

POLICY

A complete explanation of Your plan

*Individual and Family Silver 70 Off Exchange EnhancedCare PPO Plan
Policy
EnhancedCare PPO Plan (552600)*

Important benefit information – please read

Notice of Right to Examination:

If You are not satisfied with Your coverage under this *Policy*, You may return this *Policy* to HNL within 10 days of receipt for a refund of any premiums paid.

Policyholders age 65 and older have the right to return the *Policy* to HNL within 30 days of receipt for a full refund of all premiums and any policy fee paid.

Upon timely return of the *Policy* by mail or delivery, HNL will consider the *Policy* void from the beginning (as if it had never been issued).



**NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION**

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association (“the Association”). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

• **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

• **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

• **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

• **Life Insurance**

80% of death benefits but not to exceed \$300,000

80% of cash surrender or withdrawal values but not to exceed \$100,000

• **Annuities and Structured Settlement Annuities**

80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed \$250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is \$300,000, regardless of the number of policies or contracts covering the individual.

• **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of April 1, 2011, is \$470,125. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send You this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage You to purchase any form of insurance. When selecting an

insurance company, You should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.



**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 black ink, appearing to read 'Steven Sickle'.

Steven Sickle
Secretary

A handwritten signature in black ink, appearing to read 'Steven Sell'.

Steven Sell
President

INSURANCE PLAN FCV

2XPQ

HEALTH NET PPO POLICY

ISSUED BY

HEALTH NET LIFE INSURANCE COMPANY

Los Angeles, California

THIS BENEFIT PLAN PROVIDES BOTH PREFERRED PROVIDER AND OUT-OF-NETWORK PROVIDER BENEFITS FOR SERVICES (INCLUDING BEHAVIORAL HEALTH TREATMENT) ONLY WITHIN CALIFORNIA. THIS BENEFIT PLAN DOES NOT PROVIDE BENEFITS FOR SERVICES (INCLUDING SERVICES FOR BEHAVIORAL HEALTH TREATMENT) OUTSIDE OF CALIFORNIA, EXCEPT FOR URGENT CARE AND EMERGENCY CARE. OUTSIDE THE UNITED STATES, COVERAGE IS LIMITED TO URGENT CARE AND EMERGENCY CARE, AS DESCRIBED BELOW UNDER "FOREIGN TRAVEL OR WORK ASSIGNMENT" IN THIS "MISCELLANEOUS PROVISIONS" SECTION.

THE ENHANCEDCARE PPO NETWORK IS ONLY AVAILABLE WITHIN THE COUNTIES LISTED IN THE SERVICE AREA. PLEASE SEE THE DEFINITION OF "SERVICE AREA" BELOW FOR A LIST OF COUNTIES AND ZIP CODES.

Service Area is the geographic area within which HNL markets and sells EnhancedCare PPO insurance plans, and is defined as the following counties in the state of California: Los Angeles, Orange, Sacramento, San Diego, and Yolo.

In addition, the Service Area consists of the following partial counties:

- **Placer:** For ZIP codes 95602, 95603, 95604, 95631, 95648, 95650, 95658, 95661, 95663, 95668, 95677, 95678, 95681, 95701, 95703, 95713, 95714, 95722, 95736, 95746, 95747, 95765
- **Riverside:** For ZIP codes 91752, 92201, 92202, 92203, 92210, 92211, 92220, 92223, 92230, 92234, 92235, 92236, 92240, 92241, 92247, 92248, 92253, 92254, 92255, 92258, 92260, 92261, 92262, 92263, 92264, 92270, 92274, 92276, 92282, 92320, 92501, 92502, 92503, 92504, 92505, 92506, 92507, 92508, 92509, 92513, 92514, 92516, 92517, 92518, 92519, 92521, 92522, 92530, 92531, 92532, 92536, 92539, 92543, 92544, 92545, 92546, 92548, 92549, 92551, 92552, 92553, 92554, 92555, 92556, 92557, 92561, 92562, 92563, 92564, 92567, 92570, 92571, 92572, 92581, 92582, 92583, 92584, 92585, 92586, 92587, 92589, 92590, 92591, 92592, 92593, 92595, 92596, 92599, 92860, 92877, 92878, 92879, 92880, 92881, 92882, 92883
- **San Bernardino:** For ZIP Codes 91701, 91708, 91709, 91710, 91729, 91730, 91737, 91739, 91743, 91758, 91759, 91761, 91762, 91763, 91764, 91784, 91785, 91786, 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92301, 92305, 92307, 92308, 92309, 92310, 92311, 92312, 92313, 92314, 92315, 92316, 92317, 92318, 92321, 92322, 92324, 92325, 92327, 92329, 92331, 92333, 92334, 92335, 92336, 92337, 92339, 92340, 92341, 92342, 92344, 92345, 92346, 92347, 92350, 92352, 92354, 92356, 92357, 92358, 92359, 92365, 92368, 92369, 92371, 92372, 92373, 92374, 92375, 92376, 92377, 92378, 92382, 92385, 92386, 92391, 92392, 92393, 92394, 92395, 92397, 92398, 92399, 92401, 92402, 92403, 92404, 92405, 92406, 92407, 92408, 92410, 92411, 92413, 92415, 92418, 92423, 92427

Preferred Providers are providers who participate in the Health Net EnhancedCare PPO Network ("EnhancedCare PPO Network"). Providers that are not designated as part of the EnhancedCare PPO Network are treated as Out-of-Network Providers, even if they are included in the network for other Health Net plans.

Benefits may be modified by *Policy* amendments which may provide greater or lesser benefits. Any *Policy* amendments issued to You should be attached to this *Policy*.

HEALTH NET LIFE INSURANCE COMPANY (herein called HNL) agrees to provide benefits as described in this *Policy* to the Policyholder (herein called "You" or "Your") and Your eligible Dependents.

The coverage described in this *Policy* shall be consistent with the Essential Health Benefits coverage requirements in accordance with the Affordable Care Act (ACA). The Essential Health Benefits are not subject to any annual dollar limits.

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

HNL will provide 60 days advance notice to Policyholders before the effective date of any material modification to this *Policy*, including changes in Preventive Care Services.

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

How to Obtain Care

Selecting a Primary Care Physician. HNL believes maintaining an ongoing relationship with a Physician who knows You well and whom You trust is an important part of a good health care program. That's why You are required to select a primary care Physician for yourself and each member of Your family, even though You may go directly to any Preferred Provider without first seeing Your primary care Physician. Primary care Physicians can help provide, arrange and coordinate Your health care. Your out-of-pocket costs will depend on if the providers are Preferred Providers or Out-of-Network Providers.

You may designate any primary care Physician who participates in Our EnhancedCare PPO Network, and who is available to accept You or Your Dependents. Dependents may select different primary care Physicians. An obstetrician/gynecologist may be designated as a primary care Physician. For children, a pediatrician may be designated as the primary care Physician. Until You make this primary care Physician designation, HNL designates one for You. Information on how to select a primary care Physician and a listing of the participating Physicians in the EnhancedCare PPO Network are available on the HNL website at www.myhealthnetca.com. You can also call the Customer Contact Center at the number shown on Your HNL ID card to request provider information or if You have questions involving reasonable access to care. Primary care Physicians include general and family practitioners, internists, pediatricians and obstetricians/gynecologists.

You do not need prior Certification from HNL or from any other person (including a primary care Physician) in order to obtain access to obstetrical or gynecological care from a health care professional in Our Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior Certification for certain services, following a pre-approved treatment plan, or procedures for making referrals.

You do not need to obtain a referral from your primary care Physician or any other provider prior to receiving coverage or services for reproductive and sexual health care. Reproductive and sexual health care services include but are not limited to: pregnancy services, including contraceptives and treatment; diagnosis and treatment of sexual transmitted disease (STD); medical care due to rape or sexual assault, including collection of medical evidence; and HIV testing.

Preferred Providers are providers who have agreed to "participate" in the EnhancedCare PPO Network of 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 "Contracted Rate" 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.myhealthnetca.com and selecting "Provider Search" or one can contact the Customer Contact Center at the telephone number on the HNL ID card to obtain a copy of the Preferred Provider Directory at no cost. If Medically Necessary care is not available through a Preferred Provider, HNL will arrange for the required care with available and accessible Out-of-Network Providers.

The EnhancedCare PPO Network is subject to change. It is Your responsibility to choose a provider that is listed as participating in the EnhancedCare PPO provider network directory. **IMPORTANT NOTE:** Please be aware that it is Your responsibility and in Your best financial interest to verify that the health care providers treating You are Preferred Providers, including:

- The Hospital or other facility where care will be given. After verifying that the Hospital or the facility is a Preferred Provider, You should not assume all providers at that Hospital or facility are also Preferred Providers; if You receive services from an Out-of-Network Provider at that Hospital or other facility, refer to "When Out-of-Network Services are received at an In-Network Health Facility" below for information on how those services are paid.
- The provider You select, or to whom You are referred, at the specific location at which You will receive care. Some providers participate at one location, but not at others.

Note: Not all providers who contract with HNL are Preferred Providers under this Policy. Providers that are not designated as part of the EnhancedCare PPO Network are considered Out-of-Network Providers, even if they have a contract with HNL for Health Net PPO or other plans.

Out-of-Network Providers have not agreed to participate in the EnhancedCare PPO Network. You may choose to obtain Covered Services and Supplies from an Out-of-Network Provider.

WHEN YOU USE OUT-OF-NETWORK PROVIDERS, BENEFITS ARE SUBSTANTIALLY REDUCED. WHEN YOU USE OUT-OF-NETWORK PROVIDERS YOU 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 Preferred Providers; (2) HNL's benefit for Out-of-Network Providers is based on a percentage of the Maximum Allowable Amount; and (3) the Covered Person is financially responsible for any amounts Out-of-Network Providers charge in excess of this amount. Please refer to the definition of Maximum Allowable Amount in the "Definitions" section for details.

When Services are not Available through a Preferred Provider: If HNL determines that the Medically Necessary care You require is not available within the EnhancedCare PPO Preferred Provider network, HNL will authorize You to receive the care and will arrange for the required medically appropriate care from an available and accessible Out-of-Network Provider or facility. Covered Services and Supplies received from Out-of-Network Providers under these circumstances will be payable at the Preferred Provider level of coverage. Cost-sharing paid at the Preferred Provider level of coverage will apply toward the in-network Deductible and accrue to the in-network Out-of-Pocket Maximum and You will not be responsible for any amounts in excess of the Maximum Allowable Amount. If You need access to medically appropriate care that is not available in the EnhancedCare PPO Preferred Provider network, or are being billed for amounts in excess of the Maximum Allowable Amount for Covered Services received under these circumstances, please call the Customer Contact Center at the number shown on your HNL ID card.

When Out-of-Network Services are received at an In-Network Health Facility: In addition, if You receive covered non-emergent services at an in-network (EnhancedCare PPO network) health facility (including, but not limited to, a licensed Hospital, an ambulatory surgical center or other outpatient setting, a laboratory, or a radiology or imaging center), at which, or as a result of which, You receive non-emergent Covered Services by an Out-of-Network Provider, the non-emergent services provided by the Out-of-Network Provider will be payable at the Preferred Provider level of cost-sharing and Deductible, if applicable, and without balance billing (balance billing is the difference between a provider's billed charge and the Maximum Allowable Amount); the cost-sharing and Deductible will accrue to the Out-of-Pocket Maximum).

The Out-of-Network Provider may bill or collect from You the difference between a provider's billed charge and the Maximum Allowable Amount in addition to any applicable Out-of-Network Deductible(s), Copayments and/or Coinsurance, only when You consent in writing at least 24 hours in advance of care. In order to be valid, that consent must meet all of the following requirements: (1) The consent shall be obtained by the Out-of-Network Provider in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent shall not be obtained by the facility or any representative of the facility. The consent shall not be obtained at the time of admission or at any time when You are being prepared for surgery or any other procedure; (2) At the time the consent is provided, the Out-of-Network Provider shall give You a written estimate of Your total out-of-pocket cost of care. The written estimate shall be based on the Out-of-Network Provider's billed charges for the service to be provided. The Out-of-Network Provider shall not attempt to collect

more than the estimated amount without receiving separate written consent from You or Your authorized representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the provider to change the estimate; (3) The consent shall advise You that You may elect to seek care from a Preferred Provider or may contact HNL in order to arrange to receive the health service from a Preferred Provider for lower out-of-pocket costs; (4) The consent shall also advise You that any costs incurred as a result of Your use of the Out-of-Network benefit shall be in addition to Preferred Provider cost-sharing amounts and may not count toward the annual Out-of-Pocket Maximum on Preferred Provider benefits or a Deductible, if any, for in-network benefits; and (5) The consent and estimate shall be provided in the language spoken by You, in certain circumstances.

For information regarding HNL's payment for Out-of-Network Emergency Care, please refer to the Maximum Allowable Amount definition in the "Definitions" section of this *Policy*.

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 EnhancedCare PPO insurance plan, Covered Persons must use Preferred Providers.

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

Some Hospitals and other providers do not provide one or more of the following services that may be covered under this *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, Preferred Provider, or clinic, or call HNL's Customer Contact Center at the telephone number on his or her HNL ID card, to ensure that the health care services needed can be obtained.

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

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 10196
Van Nuys, CA 91410-0196
1-800-522-0088**

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

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

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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*.

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

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

BARIATRIC SURGERY PERFORMANCE CENTER is a provider in HNL's designated network of California bariatric surgical centers and surgeons that perform weight loss surgery. Providers that are not designated as part of HNL's network of Bariatric Surgery Performance Centers are considered Out-of-Network Providers, even if they have a contract with HNL, for purposes of determining coverage and benefits for weight loss surgery and are not covered.

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

CALENDAR YEAR is the continuous, twelve-month period commencing January 1 of each year at 12:01 a.m., Pacific Time.

CALENDAR YEAR DEDUCTIBLE is the amount of medical 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.

CERTIFICATION refers to the process of obtaining approval from Us in advance of receiving certain services and supplies covered under this *Policy*. The "Schedule of Benefits" shows the penalties applicable to those expenses that are not certified in accordance with the provisions of this *Policy*. The requirements for Certification are described in the "Certification Requirement" section.

CHEMICAL DEPENDENCY is alcoholism, drug addiction or other chemical dependency problems.

COINSURANCE is the percentage of the Covered Expenses, for which the Covered Person is responsible, as specified in the "Schedule of Benefits."

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

COPAYMENT is a fixed dollar fee charged to 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.

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

COVERED DENTAL SERVICE is a Dental Service or Dental Procedure for which benefits are provided under this *Policy*.

COVERED EXPENSES are the maximum charges for which HNL will pay benefits for each Covered Service or Supply (including covered services related to Mental Disorders and Chemical Dependency). The amount of Covered Expenses varies by whether the Covered Person obtains services from a Preferred Provider, or an Out-of-

Network Provider. Covered Expenses are the lesser of the billed charge or: (i) Contracted Rate, for services or supplies provided by a Preferred Provider; (ii) the Maximum Allowable Amount for the services or supplies from an inpatient Hospital, Skilled Nursing Facility, Home Health Care Agency, for Outpatient surgery or for Emergency Care received during Foreign Travel or Work Assignment, provided by an Out-of-Network Provider; or (iii) for the cost of services or supplies from any other Out-of-Network Provider, the Maximum Allowable Amount.

COVERED PERSON means You and Your Dependents who are covered under this *Policy*.

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*.

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

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

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

DENTAL PROVIDER is any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

DENTAL SERVICE or DENTAL PROCEDURES is dental care or treatment provided by a Dental Provider to a Covered Person while the *Policy* is in effect, provided such care or treatment is a generally accepted form of care or treatment according to prevailing standards of dental practice.

DEPENDENT includes:

1. A Policyholder's legally married spouse or Domestic Partner as defined by California law;
2. A Policyholder's child who is:
 - (a) under the age of 26; or
 - (b) over the age of 26 and incapable of self-sustaining employment by reason of physical or mental disability incurred prior to attainment of age 26 and who is chiefly dependent upon the Policyholder or Policyholder's spouse or Domestic Partner for support;

The term "child" includes a stepchild, a legally adopted child from the moment of placement in Your home, and any other child for whom You or Your spouse or Domestic Partner has assumed a parent-child relationship, as indicated by intentional assumption of parental duties, as certified by You or Your Domestic Partner at the time of enrollment of the child, and annually thereafter up to age 26.

An enrolled Dependent child who reaches age 26 during a Calendar Year may remain enrolled as a Dependent until the end of that Calendar Year. The Dependent coverage shall end on the last day of the Calendar Year during which the Dependent child becomes ineligible.

DOMESTIC PARTNER is a person eligible for coverage as a Dependent provided that the partnership is with the Policyholder and who is a registered domestic partner and meets all domestic partnership requirements under specified by section 297 or 299.2 of the California Family Code.

DURABLE MEDICAL EQUIPMENT:

- Serves a medical purpose (its reason for existing is to fulfill a medical need or health condition, it is not for convenience and/or comfort and it is not useful to anyone in the absence of a health condition);
- Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities;

- Withstands repeated use; and
- Is appropriate for use in a home setting.

EFFECTIVE DATE is the date on which the Policyholder (and enrolled Dependents) becomes covered by or entitled to the benefits under this *Policy*. The precise Effective Date can be found on the Notice of Acceptance. Enrolled Dependents may have a different Effective Date than the Policyholder if they are added later to the *Policy*.

ELIGIBLE DENTAL EXPENSES for Covered Dental Services, incurred while the *Policy* is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Eligible Dental Expenses are our contracted fee(s) for Covered Dental Services with that provider.
- For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dental Providers, Eligible Dental Expenses is the Maximum Allowable Amount, as defined below.

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

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

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

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

Emergency Care is available and accessible to all Covered Persons in the Service Area 24 hours a day, seven days a week. Emergency Care is also covered outside the Service Area, including outside the United States. Emergency Care includes air and ground Ambulance transport services provided through the **911** emergency response system if the request was made for Emergency Care. Ambulance services will transport the Covered Person to the nearest 24-hour emergency facility with Physician coverage.

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

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

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

See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" under "Specific Provisions" for the procedure to request an Independent Medical Review of a Plan denial of coverage for Emergency Care.

ESSENTIAL HEALTH BENEFITS are a set of health care service categories (as defined by the Affordable Care Act and section 10112.27 of the California Insurance Code) that must be covered by all health benefits plans starting in 2014. Categories include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment,

prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including dental and vision care.

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

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

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

EYEMED VISION CARE, LLC, a contracted vision services provider panel, provides and administers the vision services benefits through a network of dispensing opticians and optometric laboratories.

HEALTH NET ENHANCEDCARE PPO NETWORK ("ENHANCEDCARE PPO NETWORK") is a network of providers who have a Health Net PPO agreement in effect with HNL and have agreed to participate in the Health Net EnhancedCare PPO Network to provide the Preferred Provider benefits under this *Policy*. Providers that are not designated as part of the EnhancedCare PPO Network are considered Out-of-Network Providers, even if they have a contract with HNL for Health Net PPO or other plans.

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

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 Providers with whom HNL has contracted to provide services at the Contracted Rate; or else any Out-of-Network Provider. HNL underwrites the benefits of Health Net PPO.

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

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

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

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

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

INTERMITTENT SKILLED NURSING SERVICES are services requiring the skilled services of a registered nurse or LVN, which do not exceed 6 hours in total, provided either continuously or intermittently, in a 24-hour period. Home health aide services are covered under the Home Health Care benefit if the Covered Person's condition requires the services of a nurse, physical therapist, occupational therapist, or speech therapist.

INPATIENT means being confined as a bed patient in a Hospital, Hospice or Skilled Nursing Facility.

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

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

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

MAXIMUM ALLOWABLE AMOUNT (MAA) is the amount on which HNL bases its reimbursement for Covered Services and Supplies provided by an Out-of-Network Provider, which may be less than the amount billed for those services and supplies. HNL calculates Maximum Allowable Amount as the lesser of the amount billed by the Out-of-Network Provider or the amount determined as shown below. Maximum Allowable Amount is not the amount that HNL pays for a Covered Service; the actual payment will be reduced by applicable Coinsurance, Copayments, Deductibles and other applicable amounts shown in this *Policy*.

- **Maximum Allowable Amount for Covered Services and Supplies, excluding Emergency Care, pediatric Dental Services, and outpatient pharmaceuticals**, received from an Out-of-Network Provider is a percentage of what Medicare would pay, known as the Medicare Allowable Amount, as defined in this *Policy*.

For illustration purposes only, Out-of-Network Provider: 70% Plan Payment / 30% Coinsurance:

Nonparticipating Provider's billed charge for extended office visit	\$128.00
MAA allowable for extended office visit (example only; does not mean that MAA always equals this amount)	\$102.40
Your Coinsurance is 30% of MAA: 30% x \$102.40 (assumes Deductible has already been satisfied)	\$30.72
You are also responsible for the difference between the billed charge (\$128.00) and the MAA amount (\$102.40)	\$25.60
TOTAL AMOUNT OF \$128.00 CHARGE THAT IS YOUR RESPONSIBILITY	\$56.32

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

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

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

- a. Maximum Allowable Amount for professional and ancillary services shall be 100% of FAIR Health's Medicare gapfilling methodology. Services or supplies not priced by gapfilling methodology shall be the lesser of: (1) the average amount negotiated with Preferred Providers within the geographic region for the same Covered Services or Supplies provided; (2) 50th percentile of FAIR Health database of professional and ancillary services not included in FAIR Health Medicare gapfilling methodology; (3) 100% of Medicare Allowable Amount for the same Covered Services or Supplies under alternative billing codes published by Medicare; or (4) 50% of the Out-of-Network Provider's billed charges for Covered Services. A similar type of database or valuation service will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination.
 - b. Maximum Allowable Amount for facility services shall be the lesser of: (1) the average amount negotiated with Preferred Providers within the geographic region for the same Covered Services or Supplies provided; (2) 100% of the derived amount using a method developed by Data iSight for facility services (a data service that applies a profit margin factor to the estimated costs of the services rendered), or a similar type of database or valuation service, which will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination; (3) 150% of the Medicare Allowable Amount for the same Covered Services or Supplies under alternative billing codes published by Medicare; or (4) 50% of the Out-of-Network Provider's billed charges for Covered Services.
- **Maximum Allowable Amount for Out-of-Network Emergency Care** will be the greatest of: (1) the amount negotiated with Preferred Providers for the emergency service provided, excluding any in-network Copayment or Coinsurance; (2) the amount calculated using the same method HNL generally uses to determine payments for Out-of-Network providers, excluding any in-network Copayment or Coinsurance; or (3) the amount paid under Medicare Part A or B, excluding any in-network Copayment or Coinsurance.
 - **Maximum Allowable Amount for non-emergent services at an in-network (EnhancedCare PPO network) health facility, at which, or as a result of which, You receive non-emergent Covered Services by an Out-of-Network Provider, the non-emergent services provided by the Out-of-Network Provider** will be payable at the greater of the average Contracted Rate or 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered unless otherwise agreed to by the noncontracting individual health professional and HNL.
 - **Maximum Allowable Amount for covered outpatient pharmaceuticals** (including but not limited to injectable medications) dispensed and administered to the patient in an outpatient setting, including, but not limited to, Physician office, outpatient Hospital facilities, and services in the patient's home, will be the lesser of billed charges or the Average Wholesale Price for the drug or medication.
 - **Maximum Allowable Amount for pediatric Dental Services** is calculated by HNL based on available data resources of competitive fees in that geographic area and must not exceed the fees that the Dental Provider would charge any similarly situated payor for the same services for each Covered Dental Service. The data resources of competitive fees are supplied by FAIR Health, which are updated twice a year. HNL reimburses non-Network Dental Providers at 55% of FAIR Health rates. You must pay the amount by which the non-Network provider's billed charge exceeds the Eligible Dental Expense.

The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses. See "Schedule of Benefits," "Medical Benefits," and "General Exclusions and Limitations" sections for specific benefit limitations, maximums, prior certification requirements and payment policies that limit the amount HNL pays for certain Medical Services. In addition to the above, from time to time, HNL also contracts with vendors that have contracted fee arrangements with providers ("Third Party Networks"). In the event HNL contracts with a Third Party Network that has a contract with the Out-of-Network Provider, HNL may, at its option, use the rate agreed to by the Third Party Network as the Maximum Allowable Amount. Alternatively, HNL may, at its option, refer a claim for Out-of-Network Services to a fee negotiation service to negotiate the Maximum Allowable Amount for the service or supply provided directly with the Out-of-Network Provider. In either of these two circumstances, You will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance at the Out-of-Network level.

NOTE: When the Centers for Medicare and Medicaid Services (CMS) adjust the Medicare Allowable Amount, HNL will adjust, without notice, the Maximum Allowable Amount based on the CMS schedule currently in effect. Claims payment will be determined according to the schedule in effect at the time the charges are incurred.

Claims payment will also never exceed the amount the Out-of-Network Provider charges for the service or supply. You should contact the Customer Contact Center if You wish to confirm the Covered Expenses for any treatment or procedure You are considering.

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

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

MEDICALLY NECESSARY (OR MEDICAL NECESSITY) means health care services and outpatient Prescription Drug benefits that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, or health condition, and that are:

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

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

For Pediatric Dental Services, Medically Necessary means Dental Services and supplies under this *Policy*, which are based on accepted dental practices and meet all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
 - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
 - Safe with promising efficacy
 - ♦ For treating a life threatening dental disease or condition.
 - ♦ Provided in a clinically controlled research setting.
 - ♦ Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.
- For orthodontic benefits, when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this *Policy*. The definition of Necessary used in this *Policy* relates only to Benefits under this *Policy* and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

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

MEDICARE ALLOWABLE AMOUNT: HNL uses available guidelines of Medicare to assist in its determination as to which services and procedures are eligible for reimbursement. HNL will, to the extent applicable, apply Medicare claim processing rules to claims submitted. HNL will use these rules to evaluate the claim information and determine accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying Medicare rules may affect the Maximum Allowable Amount if it is determined the procedure and/or diagnosis codes used were inconsistent with Medicare procedure coding rules or reimbursement policies.

Medicare pays 100% of the Medicare Allowable Amount. The Medicare Allowable Amount is subject to automatic adjustment by the Centers for Medicare and Medicaid Services (CMS), an agency of the federal government which regulates Medicare.

MENTAL DISORDERS are a nervous or mental condition identified as a "mental disorder" in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) that results in clinically significant distress or impairment of mental, emotional or behavioral functioning.

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

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

- To restore function; or
- To support, align, prevent, or correct a defect or function of a body part; or
- To improve natural function; or
- As part of habilitative services, which includes keeping, learning or improving skills and functioning; or
- To restrict motion.

OUT-OF-NETWORK PROVIDERS are Physicians, Hospitals, laboratories or other providers of health care who are not part of the Health Net EnhancedCare PPO Network, except as noted under the definitions for "Bariatric Surgery Performance Center" and "Transplant Performance Center."

OUT-OF-POCKET MAXIMUM is the maximum dollar amount of Deductibles, Copayments and Coinsurance for which You or Your family must pay for medical, outpatient Prescription Drug, pediatric dental and pediatric vision Covered Expenses during a Calendar Year. After that maximum is reached for services provided by a Preferred Provider, and out-of-network Emergency Care (including emergency Hospital care and emergency transportation), Your payment responsibilities for Copayments and Coinsurance will no longer apply for Covered Expenses incurred during the remainder of that Calendar Year, as shown in the "Schedule of Benefits." Penalties paid for services which were not certified as required will not be applied to the Out-of-Pocket Maximum, and Your responsibility for these penalties will continue to apply to these expenses after the Out-of-Pocket Maximum is reached. For a family plan, an individual is responsible only for meeting the individual Out-of-Pocket Maximum. Deductibles, Copayments and Coinsurance for out-of-network Emergency Care, including emergency Hospital care and emergency medical transportation, accrues to the in-network Out-of-Pocket Maximum.

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.

PARTICIPATING VISION PROVIDER Is an optometrist, ophthalmologist or optician licensed to provide Covered Services and who or which, at the time care is rendered to a Covered Person, has a contract in effect with HNL to

furnish care to Covered Persons. The names of Participating Vision Providers are shown in Health Net's Participating Vision Provider Directory. The names of Participating Vision Providers and their locations and hours of practice may also be obtained by contacting the Customer Contact Center.

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.)
 - s. Other Mental Health providers, including, but not limited to the following: Chemical Dependency Counselor (L.C.D.C.), Licensed Professional Counselor (L.P.C.)

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*.

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 rate known as the Contracted Rate. See the definitions for "Bariatric Surgery Performance Center" and "Transplant Performance Center" for additional provider participation requirements for bariatric surgery and organ, tissue and stem cell transplants.

PREFERRED PROVIDERS are Physicians, Hospitals, laboratories or other providers of health care who have a written agreement with HNL to participate in the EnhancedCare PPO Network and have agreed to provide Covered Persons with Covered Services and Supplies at the Contracted Rate. See the definitions for "Bariatric Surgery Performance Center" and "Transplant Performance Center" for additional provider participation requirements for bariatric surgery and organ, tissue and stem cell transplants. The Covered Person must pay any Deductible(s), Copayment or Coinsurance required, but is not responsible for any amount charged in excess of the Contracted Rate. Preferred Providers are listed in the Preferred Provider Directory given to each Covered

Person upon enrollment. The Preferred Provider Directory is periodically updated. To ensure the participation by any Preferred Provider, please contact Our Customer Contact Center at the telephone number on the HNL ID card before services are received.

Note: Not all providers who contract with HNL are Preferred Providers under this Policy. Providers that are not designated as part of the EnhancedCare PPO Network are considered Out-of-Network Providers, even if they have a contract with HNL for Health Net PPO or other plans.

PREVENTIVE CARE SERVICES (including services for the detection of asymptomatic diseases) are services provided under a Physician's supervision and which include, but are not limited to, the following:

- Reasonable health appraisal examinations on a periodic basis
- A variety of family planning services
- Preventive prenatal and postnatal care in accordance with the guidelines of the Health Resources and Services Administration (HRSA)
- Vision and hearing testing for Covered Persons
- Immunizations for children in accordance with the recommendations of the American Academy of Pediatrics and immunizations for adults as recommended by the U.S. Public Health Service
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA
- For women, evidence-informed preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the HRSA
- Venereal disease tests
- Cytology examinations on a reasonable periodic basis
- Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided through HNL
- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF)

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

PREMIUM is the amount the Policyholder pays HNL for the insurance provided under this *Policy*.

PROFESSIONAL VISION SERVICES include examination, material selection, fitting of eyeglasses or contact lenses, related adjustments, instructions, etc.

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

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

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

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

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

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

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

SERVICE AREA is the geographic area within which HNL markets and sells EnhancedCare PPO insurance plans, and is defined as the following counties in the state of California: Los Angeles, Orange, Sacramento, San Diego and Yolo.

In addition, the Service Area consists of the following partial counties:

- **Placer:** For ZIP codes 95602, 95603, 95604, 95631, 95648, 95650, 95658, 95661, 95663, 95668, 95677, 95678, 95681, 95701, 95703, 95713, 95714, 95722, 95736, 95746, 95747, 95765
- **Riverside:** For ZIP codes 91752, 92201, 92202, 92203, 92210, 92211, 92220, 92223, 92230, 92234, 92235, 92236, 92240, 92241, 92247, 92248, 92253, 92254, 92255, 92258, 92260, 92261, 92262, 92263, 92264, 92270, 92274, 92276, 92282, 92320, 92501, 92502, 92503, 92504, 92505, 92506, 92507, 92508, 92509, 92513, 92514, 92516, 92517, 92518, 92519, 92521, 92522, 92530, 92531, 92532, 92536, 92539, 92543, 92544, 92545, 92546, 92548, 92549, 92551, 92552, 92553, 92554, 92555, 92556, 92557, 92561, 92562, 92563, 92564, 92567, 92570, 92571, 92572, 92581, 92582, 92583, 92584, 92585, 92586, 92587, 92589, 92590, 92591, 92592, 92593, 92595, 92596, 92599, 92860, 92877, 92878, 92879, 92880, 92881, 92882, 92883
- **San Bernardino:** For ZIP Codes 91701, 91708, 91709, 91710, 91729, 91730, 91737, 91739, 91743, 91758, 91759, 91761, 91762, 91763, 91764, 91784, 91785, 91786, 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92301, 92305, 92307, 92308, 92309, 92310, 92311, 92312, 92313, 92314, 92315, 92316, 92317, 92318, 92321, 92322, 92324, 92325, 92327, 92329, 92331, 92333, 92334, 92335, 92336, 92337, 92339, 92340, 92341, 92342, 92344, 92345, 92346, 92347, 92350, 92352, 92354, 92356, 92357, 92358, 92359, 92365, 92368, 92369, 92371, 92372, 92373, 92374, 92375, 92376, 92377, 92378, 92382, 92385, 92386, 92391, 92392, 92393, 92394, 92395, 92397, 92398, 92399, 92401, 92402, 92403, 92404, 92405, 92406, 92407, 92408, 92410, 92411, 92413, 92415, 92418, 92423, 92427

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

SPECIAL CARE UNITS are special areas of a Hospital which have highly skilled personnel and special equipment for the care of inpatients with acute conditions that require constant treatment and monitoring including, but not limited to, an intensive care, cardiac intensive care, and cardiac surgery intensive care unit

SILVER 70 OFF EXCHANGE ENHANCED CARE PPO

SCHEDULE OF BENEFITS

Health Net PPO Plan FCV

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*.

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.

Except for urgent care and Emergency Care, services and supplies provided by Out-of-Network Providers are not covered outside California.

COPAYMENTS AND COINSURANCE

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

Copayments: Copayments are fixed dollar amount charges, shown below, for which the Covered Person is responsible. Health Net Life (HNL) will pay 100% of Covered Expenses for the services listed below after the Copayment is made. The Covered Person's out-of-pocket charge will never exceed the cost of the benefit to HNL. 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 below.

Coinsurance: Coinsurance is the percentage, shown below, of Covered Expenses (as defined) for which the Covered Person is responsible. After any applicable 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:

- The Covered Person will also be required to pay any charges billed by an Out-of-Network Provider that exceed Covered Expenses (Maximum Allowable Amount). You will not be reimbursed for any amount in excess of Covered Expenses (Maximum Allowable Amounts). Any Copayment or Coinsurance paid for the services of a Preferred Provider will apply toward the out-of-pocket Covered Expenses (as defined).
- Certification of Covered Expenses is required in some instances or benefits will be subject to the noncertification penalty as shown in the "Noncertification Penalties" section below. Please see the "Certification Requirements" section of this *Policy* for a list of services and supplies which require Certification.

OUT-OF-POCKET LIMITS ON EXPENSES

Out-of-Pocket Maximum:

For Covered Persons: After the Covered Person has paid Deductible, Copayments and Coinsurance equal to the Out-of-Pocket Maximum amount shown below, he or she will not be required to pay further Deductibles, Copayments and Coinsurance for Covered Expenses incurred during the remainder of the Calendar Year. Deductibles, Copayments or Coinsurance for out-of-network Emergency Care, including emergency Hospital care and emergency medical transportation, accrues to the Out-of-Pocket Maximum for Preferred Providers. Please see "**Exceptions to the Out-of-Pocket Maximum**" below for payments that do not apply toward the Out-of-Pocket Maximum.

After the Covered Person has met the Out-of-Pocket Maximum amount, HNL will pay 100% of Covered Expenses for any additional Covered Services and Supplies, except as stated below. The Covered Person will continue to

be responsible for any charges billed in excess of Covered Expenses (Maximum Allowable Amounts) for the services of Out-of-Network Providers and will not be reimbursed for any amounts in excess of Maximum Allowable Amounts.

For services or supplies provided by a Preferred Provider\$7,550
For services or supplies provided by an Out-of-Network Provider\$25,000

For Families: Each Covered Person is responsible only for meeting his or her individual Out-of-Pocket Maximum. However, if enrolled Covered Persons of the same family have paid Covered Expenses equal to the amounts shown below, then the Out-of-Pocket Maximum will be considered to have been met for the entire family. No Deductible, Copayments or Coinsurance shall be required from any enrolled Covered Person in that family for the remainder of the Calendar Year. The Covered Person will continue to pay any charges billed in excess of Covered Expenses for the services of Out-of-Network Providers.

NOTE: In order for the Family Out-of-Pocket Maximum to apply, all Dependents must be enrolled under a single Policyholder as a family unit. Dependents enrolled as separate Policyholders are each subject to the per Covered Person Out-of-Pocket Maximum.

For services or supplies provided by a Preferred Provider\$15,100
For services or supplies provided by an Out-of-Network Provider\$50,000

Any Deductibles, Copayments or Coinsurance paid for the services of a Preferred Provider which are Covered Expenses will only apply toward the Out-of-Pocket Maximum for Preferred Providers and will not apply toward the Out-of-Pocket Maximum for Out-of-Network Providers. In addition, Deductibles, Copayments, and Coinsurance paid for the services of an Out-of-Network Provider will only apply toward the Out-of-Pocket Maximum for Out-of-Network Providers and will not apply toward the Out-of-Pocket Maximum for Preferred Providers. However, Deductibles, Copayments or Coinsurance paid for Out-of-Network Emergency Care (including emergency medical transportation, and emergency Hospital care) will be applied to the Out-of-Pocket Maximum for Preferred Providers.

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

- Penalties paid for services for which Certification was required but not obtained.
- Charges billed in excess of Covered Expenses (Maximum Allowable Amounts) for the services of Out-of-Network Providers.

MEDICAL DEDUCTIBLE

The following Calendar Year Deductibles apply to the medical benefits. It applies to all services unless specifically noted otherwise below. Once Your payment for medical Covered Expenses equals the amount shown below, the medical benefits will become payable by Us (subject to any Copayment or Coinsurance as described herein).

Calendar Year Deductible, for Preferred Provider services per Covered Person \$2,500, medical only
Calendar Year Deductible, for Out-of-Network services per Covered Person \$5,000, medical only
Family Calendar Year Deductible (all enrolled members of a family, for Preferred Provider services, during a Calendar Year) \$5,000, medical only
Family Calendar Year Deductible (all enrolled members of a family, for Out-of-Network services, during a Calendar Year) \$10,000, medical only

Note: Any amount applied toward the Calendar Year Deductible for Covered Services and Supplies received from a Preferred Provider will only apply toward the Calendar Year Deductible for Preferred Providers and will not apply toward the Calendar Year Deductible for Out-of-Network Providers. In addition, any amount applied toward the Calendar Year Deductible for Covered Services and Supplies received from an Out-of-Network Provider will only apply toward the Calendar Year Deductible for Out-of-Network Providers and will not apply toward the Calendar Year Deductible for Preferred Providers.

Each Covered Person is responsible only for meeting his or her individual Calendar Year Deductible. However, if enrolled Covered Persons of the same family have met the Family Calendar Year Deductible shown above, no additional Calendar Year Deductible shall be required from any enrolled Covered Person in that family for the remainder of that Calendar Year.

Your payments under the Outpatient Prescription Drug Benefits, Pediatric Vision and Pediatric Dental are not applied to the Medical Deductible.

NONCERTIFICATION PENALTIES

	<u>Preferred Providers</u>	<u>Out-of-Network</u>
Medically Necessary services for which Certification was required but not obtained.....	\$250	\$500

Notes:

- The noncertification penalty will not exceed the cost of the benefit to 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.

VISITS TO A HEALTH CARE PROVIDER'S OFFICE OR CLINIC

	<u>Preferred Providers</u>	<u>Out-of-Network</u>
Primary care visits to treat an injury or illness		
In a Physician's office.....	\$40, Deductible Waived	50%
At a Covered Person's home	\$40, Deductible Waived	50%
Specialist consultation		
In a Physician's office.....	\$80, Deductible Waived	50%
At a Covered Person's home	\$80, Deductible Waived	50%
Urgent care services.....	\$40, Deductible Waived	50%
Vision examination (for refractive eye exams at an ophthalmologist) (age 19 and over; for birth to age 19, see "Child Needs Dental or Eye Care" below).....	\$80, Deductible Waived	Not Covered
Vision examination (for refractive eye exams at an optometrist) (age 19 and over; for birth to age 19, see "Child Needs Dental or Eye Care" below).....	\$40, Deductible Waived	Not Covered
Hearing examination (for diagnosis or treatment)	\$40, Deductible Waived	Not Covered
Allergy testing	\$80, Deductible Waived	50%
Allergy serum.....	20%, Deductible Waived	50%
Allergy injections.....	\$40, Deductible Waived	50%
Other practitioner office visit (including acupuncturist).....	\$40, Deductible Waived	Not Covered
Medical social services	\$40, Deductible Waived	Not Covered
Patient education		
Diabetes education	\$0, Deductible Waived	50%
Asthma education	\$0, Deductible Waived	50%
Weight management education	\$0, Deductible Waived	Not Covered
Stress management education	\$0, Deductible Waived	50%
Tobacco cessation education	\$0, Deductible Waived	Not Covered
Preventive Care Services	\$0, Deductible Waived	Not Covered

Notes:

- Preventive Care Services are covered at no cost to You and are not subject to any Deductible. Covered Services and Supplies include, but are not limited to, annual preventive physical examinations, immunizations, screening and diagnosis of prostate cancer, well-woman examinations, preventive services for pregnancy, other women's preventive services as supported by the Health Resources and Services Administration (HRSA), breast feeding support and supplies, weight management intervention services, tobacco cessation intervention services, and preventive vision and hearing screening examinations. Refer to the "Preventive Care Services" portion of the "Medical Benefits" section for details. If You receive any other Covered Services and Supplies in addition to Preventive Care Services during the same visit, You will also pay the applicable Copayment or Coinsurance for those services.
- Hearing examinations for newborns are covered at no cost to You and are not subject to any Deductible.
- Acupuncture Services are provided by HNL. HNL contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage. With this program, you may obtain care by selecting a contracted acupuncturist from the *ASH Plans Contracted Acupuncturist Directory*.
- Preferred Provider Copayments, Coinsurance, and Deductible (as applicable) will apply to Urgent Care services received outside of California and will accumulate towards the Preferred Provider Out-of-Pocket Maximum.

TESTS

	Preferred Providers	Out-of-Network
Laboratory tests	\$35, Deductible Waived	50%
X-rays and diagnostic imaging ¹	\$75, Deductible Waived	50%
Imaging (CT, PET, MRI) ²	\$300, Deductible Waived	50%

¹ Certification may be required. Please refer to the "Certification Requirements" section for details. Payment of benefits will be subject to the noncertification penalty as shown in this "Schedule of Benefits" section if Certification is required but not obtained.

² Certification is required, except in the case of an emergency. Please refer to the "Certification Requirements" section for details. A noncertification penalty will apply as shown in this "Schedule of Benefits" section if Certification is not obtained.

OUTPATIENT SURGERY AND SERVICES

	Preferred Providers	Out-of-Network
Facility fee		
Outpatient surgery and services ^{1,2}	20%, Deductible Waived	50%
Physician/surgeon fees		
Surgery ¹	20%, Deductible Waived	50%
Anesthetics ³	20%, Deductible Waived	50%
Sterilization of male	20%, Deductible Waived	50%
Sterilization of females ⁴	\$0, Deductible waived	50%
Outpatient infusion therapy ^{1,3}	20%, Deductible Waived	Not Covered
Blood or Blood Products, and administration of Blood or Blood Products ⁵	20%, Deductible Waived	50%
Chemotherapy and radiation therapy ^{1,3}	20%, Deductible Waived	50%
Nuclear medicine ^{1,3}	20%, Deductible Waived	50%
Organ, stem cell or tissue transplant (not Experimental or Investigational) ¹	20%, Deductible Waived	Not Covered
Renal dialysis	20%, Deductible Waived	50%

Notes:

- Other professional services performed in the outpatient department of a Hospital, Outpatient Surgical Center or other licensed outpatient facility such as a visit to a Physician (office visit), laboratory and x-ray services, physical therapy, etc., may require a Copayment or Coinsurance when these services are performed. Look under the headings for the various services such as office visits, neuromuscular rehabilitation and other services to determine any additional Copayments or Coinsurances that may apply.
- Screening colonoscopy and sigmoidoscopy procedures (for the purposes of colorectal cancer screening) will be covered under "Preventive Care Services" in the "Visit to a Health Care Provider's Office or Clinic" provision above. Diagnostic endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an outpatient facility require the Copayment or Coinsurance applicable for outpatient facility services.

¹ Some outpatient surgical procedures and services require Certification. Please refer to the "Certification Requirements" section for details. Payment of benefits will be subject to the noncertification penalty shown herein if Certification is required but not obtained.

² A noncertification penalty will apply as set forth herein if Certification is required but not obtained for outpatient facility services.

³ The Coinsurance for these services applies to both the administration of the medication and the medication itself.

⁴ Sterilization of females and women's contraception methods and counseling, as supported by HRSA guidelines, are covered under "Preventive Care Services" in the "Visit to a Health Care Provider's Office or Clinic" provision in this section.

⁵ The Coinsurance for blood or Blood Products applies to both the administration of the medication and the medication itself; however, blood factors provided in an outpatient setting are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefit even if they are administered in a Physician's office. If You need to have the provider administer the Specialty Drug, You can coordinate delivery of the Specialty Drug directly to the provider's office through the Specialty Pharmacy Vendor. Please refer to the "Specialty Pharmacy Vendor" portion of this "Schedule of Benefits" section for the applicable Copayment or Coinsurance.

NEED IMMEDIATE ATTENTION**Services in an Emergency Room**

	Preferred Providers	Out-of-Network
Emergency room care facility	\$350, Deductible Waived ...	\$350, Deductible Waived
Emergency room care professional services	\$0, Deductible Waived	\$0, Deductible Waived
Emergency medical transportation (air Ambulance or ground Ambulance)	\$255.....	\$255 ¹

Notes:

- For all services which meet the criteria for Emergency Care, the Copayment and Coinsurance will be the amount shown for Preferred Providers, even if the services were provided by an Out-of-Network Provider. HNL uses a prudent layperson standard to determine whether the criteria for Emergency Care have been met. HNL applies the prudent layperson standard to evaluate the necessity of medical services which a Covered Person accesses in connection with a condition that the Covered Person perceives to be an emergency situation. Please refer to "Emergency Care" in the "Definitions" section to see how the prudent layperson standard applies to the definition of "Emergency Care."
- The emergency room Copayments will not apply if the Covered Person is admitted to a Hospital directly from an emergency room. Non-emergency Hospital stays at an Out-of-Network Hospital will be subject to the Out-of-Network Coinsurance. See "Hospital Stay" below for applicable Coinsurance.

¹ Emergency Care that is received from Out-of-Network providers is subject to the Medical Deductible for Preferred Providers.

HOSPITAL STAY

	Preferred Providers	Out-of-Network
Facility fee ^{1,2}	20%	50%
Confinement for bariatric (weight loss) surgery ¹	20%	Not Covered
Physician/surgeon fees ⁴		
Surgery ¹	20%, Deductible waived	50%
Anesthetics ³	20%, Deductible waived	50%
Physician visit to Hospital.....	20%, Deductible waived	50%
Blood or Blood Products, and administration of Blood or Blood Products ³	20%, Deductible Waived	50%
Chemotherapy and radiation therapy ^{1,3}	20%, Deductible Waived	50%
Nuclear medicine ³	20%, Deductible Waived	50%
Organ, stem cell or tissue transplant (not Experimental or Investigational) ¹	20%, Deductible waived	Not Covered
Renal dialysis	20%, Deductible Waived	50%

Notes:

- The Preferred Provider Coinsurance and Deductible (as applicable) will apply if the Covered Person is admitted to a Hospital directly from an emergency room and services will accumulate towards the Preferred Provider Out-of-Pocket Maximum. The Covered Person will remain responsible for amounts billed in excess of Covered Expenses (Maximum Allowable Amounts) for the inpatient stay by an Out-of-Network Provider. You will not be reimbursed for any amounts in excess of Maximum Allowable Amounts billed by an Out-of-Network Provider. The Covered Person should request a transfer to a preferred facility after their emergency condition has been stabilized to avoid incurring charges billed in excess of the Maximum Allowable Amounts.
- If the Covered Person receives a non-emergency covered service at a preferred facility by an Out-of-Network Provider, the Covered Person will be responsible for the Preferred Provider Coinsurance and Deductible (as applicable).
- The above Coinsurance for inpatient Hospital or Special Care Unit services is applicable for each admission for the hospitalization of an adult, pediatric or newborn patient. If a newborn patient requires admission to a Special Care Unit, a separate Coinsurance for inpatient Hospital services for the newborn patient will apply.

¹ Certification is required for Hospital stay, including the facility and some services received while admitted to the Hospital, except in the case of an emergency. Please refer to the "Certification Requirements" section for details.

² If Certification is not obtained for Hospital facility stay, payment will be subject to the noncertification penalty as shown in this "Schedule of Benefits".

³ The Coinsurance for these services applies to both the administration of the medication and the medication itself.⁴ For facilities that do not separate charges for inpatient Facility fee and inpatient Physician/surgeon services, the inpatient Facility fee applies to the entire charge.

MENTAL HEALTH, BEHAVIORAL HEALTH OR SUBSTANCE ABUSE NEEDS

Mental Disorders and Chemical Dependency benefits are administered by MHN Services, an affiliate behavioral health administrative services company, which contracts with HNL to administer these benefits.

<u>Mental Disorders</u>	<u>Preferred Providers</u>	<u>Out-of-Network</u>
Outpatient office visits (psychological evaluation or therapeutic session in an office or other outpatient setting, including individual and group therapy sessions, medication management and drug therapy monitoring) ¹	\$0, Deductible Waived	50%
Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care program, day treatment, partial hospitalization, medical treatment of withdrawal symptoms, and other outpatient procedures including behavioral health treatment for pervasive developmental disorder or autism) ¹	\$0, Deductible Waived	50%
Inpatient facility ²	20%	50%
Physician visit to Hospital, behavioral health facility or Residential Treatment Center ³	20%, Deductible waived	50%

<u>Chemical Dependency</u>	<u>Preferred Providers</u>	<u>Out-of-Network</u>
Outpatient office visits (psychological evaluation or therapeutic session in an office or other outpatient setting, including individual and group therapy sessions, medication management and drug therapy monitoring)	\$0, Deductible Waived	50%
Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care program, day treatment, partial hospitalization, medical treatment for withdrawal symptoms and other outpatient services)	\$0, Deductible Waived	50%
Inpatient facility ²	20%	50%
Physician visit to Hospital, behavioral health facility or Residential Treatment Center ³	20%, Deductible waived	50%
Inpatient detoxification ²	20%	50%

Notes:

- The applicable Copayment or Coinsurance for outpatient services is required for each visit.

¹ Outpatient services include services for treating gender dysphoria. For benefits covered under outpatient office visits and outpatient services other than office visits, refer to the "Mental Health, Behavioral Health or Substance Abuse Needs" section of the *Policy*.

² Certification is required for inpatient facility stays, including the facility and some services received while admitted to the inpatient facility, except in the case of an emergency. Please refer to the "Certification Requirements" section for details. Payment of benefits will be subject to the noncertification penalty as shown in this "Schedule of Benefits" section if Certification is not obtained.

³ For facilities that do not separate charges for inpatient Facility fee and inpatient Physician/surgeon services, the inpatient Facility fee applies to the entire charge.

PREGNANCY

	Preferred Providers	Out-of-Network
Prenatal care and preconception visits.....	\$0, Deductible Waived	50%
Preventive postnatal office visits	\$0, Deductible Waived	50%
Non-Preventive postnatal office visits.....	\$40, Deductible Waived	50%
California Prenatal Screening Program services administered by the California State Department of Public Health	\$0, Deductible Waived ...	\$0, Deductible Waived
Delivery and all inpatient services		
Hospital ¹	20%	50%
Professional (including terminations of pregnancy and circumcision of newborn ²) ³	20%, Deductible waived	50%
Professional (genetic testing of fetus).....	\$35, Deductible Waived	50%

Notes:

- Applicable Deductible, Copayment or Coinsurance requirements apply to any services and supplies required for the treatment of an illness or condition, including but not limited to, complications of pregnancy. For example, if the complication requires an office visit, then the office visit Copayment or Coinsurance will apply.
- Prenatal, postnatal and newborn care that are Preventive Care Services are covered in full by Preferred Providers and the Calendar Year Deductible does not apply. See "Preventive Care Services" in the "Visit to a Health Care Provider's Office or Clinic" provision above.

¹ HNL does not require Certification for maternity care. 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, please notify HNL within 24 hours following birth or as soon as reasonably possible. Certification must be obtained if the Physician determines that a longer Hospital stay is Medically Necessary either prior to or following the birth.

² Circumcisions for Covered Persons aged 31 days and older are covered when Medically Necessary under "Outpatient Surgery and Services." Refer to the "Outpatient Surgery and Services" section for applicable Copayments and Coinsurance.

³ For facilities that do not separate charges for inpatient Facility fee and inpatient Physician/surgeon services, the inpatient Facility fee applies to the entire charge.

HELP RECOVERING OR OTHER SPECIAL HEALTH NEEDS

	Preferred Providers	Out-of-Network
Home Health Care Services ¹	\$45, Deductible Waived	Not Covered
<i>Number of visits covered during a Calendar Year</i> ²	100	Not Applicable
Rehabilitation services (physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy) ¹	\$40, Deductible Waived	Not Covered
Habilitative services (physical therapy, speech therapy, occupational therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy) ¹	\$40, Deductible Waived	Not Covered
Confinement in a Skilled Nursing Facility ³	20%	50%
Physician visit to Skilled Nursing Facility	20%	50%
Durable Medical Equipment ⁴	20%, Deductible Waived	Not Covered
Orthotics (such as br		

Hospice ³	\$0, Deductible Waived	50%
Office-based injections ¹	20%, Deductible Waived	50%
Self-injectable drugs ^{1,5}	See note below	See note below
Infertility services (all covered services that diagnose, evaluate or treat Infertility)	Not Covered	Not Covered
Teladoc consultation telehealth services.....	\$0, Deductible waived	Not Covered

Notes:

- Confinement in a Skilled Nursing Facility is not subject to a maximum number of days.
- Diabetic equipment and Orthotics which are covered under the medical benefit include blood glucose monitors, insulin pumps and Corrective Footwear.
- Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under "Preventive Care Services" in "Visit to a Health Care Provider's Office or Clinic" in this section. For additional information, please refer to the "Preventive Care Services" provision in the "Medical Benefits" section.
- Durable Medical Equipment is covered when Medically Necessary and acquired or supplied by an HNL designated contracted vendor for Durable Medical Equipment. Preferred Providers that are not designated by HNL as a contracted vendor for Durable Medical Equipment are considered Out-of-Network Providers for purposes of determining coverage and benefits. Durable Medical Equipment is not covered if provided by an Out-of-Network Provider. Certification is required. Please refer to the "Certification Requirements" section for details. Payment of benefits will be subject to the noncertification penalty as shown in this "Schedule of Benefits" section if Certification is not obtained. For information about HNL's designated contracted vendors for Durable Medical Equipment, please contact the Customer Contact Center at the telephone number on Your HNL ID Card.
- Diabetic Corrective Footwear is only covered when Medically Necessary, custom-made for the Covered Person and permanently attached to a Medically Necessary Orthotic device that is also a covered benefit under this *Policy*. Corrective Footwear for the management and treatment of diabetes-related medical conditions is covered as diabetic equipment as Medically Necessary.
- Hospice care provided by a Preferred Provider is covered at no charge to You regardless of place of the service.

¹ Certification may be required. Please refer to the "Certification Requirements" section for details. Payment of benefits will be subject to the noncertification penalty as shown in this "Schedule of Benefits" section if Certification is required but not obtained.

² Home health care rehabilitative or habilitative services will each have a separate Calendar Year maximum of 100 visits. Home Health Care visits are limited to 3 visits per day, up to 2 hours per visit by a nurse, medical social worker, physical/occupational/speech therapist, or up to 4 hours per visit by a home health aide.

³ Certification is required for Skilled Nursing Facility or Hospice stay, including the facility and some services received while admitted to the Skilled Nursing Facility or Hospice. Please refer to the "Certification Requirements" section for details. Payment of benefits will be subject to the noncertification penalty as shown in this "Schedule of Benefits" section if Certification is not obtained.

⁴ Certification is required for Durable Medical Equipment, Orthotics and Prostheses. Please refer to the "Certification Requirements" section for details. Payment of benefits will be subject to the noncertification penalty as shown in this "Schedule of Benefits" section if Certification is not obtained.

⁵ Injectable drugs which are self-administered are covered under the pharmacy benefit. Specialty Drugs are not covered under the medical benefit even if they are administered in a Physician's office. If You need to have the provider administer the Specialty Drug, You can coordinate delivery of the Specialty Drug directly to the provider's office through the Specialty Pharmacy Vendor. Please refer to the "Specialty Pharmacy Vendor" portion of this "Schedule of Benefits" section for the applicable Copayment or Coinsurance.

OUTPATIENT PRESCRIPTION DRUGS

Subject to the provisions of the "Outpatient Prescription Drugs" section of this *Policy*, all Medically Necessary Prescription Drugs are covered.

The Outpatient Prescription Drug benefits are subject to the Out-of-Pocket Maximums as described at the beginning of this section. The Outpatient Prescription Drug benefits are not subject to the Medical Deductible as described at the beginning of this section.

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

Pharmacy Deductible

Pharmacy Deductible required for Tier 1, Tier 2, Tier 3 and Tier 4 Drugs (per Covered Person, per Calendar Year)	\$200
Pharmacy Deductible required for Tier 1, Tier 2, Tier 3 and Tier 4 Drugs (per family, per Calendar Year)	\$400

If you are a Covered Person in a family of two or more members, You reach the Pharmacy Deductible either when You meet the amount for any one Covered Person, or when Your entire family reaches the family amount.

The Pharmacy Deductible applies to Tier 1, Tier 2, Tier 3 and Tier 4 Drugs, insulin, and diabetic supplies. Once Your payment of Outpatient Prescription Drug Covered Expenses for Tier 1, Tier 2, Tier 3 and Tier 4 Drugs, insulin, and diabetic supplies equals the Pharmacy Deductible shown above, You are only responsible for the applicable Copayment or Coinsurance as described herein. The Medical Deductible does not apply to Outpatient Prescription Drug benefits.

Benefit Maximums

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

Notes:

- Except for insulin, diabetic supplies (blood glucose testing strips, lancets, disposable needles & syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (i.e. opened in order to dispense the product in quantities other than those packaged). When a prescription is dispensed, You will receive the size of package and/or number of packages required for You to test the number of times Your Physician has prescribed for up to a 30-day period.
- Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order.
- Schedule II narcotic drugs are not covered through mail order. Schedule II drugs are drugs classified by the Federal Drug Enforcement Administration as having a high abuse risk but also safe and accepted medical uses in the United States. A partial prescription fill, which is of a quantity less than the entire prescription, can be requested by You or Your Member Physician. Partial prescription fills are subject to a prorated Copayment based on the amount of the prescription that is filled by the pharmacy.

Copayments and Coinsurance

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

Retail Pharmacy

	Participating Pharmacy	Nonparticipating Pharmacy
Tier 1 Drugs (most Generic Drugs and low-cost preferred Brand Name Drugs).....	\$15	Not Covered
Tier 2 Drugs (higher cost Generic Drugs and preferred Brand Name Drugs).....	\$55	Not Covered
Tier 3 Drugs (non-preferred Brand Name Drugs, Brand Name Drugs with a generic equivalent on a lower tier, or drugs that have a preferred alternative on a lower tier)	\$80	Not Covered
Preventive drugs and women's contraceptives	\$0, Deductible Waived	Not Covered

Specialty Pharmacy Vendor

	Specialty Pharmacy
Tier 4 Drugs (Specialty Drugs) (drugs made using biotechnology, drugs that must be distributed through a specialty pharmacy, drugs that require special training for self-administration, drugs that require regular monitoring of care by a pharmacy, and drugs that cost more than six hundred dollars for a one-month supply)	20% (up to \$250)

Maintenance Drugs through the Mail Order Program

	Mail Order Program
Tier 1 Drugs (most Generic Drugs and low-cost preferred Brand Name Drugs).....	\$30
Tier 2 Drugs (higher cost Generic Drugs and preferred Brand Name Drugs).....	\$110
Tier 3 Drugs (non-preferred Brand Name Drugs, Brand Name Drugs with a generic equivalent on a lower tier, or drugs that have a preferred alternative on a lower tier)	\$160
Preventive drugs and women's contraceptives	\$0, Deductible Waived

Notes:

- Orally administered anti-cancer drugs will have a Copayment and Coinsurance maximum of \$200 for an individual prescription of up to a 30-day supply or \$600 for up to a 90-day supply through mail order.
- After the Pharmacy Deductible has been met, Tier 4 Drugs will have a Copayment and Coinsurance maximum of \$250 for an individual prescription of up to a 30-day supply.
- If the pharmacy's retail price is less than the applicable Copayment or Coinsurance, You will pay the pharmacy's retail price.
- Generic Drugs will be dispensed when a Generic Drug equivalent is available. We will cover Brand Name Drugs, including Tier 4 Drugs (Specialty Drugs), that have a generic equivalent only when the Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from HNL. Covered Brand Name Drugs are subject to the applicable Copayment or Coinsurance for Tier 2 Drugs, Tier 3 Drugs or Tier 4 Drugs (Specialty Drugs).
- Preventive drugs, including smoking cessation drugs and FDA-approved women's contraceptive drugs, devices, and other products, including those available over the counter, are covered as shown above. Please see the "Preventive Drugs and Women's Contraceptives" provision in the "Outpatient Prescription Drug Benefits" section for additional details. If Your Physician determines that none of the methods designated by

HNL are medically appropriate for You, We shall cover some other FDA-approved prescription contraceptive method at no cost to You.

- Up to a 12-consecutive-calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order.
- **The Pharmacy Deductible does not apply to preventive drugs and women's contraceptives.**
- Some drugs may require Prior Authorization from HNL to be covered. You will be subject to a penalty of 50% of the Average Wholesale Price if Prior Authorization was not obtained, except for Emergency or Urgently Needed care.
- Generic or Brand Name Drugs not listed in the Essential Rx Drug List which are prescribed by Your Physician and not excluded or limited from coverage may be covered as an exception and are subject to the Tier 3 Drug Copayment or Coinsurance, as applicable. Specialty drugs not listed on the Essential Rx Drug List that are covered as an exception would be subject to the Tier 4 (specialty drug) coinsurance. Refer to "Prior Authorization and Exception Request Process" under the "Outpatient Prescription Drug Benefits" portion of the *Policy* for more information on the exception request process.
- 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. Maintenance Drugs on the Health Net Maintenance Drug List may also be obtained at a CVS retail pharmacy for up to a 90-day supply under the mail order program benefits. Maintenance drugs are also available for up to a 30-day supply from any participating retail pharmacy.
- Drugs on the Essential Rx Drug List when Medically Necessary for treating sexual dysfunction are limited to a maximum of 8 doses in any 30-day period.
- Specialty Drugs are not available through mail order. Most Specialty Drugs must be obtained through the Health Net contracted Specialty pharmacy.

CHILD NEEDS DENTAL OR EYE CARE

Pediatric Dental Services

Refer to the "Pediatric Dental Services" portion of the "Medical Benefits" section of this *Policy* for complete benefit information. The Calendar Year Deductible does not apply to these benefits.

All of the following services must be provided by a Health Net Participating Dental Provider in order to be covered. Refer to the "Child Needs Dental or Eye Care" portion of the "Medical Benefits" section for limitations on covered dental services.

Benefit Description	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Benefits	\$0, Deductible Waived
Preventive Benefits	\$0, Deductible Waived
Restorative Benefits	20%, Deductible Waived
Periodontal Maintenance Services (D4910)	20%, Deductible Waived
Endodontics	50%, Deductible Waived
Periodontics (other than Periodontal Maintenance (D4910))	50%, Deductible Waived
Maxillofacial Prosthetics	50%, Deductible Waived
Implant Services	50%, Deductible Waived
Prosthodontics (Removable)	50%, Deductible waived
Fixed Prosthodontics	50%, Deductible waived
Oral and Maxillofacial Surgery	50%, Deductible waived
Medically Necessary Orthodontics	50%, Deductible Waived
Adjunctive Services	50%, Deductible Waived

Pediatric Vision Services

We provide toll-free access to our Customer Service Associates to assist you with benefit coverage questions, resolving problems or changing your vision office. Customer Service can be reached Monday through Friday at **(866) 392-6058** from 5:00 a.m. to 8:00 p.m. Pacific Standard Time. Automated service is also provided after hours for eligibility verification and vision office transfers.

All of the following services must be provided by a Health Net Participating Vision Provider in order to be covered. Refer to the "Pediatric Vision Services" portion of the "General Exclusions and Limitations" section for limitation on covered vision services.

The vision services benefits are provided by Health Net. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the vision services benefits.

Routine eye exam limit: 1 per Calendar Year Exam Options: • Standard Contact Lens Fit including Follow-up visit (routine applications of soft, spherical daily wear contact lenses for single vision prescriptions) • Premium Contact Lens Fit including Follow-up visit (more complex applications, including, but not limited to toric, bifocal/multifocal, cosmetic color, post-surgical and gas permeable)	\$0 Copayment, Deductible Waived
Lenses limit: 1 pair per Calendar Year, including • Single vision, bifocal, trifocal, lenticular • Glass, or Plastic, including polycarbonate • Oversized and glass-grey #3 prescription sunglass lenses	\$0 Copayment, Deductible Waived
Provider selected frames limit: 1 per Calendar Year	\$0 Copayment, Deductible Waived
Optional Lenses and Treatments including • UV Treatment • Tint (Fashion & Gradient & Glass-Grey) • Standard Plastic Scratch Coating • Standard Polycarbonate • Photochromatic / Transitions Plastic • Standard, Premium and Ultra Anti-Reflective Coating • Polarized • Standard, Premium, Select, and Ultra Progressive Lens • Hi-Index Lenses • Blended segment Lenses • Intermediate vision Lenses • Select or ultra progressive lenses • Premium Progressive Lens	\$0 Copayment, Deductible Waived
Provider selected contact lenses, a one year supply is covered every Calendar Year (in lieu of eyeglass lenses): • Disposables • Conventional • Medically Necessary¹	\$0 Copayment, Deductible Waived
Subnormal or Low Vision Services and Aids - one comprehensive low vision evaluation every 5 years; low vision aids, including high-power spectacles, magnifiers or telescopes (limited to one aid per year) and follow-up care (limited to 4 visits every 5 years).	\$0 Copayment, Deductible Waived

¹ Medically Necessary Contact Lenses:

Contact Lenses may be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, Contact Lenses may be Medically Necessary and appropriate when the use of Contact Lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

Contact Lenses may be Medically Necessary for the treatment of conditions, including, but not limited to: keratoconus, pathological myopia, aphakia, anisometropia, aniridia, corneal disorders, post-traumatic disorders and irregular astigmatism.

Medically Necessary Contact Lenses are dispensed in lieu of other eyewear.

TERM OF *POLICY* AND PREMIUMS

A. TERM OF *POLICY* AND TERMINATION

Coverage for this *Policy* will commence on the date shown 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 30-day grace period. The Policyholder is liable for all Premiums due for the period coverage is in force.
- 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 eligibility.
- 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 eligibility.
- On midnight of the date 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 obtains or attempts to obtain benefits under this *Policy* by means of fraud or intentional misrepresentations of material fact with respect to claims under this *Policy*, HNL may cancel coverage upon 30-day written notice.
- If a Policyholder performs an act or practice constituting fraud or makes an intentional misrepresentation of material fact with respect to an application for coverage, HNL may rescind this *Policy* upon 30 days written notice to the Policyholder, within 24 months following issuance of the *Policy*. After 24 months following the issuance of the *Policy*, HNL will not cancel the *Policy*, limit any of the provisions of the *Policy*, or raise Premiums on the *Policy* due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not.

The Policyholder has the right to request a review by the California Insurance Commissioner if the Policyholder believes his or her health insurance policy has been or will be wrongly canceled, rescinded or not renewed. HNL's notice of intent to cancel, rescind or non-renew the *Policy* will include information on how the Policyholder may request review by the California Insurance Commissioner

- c. Offer to each affected Policyholder whose coverage is being discontinued, the option of replacing the discontinued plan with any other individual plan currently being offered by HNL in California, for which the Policyholder is eligible.

The written notice given by HNL to notify the Policyholder that coverage has terminated will be delivered to or mailed to the Policyholder at his/her last address as shown on HNL's records.

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. This *Policy* is guaranteed renewable and HNL may only non-renew or cancel coverage for nonpayment of Premiums.

D. CHANGES IN PREMIUMS

Premiums may be changed by HNL on at least 60 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 Calendar Year.

If a governmental authority (a) imposes a tax or fee that is computed on Premiums or (b) requires a change in coverage or administrative practice that increases HNL's risk, HNL may amend this *Policy* and increase the Premium sufficiently to cover the tax, fee or risk. The effective date shall be the date shown in a written notice from HNL to the Policyholder. The effective date shall become effective only upon renewal on the first day of the Calendar Year.

If this *Policy* is terminated for any reason, the Policyholder shall be liable for all Premiums for any time this *Policy* is in force.

E. GRACE PERIODS

A Grace Period of 30 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 HNL to cancel in accordance with the termination provision above). If the Policyholder fails to pay the required Premium when due, coverage could be canceled after a 30-day grace period. Before the 1st day of the grace period, HNL will send the Policyholder the Notice of Premium Delinquency, Grace Period and Intent to Nonrenew. During the

G. PAYMENT OF PREMIUMS

The Policyholder is responsible for payment of Premiums to HNL. Except for family members of the Policyholder or as required by law, HNL does not accept payments of Premiums on behalf of the Policyholder directly or indirectly from a Hospital, Home Health Care Agency, Hospice, Outpatient Surgical Center, Physician, Qualified Autism Provider, Residential Treatment Center, Skilled Nursing Facility, or other entities or persons which provide Covered Services and Supplies. An insurance agent or broker may remit payment of Premiums to HNL on behalf of the insured using only funds received from the insured or the insured's family members. HNL will not accept payment of Premiums remitted by an agent or broker using funds from financially interested third parties that are not authorized by law to pay Premiums on behalf of the insured. Upon discovery of any unacceptable payment described in this section, HNL will return it and inform the Policyholder that the payment is rejected and that the Premium remains due. A 30-day grace period will be allowed for payment of the Premium due, beginning on the date that HNL notifies the Policyholder that the payment was rejected. If HNL does not receive payment on or before the last day of the grace period, HNL will cancel coverage after the end of the grace period. Refer to the "Grace Periods" provision above for further information.

ELIGIBILITY AND ENROLLMENT

This *Policy* is subject to the Guaranteed Availability and Guaranteed Renewability rules of the Affordable Care Act (ACA).

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 the Covered Services and Supplies under this *Policy*, the Policyholder must reside in Our Service Area and must meet the following criteria:

- Not be incarcerated, other than incarceration pending the disposition of charges; and
- Apply for enrollment during an open enrollment period or during a special enrollment period as defined below under "Special Enrollment Periods." Open enrollment takes place October 15, 2018 to January 15, 2019, inclusive, then annually on and after January 1, 2019, from October 15 to January 15 of the following year, inclusive.

If You have end-stage renal disease and are eligible for Medicare, You remain eligible for enrollment in this plan until You are enrolled in Medicare. 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. Dependents can live outside the Service Area but must reside in the United States. The following types of Dependents describe those who may enroll in this *Policy*:

- Spouse: The legal spouse, as defined by California law.
- Domestic Partner: The registered Domestic Partner, as defined by California law.
- Children: The children of the Policyholder or the Policyholder's spouse or Domestic Partner (including legally adopted children, stepchildren and wards, as defined in the following provision), who are under 26 years of age. Coverage terminates on the last day of the Calendar Year in which the child turns 26 years of age unless the child is disabled.
- Wards: Children for whom the Policyholder or the Policyholder's spouse or Domestic Partner is a court-appointed guardian.
- Other child: Any child that You have assumed a parent-child relationship, in lieu of a parent-child relationship described above, as indicated by court order, intentional assumption of parental status, or assumption of parental duties by You, as certified by You at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled. Coverage terminates on the last day of the Calendar Year in which the child turns 26 years of age unless the child is disabled.

Disabled children 26 years of age and older

Following the disabled child's 28th birthday and no more often than annually thereafter, HNL may request that the Policyholder provide satisfactory evidence of the child's disability, and the Policyholder shall have 60 days to respond. A disabled child may remain covered by this plan for as long as he or she remains incapacitated and continues to meet the eligibility criteria described above.

Application for Coverage (Enrollment) and Effective Date for Newly Eligible Dependents

You are entitled to add newly eligible Dependents (subject to the applicable Premium payment) to this *Policy* as shown below:

- An application to add coverage for a newly married spouse or Domestic Partner will only be considered if we receive a completed application within sixty (60) days of marriage or Declaration of Domestic Partnership. Coverage shall begin on the first day of the month following the date the application for coverage is received. Other Dependents may also be added to the *Policy*.
- A newly adopted child, or a child who is being adopted, becomes eligible on the date of adoption or the date the Policyholder or his or her spouse or Domestic Partner receives physical custody of the child or the date of adoption or placement for adoption.

At the Policyholder's option, coverage begins effective either on (a) the date the Policyholder or his or her spouse or Domestic Partner receives physical custody of the child or the date of adoption or placement of adoption or (b) on the first day of the month following the date the Policyholder or his or her spouse or Domestic Partner receives physical custody of the child or the date of adoption or placement of adoption. Coverage will continue for 31 days from the date of eligibility. The Policyholder must enroll the child by the 60th day for coverage to continue beyond the first 31 days.

- Coverage for newborn children will be effective upon birth and will continue during the first thirty-one (31) days following birth. However, coverage after thirty-one (31) days is contingent upon the Policyholder enrolling the newborn within sixty (60) days following birth. Alternatively, the Policyholder may elect for coverage to begin on the first day of the month following the date of birth.
- If a court has ordered the Policyholder to provide coverage for an eligible Dependent, coverage will begin on the date the court order is effective or, at the option of the Policyholder, a date following enrollment. The Policyholder must enroll the eligible Dependent within sixty (60) days of the effective date of the court order and pay any required Premiums.

Special Enrollment Periods

- The individual or his or her Dependent gained access to new health plans as a result of a permanent move;
- The individual or his or her Dependent was receiving services under another health plan from a contracting provider, who no longer participates in that health plan, for any of the following conditions: (a) An acute condition (a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.); (b) A serious chronic condition (a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.); (c) A pregnancy (the three trimesters of pregnancy and the immediate postpartum period.); (d) A terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less.); (e) The care of a newborn between birth and age 36 months.; or (f) Performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a new Covered Person;
- The individual or his or her Dependent's enrollment or non-enrollment in the health benefit plan was unintentional, inadvertent or erroneous and is the result of the error, misrepresentation, misconduct or inaction of an officer, employee or agent of Covered California or the health benefit plan, or its instrumentalities as evaluated and determined by Covered California. In such cases, Covered California may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation or inaction;
- The individual or his or her Dependent demonstrates to the Exchange (Covered California), with respect to health plans offered through Covered California, or the California Department of Insurance, with respect to health plans offered outside the Exchange that the individual or his or her Dependent did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual or his or her Dependent because the individual or his or her Dependent were misinformed about being covered under minimum essential coverage;
- It is determined by Covered California on a case-by-case basis that the individual or enrollee, or his or her Dependents, was not enrolled as a result of misconduct on the part of a non-Covered California entity providing enrollment assistance or conducting enrollment activities.
- The individual or his or her Dependent adequately demonstrated to Covered California that the health benefit plan substantially violated a material provision of its contract in relation to the enrollee;
- The individual or his or her Dependent is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty under Title 32 of United States Code.
- The individual is a victim of domestic abuse or spousal abandonment, as defined by 26 Code of Federal Regulation 1.36B-2, including a dependent or unmarried victim within a household, are enrolled in minimum essential coverage and seek to enroll in coverage separate from the perpetrator of the abuse or abandonment. Dependents of the victim, who are on the same application as the victim, are also eligible to enroll at the same time as the victim.
- The individual or his or her Dependent applies for coverage through Covered California during the annual open enrollment period or

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*.

In addition, many of the Covered Services and Supplies listed herein are subject to Certification in many instances, prior to the expenses being incurred. If Certification is not obtained, the available benefits will be subject to the noncertification penalty as shown in the "Schedule of Benefits." Please refer to the "Certification Requirements" 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.

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

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.

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 Exclusions and Limitations," for details of any restrictions placed on the benefits.

TELEPHONE TRIAGE & SCREENING SERVICES

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

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 Maximum Allowable Amount as defined in the "Definitions" section.

Since the Out-of-Network Provider has **not** agreed to accept the Maximum Allowable Amount as payment in full, the amount billed by the Out-of-Network Provider may exceed the Maximum Allowable Amount. 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. Once the Maximum Allowable Amount is determined, the amount that HNL pays an Out-of-Network Provider and the amount which will be Your responsibility are determined as follows:

HNL pays an Out-of-Network Provider an amount equal to the Maximum Allowable Amount, less any Deductible(s), Copayments and/or Coinsurance applicable to the Covered Expense for the service or supply that You receive.

The portion of the Maximum Allowable Amount that will be Your responsibility is any Deductible(s), Copayments and/or Coinsurance applicable to the Covered Expense for the service or supply that You receive.

Unless the Out-of-Network Provider has agreed to accept the Maximum Allowable Amount as payment in full, as described in the definition of Maximum Allowable Amount, the amount billed by the Out-of-Network Provider may exceed the Maximum Allowable Amount. You will be responsible for that excess amount, in addition to any applicable Deductible(s), Copayments and/or Coinsurance payment required. In addition, You are always responsible for services or supplies not covered by this plan.

When Services are not Available through a Preferred Provider: If HNL determines that the Medically Necessary care you require is not available within the EnhancedCare PPO Preferred Provider network, HNL will authorize You to receive the care from an Out-of-Network Provider or facility and will arrange for the required medically appropriate care with an available and accessible Out-of-Network Provider or facility. Covered Services and Supplies received from Out-of-Network Providers under these circumstances will be payable at the Preferred Provider level of coverage. Cost-sharing paid at the Preferred Provider level of coverage will apply toward the in-network Deductible and accrue to the in-network Out-of-Pocket Maximum and You will not be responsible for any amounts in excess of the Maximum Allowable Amount. If you need access to medically

was given that would require the provider to change the estimate; (3) the consent shall advise You that You may elect to seek care from a Preferred Provider or may contact HNL in order to arrange to receive the health service from a Preferred Provider for lower out-of-pocket costs; (4) The consent shall also advise You that any costs incurred as a result of Your use of the Out-of-Network benefit shall be in addition to Preferred Provider cost-sharing amounts and may not count toward the annual Out-of-Pocket Maximum on Preferred Provider benefits or a Deductible, if any, for in-network benefits; and (5) the consent and estimate shall be provided in the language spoken by You, in certain circumstances.

For information regarding HNL's payment for Out-of-Network Emergency Care, please refer to the Maximum Allowable Amount definition in the "Definitions" section of this *Policy*.

Important Note: Even if a Hospital is a Preferred Provider, the Covered Person should not assume that all Physicians at the Hospital and other individual providers of health care are Preferred Providers. If you receive services from an Out-of-Network Provider at that Hospital or other facility, refer to "When Out-of-Network Services are received at an In-Network Health Facility" above for information on how those services are paid.

OUT-OF-POCKET LIMITS ON EXPENSES

When the Covered Person's total Copayments, Coinsurance, and Calendar Year Deductible payments for the medical, Prescription Drug, pediatric vision, and pediatric dental benefits, during any Calendar Year, equal the Out-of-Pocket Maximum shown in the "Schedule of Benefits" section, no further Deductibles, 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.)

Copayments or Coinsurance paid for the services of a Preferred Provider will not 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 not apply toward the Out-of-Pocket Maximum for Preferred Providers. However, Deductibles, Copayments or Coinsurance paid for Out-of-Network Emergency Care (including emergency medical transportation and emergency Hospital care) will be applied to the Out-of-Pocket Maximum for Preferred Providers.

MEDICAL DEDUCTIBLES

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Persons of the diabetic's family about the disease process, medical nutrition therapy, and the daily management of diabetic therapy.

In addition, HNL will cover tobacco cessation, asthma education, weight management classes and stress management classes that are provided by nonphysician providers.

Preventive Care Services

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

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

- U.S. Preventive Services Task Force Grade A & B recommendations (<http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>)
- The Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Center for Disease Control and Prevention (<http://www.cdc.gov/vaccines/schedules/index.html>)
- Guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA) (<https://www.hrsa.gov/womens-guidelines-2016/index.html>)
- For infants, children and adolescents, please refer to the American of Pediatrics Bright Futures Recommendations for Pediatric Preventive Health Care (<https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx>), and the Uniform Screening Panel recommended by the U.S. Department of Health and Human Services Secretary's Discretionary Advisory Committee on Heritable Disorders in New-born and Children (<http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/>)

Your Physician will evaluate Your health status (including, but not limited to, Your risk factors, family history, gender and/or age) to determine the appropriate Preventive Care Services and frequency. The list of Prevent

- USPSTF recommended obesity screening for adults. For obese adults, 12-26 sessions per year of intensive, multicomponent behavioral interventions are covered for weight management.
- USPSTF recommended healthy diet and physical activity counseling to prevent cardiovascular disease (CVD) for adults with cardiovascular risk factors. For adults who are overweight or obese and have an additional CVD risk factor (hypertension, dyslipidemia, impaired fasting glucose, or metabolic syndrome), 12-26 sessions per year of intensive behavioral counseling interventions to promote a healthful diet and physical activity.
- Group and individual counseling sessions for weight management; other weight management intervention services, including behavioral management activities, such as setting weight-loss goals; improving diet or nutrition and increasing physical activity; addressing barriers to change; self-monitoring; and strategizing how to maintain lifestyle changes
- Developmental screenings to diagnose and assess potential developmental delays
- Counseling on such topics as quitting smoking, lactation, losing weight, eating healthfully, and prevention of sexually-transmitted diseases
- Smoking cessation intervention services, including behavioral management activities, tailored self-help materials, and tobacco cessation counseling sessions. We provide coverage for 4 in-person, 10-minute long individual or group counseling sessions, as well as 3 telephone counseling sessions. For information regarding smoking cessation behavioral modification support programs available through HNL, contact the Customer Contact Center at the telephone number on the HNL ID card or visit Our website at www.myhealthnetca.com
- Alcohol misuse: screening and counseling, including brief behavioral counseling interventions
- Routine immunizations against diseases such as measles, polio, or meningitis
- Flu and pneumonia shots
- Vaccination for acquired immune deficiency disorder (AIDS) that is approved for marketing by the FDA and that is recommended by the United States Public Health Service
- Counseling, screening, and immunizations to ensure healthy pregnancies
- Regular well-baby and well-child visits
- Well-woman visits
- Routine prenatal and preventive postnatal care office visits

Preventive Care Services for women also include screening for gestational diabetes; sexually-transmitted infection counseling; human immunodeficiency virus (HIV) counseling; all FDA-approved contraceptive drugs, devices, and other products for women, including all FDA-approved contraceptive drugs, devices, and other products available over-the-counter (including, but not limited to, IUDs, injectable and implantable contraceptives) and contraceptive counseling (including, but not limited to, follow-up and management of side effects of contraceptives, counseling for continued adherence and contraceptive device placement and removal); sterilization procedures, breastfeeding support and lactation consultation, supplies and counseling; and domestic violence screening and counseling.

One breast pump and the necessary supplies to operate it (as prescribed by Your

TESTS

Diagnostic Imaging (Including X-Ray) and Laboratory Procedures

All Medically Necessary prescribed diagnostic imaging (including X-ray) and laboratory procedures, services and materials, including cancer screening tests; mammography for purposes other than Preventive Care Services; electrocardiography; electroencephalography; ultrasounds; effectiveness of dialysis; fecal occult blood test; tests for specific genetic disorders for which genetic counseling is available; CT and PET scans; MRIs; ultraviolet light treatments; and bone density scans (CT and DEXA). Mammography and genetic testing for purposes of Preventive Care Services and human immunodeficiency virus (HIV) screening are covered under the "Preventive Care Services" provision in this section.

OUTPATIENT SURGERY AND SERVICES

Professional Surgical Services

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

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

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

Certification may be required. Please refer to the "Certification Requirements" section of this *Policy* for details. Payment of benefits for some outpatient facility services will be subject to the noncertification penalty shown in the "Schedule of Benefits" if Certification is required but 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. Certification will be required.

Outpatient Surgical Center

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

Certification may be required for outpatient surgery, including Outpatient Surgical Center and professional surgical services. Please refer to the "Certification Requirements" section of this *Policy* for details. Payment of benefits for outpatient surgery will be subject to the noncertification penalty as shown in the "Schedule of Benefits" if Certification is required but not obtained.

Outpatient Infusion Therapy

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

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

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

Covered supplies include inject

Radiation Therapy, Chemotherapy and Renal Dialysis Treatment

Radiation therapy and nuclear medicine, chemotherapy and renal dialysis treatment are covered when Medically Necessary. We also cover inpatient dialysis; routine outpatient visits with multidisciplinary nephrology team for a consultation, exam, or treatment; hemodialysis; and home hemodialysis and peritoneal dialysis and necessary equipment and medical supplies provided the Covered Person receives appropriate training at a dialysis facility.

Please notify HNL upon initiation of renal dialysis treatment.

Certification is required for radiation therapy. Please refer to the "Certification Requirements" section of this *Policy* for details. Payment of benefits for radiation therapy will be subject to the noncertification penalty as shown in the "Schedule of Benefits" if Certification is required but not obtained.

Organ, Tissue And Stem Cell Transplants

Organ, tissue and stem cell transplants that are not Experimental or Investigational are covered only if the transplant is authorized and certified by HNL. The transplant must be Medically Necessary and the Covered Person must qualify for the transplant. Please refer to the "Certification Requirements" section for information on how to obtain Certification.

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

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

- For the enrolled Covered Person who receives the transplant, and
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Please refer to "Emergency Care" in the "Definitions" section to see how the prudent layperson standard applies to the definition of "Emergency Care."

Emergency Care is available and accessible to all Covered Persons in the Service Area 24 hours a day, seven days a week. Emergency Care is also covered outside the Service Area, including outside the United States. See "Foreign Travel or Work Assignment" in the "General Provisions" section for more details. Please see the "Schedule of Benefits" for the applicable Copayments.

Urgent Care

Urgent Care is covered as long as services would have otherwise been covered under this *Policy*.

Ambulance Services

Air or ground Ambulance and Ambulance transport services provided through a Preferred Provider or an Out-of-Network Provider as a result of a **911** emergency response system call will be covered, when either of the following conditions apply:

- The request was made for an emergency medical condition and Ambulance transport services were required; or
- The Covered Person reasonably believed that his or her medical condition was an emergency medical condition and required Ambulance transport services.

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

Non-emergency Ambulance and psychiatric transport van services are covered if a Physician determines that the Covered Person's condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger the Covered Person's health. Services are only covered when the vehicle transports insured to or from covered services. Non-emergency ambulance services do not include transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), even if it is the only way to travel to a provider.

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- Other diagnostic, therapeutic and rehabilitative services, as appropriate;
- Biologicals and radioactive materials;
- Anesthesia and oxygen services,
- Durable Medical Equipment and supplies;
- Medical social services;
- 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;
- 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; and
- Coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

Certification is required for Hospital stay, including the facility and some services received while admitted to the Hospital. Please refer to the "Certification Requirements" section for details. Payment of benefits for Hospital facility stay will be subject to the noncertification penalty as shown in the "Schedule of Benefits" if Certification is not obtained.

Bariatric (Weight Loss) Surgery

Bariatric surgery (modifying the gastrointestinal tract to reduce nutrient absorption) provided for the treatment of obesity is covered when Medically Necessary and the Covered Person has completed a pre-surgical education program. The surgery must be authorized by HNL and performed at a Bariatric Surgery Performance Center by an HNL Bariatric Surgery Performance Center network surgeon who is affiliated with the HNL Bariatric Surgery Performance Center. Providers that are not designated as part of HNL's network of Bariatric Surgery Performance Centers are considered Out-of-Network Providers, even if they have a contract with HNL, for purposes of determining coverage and benefits for weight loss surgery and are not covered.

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

- Other reasonable expenses not to exceed \$25 per day, up to two (2) days per trip for the pre-surgical work-up visit, pre-surgical visit and follow-up visit and up to four (4) days for the surgery visit.

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

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

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

If You disagree with a determination by HNL, You can appeal the determination. The complaint and appeals process, including independent medical review from the California Department of Insurance, is described in the "Grievance and Appeals Process" and "Independent Medical Review of Grievances Involving a Disputed Health Care Service" sections of this *Policy*. You may also call HNL at the telephone number on Your ID card.

Radiation Therapy, Chemotherapy and Renal Dialysis Treatment

Radiation therapy and nuclear medicine, chemotherapy and renal dialysis treatment are covered when Medically Necessary. We also cover inpatient dialysis; routine outpatient visits with multidisciplinary nephrology team for a consultation, exam, or treatment; hemodialysis; and home hemodialysis and peritoneal dialysis and necessary equipment and medical supplies provided the Covered Person receives appropriate training at a dialysis facility.

Please notify HNL upon initiation of renal dialysis treatment.

Certification is required for radiation therapy. Please refer to the "Certification Requirements" section of this *Policy* for details. Payment of benefits for radiation

If You disagree with a determination by HNL, You can appeal the determination. The complaint and appeals process, including independent medical review from the California Department of Insurance, is described in the "Grievance and Appeals Process" and "Independent Medical Review of Grievances Involving a Disputed Health Care Service" sections of this *Policy*. You may also call HNL at the telephone number on Your ID card.

MENTAL HEALTH, BEHAVIORAL HEALTH OR SUBSTANCE ABUSE NEEDS

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

Provider services for Mental Disorders and Chemical Dependency benefits are administered by MHN Services, an affiliate behavioral health administrative services company which contracts with HNL to administer these benefits.

Telehealth services for Mental Disorders and Chemical Dependency are provided by Teladoc as described under "Teladoc Consultation Telehealth Services" in this "Medical Benefits" section.

The list of services subject to Certification appears in the "Certification Requirements" section. Payment of benefits for Covered Services will be subject to the noncertification penalty as shown in the "Schedule of Benefits" if Certification is required but not obtained prior to the services being rendered.

The following benefits are provided:

The diagnosis of and all Medically Necessary treatment of Mental Disorders and Chemical Dependency, including Severe Mental Illness of a person of any age, and Serious Emotional Disturbances of a Child are covered by this *Policy*.

Serious Emotional Disturbances of a Child (SED) - The treatment and diagnosis of Serious Emotional Disturbances of

Covered services include:

- Outpatient office visits for Mental Disorders, including gender dysphoria, and Chemical Dependency to Physicians and other licensed providers, as described in this *Policy*: Includes outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy, individual and group mental health evaluation and treatment, medication management and drug therapy monitoring, and in connection with gender dysphoria: physician office visits for hormone therapy (including hormone injections);
- Outpatient services other than office visits for Mental Disorders, including gender dysphoria, and Chemical Dependency, as ordered by a Physician or other licensed provider described in this *Policy*: Includes psychological and neuropsychological testing when necessary to evaluate a Mental Disorder, intensive outpatient care program, day treatment programs, partial hospitalization programs, medical treatment for withdrawal symptoms and other outpatient procedures, and in connection with gender dysphoria: fertility preservation, speech therapy, and surgical services (such as hysterectomy, ovariectomy and orchiectomy, breast surgery, genital surgery, mastectomy, and reconstructive surgery i.e. facial reconstruction);
- Intensive outpatient care program is a treatment program that is utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week;
- Partial hospitalization/day treatment program is a treatment program that may be free-standing or Hospital-based and provides services at least four (4) hours per day and at least four (4) days per week;
- Intensive psychiatric treatment programs, including short-term Hospital-based intensive outpatient care (partial hospitalization), short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program, short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis, and psychiatric observation for an acute psychiatric crisis;
- Outpatient professional services for behavioral health treatment are covered as shown in the "Schedule of Benefits" section under "Mental Health, Behavioral Health or Substance Abuse Needs." Behavioral Health Treatment (BHT) for Pervasive Developmental Disorder or Autism:
 - Professional services for behavioral health treatment including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of a Covered Person diagnosed with the Severe Mental Illnesses of pervasive developmental disorder or autism are covered as shown in the "Schedule of Benefits" section under "Mental Health, Behavioral Health or Substance Abuse Needs".
 - A licensed Physician or licensed psychologist must establish the diagnosis of

Covered Services and Supplies include:

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

Detoxification - Inpatient services for acute detoxification and treatment of acute medical conditions relating to Chemical Dependency are covered. Inpatient detoxification includes hospitalization only for medical management of withdrawal symptoms, including room and board, Physician services, drugs, dependency recovery services, education and counseling.

PREGNANCY

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

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

Breastfeeding support and lactation consultation, supplies and counseling, as supported by the Health Resources and Services Administration (HRSA) guidelines, are covered as preventive care.

Please notify HNL at the time of the first prenatal visit.

HELP RECOVERING OR OTHER SPECIAL HEALTH NEEDS

Home Health Care Services

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

Home Health Care Services include diagnostic and treatment services which can reasonably be provided in the home, including nursing care, performed by a registered nurse, public health nurse, licensed vocational nurse or certified home health aide. House calls by a Physician or registered nurse are covered when care can best be provided in the home as determined by the Physician.

Home Health Care Services must be ordered by Your Physician. The following conditions must be met in order to receive Home Health Care Services:

- The skilled nursing care is appropriate for the medical treatment of a condition, illness, disease or injury;
- The Covered Person is homebound (this means that the Covered Person is normally unable to leave home unassisted, and, when the Covered

acupressure, occupational therapy, speech therapy, cardiac therapy, pulmonary therapy, inhalation therapy, Durable Medical Equipment and Prostheses. Certification is required for physical therapy, occupation therapy, speech therapy, Durable Medical Equipment and Prostheses, as described in the "Certification Requirements" section.

Payment of benefits for habilitative services will be subject to the noncertification penalty as shown in the "Schedule of Benefits" if Certification is not obtained.

If You disagree with a determination by HNL, You can appeal the determination. The complaint and appeals process, including independent medical review from the California Department of Insurance, is described in the "Grievance and Appeals Process" and "Independent Medical Review of Grievances Involving a Disputed Health Care Service" sections of this *Policy*. You may also call HNL at the telephone number on Your ID card.

Cardiac Rehabilitation Therapy

Medically Necessary cardiac rehabilitation therapy is provided in accordance with the "Schedule of Benefits" section, except as stated in the "General Exclusions and Limitations" section.

Pulmonary Rehabilitation Therapy

Pulmonary rehabilitation therapy provided in connection with the treatment of chronic respiratory impairment is covered, when Medically Necessary, in accordance with the "Schedule of Benefits" section, except as stated in the "General Exclusions and Limitations" section.

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:

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

- Tracheostomy equipment: artificial larynx; replacement battery for artificial larynx; tracheoesophageal voice prosthesis; tracheostomy supplies, including: adhesive disc, filter, inner cannula, tube, tube plug/stop, tube collar/holder, cleaning brush, mask, speaking valve, gauze, sterile water, waterproof tape, and tracheostomy care kits;
- Canes and crutches: adjustable and fixed canes, including standard curved handle and quad canes; adjustable and fixed crutches, including underarm and forearm crutches; replacement supplies for canes and crutches, including handgrips, tips and underarm pads;
- Dry pressure pad for a mattress;
- Cervical traction equipment (over door);
- Osteogenesis stimulation devices: non-invasive electrical osteogenesis stimulators, for spinal and non-spinal applications; non-invasive low density ultrasound osteogenesis stimulator;
- Respiratory drug delivery devices: large and small volume nebulizers; disposable and non-disposable administration sets; aerosol compressors; aerosol mask; disposable and non-disposable corrugated tubing for nebulizers; disposable and non-disposable filters for aerosol compressors; peak expiratory flow rate meter; distilled water for nebulizer; water collection device for nebulizer;
- IV Pole;
- Enteral and parenteral nutrition: enteral formula and additives, adult and pediatric, including for inherited diseases of metabolism; enteral feeding supply kits; enteral nutrition infusion pump; enteral tubing; gastrostomy/jejunostomy tube and tubing adaptor; nasogastric tubing; parenteral nutrition infusion pump; parenteral nutrition solutions; stomach tube; supplies for self-administered injections;
- Phototherapy (bilirubin) light with photometer;
- Lymphedema garments;
- Non-segmental

We also cover up to two Medically Necessary Contact Lenses per eye (including fitting and dispensing) in any 12-month period to treat conditions of aniridia (missing iris). An aniridia Contact Lens will not be covered if we covered more than one aniridia contact lens for that eye within the previous 12 months.

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

Breastfeeding devices and supplies, including Hospital-grade breast pumps and double breast pump kit, as supported by HRSA guidelines, are covered as Preventive Care Services. We will determine the type of equipment, whether to rent or purchase the equipment, and the vendor. For additional information, please refer to the "Preventive Care Services" provision in this "Medical Benefits" section.

Diabetic Equipment

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

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

* These items (as well as insulin and Prescription Drugs for the treatment and management of

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

In addition, the following prostheses are covered:

- If all or part of a breast is surgically removed for Medically Necessary reasons, reconstructive surgery and a prosthesis incident to the mastectomy (including lumpectomy), including custom-made prostheses when Medically Necessary; adhesive skin supports for external prostheses and brassieres to hold a breast prosthesis;
- Intraocular lenses, cochlear implants and osseointegrated hearing devices;
- Prostheses to replace all or part of an external facial body part that has been removed or impaired by disease, injury or congenital defect; Medically Necessary compression burn garments and lymphedema wraps; light compression bandage; manual compression bandage; moderate compression bandage;
- Prostheses for restoring a method of speaking following a laryngectomy; and
- Ostomy and urological supplies, including the following:
 - Adhesives - liquid, brush, tube, disc or pad
 - Adhesive removers
 - Belts - ostomy
 - Belts - hernia
 - Catheters
 - Catheter Insertion Trays
 - Cleaners
 - Drainage Bags/Bottles - bedside and leg
 - Dressing Supplies
 - Irrigation Supplies
 - Lubricants
 - Miscellaneous Supplies - urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; soma caps tape; colostomy plugs; ostomy inserts; irrigation syringes, bulbs and pistons; tubing; catheter clamps, leg straps and anchoring devices; penile or urethral clamps and compression devices
 - Pouches - urinary, drainable, ostomy
 - Rings - ostomy rings
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health agency with federal I certification and must provide interdisciplinary team care with development and maintenance of an appropriate plan of care.

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

- All Medically Necessary services and supplies furnished by the Hospice. This includes doctors' and nurses' services; homemaker services and drugs; and incontinence supplies;
- Bereavement services;
- Social and counseling services with medical social services provided by a qualified social worker. Dietary counseling, when necessary, provided by a qualified provider;
- Medical direction with the medical director also responsible for meeting general medical needs to the extent that these needs are not met by the attending Physician;
- Volunteer services;
- Short-term inpatient care;
- Physical, occupational and speech therapy for the purposes of symptom control or enable the Covered Person to maintain activities of daily living and basic functional skills;
- During periods of crisis (a period in which the Covered Person requires continuous care to achieve palliation or management of acute medical symptoms), nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain the Covered Person at home. Hospitalization will be covered when inpatient skilled nursing care is required at a level that cannot be provided in the home; and
- 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.

All of these services and supplies will be provided or arranged by the Hospice.

Payment of benefits

"Schedule of Benefits" section as would be required for covered services to treat any illness or condition under this *Policy*.

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

Implanted Lens(es) Which Replace the Organic Eye Lens

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

Reconstructive Surgery

Reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or diseases, including gender dysphoria, to

Osteoporosis

HNL shall provide coverage for services related to diagnosis, treatment, and appropriate management of osteoporosis including, but not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate.

Degenerative Illness

HNL shall provide coverage for Covered Persons diagnosed as having any significant destruction of brain tissue with resultant loss of brain function (progressive, degenerative, and dementing illnesses such as Alzheimer's disease).

Dental Injury

"Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Routine patient care costs" are the costs associated with the provision of health care services, including drugs, items, devices and services that would otherwise be covered under this *Policy*, if those health care services were not provided in connection with a clinical trials program.

Routine patient care costs include the following:

- Health care services typically provided absent a clinical trial.
- Health care services required solely for the provision of the Investigational drug, item, device or service.
- Health care services required for the clinically appropriate monitoring of the Investigational item or service.
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Dependency conditions and can also prescribe certain medications. You do not need to contact Your Primary Care Physician prior to using Teladoc consultation services.

Teladoc consultation services may be obtained by calling **1-800-TELADOC (800-835-2362)** or visiting <http://www.teladoc.com/hn>. Before Teladoc services may be accessed, You must complete a Medical History Disclosure (MHD) form, which can be completed online at Teladoc's website at no charge or printed, completed and mailed or faxed to Teladoc.

Prescription Drug Orders received from a Teladoc Physician are subject to the applicable Deductible, Copayment or Coinsurance shown in the "

ordinarily lower than the provider's billed charge. In no event, will You be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

A Network provider cannot charge You or us for any service or supply that is not Medically Necessary as determined by us. If You agree to receive a service or supply that is not Medically Necessary the Network provider may charge You. However, these charges will not be considered Covered Dental Services and Benefits will not be payable.

Covered Dental Services

Benefits are available only for Medically Necessary Dental Services. The fact

D0210	Intraoral – complete series of radiographic images
D0220	Intraoral – periapical first radiographic image
D0230	Intraoral – periapical each additional radiographic image
D0240	Intraoral – occlusal radiographic image
D0250	Extraoral – first radiographic image
D0251	Extra-oral posterior dental radiographic image
D0270	Bitewing – single radiographic image
D0272	Bitewings – two radiographic images
D0273	Bitewings – three

D2331	Resin-based composite – two surfaces, anterior
D2332	Resin-based composite – three surfaces, anterior
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)
D2390	Resin-based composite crown, anterior
D2391	Resin-based composite – one surface, posterior
D2392	Resin-based composite – two surfaces, posterior
D2393	Resin-based composite – three surfaces, posterior
D2394	Resin-based composite – four or more surfaces, posterior

D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)
D3330	Endodontic therapy, molar tooth (excluding final restoration)
D3331	Treatment of root canal

D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clas
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