitating condition.
- The Covered Person's Physician must certify to HNL that he or she has a life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving the Covered Person's condition or are otherwise medically inappropriate, and there is no more beneficial therapy covered by HNL.
- The Covered Person's Physician must certify that the proposed Experimental or Investigational therapy is likely to be more beneficial than available standard therapies or as an alternative, the Covered Person 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.
- The Covered Person has been denied coverage by HNL for the recommended or requested therapy.
- 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 the Covered Person meets the eligibility requirements, HNL will notify the Covered Person within five business days of its decision and his or her opportunity to request an external review of HNL's decision through IMR. HNL will provide the Covered Person with an application form to request an IMR of HNL's decision. The IMR process is in addition to any other procedures or remedies that may be available. The Covered Person pays no application or processing fees of any kind for IMR. The Covered Person has the right to provide information in support of his or her request for IMR. If the Covered Person's Physician determines that the proposed therapy should begin promptly, he or she may request expedited review and the experts on the IMR panel will render a decision within seven days of the request. If the IMR panel recommends that HNL cover the recommended or requested therapy, coverage for the services will be subject to the terms and conditions generally applicable to other benefits the Covered Person is entitled to. A decision not to participate in the IMR process may cause the Covered Person to forfeit any statutory right to pursue legal action against HNL regarding the denial of the recommended or requested therapy. For more information, please call the Member Services Department at the telephone number on your HNL ID card.

A. 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 *Policy*, 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 Policy Holder, 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 *Policy*, 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.

B. ACTS OF THIRD PARTIES:

If the Covered Person is ever injured through the act or omission of another person, HNL shall advance the benefits of this Policy. However, if the injured Covered Person is entitled to recovery for such injury from any third party, such Covered Person shall agree in writing:

- **To reimburse HNL to the extent of any benefits paid by HNL, on behalf of the Covered Person, relating to the injury. Such reimbursement must be made immediately upon collection of damages for medical expenses by the Covered Person whether by action at law, settlement or otherwise.**
- **To provide HNL with a lien against any third party recovery for medical expenses to the extent of any benefits paid by HNL, on behalf of the Covered Person, relating to the injury. Such lien may be filed with the person whose act caused the injury, such person's agent or the court.**

Steps the Covered Person Must Take

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

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

- Telling HNL and the medical providers, the name and address of the third party, if the Covered Person knows 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,

- Notifying the lien holders immediately upon the Covered Person or his or her lawyer receiving any money from the third parties or their insurance companies,
- Holding any money that he or she receives 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 he or she is paid by the third party.

How the Amount of the Covered Person Reimbursement is Determined

The Covered Person’s reimbursement to HNL or the medical provider under this lien is based on the value of the services received and the costs of perfecting this lien. For 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 the Covered Person was responsible for some portion of his or her injuries.
- The amount of the reimbursement owed HNL or the medical provider will also be reduced by a pro rata share for any legal fees or costs paid from money the Covered Person received.
- The amount the Covered Person will be required to reimburse HNL or the medical provider for services received under this plan will not exceed one-third on the money the Covered Person received if he or she engages a lawyer, or one-half of the money received if a lawyer is not engaged.

C. OUT-OF-CALIFORNIA PROVIDERS

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

If a Covered Person traveling outside California, requires medical care or treatment and uses a provider from the out-of-California provider network, the Covered Person’s out-of-pocket expenses may be lower than those incurred when the Covered Person uses an Out-of-Network Provider.

When a Covered Person obtains services outside California through the out-of-California provider network, the Covered Person will be subject to the same Copayments, Coinsurance, deductibles, maximums and limitations as the Covered Person would be if the Covered Person obtained services from a Preferred Provider in California. 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-California 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 the Covered Persons Covered Expenses.

D. TERMINATION OF MEMBERSHIP FOR CAUSE:

HNL may terminate a Policyholder and/or any enrolled Dependent’s coverage under this Policy:

- If any Premium as specified in the Notice of Acceptance is not paid before the end of the Grace Period, this Policy will terminate effective on midnight of the last day of the month for which full Premiums have last been paid. If the Policyholder brings current the delinquent amount during this Grace Period, this Policy will be reinstated. The Policyholder is liable for all Premiums due for the period coverage is in force. HNL may collect from the Policyholder or enrolled Dependent the amount expended by HNL for health care services provided to the Policyholder and any enrolled Dependents after the effective date of termination of coverage.
- If the Policyholder ceases to be eligible according to the eligibility provisions of this Policy, coverage will be terminated for the Policyholder and any enrolled Dependents effective on midnight of the last day of the month in which loss of eligibility occurred.
- If a Dependent ceases to be eligible according to the eligibility provisions of this Policy, coverage will be terminated only for that person effective on midnight of the last day of the month in which loss of eligibility occurred.

- Coverage may be continued for any Dependent who is a registered, full-time student at an accredited college or university outside the Service Area as long as the Policyholder maintains a permanent residence with the Service Area and the child qualifies as the Policyholder's Dependent under Internal Revenue Service standards.
- On midnight of the last day of the month in which entry of the final decree of dissolution of marriage, annulment or termination of domestic partnership occurs, a spouse or domestic partner shall cease to be an eligible Dependent. Children of the spouse or domestic partner who are not also the natural or legally adopted children of the Policyholder shall cease to be eligible Dependents at the same time.
- If a Policyholder makes a false statement or omission as to the Policyholder's health status or history or that of any of the Policyholder's Dependents in applying for this insurance plan, or obtains or attempts to obtain Covered Services by means of deception or false, misleading or fraudulent information, acts or omissions, HNL may terminate coverage immediately upon notice.

E. 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.

Policyholder Responsibility

The Policyholder must:

- File accurate claims. If someone else, such as the Policyholder's spouse, domestic partner or another Dependent, 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 **1-800-839-2172**. All calls are strictly confidential.

F. CONFIDENTIALITY OF MEDICAL RECORDS

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

GENERAL PROVISIONS

- A. FORM OR CONTENT OF POLICY:** No agent or employee of HNL is authorized to change the form or content of this Policy. Any changes can be made only through an endorsement authorized and signed by an officer of HNL.
- B. ENTIRE CONTRACT:** This Policy, the Policyholder's application for this Policy and any riders and endorsements to the Policy shall constitute the entire contract between the Company and the Policyholder. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions
- All statements made by the Policyholder or any of the insured persons will be considered except for fraud, to be representations and not warranties. No statement made by an insured person will be used to void his or her insurance or in defense of a claim unless it is in writing and a copy has been given to the insured person or his or her beneficiary.
- C. CHARTER NOT PART OF POLICY:** None of the terms or provisions of the charter, constitution or bylaws of HNL shall form a part of this Policy or be used in the defense of any suit hereunder, unless the same is set forth in full in this Policy.
- D. NOTICE OF RIGHT OF EXAMINATION:** If the Policyholder is not satisfied with his or her coverage under this Policy, he or she may return it within 10 days of receipt. The Policy must be mailed or delivered to HNL. If the Policy is returned to HNL within 10 days of receipt, HNL will refund any Premium paid and the Policy will be considered canceled.
- E. BENEFITS NOT TRANSFERABLE:** No person other than the Covered Person is entitled to receive benefits to be furnished by HNL under this Policy. Such right to benefits is not transferable. ***Fraudulent use of such benefits will result in cancellation of the Covered Person's eligibility under this Policy and appropriate legal action.***
- F. BENEFIT CHANGES:** HNL will provide the Policyholder at least 30 days' notice in advance of any changes in benefit or Policy provisions. There is no vested right to receive the benefits of this Policy.
- G. TIME LIMIT ON CERTAIN DEFENSES:** After this Policy has been in force for a period of two years, no statements relating to insurability made by any Covered Person eligible for coverage under this Policy can be contested or used to deny any claim.
- H. 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 14702, Lexington, KY 40512. Notice should include information sufficient for Us to identify the Covered Person.
- I. 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.
- J. 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.
- K. TIME OF PAYMENT OF CLAIM:** We will pay benefits promptly upon receipt of due written proof of loss.
- L. CLAIMS DENIAL:**
- 1. DENIAL:** If the Covered Person submits a fully completed claim to HNL, and it is partially or totally denied, he or she should be notified in writing of the denial within 30 days from the date the claim was submitted. The Covered Person will be given the specific reasons and sections of the Policy on which the denial is

based. If the claim might be paid with more information, the Covered Person will be told what additional information is necessary and why.

In some cases, more than 90 days will be needed to make a decision on the claim. The Covered Person will be notified in writing if more time is needed, but in no case will a decision take longer than 180 days from the date the fully completed claim is submitted. Although HNL is required to give the Covered Person this written notice if his or her claim is denied, if notice is not received within 30 days of the date of the claim, the Covered Person can assume the claim has been denied and he or she can begin the appeal process explained below.

2. **APPEAL:** The Covered Person or his or her authorized representative has the right to appeal the denial or partial denial of any claim made under the Policy by requesting a review of the claim. The request must be made in writing to HNL within 60 days of the date that appears on the claims denial.

If the request is not made within the 60 day period, the Covered Person waives the right to a review.

This request must include the Covered Person's name, address, date of denial and the reasons upon which the request for review is based. Any facts that support these reasons and any issues or comment the Covered Person or the representative deems relevant should be included. In addition, the Covered Person or the representative may examine pertinent documents that relate to the denial of the claim and that HNL has authorized for release.

3. **REVIEW AND DECISION:** Upon receipt of the request for review, HNL will make full and fair review of the claim and its denial.

HNL has a period of 60 days in which to make a decision, unless special circumstance requires an extension of time for processing. The Covered Person will be notified if an extension of time beyond 60 days is necessary. A decision will be made as soon as possible, but no later than 120 days after receipt of a request for review.

The decision on the request for review will be in writing and will include the specific reasons supporting it and specific references to the pertinent Policy provisions on which the decision is based. This written notice shall be final and binding.

M. PAYMENT TO PROVIDERS OR POLICYHOLDER:

1. **DIRECT PAYMENT:** Benefit payment for Covered Expenses will be made directly to:
 - a. **Contracting Hospitals:** Hospitals which have provider service agreements with HNL to provide services to Covered Persons.
 - b. **Providers of Ambulance Transportation and Certified Nurse Midwives:** As required by the California Insurance Code, this must occur, even if written assignment has not been made by the Covered Person. But, if the submitted provider's statement or bill indicates that the charges have been paid in full, payment will be made to the Policyholder.
 - c. **Other Providers of Service** not mentioned in a. and b. above, Hospital and professional, when the Covered Person assigns benefits to them in writing.
2. **JOINT PAYMENT:** Benefit payment for Covered Expenses will be made jointly to other providers and the Policyholder:
 - a. When a written assignment stipulates joint payment.
 - b. When the benefit payment is \$2,000 or greater and the submitted bill indicates that there is a balance due.
 - c. Joint payment will not be made to contracting Hospitals and providers of Ambulance services. Payment to them will be direct as described in 1.a. and 1.b. above.
3. **DIRECT PAYMENT TO POLICYHOLDER:** In situations not described above, payment will be made to the Policyholder.

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

- O. 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 claim as often as is reasonably required while the claim is pending.
- P. 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 in the USA for the same or a comparable service.
- Q. WORKERS' COMPENSATION INSURANCE:** This Policy is not in lieu of and does not affect any requirement for, or coverage by, Workers' Compensation Insurance.
- R. NOTICE:** Any notice required of HNL shall be sufficient if mailed to the Policyholder, at the address appearing on the records of HNL; and, if notice is required of the Policyholder, it will be sufficient if mailed to the principal office of HNL in Woodland Hills, California.
- S. REGULATION AND INTERPRETATION OF POLICY:** This Policy is issued with and is governed by the state of California. The laws of the state of California shall be applied to interpretations of this Policy.
- T. NONDISCRIMINATION:** HNL hereby agrees that no person who is otherwise eligible for coverage under this Policy shall be refused enrollment nor shall his or her coverage be canceled solely because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, or physical or mental handicap.
- U. 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.
- V. 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 Participating and Preferred Providers
- W. FREE CHOICE OF PROVIDER:** This Health Net PPO plan does not interfere with the Covered Person's 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, the Covered Person's choice of provider may affect the amount of benefits payable.
- X. PROVIDING OF CARE:** HNL is not responsible for providing any type for Hospital, medical or similar care. HNL is also not responsible for the quality of any type of Hospital, medical or similar care.

If the Covered Person would like more information on how to request continued care please contact Member Services at the telephone number on the HNL ID Card.
- Y. RELATIONSHIP OF PARTIES:** The relationship, if any, between HNL and any health care providers is that of an independent contractor relationship. Physicians, Hospitals, Skilled Nursing Facilities and other health care providers and community agencies are not agents or employees of HNL. HNL shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Covered Person while receiving care from any health care provider. No 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 Policy. If HNL does designate or replace any administrator, HNL will inform the Covered Persons of all new procedures. Any administrator designated by HNL is an independent contractor and not an employee or agent of HNL.
- Z. 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 Person, 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, Copayments, claims payments, Coinsurance 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 Persons 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 rate making 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.

AA. NOTICE OF PRIVACY PRACTICES: THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT THE COVERED PERSON MAY BE USED AND DISCLOSED AND HOW THE COVERED PERSON CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells the Covered Person about the ways in which Health Net Life (referred to as "We" or "the Plan") may collect, use and disclose you're a Covered Person's protected health information and the Covered Person rights concerning the Covered Person's protected health information. "Protected health information" is

information about the Covered Person, including demographic information, that can reasonably be used to identify the Covered Person and that relates to the Covered Person's past, present or future physical or mental health or condition, the provision of health care to the Covered Person or the payment for that care.

We are required by federal and state laws to provide the Covered Person with this notice about the Covered Person's rights and Our legal duties and privacy practices with respect to the Covered Person 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 the Covered Person's protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures We may make without the Covered Person's authorization for payment, health care operations and treatment.

1. **Payment.** We use and disclose the Covered Person's protected health information in order to pay for the Covered Person's covered health expenses. For example, We may use the Covered Person's protected health information to process claims or be reimbursed by another insurer that may be responsible for payment.
2. **Health Care Operations.** We use and disclose the Covered Person's protected health information in order to perform Our plan activities, such as quality assessment activities or administrative activities, including data management or customer service. In some cases, We may use or disclose the information for underwriting or determining premiums.
3. **Treatment.** We may use and disclose the Covered Person's protected health information to assist the Covered Person's health care providers (doctors, dentists, pharmacies, hospitals and others) in the Covered Person's diagnosis and treatment. For example, We may disclose the Covered Person's protected health information to providers to provide information about alternative treatments.
4. **Plan Sponsor.** If the Covered Person are enrolled through a group health plan, We may provide summaries of claims and expenses for enrollees in a group health plan to the plan sponsor, which is usually the employer.
5. **Enrolled Dependents.** We will mail explanation of benefits forms and other mailings containing protected health information to the address We have on record for the Policyholder of the health plan.

- **Other Permitted Or Required Disclosures**

1. **As Required by Law.** We must disclose protected health information about the Covered Person when required to do so by law.
2. **Public Health Activities.** We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
3. **Victims of Abuse, Neglect or Domestic Violence.** We may disclose protected health information to government agencies about abuse, neglect or domestic violence.
4. **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g., state insurance departments) for activities authorized by law.
5. **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 the Covered Person in certain cases in response to a subpoena, discovery request or other lawful process.
6. **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.
7. **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.

8. **Research.** Under certain circumstances, We may disclose protected health information about the Covered Person for research purposes, provided certain measures have been taken to protect the Covered Person's privacy.
9. **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about the Covered Person, with some limitations, when necessary to prevent a serious threat to the Covered Person's health and safety or the health and safety of the public or another person.
10. **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
11. **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 the Covered Person's protected health information will be made only with the Covered Person's written authorization, unless otherwise permitted or required by law. The Covered Person 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.

- **A Covered Person's Rights Regarding Your Protected Health Information**

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

1. **Right To Access A Covered Person's Protected Health Information.** the Covered Person have the right to review or obtain copies of the Covered Person's 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 the Covered Person's protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing the Covered Person's requested information, but We will tell the Covered Person the cost in advance.
2. **Right To Amend A Covered Person's Protected Health Information.** If the Covered Person feel that protected health information maintained by the Plan is incorrect or incomplete, the Covered Person may request that We amend the information. Your request must be made in writing and must include the reason the Covered Person are seeking a change. We may deny the Covered Person's request if, for example, the Covered Person ask Us to amend information that was not created by the Plan, as is often the case for health information in Our records, or the Covered Person ask to amend a record that is already accurate and complete.

If We deny the Covered Person's request to amend, We will notify the Covered Person in writing. the Covered Person 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.

3. **Right to an Accounting of Disclosures by the Plan.** the Covered Person have the right to request an accounting of disclosures We have made of the Covered Person's protected health information. The list will not include Our disclosures related to the Covered Person's treatment, Our payment or health care operations, or disclosures made to the Covered Person or with the Covered Person's 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 the Covered Person 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 the Covered Person want the list (for example, on paper or electronically). The first accounting that the Covered Person 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 the Covered Person the cost in advance.

4. **Right To Request Restrictions on the Use and Disclosure of A Covered Person's Protected Health Information.** the Covered Person have the right to request that We restrict or limit how We

use or disclose the Covered Person's protected health information for treatment, payment or health care operations. **We may not agree to a Covered Person request.** If We do agree, We will comply with the Covered Person's request unless the information is needed for an emergency. the Covered Person's request for a restriction must be made in writing. In the Covered Person's request, the Covered Person's must tell Us (1) what information the Covered Person want to limit; (2) whether the Covered Person want to limit how We use or disclose the Covered Person's information, or both; and (3) to whom the Covered Person want the restrictions to apply.

5. **Right To Receive Confidential Communications.** The Covered Person has the right to request that We use a certain method to communicate with the Covered Person about the Plan or that We send Plan information to a certain location if the communication could endanger the Covered Person. The Covered Person's request to receive confidential communications must be made in writing. The Covered Person's request must clearly state that all or part of the communication from Us could endanger the Covered Person. We will accommodate all reasonable requests. The Covered Person's request must specify how or where the Covered Person wish to be contacted.
6. **Right to a Paper Copy of This Notice.** The Covered Person have a right at any time to request a paper copy of this notice, even if the Covered Person had previously agreed to receive an electronic copy.
7. **Contact Information for Exercising The Covered Person's Rights.** The Covered Person's 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 the Covered Person's 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 the Covered Person as well as any information that We receive in the future. We will provide the Covered Person 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 the Covered Person believe that your privacy rights have been violated, the Covered Person 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 the Covered Person's right to protect the privacy of the Covered Person's protected health information. **We will not retaliate against the Covered Person or penalize the Covered Person for filing a complaint.**

- **Contact The Plan**

If the Covered Person has any complaints or questions about this notice or the Covered Person wants to submit a written request to the Plan as required in any of the previous sections of this notice, the Covered Person may send it in writing to:

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

the Covered Person may also contact Us at:

Telephone: **1-800-676-6941**

Fax: **1-818-676-8981**

Email: Privacy@healthnet.com

OUTPATIENT PRESCRIPTIONS DRUG BENEFITS

The preceding sections of this Policy provide for coverage for Prescription Drugs obtained while an Inpatient in a Hospital. The provisions which follow are in addition to, and do not replace, any other provision under this Policy which may apply to Prescription Drugs.

A. DEFINITIONS

The following definitions apply to the coverage provided under this "Outpatient Prescription Drug Benefits" section. Other "Definitions" appearing within this Policy also apply to the coverage provided under this "Outpatient Prescription Drug Benefits" section.

1. **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.
2. **COMPOUNDED DRUGS** are Prescription Orders that are combined or manufactured by the pharmacist and placed in an ointment, capsule, solution, or cream using FDA approved drugs, with the primary drug being on the Recommended Drug List and used for a FDA approved indication, are only covered at the Level III Drug Copayment.
3. **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 database 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.
4. **HEALTH NET RECOMMENDED DRUG LIST (also known as Recommended Drug List or the List)** is list of the Prescription Drugs that are covered under this *Policy*. The Covered Person may call the Member Services Department at the telephone number on his or her Health Net PPO ID card to find out if a particular drug is listed in the Recommended Drug List. The Covered Person may also request a copy of the current List, and it will be mailed by HNL. The current List is also available on the internet at www.healthnet.com. It is prepared by HNL and given to all Participating or Preferred Providers and Participating Pharmacies. It may be revised periodically. Some drugs in the Recommended Drug List may require Prior Authorization in order to be covered.
5. **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.
6. **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.
7. **LEVEL III DRUGS** are Prescription Drugs not listed in the Health Net Recommended Drug List that are not excluded or limited from coverage are covered. A Covered Person requesting a Prescription Drug that is not listed is responsible for a higher Copayment as shown in the "Schedule of Benefits" section. Some Prescription Drugs that are not on the List require Prior Authorization from HNL to be covered.

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.

8. **PRIOR AUTHORIZATION PROCESS:** 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 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.

Once a medication is approved, its authorization becomes effective immediately.

9. **MAINTENANCE DRUGS** are Prescription Drugs taken continuously to manage chronic or long term conditions where Covered Persons respond positively to drug treatment, and dosage adjustments are either no longer required or are made infrequently.
10. **PARTICIPATING PHARMACY** is a facility authorized by HNL to dispense Prescription Drugs to persons eligible for benefits under the terms of this Policy. A list of Participating Pharmacies and a detailed explanation of how the program operates has been provided or will be provided by HNL.
11. **PRESCRIPTION DRUG** is a drug or medicine which, according to federal law, can be obtained only by a Prescription Order and is required to bear a label which says, "Caution, Federal Law Prohibits Dispensing Without a Prescription" or is restricted to prescription dispensing by state law. Insulin is also included.
12. **PRESCRIPTION ORDER** is a written or oral order for Prescription Drugs or medicines 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.
13. **NONPARTICIPATING PHARMACY** is a facility not authorized by HNL to be a Participating Pharmacy.
14. **SPECIALTY PHARMACY VENDOR** is a pharmacy contracted with HNL specifically to provide injectable medications.
15. **OFF-LABEL** is a term of classification for Prescription Drugs that are approved by the Food and Drug Administration, but that are used for indications other than those stated in the marketing label. 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:
 - a. Approved by the Food and Drug Administration (FDA).
 - b. Prescribed or administered by a licensed health care professional for the treatment of:
 - i. A life-threatening condition, or
 - ii. A chronic or seriously debilitating condition in which the drug is determined to be Medically Necessary to treat such condition.
 - c. Recognized for treatment of the life-threatening or chronic and seriously debilitating conditions by one of the following:
 - i. The American Medical Association Drug Evaluations
 - ii. The American Hospital Formulary Service Drug Information
 - iii. The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional."
 - iv. 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.
 - d. Otherwise Medically Necessary.

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

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

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

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

B. BENEFITS

Each Covered Person must satisfy the Calendar Year Deductible before benefits for Prescription Drugs become payable by Health Net Life. Refer to the "Schedule of Benefits" section for details

Outpatient Prescription Drug Benefits shall be provided if a Covered Person, while covered under this Policy, incurs an expense for Prescription Drugs which were prescribed by any Physician who is either a Participating or Preferred Provider or Out-of-Network Provider.

Health Net Recommended Drug List (also known as Recommended Drug List or the List)

The Health Net Recommended Drug List is the approved list of drugs which are covered. It was developed to identify the safest and most effective medications for Health Net Life Covered Persons while attempting to maintain affordable pharmacy benefits. We specifically suggest to all 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 Prior Authorization is required.

Diabetic Drugs and Supplies

Prescription drugs for the treatment of diabetes are covered. Diabetic supplies are also covered, including, but not limited to, insulin needles and syringes, reusable pen delivery systems, disposable insulin needles and syringes, disposable insulin pen needles, blood glucose monitors (specific brands only) and test strips (specific brand only), Ketone test strips and lancets used in monitoring blood glucose levels. Refer to the "Schedule of Benefits" section for details about the supply amounts that are covered at the applicable Copayment, after satisfying the Calendar Year Deductible.

Contraceptives

Oral contraceptives and emergency contraceptives are covered. Vaginal contraceptives are limited to diaphragms and cervical caps, when a Covered Person's 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.

Level I Drugs (Primarily Generic) and Level II Drugs (Primarily Brand) Included in the Health Net Recommended Drug List

Prescription Drugs listed in the Health Net Recommended Drug List are covered, when dispensed by Participating Pharmacies and prescribed by a Physician, an authorized referral specialist or an emergent or urgent care Physician. Some Prescription Drugs require Prior Authorization from HNL to be covered.

Level III Drugs (Drugs Not Included in the Health Net Recommended Drug List)

Prescription Drugs not listed in the Health Net Recommended Drug List that are not excluded or limited from coverage are covered. A Covered Person requesting a Prescription Drug that is not listed is responsible for a higher Copayment as shown in the "Schedule of Benefits" section. Some Prescription Drugs that are not on the List require Prior Authorization from HNL to be covered.

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.

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.

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 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.

Once a medication is approved, its authorization becomes effective immediately.

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.

1. 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.

For a complete and up-to-date list of Participating Pharmacies, please visit Our website at www.healthnet.com or call the Member Services Department at the telephone number on the HNL ID Card. The Covered Person, upon presentation of a valid Health Net PPO Identification Card which indicates coverage for Prescription Drugs, shall be entitled to have a Prescription Order filled by a Participating Pharmacy for up to a 30 consecutive calendar day supply per prescription, subject to the following:

(If the Health Net PPO identification card has not been received or if it has been lost, refer to the subsection titled "When the Health Net PPO Identification Card is Not in the Covered Person's Possession" below.)

- a. **IF A GENERIC DRUG IS DISPENSED** by a Participating Pharmacy, after satisfying the Calendar Year Deductible, the Covered Person must pay the Participating Pharmacy the Copayment specified in the "Schedule of Benefits" for each Generic Drug dispensed.
- b. **IF A BRAND NAME DRUG IS DISPENSED** by a Participating Pharmacy and there is an equivalent Generic Drug available, after satisfying the Calendar Year Deductible, the Covered Person must pay the pharmacy the difference between the cost of the Generic Drug and the cost of Brand Name Drug, as well as the Copayment specified in the "Schedule of Benefits."

A Covered Person may avoid paying this additional amount by requesting that the Level I Generic Drug be substituted.

2. PRESCRIPTION DRUGS DISPENSED BY A NONPARTICIPATING PHARMACY

There are **no benefits** for Prescription Drugs which are dispensed by Nonparticipating Pharmacies. The only exception are those Prescription Drugs used in conjunction with Emergency Care.

3. PRESCRIPTION DRUGS DISPENSED THROUGH THE MAIL SERVICE PRESCRIPTION DRUG PROGRAM

If the Covered Person prescription is for a Maintenance Drug, the Covered Person shall be entitled to have a Prescription Order filled through a mail delivery program selected by HNL. Through this program a Covered Person can receive, through the mail, up to a 90-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, and will be limited to a 30-consecutive calendar day supply. After satisfying the Calendar Year Deductible, the lessor of twice the applicable Copayments or the mail order pharmacy's usual and customary charge will be required.

To use this program, the Covered Person must place an order through the mail by completing a Prescription Mail Order Form. It must be accompanied by the original Prescription 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 call Member Services at the telephone number shown on the HNL ID card.

When a Brand Name Drug is dispensed, but there is an equivalent Generic Drug available, the Covered Person will be billed the difference between the cost and the cost of the Brand Name Drug as well as any Copayment specified in the "Schedule of Benefits."

A Covered Person may avoid paying this additional amount by requesting that the Generic Drug be substituted.

Note: Schedule II narcotic drugs are not covered through the mail order program. Refer to the "Exclusions" section below for more information.

4. WHEN THE HEALTH NET PPO IDENTIFICATION CARD IS NOT IN THE COVERED PERSON'S POSSESSION

If the Covered Person needs to have a Prescription Order filled by a Participating Pharmacy and has not received a Health Net PPO Identification Card, or it has been lost, the Covered Person must pay the cost of the drug(s). The Covered Person may then be entitled to partial reimbursement. After the Health Net PPO Identification Card has been received, the Covered Person must file a claim. Claim forms will be provided by HNL upon request.

C. GENERAL PROVISIONS

The following "General Provisions" apply to the coverage provided under this Part XIII. Other General Provisions appearing within this Policy also apply.

- Expense must be incurred on or after the Covered Person's Effective Date of coverage under this Policy and prior to termination of such coverage. An expense will be considered to have been incurred on the date that the Prescription Drug is dispensed.
- The amount of Prescription Drugs (including insulin) which may be dispensed per Prescription Order or refill at a pharmacy will be in quantities normally prescribed by a Physician up to and including a thirty(30) consecutive calendar day supply, provided that a 30-consecutive calendar day supply is within the FDA's guidelines for indicated usage. This 30-consecutive calendar day maximum is applicable to all forms of the Prescription Drug, including pills, vials, ampoules, tubes, manufacturer's packages or inhalers.
- Up to a 90 consecutive calendar day supply of Maintenance Drugs (see the "Definitions" subsection above) may be dispensed through the Mail Service Prescription Drug Program. Prescription Drugs that are not Maintenance Drugs will also be dispensed by the mail order program, but the quantity dispensed may be less than a 90 day quantity. For information, the Covered Person should call the mail order program at 1-888-858-2951.
- Any Participating Pharmacy furnishing benefits to the Covered Person does so as an independent contractor and HNL shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by the Covered Person.
- HNL shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with the manufacturing, compounding, dispensing or use of any Prescription Drug covered under this Policy.
- HNL retains the right to replace any third-party contracting agency through which Covered Persons may be required to obtain Prescription Drugs. If HNL should replace any such third-party contracting agency, the Policyholder would be notified of all new procedures. HNL also retains the right to modify the program with due notice to Covered Persons.

D. EXCLUSIONS:

In addition to any applicable "General Limitations" contained elsewhere in this Policy, the following "Exclusions" shall apply to the coverage described under this "Outpatient Prescription Drug Benefits" section.

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

- Prescription Drugs which are covered by any other benefits provided by this Policy, 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.

- Drugs prescribed for a condition or treatment that is not covered by this Policy. However, the *Policy* 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).
- Services or supplies for which the Covered Person is not legally required to pay.
- Services or supplies for which no charge is made.
- 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 Order, even if a Physician writes a Prescription for such drug, equipment or supply. These are commonly called over-the-counter drugs. Insulin is an exception to this rule. 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 is previously available by prescription becomes available in an over-the-counter (OTC) form in the same prescription strength, this drug and similar agents that have comparable clinical effect(s), will only be covered when Medically Necessary and Prior Authorization is obtained from Health Net.

- Prescription 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.
- Drugs prescribed by a dentist.
- 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.
- Drugs prescribed for cosmetic or enhancement purposes as determined by HNL, including and not limited to those intended to treat wrinkles, baldness or conditions of hair loss, sexual performance, athletic performance, anti-aging and mental performance are not covered. Examples of these drugs include but are not limited to Penlac, Renova, Vaniqua, Propecia, Lustra, Xenical, or Meridia.
- Cosmetics and health or beauty aids.
- Drugs for the treatment of obesity.
- Vitamins and nutritional supplements, unless listed in the Recommended Drug List. Phenylketonuria (PKU) is covered under the medical benefit (see the "Phenylketonuria" provision of the "Medical Benefits" section)
- Drugs when prescribed to shorten the duration of the common cold.
- Immunizing agents.
- Allergy desensitization products, whether administered by injection or drops placed in the nose or mouth (transmucosal absorption), for the purpose of treating allergies by desensitization (to lessen or end the person's allergic reactions). (These products are sometimes described as "allergy serum.") Allergy serum is covered as a medical benefit. See the "Allergy and Injection Services" portion of the "Schedule of Benefits" section and the "Allergy Testing and Treatment" provision in the "Medical Benefits" section.
- Prescription Drugs or medicines delivered or administered to the patient by the attending Physician, or which are billed by a Hospital or Skilled Nursing Facility, or are covered under another section of this Policy.
- Drugs used to reduce or cease smoking or for nicotine addiction are not covered.
- Hypodermic syringes and needles are limited to insulin needles, syringes and reusable pen devices. Needles and syringes required to administer self-injected medications will be provided when obtained through Our Specialty Pharmacy Vendor. All other syringes and needles are not covered.

- Medications limited by law to Investigational use, prescribed for Experimental purposes or prescribed for indications not approved by the Food and Drug Administration (unless the drug is being prescribed or administered by a licensed health care professional for the treatment of a life-threatening or chronic and seriously debilitating condition and the Off-Label use of the drug for that purpose has generally been recognized as safe and effective as described in this section, or is otherwise Medically Necessary).
- 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).
- Drugs prescribed for sexual dysfunction. This includes drugs that establish, maintain or enhance sexual function or satisfaction.
- Oral contraceptives and emergency contraceptives are covered, as described in the "Outpatient Prescription Drug Benefits" portion of the "Medical Benefits" section. Vaginal contraceptives are limited to 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.

- Lost, stolen or damaged drugs are not covered. The Covered Person will have to pay the retail price for replacing them.
- Schedule II narcotic drugs are not covered through mail order. Schedule II drugs are drugs classified by the Federal Drug Enforcement Administration as having a high abuse risk but also safe and accepted medical uses in the United States.
- Supply amounts for prescriptions that exceed the Food and Drug Administration's (FDA) or HNL's indicated usage recommendation unless Medically Necessary and Prior Authorization is obtained from HNL.
- 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 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.
- Individual doses of medication dispensed in plastic, unit doses, or foil packages (unit dose packaging) and dosage forms used for convenience as determined by HNL, unless Medically Necessary or only available in that form.
- Drugs that are combined by the pharmacist and placed in an ointment or capsule (compounded drugs).
- Self-injectable medications, hypodermic syringes and/or needles, except when dispensed for use with insulin.
- Unit dose or "bubble" packaging (an individual dose of medication dispensed in plastic or foil packages.)

For more information, please contact us at:

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