CERTIFICATE OF INSURANCE

A complete explanation of your plan

EPO (Plan 2G8) EOCID:193004

For University of California non-Medicare members in the Imperial and San Luis Obispo Counties
Effective 1/1/2008

Important benefit information – please read

Health Net®
LIFE INSURANCE COMPANY

Dear Health Net Life Covered Person:

This is Your new Health Net Life EPO Certificate of Insurance.

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

Thank You for choosing Health Net Life.

Schedule changes in 2008

This page is not an official statement of benefits. Your benefits are described in detail in the *Evidence of Coverage*. We have also edited and clarified language throughout the *Evidence of Coverage* in addition to the items listed below.

Changes to this Plan

Mental Health and Substance Abuse Services

- Mental Health and Substance Abuse services will now be administered by United Behavior Health.

Schedule of Benefits and Copayments

- Amended text to show **"Periodic health evaluations"** at $0, under the **"Office Visits"** section (2008 benefit change).
- Amended text to show **"Other Immunizations"** at $0, under the **"Allergy, Immunizations, and Injections"** section (2008 benefit change).
- Amended text for "Smoking Cessation Drugs," to $20, under the **"Retail Pharmacy (up to a 30 day supply)"** section, under the **"Prescription Drug Benefits"** section (2008 benefit change).

UNIVERSITY OF CALIFORNIA
ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS
January 1, 2008

The following information applies to the University of California plan and supersedes any corresponding information that may be contained elsewhere in the document to which this insert is attached. The University establishes its own medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations ("Regulations") and any corresponding Administrative Supplements. Portions of these Regulations are summarized below.

ELIGIBILITY

The following individuals are eligible to enroll in this Plan. If the Plan is a Health Maintenance Organization (HMO) or Exclusive Provider Organization (EPO) Plan, they are only eligible to enroll in the plan if they meet the Plan's geographic service area criteria. Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health plan.

Subscriber

Employee: You are eligible if you are appointed to work at least 50% time for twelve months or more or are appointed at 100% time for three months or more or have accumulated 1,000***** hours while on pay status in a twelve-month period. To remain eligible, you must maintain an average regular paid time****** of at least 17.5 hours per week and continue in an eligible appointment. If your appointment is at least 50% time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

* Lecturers - see your benefits office for eligibility.

****** Average Regular Paid Time - For any month, the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked in the preceding twelve (12) month period. Average regular paid time does not include full or partial months of zero paid hours when an employee works less than 43.75% of the regular paid hours available in the month due to furlough, leave without pay or initial employment.

Retiree: A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

You may continue University medical plan coverage as a Retiree when you start collecting retirement or disability benefits from a University-sponsored defined benefit plan. You must also meet the following requirements:

(a) you meet the University's service credit requirements for Retiree medical eligibility;
(b) the effective date of your Retiree status is within 120 calendar days of the date employment ends (or the date of the Employee/Retiree's death for a Survivor); and
(c) you elect to continue medical coverage at the time of retirement.

A **Survivor—**a deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan—may be eligible to continue coverage as set forth in the University's Group Insurance Regulations. For more information, see the UC *Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members*.

If you are eligible for Medicare, you must follow UC's Medicare Rules. See "Effect of Medicare on Retiree Enrollment" below.

Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), adoption records, Federal Income Tax Return, or other official documentation.

Spouse: Your legal spouse.

Child: All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors. The following categories are eligible:

(a) your natural or legally adopted children;
(b) your stepchildren (natural or legally adopted children of your spouse) if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
(c) grandchildren of you or your spouse if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
(d) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental disability may continue to be covered past age 23 provided:

- the incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous;
- the child is claimed as your dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income; and
- the child lives with you if he or she is not your or your spouse's natural or adopted child.

Application must be made to the Plan at least 31 days before the child's 23rd birthday and is subject to approval by the Plan. The Plan may periodically request proof of continued disability. Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an incapacitated child, you may also apply for coverage for that child. The child must have had continuous group medical coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility.

Other Eligible Dependents (Family Members)

You may enroll a same-sex domestic partner (and the same -sex domestic partner's children/grandchildren/stepchildren) as set forth in the University of California Group Insurance Regulations.

The University will recognize an opposite-sex domestic partner as a family member that is eligible for coverage in UC-sponsored benefits if the employee/retiree or domestic partner is age 62 or older and eligible to receive Social Security benefits and both the employee/retiree and domestic partner are at least 18 years of age.

An adult dependent relative is no longer eligible for coverage. Only an adult dependent relative
who was enrolled as an eligible dependent as of December 31, 2003 may continue coverage in UC-sponsored plans.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Survivor or a Family Member, but not under any combination of these. If an Employee and the Employee's spouse or domestic partner are both eligible Subscribers, each may enroll separately or one may cover the other as a Family Member. If they enroll separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's or eligible domestic partner's coverage but not under both. Additionally, a child who is also eligible as an Employee may not have dual coverage through two University-sponsored medical plans.

More Information

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's Customer Service Center. You may also access eligibility factsheets on the web site: http://atyourservice.ucop.edu.

ENROLLMENT

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are a Retiree, contact the University's Customer Service Center. Enrollment transactions may be completed by paper form or electronically, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

If you are an Employee, you may enroll yourself and any eligible Family Members during your PIE. Your PIE starts the day you become an eligible Employee.

You may enroll any newly eligible Family Member during his or her PIE. The Family Member's PIE starts the day your Family Member becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family members are only eligible for the same plan in which you are enrolled.

(a) For a spouse, on the date of marriage.

(b) For a natural child, on the child's date of birth.
(c) For an adopted child, the earlier of:
  (i) the date you or your Spouse has the legal right to control the child's health care, or
  (ii) the date the child is placed in your physical custody.

  If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.

(d) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you decline enrollment for yourself or your eligible Family Members because of other group medical plan coverage and you lose that coverage involuntarily (or if the employer stops contributing toward the other coverage for you or your Family Members), you may be able to enroll yourself and those eligible Family Members during a PIE that starts on the day the other coverage is no longer in effect.

If you are in an HMO, POS or EPO Plan and you move or are transferred out of that Plan's service area, or will be away from the Plan's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan. Your PIE starts with the effective date of the move or the date you leave the Plan's service area.

At Other Times For Employees And Retirees
You and your eligible Family Members may also enroll during a group open enrollment period established by the University.

If you are an Employee and opt out of medical coverage or fail to enroll yourself during a PIE or open enrollment period, you may enroll yourself at any other time upon completion of a 90 consecutive calendar day waiting period.

If you are an Employee or Retiree and fail to enroll your eligible Family Members during a PIE or open enrollment period, you may enroll your eligible Family Members at any other time upon completion of a 90 consecutive calendar day waiting period.

The 90-day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits office and ends 90 consecutive calendar days later.

If you have one or more children enrolled in the Plan, you may add a newly eligible Child at any time. See "Effective Date".

If you are an Employee or a Retiree and there is a lifetime maximum for all benefits under this plan, and you or a Family Member reaches that maximum, you and your eligible Family Members may be eligible to enroll in another UC-sponsored medical plan. Contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan (or its Medicare version) you were enrolled in immediately before retiring. You must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin).

If you are a Survivor, you may not enroll your legal spouse or domestic partner.

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Effective Date

The following effective dates apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Family Members is effective the date the PIE starts.

If you are a Retiree continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.

An Employee or Retiree already enrolled in adult plus child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:

(a) the date the Child becomes eligible, or
(b) a maximum of 60 days prior to the date your Child's enrollment transaction is completed.

Change in Coverage

In order to change from single to adult plus child(ren) coverage, or two adult coverage, or family coverage, or to add another Child to existing family coverage, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Effect of Medicare on Retiree Enrollment

If you are a Retiree and you and/or an enrolled Family Member is or becomes eligible for premium-free Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous. This includes anyone who is entitled to Medicare benefits through their own or their spouse's employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan.

Retirees or their Family Member(s) who become eligible for premium-free Medicare Part A on or after January 1, 2004 and do not enroll in Part B will permanently lose their UC-sponsored medical coverage.

Retirees and their Family Members who were eligible for premium-free Medicare Part A prior to January 1, 2004, but declined to enroll in Part B of Medicare, are assessed a monthly offset fee by the University to cover increased costs. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B.

Retirees or Family Members who are not eligible for premium-free Part A will not be required to enroll in Part B, they will not be assessed an offset fee, nor will they lose their UC-sponsored medical coverage. Documentation attesting to their ineligibility for Medicare Part A will be required. (Retirees/Family Members who are not entitled to Social Security and premium-free Medicare Part A will not be required to enroll in Part B.)

An exception to the above rules applies to Retirees or Family Members in the following categories who will be eligible for the non-Medicare premium applicable to this plan and will also be eligible for the benefits of this plan without regard to Medicare:

a) Individuals who were eligible for premium-free Part A, but not enrolled in Medicare Part B prior to July 1, 1991.

b) Individuals who are not eligible for premium-free Part A.

You should contact Social Security three months before your or your Family Member's 65th birthday to inquire about your eligibility and how to enroll in the Hospital (Part A) and Medical (Part B) portions of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

Upon Medicare eligibility, you or your Family Member must complete a University of California Medicare Declaration form, as well as submit a copy of your Medicare card. This notifies the University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration form is available through the University's Customer Service Center or from the web site: http://atyourservice.ucop.edu. Completed forms should be returned to University of California, Human Resources and Benefits, Health & Welfare Administration-Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-9911.

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care Contract must assign his/her Medicare benefit to that plan or lose UC-sponsored medical coverage. Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health plan.

Medicare Secondary Payer Law (MSP)

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. UC Retirees re-hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For Employees or their spouses who are age 65 or older and eligible for a group health plan due to employment, MSP indicates that Medicare becomes the secondary payer and the employer plan becomes the primary payer. You should carefully consider the impact on your health benefits and premiums should you decide to return to work after you retire.

Medicare Private Contracting Provision and Providers Who do Not Accept Medicare
Federal Legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services **(that would otherwise be covered by Medicare)** from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners. These private agreements will require the beneficiary to be responsible for all payments to such medical providers. Since services provided under such "private contracts" are not covered by Medicare or this Plan, the Medicare limiting charge will not apply.

Some physicians or practitioners have **never** participated in Medicare. Their services (that would be covered by Medicare if they participated) will not be covered by Medicare or this Plan, and the Medicare limiting charge will not apply.

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage), are enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement as described above with one or more physicians or practitioners, or if you choose to obtain services from a provider who does not participate in Medicare, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. In either case, no benefits will be paid by this Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered. Therefore, it is important that you confirm that your provider takes Medicare prior to obtaining services for which you wish the Plan to pay.

However, even if you do sign a private contract or obtain services from a provider who does not participate in Medicare, you may still see **other** providers who have not opted out of Medicare and receive the benefits of this Plan for those services.

TERMINATION OF COVERAGE

The termination of coverage provisions that are established by the University of California in accordance with its Regulations are described below. Additional Plan provisions apply and are described elsewhere in the document.

Deenrollment Due to Loss of Eligible Status

If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month in which premiums are taken from earnings based on an eligible appointment.

If you are a Retiree or Survivor and your annuity terminates, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for an annuity.

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on deenrollment procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Deenrollment Due to Fraud

Coverage for you or your Family Members may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Such termination shall be effective upon the mailing of written notice to the Subscriber (and to the University if notice is given by the Plan). A Family Member who commits fraud or deception will be permanently deenrolled while any other Family Member and the Subscriber will be deenrolled for 12 months. If a Subscriber commits fraud or deception, the Subscriber and any Family Members will be deenrolled for 12 months.

Leave of Absence, Layoff or Retirement

Contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff or retirement.

Optional Continuation of Coverage

If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice "Continuation of Group Insurance Coverage", available from the University's "At Your Service" website (http://atyourservice.ucop.edu). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or to the University's Customer Service Center if you are a Retiree.

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PLAN ADMINISTRATION

By authority of the Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the Group Hospital and Professional Service Agreement. What is written in this document does not constitute a guarantee of plan coverage or benefits--particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plan is administered and what your rights are.

Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and administrator for the Plan described in this booklet. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
Health & Welfare Administration
300 Lakeside Drive, 12th Floor
Oakland, CA 94612
(800) 888-8267

Retirees may also direct questions to the University's Customer Service Center at the above phone number.

Claims under the Plan are processed by Health Net at the following address and phone number:

Health Net Commercial Claims
PO Box 14702
Lexington, KY 40512
1-800-539-4072

Group Contract Number

The Group Contract Number for this Plan are: 22185A, 22185B, 22185C, 22185D, 22185E, 22185F, 22185G, 22185H, 22185J, 22185K, 22185L, 22185M, 22185N, 22185Q, 22185R, 22185S, 22185T, 22185U, 22185V, 22185W, 22185X, 22185Y, 22185Z, 2218AA, 2218AB, 2218AC, 2218AD, 2218AD, 2218AE, 2218AF, 2218AG, 2218AH, 2218AJ, 2218AK, 2218AL, 2218AN, 2218AP, 2218AQ, 2218AQ, 2218AS, 2218AT, 2218AU, 2218AV, 2218AW, 2218AX, 2218AY

Type of Plan

This Plan is a health and welfare plan that provides group medical care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

Plan Year

The plan year is January 1 through December 31.

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Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premiums that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.

Financial Arrangements

The benefits under the Plan are provided by Health Net under a Group Service Agreement.

The plan costs are currently shared between you and the University of California.

Agent for Serving of Legal Process

Legal process may be served on Health Net at the address listed above.

Your Rights under the Plan

As a participant in a University of California medical plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the Group Service Agreement, at a time and location mutually convenient to the participant and the Plan Administrator.

- Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims under the Plan

To file a claim or to appeal a denied claim, refer to page 71 of this document.

Nondiscrimination Statement

In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

California Life and Health Insurance Guarantee Association Act Summary Document and Disclaimer

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the California Life and Health Insurance Guarantee Association ("CLHIGA"). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guarantee Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided through the Association is not unlimited, as noted in the box below, and is not a substitute for consumers' care in selecting insurers.

The California Life and Health Insurance Guarantee Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. ***However, insurance companies and their agents are prohibited by law from using the existence of the Guarantee Association to induce you to purchase any kind of insurance policy.***

Policyholders with additional questions should first contact their insurer or agent or may then contact:

California Life and Health Insurance Guarantee Association P.O. Box 17319 Beverly Hills, CA 90209-3319	or	Consumer Service Division California Department of Insurance 300 South Spring Street Los Angeles, CA 90013

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

COVERAGE

Generally, individuals will be protected by the California Life and Health Insurance Guarantee Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guarantee Association if:

- Their insurer was not authorized to do business in this state when it issued the policy or contract;
- Their policy was issued by a health care service plan (HMO), Blue Cross, Blue Shield, 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;
- They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.

The Guarantee Association also does not provide coverage for:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contract holders, not individuals;
- Employer and association plans, to the extent they are self funded or uninsured;
- Synthetic guaranteed interest contracts;
- 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 a variable contract sold by prospectus;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields that exceed an average rate;
- Any portion of a contract that provides dividends or experience rating credits.

LIMITS ON AMOUNTS OF COVERAGE

The Act limits the Association to pay benefits as follows:

LIFE AND ANNUITY BENEFITS

- 80% of what the life insurance company would owe under a life policy or annuity contract up to:
- $100,000 in cash surrender values,
- $100,000 in present value of annuities, or
- $250,000 in life insurance death benefits.

A maximum of $250,000 for any one member life no matter how may policies and contracts there were with the same company, even if the policies provided different types of coverages.

HEALTH BENEFITS

- A maximum of $200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

PREMIUM SURCHARGE

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for health insurance policies to which the Act applies.

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HEALTH NET LIFE EPO CERTIFICATE OF INSURANCE

ISSUED IN CONNECTION WITH THE HNL EPO GROUP INSURANCE POLICY

UNDERWRITTEN

BY

HEALTH NET LIFE INSURANCE COMPANY

Los Angeles, California

Benefits under this medical plan are restricted to the Health Net Life Exclusive Provider Organization (EPO) network within the Service Area defined under this section. This benefit plan does not provide benefits for services provided outside the Service Area, except for Emergency Care.

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

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

The HNL plan You have enrolled with provides benefits through an EPO network which consists of Participating Providers from whom You are required to obtain all medical care, services and supplies which are covered under this *Certificate*.

Participating Providers are providers who have agreed to participate in the HNL EPO network. They have agreed to provide Covered Persons with health care and to accept a special contracted rate, called the "Allowable Charge," as payment in full for services which are covered under this plan. Your share of the cost for covered services is based on that contracted rate.

Covered services under this HNL EPO *Certificate* are payable by HNL only when You access care, services or supplies from the designated Participating Providers of this HNL EPO plan.

HOW TO OBTAIN CARE

In addition to the requirement that benefits of this plan (except Emergency Care) must be provided by Participating Providers in order for the services to be payable under this *Certificate*, the provision of medical services must be coordinated by a Primary Care Physician (PCP) who is a Participating Provider in the HNL EPO network.

This means that all medical care and supplies which You obtain must be provided by, authorized by or arranged by Your PCP in order for the services to be Covered Expenses under this *Certificate*.

"Primary Care Physician (PCP)" means a Participating Provider who:

- Is responsible for providing initial and primary care;
- Maintains the continuity of patient care;
- Authorizes referrals for specialist care; and
- Is listed in HNL's Exclusive Provider Directory as a Primary Care Physician.

All Covered Persons enrolling in this plan must select a PCP to perform the functions listed above. Each Covered Person of the same family can make a personal choice of their PCP from the EPO Directory. If a Covered Person does not indicate a PCP selection at the time of enrollment HNL may, at its discretion, assign such Covered Person a PCP at a location accessible from the Covered Person's residence or work address.

A Covered Person may change PCP by calling or writing to the HNL Member Services Department at the number and address which appear on the HNL ID Card and on the last page of this *Certificate*. Changes requested before the 15th of the month are effective on the first day of the following month.

For information on providers who participate in the EPO program for this benefit plan, consult the Provider Directories that were included with Your enrollment kit/package. To obtain a copy of the Directory, please contact the Member Services Department at the telephone number on Your HNL ID Card or visit the HNL website at www.healthnet.com/uc.

CONTINUITY OF CARE

If the Covered Person is receiving ongoing medical care at the time he or she enrolls with HNL, and he or she is concerned about transferring their care to their selected PCP, HNL may temporarily cover all or part of the Covered Expenses for services from a provider not affiliated with HNL, subject to applicable Copayments and any other exclusions and limitations of this Plan and under the following requirement:

- Changing providers immediately will have a negative effect on the Covered Person's health; and
- The Covered Person's nonparticipating provider is willing to accept the standard provider contract terms and conditions.

If the Covered Person feels that his or her medical condition might require special attention as he or she switches to HNL, the Covered Person should tell his or her employer or a HNL representative prior to enrollment, and no later than 15 days from the Effective Date of his or her HNL coverage. To request a copy of HNL's continuity of care policy, Covered Persons may contact the Member Services Department at the telephone number on their HNL ID Card.

EMERGENCY CARE

In the event You should require Emergency Care, You should contact the office of the selected PCP for instructions as to where to obtain medical care.

A Covered Person who requires Emergency Care should call **911** or should seek care from the nearest available Hospital or emergency room facility:

- If unable to contact anyone at the PCP's office;
- If the emergency occurs outside the Service Area of the plan; or
- If the Covered Person reasonably believes the emergency presents imminent danger to life or limb.

Coverage will be provided for Covered Services and Supplies received from non-Participating Providers treating the emergency condition until such time as it is medically appropriate to return the care of the Covered Person to the PCP or other Participating Provider, as determined by HNL. Any follow up treatment by non Participating Provider(s) after such a determination by HNL will not be covered under this *Certificate*.

For additional information, please refer to the definition of Emergency Care in this *Certificate*.

Some Hospitals and other providers do not provide one or more of the following services that may be covered under this *Certificate* and that You might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. You should obtain more information before enrollment by calling Your prospective doctor, Participating Provider, or clinic, or by calling HNL's Member Services Department at 1-800-539-4072, to ensure that the health care services needed can be obtained.

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

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

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

NO BENEFITS ARE PAYABLE FOR SERVICES OR SUPPLIES FURNISHED BY PROVIDERS OTHER THAN THE DESIGNATED EPO PROVIDERS FOR THIS PLAN AS IDENTIFIED ABOVE.

Important Notice To California Certificateholders

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

Health Net Life Insurance Company
P.O. Box 10348
Van Nuys, CA 91049

1-800-539-4072

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

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

DEFINITIONS

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

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

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

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

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

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

Covered Expenses are the maximum charges for which HNL will pay benefits for each covered service or supply. Covered Expenses are the lesser of the billed charge or the Allowable Charge, for the services or supplies provided by a Participating Provider.

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

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

Custodial Care is care that is rendered to a patient to assist in support of the essentials of daily living such as help in walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets, and supervision of medications which are ordinarily self-administered, and which a 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 each Calendar Year for specified Covered Expenses before HNL pays any benefits for those Covered Expenses.

Defined Disease is any deviation from or interruption of the normal structure or function of any part, organ, or system (or combination thereof) of the body that is manifested by a characteristic set of symptoms and signs and whose etiology, pathology and prognosis are known.

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

Domestic Partner is a person eligible for coverage provided that the partnership with the Subscriber meets all domestic partnership requirements under California law or other recognized state or local agency.

The Domestic Partner and Subscriber must:

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

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

Durable Medical Equipment is equipment which: (i) can withstand repeated use, (ii) is primarily and customarily used to serve a medical purpose, (iii) is generally not useful to a person in the absence of illness or injury, and (iv) is appropriate for use in the home.

Effective Date is the date on which You become covered or entitled to benefits under this *Certificate*. The precise Effective Date can be determined by calling the Member Services Department at the telephone number that appears on the back cover of this *Certificate*.

Emergency Care is medically necessary when medical or Hospital services are required as a result of a medical condition manifesting itself by the sudden onset of acute symptoms of sufficient severity which may include severe pain, such that a layperson with an average knowledge of health and medicine would seek if he or she was having serious symptoms, and believed that without immediate treatment, any of the following would occur:

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

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

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

Emergency Care includes Ambulance and Ambulance transport services provided through the **911** emergency response system.

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

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

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

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

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

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

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

The University may hold Special Open Enrollment Periods in addition to the annual period in exceptional circumstances. For example: Financial insolvency of other carriers currently used by the University or loss of providers in the University's service areas.

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

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

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

Health Net Life Primary EPO (HNL EPO) is the Exclusive Provider Organization (EPO) plan described in this Group *Certificate*, which allows You to obtain medical benefits from the HNL network of Participating Providers.

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

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

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

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

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

Hospital is a legally operated facility defined as a Hospital and an institution licensed by the state where it is located and approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by Medicare.

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

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

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

Investigational approaches to treatment are those that have progressed to limited use on humans but which are not widely accepted as proven and effective procedures as determined by HNL. HNL will decide whether a service or supply is considered Investigational. This includes any services or supplies that are outmoded or not efficacious, such as those defined by the federal Medicare and state Medicaid programs or drugs and devices not approved by the U.S. Food and Drug Administration.

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

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

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

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

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

Neuromusculo-skeletal Disorders are conditions with associated signs and symptoms related to the nervous, muscular and/or skeletal systems. Neuromusculo-skeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders or biomechanical dysfunction of the joints. Of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related neurological manifestations or conditions.

Orthotic Devices are those devices which are rigid or semi-rigid, affixed to the body externally, and are required to support or correct a defect of form or function of a permanently inoperative or malfunctioning body part, or is required to restrict motion in a diseased or injured part of the body.

Out-Of-Network Providers are Physicians, Hospitals, or other providers of health care who are not part of the Health Net Life Exclusive Provider Organization (EPO).

Out-of-Pocket Maximum is the maximum dollar amount of Copayments and Coinsurance for which You must pay during a Calendar Year as shown in the "Schedule of Benefits and Copayments" section of this *Certificate*. After that maximum is reached, You will not be required to pay a share (Copayments or Coinsurance) of the cost of Covered Expenses during the remainder of the Calendar Year. However, You will be required to continue paying the designated share for certain Covered Expenses, as noted in the "Schedule of Benefits and Copayments" section even when the Out-of-Pocket Maximum has been reached. Any share of the cost paid for certain Covered Expenses, as noted in the "Schedule of Benefits and Copayments" section will not be credited toward Your Out-of-Pocket Maximum.

Pain means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder or condition. Pain includes low back Pain, post-operative Pain, and post-operative dental Pain.

Participating Providers are Physicians, Hospitals or other providers of health care who have a written agreement with HNL or who subcontract with HNL through another HNL contracting entity to participate in the Exclusive Provider Organization (EPO) network and have agreed to provide You with Covered Services and Supplies at a contracted rate (the Allowable Charge). You must pay any applicable Deductible(s), Copayment or Coinsurance required, but are not responsible for any amount charged in excess of the Allowable Charge. Participating Providers are listed in the Participating Provider Directory given to You upon enrollment and periodically updated.

Physician is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.).

Period of Initial Eligibility (PIE) is the period during which an Employee or Family Member may enroll without furnishing proof of insurability. The PIE begins the day the Employee or Family Member becomes eligible and ends 31 calendar days from the first date of eligibility (or the preceding business day if the 31st day is on a weekend or a holiday).

Preventive Health Care includes diagnostic preventive procedures and is covered at the member physician's direction. Coverage for periodic health evaluations and diagnostic preventive procedures is based on recommendations published by the U.S. Preventive Services Task Force. In addition, a covered annual cervical cancer screening test includes a Pap test, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA.

Primary Care Physician (PCP) is a Participating Provider who is responsible for providing initial and primary care, maintains the continuity of patient care, authorizes referrals for specialist care and is listed in HNL's Exclusive Provider Directory as a Primary Care Physician.

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

Service Area is the geographical area within which HNL markets and sells Group EPO insurance plans requiring selection of a PCP in the counties of Butte, Humboldt, Lake, Sutter, Yuba, Calaveras, Shasta and Tuolumne in California.

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 Your admission, the facility must be approved as a Participating Skilled Nursing Facility under the Medicare program where such standards are applicable.

Specialist is a Member Physician who delivers specialized services and supplies to the Member. Any Physician other than a obstetrician/gynecologist acting as a Primary Care Physician, general or family practitioner, internist or pediatrician is considered a Specialist. With the exception of well-woman visits to an obstetrician/gynecologist, all Specialist visits must be referred by your Primary Care Physician to be covered.

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

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

SCHEDULE OF BENEFITS AND COPAYMENTS

Health Net Life EPO

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

MEDICAL BENEFITS

As noted in the introduction to this *Certificate*, enrollment in this plan requires that selection of a PCP from the list of Participating Physicians who practice in the area of Your residence or employment as reflected in the HNL EPO Provider Directory.

In the role of PCP, the selected Physician will provide basic health services and other services which are listed in this *Certificate* as covered benefits. When Medically Necessary and appropriate for Your condition, the PCP will initiate, arrange and authorize all facility admissions and specialist care from other Participating Providers in the HNL EPO network.

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

COPAYMENTS AND COINSURANCE

You may be required to pay out-of-pocket charges for specific medical services and supplies. These charges are known as the Copayments and Coinsurance. The Copayments are fixed dollar amount charges that You are responsible for. Coinsurance is the percentage, shown below, of Covered Expenses (as defined) for which You are responsible.

Emergency or Urgently Needed Care in an Emergency Room or Urgent Care Center

	Copayment
Use of emergency room (facility and professional services)	$50
Use of urgent care center (facility and professional services)	$50

Copayment Exceptions

If You are admitted to a Hospital as an inpatient directly from the emergency room or urgent care center, the emergency room or urgent care center Copayment will not apply.

Office Visits

	Copayment
Visit to Physician, Physician Assistant, or Nurse Practitioner	$15
Specialist consultation	$15
Physician visit to Covered Person's home	$15
Periodic health evaluation	$0
Vision or hearing examination	$15

Note

Self-referrals are allowed for Obstetrician and Gynecological services.

Mental Health and Substance Abuse services are not included.

Vision and hearing screenings, provided as part of a periodic health evaluation, are covered at no charge.

Hospital Visits by Physician

	Copayment
Physician visit to Hospital or Skilled Nursing Facility	$0

Allergy, Immunizations and Injections

	Copayment
Allergy testing	$15
Allergy injection services	$15
Allergy serum	$0
Immunizations for occupational purposes or foreign travel	20%
Other immunizations	$0
Injections for Infertility	50%
All other injections (including hormonal therapy related to a Gender Identity Disorder (GID))	$15

Note

Self-administered medications (except insulin) are considered injectables that are covered under the medical benefit of the plan.

Injections for Infertility are covered only when provided in connection with services which are not covered by this *Certificate.* (Refer to "Conception by Medical Procedure" portion of the "General Limitations" section of this *Certificate*.)

Rehabilitation Therapy

	Copayment
Physical therapy	$15
Occupational therapy	$15
Speech therapy	$15
Respiratory therapy	$15

Note

These services will be covered when Medically Necessary.

Coverage for physical, occupational and speech rehabilitation therapy services is subject to certain limitations as described under the heading "Rehabilitative Therapy" of the "General Limitations" section of this *Certificate*.

Care for Conditions of Pregnancy

	Copayment
Prenatal or postnatal office visit	$0
Newborn care office visit (birth through 30 days)	$0
Physician visit to the mother or newborn at a Hospital	$0
Normal delivery, including Cesarean section	$0
Complications of pregnancy, including Medically Necessary abortions	$0
Elective abortions in Contracting Physician Group's office	$15
Elective abortions in Hospital	$0
Genetic testing of fetus	$0
Circumcision of newborn (birth through 30 days)	$0

Note

The above Copayments apply to professional services only. Services that are rendered in a Hospital are also subject to the Hospital services Copayment. Look under the "Inpatient Hospital Services" and "Outpatient Hospital Services" headings to determine any additional Copayments that may apply.

Family Planning

	Copayment
Infertility services (all covered services that diagnose, evaluate or treat Infertility)	50%
Sterilization of females in Contracting Physician Group's office	$15
Sterilization of females in Hospital	$0
Sterilization of males in Contracting Physician Group's office	$15
Sterilization of males in Hospital	$0
Contraceptive devices	Not covered
Norplant Device:	
Medically necessary removal	$60
Voluntary removal (requested by Member)	$60

Note

The above Copayments apply to professional services only. Services that are rendered in a Hospital are also subject to the Hospital services Copayment. Look under the "Inpatient Hospital Services" and "Outpatient Hospital Services" headings to determine any additional Copayments that may apply.

Infertility services are covered only for the HNL Covered Person.

Other Professional Services

	Copayment
Surgery in Hospital	$0
Surgery in Contracting Physician Group's office	$15
Transgender surgery	$0
Assistance at surgery in Hospital	$0
Assistance at surgery in Contracting Physician Group's office	$15
Administration of anesthetics	$0
Chemotherapy	$0
Laboratory and diagnostic imaging (including x-ray) services	$0
Medical social services	$0
Patient education	$0
Nuclear medicine (use of radioactive materials)	$0
Renal dialysis	$0
Organ, tissue, or bone marrow transplant	$0

Note

Surgery includes surgical reconstruction of a breast incident to a mastectomy, including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Transgender surgery requires prior authorization from HNL. Transgender surgery and services related to the surgery, that are authorized by HNL are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member. Reasonable travel, lodging and meal costs, as determined by HNL, for a Member to undergo an authorized transgender surgery are included within the lifetime benefit maximum.

Medical Supplies

	Copayment
Durable Medical Equipment (including face masks and tubing)	$0
Orthotics (such as bracing, supports and casts)	$0
Diabetic supplies	$0
Diabetic footwear	$0
Corrective footwear (for the treatment of conditions not related to diabetes)*	$0
Prostheses	$0
Blood or blood products	$0
Hearing Aids (2 standard Hearing Aids every 36 months up to $2,000 total benefit maximum)	50%

Note

Diabetic Supplies and orthotics which are covered under medical supplies include blood glucose monitors, insulin pumps and corrective footwear. Please refer to "Diabetic Equipment" in the "Medical Benefits" section.

A standard Hearing Aid is one that restores adequate hearing to the member and is determined to be Medically Necessary and authorized by the members Physician Group.

*Corrective footwear for the management and treatment of diabetes are covered under the "Diabetic Supplies" benefit as Medically Necessary.

Home Health Services

	Copayment
Home health visits	$0

Hospice Services

	Copayment
Hospice care	$0

Ambulance Services

	Copayment
Ground ambulance	$0
Air ambulance	$0

Inpatient Hospital Services

	Copayment
Room and board in a semi-private room or Special Care Unit including ancillary (additional) services	$250

Exception

The Copayment for a Hospital confinement for Infertility services is 50%.

Note

The above Copayment is applicable for each admission.

Inpatient Hospital Services for transgender surgery and services related to the surgery require prior authorization by HNL and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member.

Mental Health and Substance Abuse services are not included.

Outpatient Hospital Services

Outpatient facility services (other than surgery)	$0
Outpatient surgery (Hospital or outpatient surgical center charges only)	$0

Note

Other professional services performed in the outpatient department of a Hospital, such as a visit to a Physician (office visit), laboratory and X-ray services, physical therapy, etc., are subject to the same Copayment which is required when these services are performed at the Physician's office.

Look under the headings for the various services such as office visits, neuromuscular rehabilitation, and other professional services to determine any additional Copayments that may apply.

Diagnostic endoscopic procedures, such as diagnostic colonoscopy, performed in an outpatient facility require the Copayment applicable for outpatient facility services. If, during the course of a diagnostic endoscopic procedure performed in a Hospital or Outpatient Surgical Center, a therapeutic (surgical) procedure is performed, then the Copayment applicable for outpatient surgery will be required instead of the Copayment for outpatient facility services.

Use of a Hospital emergency room appears in the first item at the beginning of this "Schedule of Benefits and Copayments."

Outpatient Hospital Services for transgender surgery and services related to the surgery require Prior Authorization by HNL and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member.

Mental Health and Substance Abuse services are not included.

Skilled Nursing Facility Services

	Copayment
Room and board in a semiprivate room with ancillary (additional) services	$0

Limitation

Skilled Nursing Facility services are covered for up to a maximum of 100 days a Calendar Year for each Covered Person.

OUTPATIENT PRESCRIPTION DRUG BENEFITS

Refer to the **Note** below for clarification of Your financial responsibility regarding Deductible and Copayment.

	Copayment
Retail Pharmacy (up to a 30 day supply)	
Level I Drugs (primarily generic) listed in the Recommended Drug List	$10
Level II Drugs (primarily brand), peak flow meters, inhaler spacers, insulin and diabetic supplies when listed in the Recommended Drug List	$20
Level III Drugs (or drugs not listed in the Recommended Drug List)	$35
Lancets	$0
Appetite Suppressants	50%
Oral Infertility drugs	50%
Smoking cessation drugs	$20
Sexual dysfunction drugs (including injectable drugs) (up to two doses per week or eight tablets per month)	50%
Contraceptive devices (including diaphragms and cervical caps)	$20
Insulin	$20

The Level II Brand Name Drug Copayment will be applicable for all covered Diabetic Supplies.

Insulin needles and syringes will be dispensed in the amount required by your Physician for a 30-day period. You must pay one Copayment for the 30-day supply.

Blood Glucose monitoring test strips and lancets will be dispensed in 50-unit, 100-unit or 200-unit packages for each 30-day period. You must pay one Copayment for each package.

UC Walk-Up Service through UC Medical Center Pharmacies

Health Net and the UC Medical Center Pharmacies have partnered to offer UC members with the ability to fill up to a 90-day prescription for maintenance medications at any of the UC designated Medical Center Pharmacies. Just like Health Net's current Mail Order Program, members can now obtain up to a 90-day supply for only two copays, at one of the UC designated Medical Center pharmacies.

Maintenance Drugs through the Mail Order Program (up to a 90 day supply)

Level I Drugs (primarily generic) when listed in the Recommended Drug List $20
Level II Drugs (primarily brand), insulin and diabetic supplies when listed in the Recommended Drug List $40
Level III Drugs (or drugs not listed in the Recommended Drug List) $70

Note

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

Your financial responsibility for covered Prescription Drugs varies by the type of drug dispensed. For a complete description of Prescription Drug benefits, exclusions and limitations, please refer to "Prescription Drugs" portions of "Covered Services and Supplies" and "Exclusions and Limitations" sections.

Copayment Exceptions:

If the pharmacy's usual and customary charge is less than the applicable Copayment, You will only pay the pharmacy's usual and customary charge.

Generic Drugs will be dispensed when a Generic Drug equivalent is available, unless the Prescription Drug Order states "do not substitute," "dispense as written," or words of similar meaning in the Physician's handwriting, in which case the specified drug will be dispensed. However, when a Generic Drug equivalent is available and a Brand Name Drug is dispensed at Your request, You must pay the following:

- The Level I Drug Copayment, plus
- The difference between the cost of the Generic Drug and the Brand Name Drug

However, if the Prescription Drug Order states "do not substitute," "dispense as written," or words of similar meaning in the Physician's handwriting, only the Level II or Level III Drug Copayment, as appropriate, will be applicable.

Prior Authorization requirements and related Copayment exceptions are described in the "Outpatient Prescription Drug Benefits" section of this *Certificate*.

Percentage Copayments will be based on HNL's contracted pharmacy rate.

Mail Order:

Up to a 90-consecutive-calendar-day supply of covered Maintenance Drugs will be dispensed at the applicable mail order Copayment or Coinsurance. However, when the retail Copayment is a percentage, the mail order Copayment is the same percentage of the cost to HNL as the retail Copayment.

UC members can also obtain their mail order prescriptions at a designated UC Medical Center pharmacy. To locate a UC Medical Center pharmacy, a listing is provided on the HR/Benefits website or contact **HNL** customer service.

Diabetic Supplies:

Except for insulin, diabetic supplies (blood glucose testing strips, lancets, disposable needles and 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 the Physician has prescribed for up to a 30-day period.

Smoking Cessation Drugs:

Drugs prescribed for smoking cessation are covered up to a twelve-week course of therapy per Calendar Year if You are concurrently enrolled in a comprehensive smoking cessation behavioral support program. The prescribing Physician must request Prior Authorization for coverage. For information regarding smoking cessation behavioral support programs available through HNL, contact Member Services at the telephone number on Your HNL ID Card or visit the HNL website at www.healthnet.com/uc.

Sexual Dysfunction Drugs:

Drugs (including injectable medications) when Medically Necessary for treating sexual dysfunction are limited to quantities specified on the Recommended Drug List. Sexual dysfunction drugs are not available through the mail order program.

Mental Health and Substance Abuse Benefits

University of California has independently contracted with United Behavioral Health (UBH), a specialized health care service plan, to provide Mental Health and Substance abuse benefits. Covered services may be obtained by receiving a referral through United Behavioral Health (UBH) at **1-888-440-UCAL(8225)**. Care must be provided by a United Behavioral Health (UBH) participating provider and approved by United Behavioral Health (UBH). Special provisions apply in the even of an emergency, and are described in detail in the United Behavioral Health (UBH) Certificate

Additional Benefits are provided for those Members having a diagnosis categorized as Severe Mental Illness. Please contact United Behavioral Health (UBH) at **1-888-440-UCAL(8225)** for a complete schedule of your Mental Health and Substance Abuse benefits.

OUT-OF-POCKET MAXIMUM

After You have paid Copayments and Coinsurance for covered services equal to the Out-of-Pocket Maximum amount shown below, You will not be required to pay further Copayments or Coinsurance for Covered Expenses incurred during the remainder of the Calendar Year. HNL will pay 100% of Covered Expenses for any additional services and supplies.

For covered services or supplies (per Covered Person).....$1000

For covered services or supplies (two Covered Persons).....$2000

For Families: In addition, 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 Copayment or Coinsurance shall be required from any enrolled Covered Person in that family for the remainder of the Calendar Year.

For covered services or supplies (three or more Covered Persons) $3000

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:

- Copayments, Coinsurance or Deductibles for outpatient prescription drugs with the exception of peak flow meters and inhaler spacers used for the treatment of asthma and diabetic supplies dispensed through a Participating Pharmacy will be applied to the Out-of-Pocket Maximum. Copayments for self-injectable drugs, which are covered under the medical benefit, will also be applied to the Out-of-Pocket Maximum amount.

Keep records (i.e. receipts and canceled checks) of Your payment for Covered Services and Supplies so that You can be credited toward meeting the Out-of-Pocket Maximum. When the total in a Calendar Year reaches the Out-of-Pocket Maximum amount shown above, contact HNL Member Services Department at the telephone number shown on the HNL ID Card for instructions.

TERM OF CERTIFICATE

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

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

ELIGIBILITY AND ENROLLMENT

Who Is Eligible for Coverage

The covered services and supplies of this Plan are available to the following people as long as they live in the continental United States, either work or live in the Health Net Life Service Area, and meet any additional eligibility requirements of the Group and this *Evidence of Coverage*:

The University of California establishes its own medical plan criteria for employees and retirees based on the University of California Group Insurance Regulations ("Regulation") and any corresponding Administrative Supplements. Portions of those regulations are summarized below.

Medicare enrollees are not eligible to participate in the United Behavioral Health portion of these plans; see section "Effect of Medicare."

Subscriber

Employee

You are eligible if you are appointed to work at least 50% time for twelve months or more or are appointed at 100% time for three months or more or have accumulated 1,000* hours while on pay status in a twelve-month period. To remain eligible, you must maintain an average regular paid time** of at least 17.5 hours per week and continue in an eligible appointment. If your appointment is at least 50% time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

*Lecturers - see your benefits office for eligibility.

** Average Regular Paid Time - For any month, the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked in the preceding twelve (12) month period. Average regular paid time does not include full or partial months of zero paid hours when an employee works less than 43.75% of the regular paid hours available in the month due to furlough, leave without pay or initial employment.

Retiree

A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

You may continue University medical plan coverage as a Retiree when you start collecting retirement or disability benefits from a University-sponsored defined benefit plan. You must also meet the following requirements:

(a) you meet the University's service credit requirements for Retiree medical eligibility;
(b) the Effective Date of your Retiree status is within 120 calendar days of the date employment ends (or the date of the Employee/Retiree's death for a Survivor); and
(c) you elect to continue medical coverage at the time of retirement.

Survivor

A deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan—may be eligible to continue coverage as set forth in the University's Group Insurance Regulations. For more information, see the UC *Group Insurance Eligibility Fact Sheet for Retirees and Eligible Family Members*.

If you are eligible for Medicare, you must follow UC's Medicare Rules. See "Effect of Medicare on Retiree Enrollment" below.

Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), adoption records, Federal Income Tax Return, or other official documentation.

Spouse

Your legal spouse

Child

All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors. The following categories are eligible:

(a) your natural or legally adopted children;
(b) your stepchildren (natural or legally adopted children of your spouse) if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
(c) grandchildren of you or your spouse if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
(d) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental disability may continue to be covered past age 23 provided:

- the incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous;
- the child is claimed as your dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income; and
- the child lives with you if he or she is not your or your spouse's natural or adopted child.

Application must be made to the Plan at least 31 days before the child's 23rd birthday and is subject to approval by the Plan. The Plan may periodically request proof of continued disability. Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an incapacitated child, you may also apply for coverage for that child. The child must have had continuous group medical coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility.

Other Eligible Dependents (Family Members)

You may enroll a same-sex Domestic Partner (and the same-sex Domestic Partner's children/grandchildren/stepchildren) as set forth in the University of California Group Insurance Regulations.

The University recognizes an opposite-sex Domestic Partner as a family Member that is eligible for coverage in UC-sponsored benefits if the employee/retiree or Domestic Partner is age 62 or older and eligible to receive Social Security benefits and both the employee/retiree and Domestic Partner are at least 18 years of age.

An adult dependent relative is no longer eligible for coverage. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003 may continue coverage in UC-sponsored plans.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Survivor or a Family Member, but not under any combination of these. If an Employee and the Employee's spouse or Domestic Partner are both eligible Subscribers, only one should enroll; however, each may enroll separately or one may cover the other as a Family Member. Eligible children may be enrolled under either parent's or eligible domestic partner's coverage but not under both. Additionally, a child who is also eligible as an Employee may not have dual coverage through two University-sponsored medical plans.

More Information

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's Customer Service Center. You may also access eligibility fact sheets on the web site: http://atyourservice.ucop.edu.

How to Enroll for Coverage

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are a Retiree, contact the University's Customer Service Center. Enrollment transactions may be completed by paper form or electronically, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

A Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

Employee

If you are an Employee, you may enroll yourself and any eligible Family Members during your PIE. Your PIE starts the day you become an eligible Employee, and ends 31 days later.

Newly Acquired Dependents

You may enroll any newly eligible Family Member during his or her PIE. The Family Member's PIE starts the day your Family Member becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family Members are only eligible for the same plan you are enrolled in.

Spouse: On the date of Marriage.

Natural Child: For a natural child, on the child's date of birth.

Newborn Child: A child newly born to the Subscriber or his or her spouse is automatically covered from the moment of birth through the 31st day of life. In order for coverage to continue beyond the 30th day of life, the Subscriber must enroll the newborn child through the employer within the Period of Initial Eligibility. The newborn's Period of Initial Eligibility begins on the date of birth and ends on the last working day within the 31 day period following that date.

If the mother is the Subscriber's spouse and an enrolled Member, the child will be assigned to the mother's Physician Group and may not transfer to another Physician Group until the first day of the calendar month following the birth. If the mother is not enrolled, the child will be automatically assigned to the Subscriber's Physician Group. If you want to choose another Physician Group for that child, the transfer will take effect only as stated in the "Transferring to Another Contracting Physician Group" portion of this section.

Adopted Child: For an Adopted Child, the earlier of:

(iii) the date you or your Spouse has the legal right to control the child's health care; or
(iv) the date the child is placed in your physical custody.
If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.
(v) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you decline enrollment for yourself or your eligible Family Members because of other group medical plan coverage and you lose that coverage involuntarily (or if the employer stops contributing toward the other coverage for you or your Family Members), you may be able to enroll yourself and those eligible Family Members during a PIE that starts on the day the other coverage is no longer in effect.

If you are in an HMO, POS or EPO Plan and you move or are transferred out of that Plan's service area, or will be away from the Plan's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan. Your PIE starts with the Effective Date of the move or the date you leave the Plan's service area.

Enrollment At Other Times For Employees And Retirees

You and your eligible Family Members may also enroll during a group Open Enrollment Period established by the University.

If you are an Employee and opt out of medical coverage or fail to enroll yourself during a PIE or Open Enrollment Period, you may enroll yourself at any other time upon completion of a 90 consecutive calendar day waiting period.

If you are an Employee or Retiree and fail to enroll Your eligible Family Members during a PIE or Open Enrollment Period, you may enroll your eligible Family Members at any other time upon completion of a 90 consecutive calendar day waiting period.

The 90-day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits office and ends 90 consecutive calendar days later.

If you have one or more children enrolled in the Plan, you may add a newly eligible Child at any time. See "Effective Date".

If you are an Employee or a Retiree and there is a lifetime maximum for all benefits under this Plan, and you or a Family Member reaches that maximum, you and your eligible Family Members may be eligible to enroll in another UC-sponsored medical plan. Contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan (or its Medicare version) you were enrolled in immediately before retiring as long as your Family Members are eligible for coverage. You must elect to continue enrollment for yourself and enrolled Family Members before the Effective Date of retirement (or the date disability or survivor benefits begin).

If you are a Survivor, you may not enroll your legal spouse or Domestic Partner.

Effective Date

The following effective dates for coverage apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Family Members is effective the date the PIE starts.

If you are a Retiree continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.

The Effective Date of coverage for enrollment during an Open Enrollment Period is the date announced by the University.

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.

An Employee or Retiree who is already enrolled in adult-plus-child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:

(a) the date the Child becomes eligible, or
(b) a maximum of 60 days prior to the date your Child's enrollment transaction is completed.

Change in Coverage

In order to change from single to adult-plus-child(ren) coverage, or two adult coverage, or family coverage, or to add another Child to existing family coverage, you should contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Effect of Medicare on Retiree Enrollment

If you are a Retiree and you and/or an enrolled Family Member is or becomes eligible for premium-free Medicare Part A (Hospital Insurance) as primary coverage, then the individual who is eligible for Part A, must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous to maintain eligibility in this plan. This rule includes anyone who is entitled to Medicare benefits through their own or their spouse's employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this Plan.

Retirees or their eligible Family Member(s) who become eligible for premium-free Medicare Part A, on or after January 1, 2004, and do not enroll in Part B, will permanently lose their UC-sponsored medical coverage.

In order to cover increased costs, the University will assess a monthly offset fee on Retirees and their Family Members who were eligible for premium-free Medicare Part A prior to January 1, 2004, but declined to enroll in Part B of Medicare. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B.

Retirees or Family Members who are not eligible for premium-free Part A will not be required to enroll in Part B, therefore, they will not be assessed an offset fee, nor will they lose their UC-sponsored medical coverage. Documentation attesting to their ineligibility for Medicare Part A will be required. (Retirees/Family Members who are not entitled to Social Security and premium-free Medicare Part A will not be required to enroll in Part B.)

An exception to the above rules applies to certain Retirees or Family Members who will be eligible for the non-Medicare premium applicable to this Plan and will also be eligible for the benefits of this Plan without regard to Medicare if they are in one of the following groups:

c) Individuals who were eligible for premium-free Part A, but not enrolled in Medicare Part B prior to July 1, 1991.
d) Individuals who are not eligible for premium-free Part A.

You should contact Social Security three months before your or your Family Member's 65th birthday to inquire about your eligibility and how you enroll in the Hospital (Part A) and Medical (Part B) portions of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

Upon Medicare eligibility, you or your Family Member must complete a University of California Medicare Declaration form, as well as submit a copy of your Medicare card. This notifies the University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration form is available through the University's Customer Service Center, or from the website: http://atyourservice.ucop.edu. Completed forms should be returned to University of California, Human Resources and Benefits, Health & Welfare Administration-Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-9911.

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care Contract must assign his/her Medicare benefit to that plan or lose UC-sponsored medical coverage. Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health Plan.

Medicare Secondary Payer Law (MSP)

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. UC Retirees re-hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For Employees or their spouses who are age 65 or older and eligible for a group health plan due to employment, the law requires that Medicare becomes the secondary payer and the employer plan becomes the primary payer for your health coverage. You should carefully consider the impact on your health benefits and premiums should you decide to return to work after you retire.

Medicare Private Contracting Provision and Providers Who do Not Accept Medicare

Federal Legislation allows Physicians or practitioners to opt out of Medicare. If you wish to continue to obtain services **(that would otherwise be covered by Medicare)** from these Physicians or practitioners you will need to enter into written "private contracts" with these Physicians or practitioners. These private agreements will require you to be responsible for all payments to such medical providers. Since services provided under such "private contracts" are not covered by Medicare or this Plan, the Medicare limiting charge will not apply.

Some Physicians or practitioners have **never** participated in Medicare. Their services (that would be covered by Medicare if they participated) will not be covered by Medicare or this Plan, and the Medicare limiting charge will not apply.

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage), are enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement as described above with one or more Physicians or practitioners, or if you choose to obtain services from a provider who does not participate in Medicare, under the law you have in effect "opted out" of Medicare for the services provided by these Physicians or other practitioners. In either case, no benefits will be paid by this Plan for services rendered by these Physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered. Therefore, it is important that you confirm that your provider takes Medicare prior to obtaining services for which you wish the Plan to pay.

However, even if you do sign a private contract or obtain services from a provider who does not participate in Medicare, you may still see **other** providers who have not opted out of Medicare and receive the benefits of this Plan for those services.

Special Reinstatement Rule For Reservists Returning From Active Duty

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

Special Reinstatement Rule Under USERRA

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

Transferring to Another Contracting Physician Group

As stated in the "Selecting a Contracting Physician Group" portion of "Introduction to Health Net Life," Section 100, each person must select a contracting Physician Group close enough to his or her residence or place of work to allow reasonable access to care. Please call the Member Services Department at the telephone number on your HNL ID Card if you have questions involving reasonable access to care.

Any individual Member may change Physician Groups, that is, transfer from one to another:

- When the Group's Open Enrollment Period occurs;
- When the Member moves to a new address (notify HNL within 30 days of the change);
- When the Member’s employment work-site changes (notify HNL within 30 days of the change);
- When determined necessary by HNL; or
- When the Member exercises the once-a-month transfer option.

Exceptions
HNL will not permit a once-a-month transfer at the Member's option, if the Member is confined to a Hospital. However, if you believe you should be allowed to transfer to another contracting Physician Group because of unusual or serious circumstances, and you would like HNL to give special consideration to your needs, please contact the Member Services Department at the telephone number on your HNL ID Card for prompt review of your request.

Effective Date of Transfer
If we receive your request for a transfer on or before the 15th day of the month, the transfer will occur on the first day of the following month. (Example: Request received March 12, transfer effective April 1.)

If we receive your request for a transfer on or after the 16th day of the month, the transfer will occur on the first day of the second following month. (Example: Request received March 17, transfer effective May 1.)

If your request for a transfer is not allowed because of a pregnancy, illness, injury, hospitalization, or surgery, and you still wish to transfer after the medical condition or treatment for it has ended, please call the Member Services Department to process the transfer request. The transfer in a case like this will take effect on the first day of the calendar month following:

- The date the pregnancy ends.
- The date the treatment for the condition causing the delay ends.

For a newly eligible child who has been automatically assigned to a Contracting Physician Group, the transfer will not take effect until the first day of the calendar month following the date the child first becomes eligible. (Automatic assignment takes place with *newborn* and *adopted* children, and is described in the "How to Enroll for Coverage" provision earlier in this section.)

Changes made during the Open Enrollment Period would be effective on the following January 1. However, any transfer which requires HNL's approval of a health status questionnaire will not take effect until the first day of the calendar month following the date of such approval.

Effect of Medicare
If you are eligible for Medicare, you must enroll in Medicare according to UC's Medicare Rules. Once you and/or a family member are enrolled in Medicare, you are ineligible for mental health and substance abuse benefits through the United Behavioral Health portion of your plan. Employees should contact the local benefits office and Retirees should contact the University's Customer Service Center to transfer to the portion of your plan for Medicare enrollees.

Termination of Coverage

The termination of coverage provisions that are established by the University of California in accordance with its Regulations are described below. Additional Plan provisions apply and are described elsewhere in the document.

Deenrollment Due to Loss of Eligible Status
If you are an Employee and lose eligibility for any reason, your coverage and that of any enrolled Family Member will stop at the end of the last month in which premiums are taken from earnings based on an eligible appointment.

If you are a Retiree or Survivor and your annuity terminates, your coverage and that of any enrolled Family Member will stop at the end of the last month in which you are eligible for an annuity.

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on deenrollment procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Deenrollment Due to Fraud

Coverage for you or your Family Members may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Such termination shall be effective upon the mailing of written notice to the Subscriber (and to the University if notice is given by the Plan). A Family Member who commits fraud or deception will be permanently deenrolled while you and any other Family Member will be deenrolled for 12 months. If you commit fraud or deception, you and any Family Members will be deenrolled for 12 months.

Leave of Absence, Layoff or Retirement

You need to contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff or retirement.

Individual Members that Establish Residency Outside the HNL Service Area

You will become ineligible if you establish your primary residency outside the HNL Service Area and do not work inside that area.

However, a child subject to a Medical Child Support Order, according to state or federal law, who moves out of the HNL Service Area does not cease to be eligible for this Plan. But, while that child may continue to be enrolled, coverage of care received outside the HNL Service Area will be limited to services provided in connection with Emergency Care or Urgently Needed Care.

Termination for Cause

HNL has the right to terminate your coverage from this Plan under certain circumstances. The following are examples of circumstances that may result in a termination:

- Disruptive or Threatening Behavior: Your coverage may be terminated upon the date the notice of termination is mailed if you threaten the safety of the health care provider, his or her office staff, the contracting Physician Group or HNL if such behavior does not arise from a diagnosed illness or condition. In addition, your coverage may be terminated upon 15 days prior written notice if you repeatedly or materially disrupt the operations of the Physician Group or HNL to the extent that your behavior substantially impairs HNL's ability to furnish or arrange services for you or other HNL Members, or substantially impairs the Physician's office or contracting Physician Group's ability to provide services to other patients.
- Misrepresentation or Fraud: Your coverage may be terminated if you knowingly omit or misrepresent a meaningful fact on your enrollment form or fraudulently or deceptively use services or facilities of HNL, its contracting Physician Groups or other contracting providers, (or knowingly allow another person to do so), including altering a prescription.

If coverage is terminated for any of the above reasons, you forfeit all rights to enroll in the HNL conversion plan, COBRA plan or any plan that is owned or operated by HNL's parent company or its subsidiaries and lose the right to re-enroll in HNL in the future. The termination is effective immediately on the date HNL mails the notice of termination, unless HNL has specified a later date in that notice.

HNL will conduct a fair investigation of the facts before any termination transfer for any of the above reasons is carried out.

Your health status or requirements for health care services will not determine eligibility for coverage. If you believe that coverage was terminated because of health status or the need for health services, you may request a review of the termination by the Director of the California Department of Managed Health Care.

Optional Continuation of Coverage

- If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice "Continuation of Group Insurance Coverage," available from the University "At Your Service" website (http://atyourservice.ucop.edu). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or to the University's Customer Service Center if you are a Retiree.

Extension of Benefits

When Benefits May Be Extended

Benefits may be extended beyond the date coverage would ordinarily end if;

- You lose your HNL coverage because the UC Standardized Contract is discontinued, and you are ***totally disabled*** at that time; or
- You lose your coverage for any reason other than discontinuance of the UC Standardized Contract and you are a ***registered bed patient*** in a Hospital or Skilled Nursing Facility when coverage ends, and the hospitalization was covered by this Plan.

When benefits are extended, you will not be required to pay subscription charges. However, the Copayments shown in "Schedule of Benefits and Copayments," Section 200, will continue to apply.

Benefits will only be extended for the condition you were hospitalized for or the condition that caused you to become totally disabled. Benefits will not be extended for other medical conditions.

Benefits will not be extended if coverage was terminated for cause as stated in "Termination for Cause" provision of "Eligibility, Enrollment and Termination," Section 400.

"Totally disabled" has a different meaning for different Family Members.

- For the Subscriber it means that because of an illness or injury, the Subscriber is unable to engage in employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience; furthermore, the Subscriber must not be employed for wage or profit.
- For a Family Member it means that because of an illness or injury, that person is prevented from performing substantially all regular and customary activities usual for a person of his or her age and family status.

How to Obtain an Extension

Member Is Confined to a Hospital

If you are confined to a Hospital or Skilled Nursing Facility when your coverage ends, benefits will be extended to you automatically. You do not have to do anything to make it happen.

When you are discharged from a Hospital or Skilled Nursing Facility, no further extension is available, unless your coverage ended because the UC Standardized Contract ended.

If your coverage ended because the UC Standardized Contract between HNL and the Group was terminated, and you are totally disabled and want to continue to have extended benefits, you must send a written request to HNL within 90 days of the discharge date. The request must include your Physician Group's written certification that you are totally disabled.

Member Is *Not* Confined to a Hospital

If a Member is totally disabled and not confined to a Hospital or Skilled Nursing Facility when the Agreement ends, send a written request to HNL within 90 days of the date the Agreement terminates. The request must include written certification by the Member's Physician Group that the Member is totally disabled.

If benefits are extended because of total disability, provide HNL with proof of total disability at least once every 90 days during the extension. The Member must ensure that HNL receives this proof before the end of each 90-day period.

When the Extension Ends

The Extension of Benefits will end on the *earliest* of the following dates:

1. **For extensions provided only because of Hospital confinement:** If the Agreement between HNL and the Group **has not been** terminated, then the Extension of Benefits will end on the earliest of the following dates:
   a. On the date the Member is discharged from the Hospital or Skilled Nursing Facility, even if the total disability continues;
   b. On the date the Member becomes covered by another private or group health insurance policy or plan; or
   c. On the date that available benefits are exhausted.
2. **For extensions provided because of total disability which may or may not involve hospitalization:** If the Agreement between HNL and the Group **has been** terminated, then the extension of benefits will end on the earliest of the following dates:
   a. On the date the Member is no longer totally disabled;
   b. On the date the Member becomes covered by a replacement health policy or plan obtained by the Group, and this coverage has no limitation for the disabling condition;
   c. On the date that available benefits are exhausted; or
   d. On the last day of the 12-month period following the date the extension began, unless the Member is confined in a Hospital or Skilled Nursing Facility on that date for the disabling condition.

Other Coverage Affects Extension of Benefits

Other Group Coverage

Extended benefits will end as stated in #1 and #2 in the section immediately above titled “When the Extension Ends.”

If other group coverage exists that does not cause the extension of benefits to end, such as coverage through a new job or coverage that existed before the loss of HNL coverage, HNL will obtain reimbursement from the other Plan through the Coordination of Benefits process.

Also, when another health maintenance organization provides that coverage, HNL may arrange for that HMO to be responsible for continuing medical care.

- **COBRA Continuation Coverage**
  If your HNL coverage continues because you were eligible for and obtained federal COBRA continuation coverage, you have not yet lost your HNL coverage. If you are still totally disabled when the COBRA continuation coverage ends, you may try to obtain an extension as described above in the section titled "How to Obtain an Extension."
- **Conversion Coverage**
  Conversion coverage affects extension of benefits when:

  1. You receive an extension of the benefits of this Plan and
  2. You have also elected conversion coverage and it is in force.

  Whichever coverage provides the higher benefits will be applied toward the disabling condition. Refer to the "Conversion Privilege" section immediately below.

Conversion Privilege

Who Is Eligible for Conversion Coverage

Except as specified below, if you lose coverage in this Plan, you have the right to purchase individual coverage through the HNL conversion plan without being required to complete a health statement.

You must pay the cost of conversion coverage (called subscription charges). Please note, however, that *the benefits, as well as the subscription charges, will not be the same as coverage through this Group Plan.*

Who Is Not Eligible for Conversion Coverage

The following people are not eligible for conversion coverage:

1. Anyone who lives outside the continental United States and who does not either live or work inside the HNL Service Area;
2. Anyone whose coverage was terminated for cause as stated in "Termination for Cause" portion of this section;
3. Anyone who is covered by another group or individual health plan; or
4. Anyone who was not covered by this Plan.

How to Apply for Conversion Coverage

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

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

Conversion coverage must become effective immediately following the date Group coverage ends. There can be no lapse in coverage.

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 *Certificate*.

An expense is incurred on the date You receive the service or supply for which the charge is made. HNL shall not pay for expenses incurred for any services or supplies in excess of any visit or benefit maximum described in the "Schedule of Benefits and Copayments" section or elsewhere in this *Certificate*, 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.

A. HOW COVERED EXPENSES ARE DETERMINED

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

1. PARTICIPATING PROVIDERS

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

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

NO BENEFITS ARE PAYABLE FOR SERVICES OR SUPPLIES FURNISHED BY PROVIDERS OTHER THAN HNL EPO PARTICIPATING PROVIDERS. THE DESIGNATED HNL EPO PARTICIPATING PROVIDERS FOR THIS PLAN HAVE BEEN IDENTIFIED AND DESCRIBED IN THE "DEFINITIONS" SECTION OF THIS *CERTIFICATE* UNDER "PLEASE READ THE FOLLOWING INFORMATION TO KNOW FROM WHOM OR WHICH GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED."

B. OUT-OF-POCKET MAXIMUMS

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

How the OOPM Works
Keep a record of your payment for covered medical services and supplies. When the total in a Calendar Year reaches the OOPM amount shown above, contact the HNL Member Services Department at the telephone number shown on your HNL ID Card for instructions.

- If an individual Member pays amounts for covered services in a Calendar Year that equal the OOPM amount for an individual Member, no further payment is required for that Member for the remainder of the Calendar Year.
- Once an individual Member in a Family satisfies the individual OOPM, the remaining enrolled Family Members must continue to pay the Copayments and Coinsurance until either (a) the aggregate of such Copayments and Coinsurance paid by the Family reaches the Family OOPM or (b) each enrolled Family Member individually satisfies the individual OOPM.
- If amounts for covered services paid for all enrolled Members equal the OOPM amount shown for a family, no further payment is required from any enrolled Member of that family for the remainder of the Calendar Year for those services.

- Only amounts that are applied to the individual Member's OOPM amount may be applied to the family's OOPM amount. Any amount you pay for covered services for yourself that would otherwise apply to your individual OOPM but exceeds the OOPM amount for one Member will be refunded to you by HNL, and will not apply toward your family's OOPM. Individual Members cannot contribute more than their individual OOPM amount to the Family OOPM

You must notify HNL when the OOPM amount has been reached. Please keep a copy of all receipts and canceled checks for payments for Covered Services as proof of Copayments and Coinsurance made.

C. MEDICAL BENEFIT MAXIMUMS

HNL will **not** make benefit payments for any Covered Persons that exceed any of the benefit limits shown in the "Schedule of Benefits and Copayments" section of this *Certificate.* Any amount shown in this *Certificate* as Your lifetime maximum benefit will be reduced by any benefits paid by HNL on Your behalf under this plan and any other HNL plan sponsored by the same employer.

D. PLAN BENEFITS

Please read this description of plan benefits carefully. Please, also read the "Schedule of Benefits and Copayments" section of this Certificate regarding Your out of pocket expenses and the "General Limitations" section of this Certificate for details of any restrictions placed on the benefits.

1. HOSPITAL

a. **Inpatient Services**

Covered Expenses include:

i. Accommodations as an inpatient in a room of two or more beds, at the Hospital's most common semi-private room rate;

ii. Services in Special Care Units;

iii. Operating, delivery and special treatment rooms including private rooms for maternity;

iv. Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services;

v. Physical therapy;

vi. Radiation therapy, chemotherapy and renal dialysis treatment;

vii. Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Hospital for use during Your stay, and

viii. Blood transfusions, including blood processing, the cost of blood and unreplaced blood and blood products. Charges related solely to the collection and storage of Your own blood for autologous blood transfusion are not covered.

However, this *Certificate* does not cover treatments which use umbilical cord blood, cord blood stem cells or adult stem cells (nor their collection, preservation and storage) as such treatments are considered to be Experimental or Investigational in nature. Please refer to "Independent Medical Review of Investigational or Experimental Therapies" in the "Specific Provisions" section.

This Plan covers transgender surgery and services related to the surgery, including reasonable travel, lodging and meal costs, to change a Member's physical characteristics to those of the opposite gender.

Inpatient Hospital Services for transgender surgery and services related to the surgery require prior authorization by HNL and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member.

b. **Outpatient Services**

Covered Expenses include:

i. Use of a Hospital emergency room or urgent care facility, supplies, ancillary services, laboratory and x-ray services, drugs and medicines administered by the Hospital emergency room or urgent care facility; and

ii. Use of the facilities of an outpatient surgical unit including operating and recovery rooms, supplies, ancillary services, laboratory and x-ray services, drugs and medicines administered by the unit.

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

This Plan covers transgender surgery and services related to the surgery, including reasonable travel, lodging and meal costs, to change a Member's physical characteristics to those of the opposite gender.

Outpatient Hospital Services for transgender surgery and services related to the surgery require prior authorization by HNL and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member.

2. AMBULATORY SURGICAL CENTER

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

3. SKILLED NURSING FACILITY

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

a. Accommodations in a room of two or more beds. Payment will be made based on the Skilled Nursing Facility's prevailing charge for two-bed room accommodations;

b. Special treatment rooms;

c. Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services;

d. Physical, occupational and speech therapy;

e. Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Skilled Nursing Facility for use during Your stay; and

f. Blood transfusions, including blood processing, the cost of blood and unreplaced blood and blood products are covered. Self-donated (autologous) blood transfusion are covered only for a scheduled surgery that has been authorized by Your Primary Care Physician. However, this *Certificate* does not cover treatments which use umbilical cord blood, cord blood stem cells and adult stem cells(nor their collection, preservation and storage) as such treatments are considered to be Experimental or Investigational in nature. Please refer to "Independent Medical Review of Investigational or Experimental Therapies" in the "Specific Provisions" section.

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

Custodial Care is not covered.

4. PROFESSIONAL SERVICES

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

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

5. ADDITIONAL SERVICES AND SUPPLIES

a. **Diagnostic Imaging (including X-Ray) and Laboratory Procedures**

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

b. **Home Health Care Services**

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

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

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

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

Custodial Care services and Private Duty Nursing, as described in the "Definitions" section 900 and any other types of services primarily for the comfort or convenience of the Covered Person**,** are not covered even if they are available through a Home Health Care Agency. Home Health Care Services do not include Private Duty Nursing or shift care. Private Duty Nursing (or shift care) is not a covered benefit under this plan even if it is available through a Home Health Care Agency or is determined to be Medically Necessary. See the "Definitions" section.

c. **Self-Injectable Drugs**

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

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

Self-injectable drugs (other than insulin), and needles and syringes used with these self-injectable drugs must be obtained through HNL's contracted Specialty Pharmacy Vendor when Prior Authorization is obtained from HNL. Upon approval, HNL will arrange for the distribution of drugs, needles and syringes from the appropriate Specialty Pharmacy Vendor. The Specialty Pharmacy Vendor may contact you directly to coordinate the delivery of your medications.

d. **Outpatient Infusion Therapy**

Outpatient infusion therapy to administer covered drugs and other substances by injection or aerosol is covered when appropriate for Your illness, injury or condition.

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

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

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

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

i. Non-Prescription Drugs or medications

ii. Any drug labeled "Caution, limited by Federal Law to investigational use" or Investigational drugs not approved by the FDA

iii. Drugs or other substances obtained outside of the United States

iv. Homeopathic or other herbal medications not approved by the FDA

v. FDA approved drugs or medications prescribed for indications that are not approved by the FDA or which do not meet medical community standards (except that non-Investigational FDA approved drugs used for off-label indications when the conditions of state law have been met)

vi. Growth hormone treatment

vii. Supplies used by a health care provider that are incidental to the administration of infusion therapy, including but not limited to: cotton swabs, bandages, tubing, syringes, medications and solutions.

e. **Ambulance Services**

The following Ambulance services:

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

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

(a) To a Hospital or Skilled Nursing Facility where You receive care which is covered under this *Certificate* as an inpatient, in the emergency room, or in the outpatient department of a Hospital when the services could not have been performed in the home.

(b) A round trip from a Hospital or Skilled Nursing Facility where covered care is being provided, to some other medical treatment facility in order to obtain specialized diagnostic or therapeutic services (for example, a CT scan or radiation therapy) which are not available at the facility where You are an inpatient.

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

(c) To Your home from a Hospital or Skilled Nursing Facility where You received covered services.

ii. **Air Ambulance Transportation,** when it is Medically Necessary, as defined in the "Definitions" section of this *Certificate*. The following will be covered:

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

All paramedic, Ambulance services and Ambulance transport services provided as the result of a **911** emergency response system call will be covered when the criteria for Emergency Care, as defined in this *Certificate*, have been met.

f. **Patient Education**

When authorized by Your PCP, HNL will pay for patient education programs on how to prevent illness or injury and how to maintain good health, including diabetes management programs.

g. **Hospice Care**

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

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

i. All Medically Necessary services and supplies furnished by the Hospice. This includes doctors' and nurses' services, homemaker services and drugs.

ii. Up to five consecutive days of respite care. Respite care is furnished to a person in an inpatient setting in order to provide relief for family members or others caring for that person.

All of these services and supplies will be provided or arranged by the Hospice. Payment by HNL for Hospice Care benefits shall not exceed the amount per day set forth in the "Schedule of Benefits and Copayments" section of this *Certificate*.

h. **Radiation Therapy, Chemotherapy and Renal Dialysis Treatment when authorized by Your PCP.**

i. **Bariatric (Weight Loss) Surgery**

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

HNL has a designated network of bariatric surgical centers to perform weight loss surgery. Your Physician can provide you with information about these centers. You will be directed to an HNL designated bariatric surgical center at the time authorization is obtained. If You live 50 miles or more from the nearest HNL designated bariatric surgical center, You are eligible to receive travel expense reimbursement. All requests for travel expense reimbursement must be prior approved by HNL. Approved travel-related expenses will be reimbursed as follows:

- Transportation for the Covered Person to and from the designated bariatric surgical center up to $130 per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion (whether or not an enrolled Covered Person) to and from the designated bariatric surgical center up to $130 per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the Covered Person and one companion not to exceed $100 per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as Medically Necessary. Limited to one room, double occupancy.
- Hotel accommodations for one companion not to exceed $100 per day for the duration of the Covered Person's initial surgery stay, up to four (4) days. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed $25 per day, up to four (4) days per trip. Expenses for tobacco, alcohol, drugs, telephone, television, delivery, and recreation are specifically excluded.

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

j. **Prostheses**

Prostheses are covered as follows:

i. Internally implanted devices, such as pacemakers, devices to restore speaking after a laryngectomy and hip joints, which are medically indicated and consistent with accepted medical practice and approved for general use by the Federal Food and Drug Administration.

ii. External prostheses and the fitting and adjustment of these devices.

iii. Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin.

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

(a) Affixed to the body externally, and

(b) Required to replace all or any part of any body organ or extremity, or

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

iv. In addition, the following prostheses are covered:

(a) If all or part of a breast is surgically removed for Medically Necessary reasons, reconstructive surgery and a prostheses incident to the mastectomy are covered.

(b) Prostheses devices for restoring a method of speaking (but not including electronic voice boxes) following a laryngectomy are covered.

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

DENTAL APPLIANCES ARE NOT A COVERED EXPENSE.

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

l. **Implanted Lens Which Replaces the Organic Eye Lens**

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

m. **Rehabilitative Services,** including physical, occupational, and speech therapy, in accordance with the "Schedule of Benefits and Copayments" section except as stated in the "General Limitations" section.

n. **Cardiac Rehabilitation Therapy** in accordance with the "Schedule of Benefits and Copayments" section except as stated in the "General Limitations" section.

o. **Pulmonary Rehabilitation Therapy** in accordance with the "Schedule of Benefits and Copayments" section except as stated in the "General Limitations" section.

p. **Allergy Testing and Treatment**

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

i. Insulin pumps and all related necessary supplies

ii. Corrective footwear to prevent or treat diabetes-related complications

iii. Specific brands of blood glucose monitors and blood glucose testing strips*

iv. Blood glucose monitors designed to assist the visually impaired

v. Ketone urine testing strips*

vi. Lancets and lancet puncture devices*

vii. Specific brands of pen delivery systems for the administration of insulin, including pen needles*

viii. Specific brands of disposable insulin needles and syringes*

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

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

i. Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin are provided through the prostheses benefit (see the "Prostheses" provision of this section).

ii. Glucagon is provided through the self-injectables benefit (see the "Self-Injectable Drugs" provision of this section).

iii. Self-management training, education and medical nutrition therapy will be covered, only when provided by licensed health care professionals with expertise in the management or treatment of diabetes. Please refer to the "Patient Education" provision of this section for more information.

r. **Hearing Aids:** Standard hearing devices inserted in or affixed to the outer ear to restore adequate hearing to the Covered Person and determined to be Medically Necessary are covered.

s. **Vision and Hearing Examinations** to determine the need for correction of vision and hearing are covered. Vision and hearing screenings, provided as part of a periodic health evaluation, are covered at no charge.

t. **Obstetrician and Gynecologist (OB/GYN) Self-Referral** is allowed for a female Covered Person who needs OB/GYN preventive care, is pregnant or has a gynecology ailment. The Covered Person may go directly to a participating OB/GYN specialist or a Physician who provides such services without first contacting the Primary Care Physician. The OB/GYN Physician will consult with the Covered Person's Primary Care Physician regarding the Covered Person's condition, treatment, and any need for follow-up care. Copayment requirements may differ depending on the service provided. Refer to the "Schedule of Benefits and Copayments" section of this *Certificate*.

u. **Periodic Health Evaluations** and diagnostic preventive procedures, for preventive health purposes, are covered, based on recommendations published by the U.S. Preventive Services Task Force. This Plan also covers an annual cervical cancer screening test that includes the conventional Pap test, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA.

v. **Immunizations and Injections**, professional services to inject the medications, and the medications that are injected are covered as shown in "Schedule of Benefits and Copayments," Section 200. However, allergy serum is specifically excluded.

Member Physicians will provide immunizations that are recommended by guidelines published by the Advisory Committee on Immunization Practices (ACIP) of the U.S. Public Health Service or the American Academy of Pediatrics (AAP).

In addition, injectable medications (including Glucagon) approved by the FDA are covered for the Medically Necessary treatment of medical conditions when prescribed by Your Primary Care Physician and authorized by HNL or the Member's Participating Physician Group.

Self injectable Drugs (other than insulin), and needles and syringes used with these self-injectable drugs may be obtained through Health Net's contracted Specialty Pharmacy Vendor or Participating Physician Group when Prior Authorization is obtained from Health Net. Upon approval, Health Net will arrange for the distribution of drugs, needles and syringes from the appropriate Specialty Pharmacy Vendor or Participating Physician Group. The Specialty Pharmacy Vendor or Participating Physician Group will charge you for the appropriate Copayment or Coinsurance shown in "Schedule of Benefits and Copayments," Section 200.

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

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

6. DENTAL INJURY

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

7. CARE FOR CONDITIONS OF PREGNANCY

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

Hospital and professional services will be covered, including prenatal and postnatal care, and delivery. Covered Expenses include prenatal diagnostic procedures in the case of high-risk pregnancies. Please refer to the "Schedule of Benefits and Copayments" section for Copayment requirements.

Terminations of pregnancy (surgical or drug) are covered only when they are Medically Necessary.

When You give birth to a child in a Hospital, You are entitled to benefits for 48 hours of inpatient care following a vaginal delivery or 96 hours following a cesarean section delivery.

If You are discharged earlier than 24 hours after a vaginal delivery or 96 hours after a cesarean section, Your Physician may arrange a home visit during the first 48 hours following discharge by a licensed health care provider whose scope of practice includes postpartum care and newborn care.

8. ORGAN, TISSUE AND BONE MARROW TRANSPLANTS

Medical Necessary services provided in connection with organ, tissue and bone marrow transplants that are not Experimental or Investigative, are covered only when performed at a facility approved by HNL. (All transplant services will be coordinated by HNL in conjunction with Your PCP.)

a. For the enrolled Covered Person's who receive the transplants; and

b. For the donor (whether or not an enrolled Covered Person), Benefits are reduced by any amounts paid or payable by the donor's own coverage.

Transplant procedures performed at a facility not approved by HNL, for organ, tissue and bone marrow transplant procedures will not be covered. Not all Participating Providers are approved by HNL for performing transplant procedures.

For more information on organ donations, including how to elect to be an organ donor, please contact the Member Services Department at the telephone number on Your HNL ID Card, or visit the Department of Health and Human Services organ donation website at www.organdonor.gov.

9. RENAL DIALYSIS

Renal dialysis services in Your home service area are covered. Dialysis services for Covered Persons with end-stage-renal disease (ESRD) who are traveling within the United States are also covered. Outpatient dialysis services within the United States but outside of Your home service area must be arranged and authorized by Your PCP or HNL in order to be performed by providers in Your temporary location. Outpatient dialysis received out of the United States is not a covered service.

10. FAMILY PLANNING

Counseling, planning and other services for problems of fertility and Infertility, when determined to be Medically Necessary by a Physician are covered in accordance with the "Schedule of Benefits and Copayments" section of this *Certificate*.

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

Sterilizations are covered only when performed or referred by Your PCP.

11. CLINICAL TRIALS

Routine patient care costs for patients diagnosed with cancer who are accepted into phase I, II, III or IV clinical trials are covered when Medically Necessary and recommended by Your treating Physician. The Physician must determine that participation has a meaningful potential to benefit You and the trial has therapeutic intent. Services rendered as part of a clinical trial may be provided by a non-Participating or Participating Provider subject to the reimbursement guidelines as specified in the law. Coverage for routine patient care shall be provided in a clinical trial that involves either a drug that is exempt from federal regulation in relation to a new drug application or is approved by one of the following:

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

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

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

Please refer to the "Clinical Trials" provision in the "General Limitations" section for more information.

12. PHENYLKETONURIA (PKU)

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

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

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

Other specialized formulas and nutritional supplements are not covered.

13. MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

University of California has independently contracted with United Behavioral Health (UBH), a specialized health care service plan, to provide Mental Health and Substance Abuse benefits. Covered services may be obtained by receiving a referral through United Behavioral Health (UBH) at **1-888-440-UCAL(8225)**. Care must be provided by a United Behavioral Health (UBH) participating provider and approved by United Behavioral Health (UBH). Special provisions apply in the even of an emergency, and are described in detail in the United Behavioral Health (UBH) Certificate

Additional Benefits are provided for those Members having a diagnosis categorized as Severe Mental Illness. Please contact United Behavioral Health (UBH) at **1-888-440-UCAL(8225)** for a complete schedule of your Mental Health and Substance Abuse benefits.

GENERAL LIMITATIONS

No payment will be made under this *Certificate* for expenses incurred for or in connection with any of the items below. Also, services or supplies that are excluded from coverage in the *Certificate*, exceed *Certificate* limitations, are follow-up care (or related to follow-up care) to *Certificate* limitations or are related in any way to *Certificate* limitations, will not be covered. However, the *Certificate* does cover Medically Necessary services for medical conditions directly related to non-covered services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery).

Not Medically Necessary

Services or supplies which HNL or Your PCP determines are not Medically Necessary, as defined in the "Definitions" section of this *Certificate*.

Clinical Trials

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

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

Cosmetic Services And Supplies

Cosmetic surgery or services and supplies performed to alter or reshape normal structures of the body solely to improve the physical appearance of a Covered Person are not covered. However, this Plan does cover Medically Necessary services and supplies for complications which exceed routine follow-up care that is directly related to cosmetic surgery (such as life-threatening complications). In addition, hair transplantation, hair analysis, hairpieces and wigs, chemical face peels, abrasive procedures of the skin, liposuction or epilation are not covered. Dental services or supplies or treatment for disorders of the jaw are not covered except as set out under the "Dental Services" and "Temporomandibular (Jaw) Joint Disorders" provisions in this section.

- However, when reconstructive surgery is performed to correct or repair abnormal structures of the body caused by, congenital defects, developmental abnormalities, trauma, infection, tumors or disease, and such surgery does either of the following: Improve function or
- Create a normal appearance to the extent possible,

then,

- Surgery to excise, enlarge, reduce or change the appearance of any part of the body;
- Surgery to reform or reshape skin or bone; or
- Surgery to excise or reduce skin, connective or fatty tissue that is loose, wrinkled, sagging or excessive on any part of the body are covered.

In addition, HNL will provide coverage for breast reconstruction surgery if HNL determines that the surgery and the services provided are Medically Necessary as follows:

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

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

This Plan covers transgender surgery and services related to the surgery, including reasonable travel, lodging and meal costs, to change a Member's physical characteristics to those of the opposite gender.

Dental Services

Dental services or supplies are limited to the following situations:

- When immediate Emergency Care to sound natural teeth as a result of an accidental injury is required.
- General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the Covered Person requires that an ordinarily non-covered dental service which would normally be treated in a dentist's office and without general anesthesia must instead be treated in a Hospital or outpatient surgical center. The general anesthesia and associated facility services must be Medically Necessary, are subject to the other exclusions and limitations of this *Certificate,* and will only be covered under the following circumstances (a) Covered Persons who are under seven years of age or, (b) Covered Persons who are developmentally disabled or (c) Covered Persons whose health is compromised and general anesthesia is Medically Necessary.
- When dental examinations and treatment of the gingival tissues (gums) are performed for the diagnosis or treatment of a tumor.
- For acupuncture treatment of postoperative dental Pain, but only when Acupuncture Services are covered under this Plan through American Specialty Health Plans of California, Inc. (ASH Plans).

Care or treatment of teeth and supporting structures; extraction of teeth; treatment of dental abscess or granuloma; dental examinations and treatment of gingival tissues other than tumors, are not covered except as stated for dental injury under the "Medical Benefits" section of this *Certificate*. Spot grinding, inlays or onlays, crowns, orthodontia (braces), bridgework or other restorations, active splints or orthotics (whether custom fit or not), mechanical devices and dental implants (materials implanted into or on bone or soft tissue) or other dental appliances or any associated procedure or related surgeries as part of the implantation or removal of implants are not covered regardless of reason for such services.

Temporomandibular (Jaw) Joint Disorders

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

Surgery And Related Services (Often Referred To As "Orthognathic Surgery" Or "Maxillary And Mandibular Osteotomy")

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

Dietary or Nutritional Supplements

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

Refractive Eye Surgery

Any eye surgery for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia), and astigmatism, unless Medically Necessary, recommended by Your treating Physician and authorized by HNL.

Optometrics, Vision Therapy And Orthoptics

Optometric services, vision therapy, eye exercises including orthoptics, except as specifically stated elsewhere in this *Certificate*. Contact or corrective lenses (except when Medically Necessary following surgery), and eyeglasses unless specifically provided elsewhere in this *Certificate*.

Sex Change

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

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

Conception By Medical Procedure
Artificial insemination (including procedures, office visits, follicle ultrasounds and sperm washing) is covered when a female Covered Person and/or her male partner is infertile (refer to Infertility in the "Definitions" section of this *Certificate*). However, if only the male partner is a Covered Person and the female partner (who is not a Covered Person) is infertile, artificial insemination will not be covered. The collection, storage or purchase of sperm is not covered. Other services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include, but are not limited to:

- In-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or any other process that involves the harvesting, transplanting, or manipulating of a human ovum, except as stated in the "Schedule of Benefits and Copayments" section of this *Certificate*. Also not covered are services and supplies (including injections and injectable medications) which prepare the Covered Person to receive these services.
- Collection, storage or purchase of sperm or ova.

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

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

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

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

Routine Physical Examinations
For insurance, licensing, employment, school, camp or other nonpreventive purposes. Routine vision and hearing exams. Any physical, vision or hearing exams which are not related to treatment of illness or injury, except as specifically stated in the "Medical Benefits" section of this *Certificate.*

Immunizations Or Inoculations
Immunizations or inoculations for adults or children are limited to those described in the "Medical Benefits" section of this *Certificate*.

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

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

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

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

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

Non-Participating Providers
Services or supplies furnished by providers who are not Participating Providers, as defined herein.

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

Physicians Treating Immediate Family Members
Routine or ongoing treatment or consultation provided by the Covered Person's parent, spouse, Domestic Partner, child or sibling. Covered Persons who receive routine or ongoing care from a member of their immediate family will be reassigned to another Physician.

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

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

Mental Health and Substance Abuse Benefits
University of California has independently contracted with United Behavioral Health (UBH), a specialized health care service plan, to provide **Mental Health** and **Substance Abuse** benefits. Services, treatments and supplies that are not Covered Services in the United Behavioral Health (UBH) **Mental Health** and **Substance Abuse** Plan are described in detail in the United Behavioral Health (UBH Certificate.

Private Duty Nursing
Inpatient and outpatient services (including incremental nursing) provided by a Private Duty Nurse.

Hyperkinetic Syndromes, Learning Disabilities, Behavioral Problems Or Mental Retardation
Expenses related to these conditions are not covered regardless of the type of service. However, certain of these conditions shall be covered as shown in the "Schedule of Benefits and Copayments" section, provided that their level of severity meets the criteria described in the "Definitions" section of this *Certificate* under "Serious Emotional Disturbances of a Child" and/or "Severe Mental Illness."

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

- Alteration of Your residence, to accommodate Your physical or medical condition, including the installation of elevators
- Disposable supplies for home use;
- Exercise equipment, including treadmills, and charges for activities or facilities normally intended or used for physical fitness
- Hygienic equipment, Jacuzzis and spas
- Corrective appliances, except prostheses, casts or splints. Surgical dressings other than primary dressings that are applied by Your PCP or a Hospital to lesions of the skin or surgical incisions.
- Support appliances and supplies such as stockings; arch supports
- Orthotics, unless custom made to fit Your body (Orthotics are supports or braces for weak or ineffective joints or muscles)

- Orthodontic appliances, to treat dental conditions related to the treatment of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders)
- Foot orthotics (whether or not custom fit) that are not incorporated into a cast, splint, brace or strapping of the foot, unless purchased by Your employer as a specific benefit for corrective footwear as shown in the "Medical Supplies" portion of the "Schedule of Benefits and Copayments" section and the "Medically Necessary Corrective Footwear" provision of the "Medical Benefits" section
- Personal or comfort items
- Air purifiers, air conditioners and humidifiers
- Food supplements (except as specifically stated in the "Outpatient Infusion Therapy" provision of the "Medical Benefits" section of this *Certificate*.)
- Educational services or nutritional counseling, except as specifically provided in the "Patient Education Program" or "Outpatient Infusion Therapy" provisions of the "Medical Benefits" section of this *Certificate*.

However, the *Certificate* does cover Medically Necessary diabetic equipment as shown in the "Medical Supplies" portion of "Schedule of Benefits and Copayments" section and the "Diabetic Equipment" provision in the "Medical Benefits" section. Visual aids (excluding Eyewear) to assist the visually impaired in the proper dosing of insulin are covered as described in the "Prosthetics and Corrective Appliances" portion of the "Covered Services and Supplies section."

Eyeglasses and Contact Lenses
This Plan does not cover Eyeglasses or Contact Lenses. However, this exclusion does not apply to an implanted lens that replaces the organic eye lens.

Treatment Of Obesity
Treatment or surgery for obesity, weight reduction or weight control is limited to the treatment of morbid obesity.

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

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

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

Expenses Before Coverage Begins
Services received before Your Effective Date.

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

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

Services Provided By Family Members
Professional services received from a person who lives in Your home or who is related to You by blood or marriage.

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

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

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

Governmental Agencies
Any services provided by or for which payment is made by, a local, state or federal government agency.

Covered Persons Disabled At The Time Of Enrollment
Generally, under the federal Health Insurance Portability and Accountability Act, HNL cannot deny You benefits due to the fact that You are disabled or hospitalized at the time of enrollment. However, if at the time of enrollment You are totally disabled or hospitalized and pursuant to state law You are entitled to an extension of benefits from the insurance carrier providing coverage to Your prior group health plan, benefits of this *Certificate* will be coordinated with benefits payable by the insurance carrier providing coverage to Your prior group health plan, so that not more than 100% of Covered Expenses are provided for services rendered to treat the disabling condition (or condition for which You are hospitalized) under both plans.

For the purposes of coordinating benefits under this *Certificate*, if You are entitled to an extension of benefits from the insurance carrier providing coverage to Your prior group health plan, and state law permits such arrangements, the insurance carrier providing coverage to Your prior group health plan shall be considered the primary plan (paying benefits first) and benefits payable under this *Certificate* shall be considered the secondary plan (paying any excess Covered Expenses), up to 100% of total Covered Expenses.

Acupuncture
Any expenses related to the puncture of the skin for diagnostic or therapeutic (counter-irritation) purposes either manually through the use of needles or electrically through the use of needles or the Transcutaneous Electrical Nerve Stimulation (TENS) device.

Chiropractic Services
Expenses related to chiropractic adjustments, manipulations and therapy.

Services Related To Pregnancy Induced Under A Surrogate Parenting Agreement
Services for conditions of pregnancy for a surrogate parent when the surrogate is a Covered Person are covered, but when compensation is obtained for the surrogacy, HNL shall have a lien on such compensation to recover its medical expense. A surrogate parent is a woman who agrees to become pregnant with the intent of surrendering custody of the child to another person.

Unlisted Services
Any service or supplies not specifically listed in this *Certificate* as covered expenses.

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

Outpatient Drugs And Medications

Any outpatient drugs, medications or other substances dispensed or administered in any outpatient setting, except as specially stated in the "Medical Benefits" or the "Outpatient Prescription Drugs" sections of this *Certificate*. This includes any nonprescription (over-the-counter) drug that can be purchased without a prescription (including a drug requiring a prescription but for which there is a non-prescription equivalent), even if a Physician writes a Prescription for a nonprescription drug. However, medical equipment and supplies which are prescribed by a Physician for the management and treatment of diabetes will be covered even if available without a prescription.

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

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

Any other nonprescription Drug, or over-the counter drugs, medical equipment or supplies that can be purchased without a Prescription Drug Order is not covered, even if a Physician writes a Prescription Drug Order for a nonprescription Drug for such order, unless listed in the Recommended Drug List.

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

Rehabilitative Services

Rehabilitation therapy is limited to services after an acute episode of care for chronic conditions, an acute illness or injury or an acute exacerbation of such an illness or injury. Rehabilitative services, in excess of the number of visits stated in the "Schedule of Benefits and Copayments" section, whether rendered in an inpatient or outpatient facility, are not covered. In addition, rehabilitation therapy services (physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy) are not covered when provided in connection with the treatment of the following conditions:

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

Outpatient Speech Therapy

Therapy which is not provided in relation to surgery, injury or disease.

Foreign Travel Or Work Assignment

If You receive services or obtain supplies in a country other than the United States, benefits will be payable for Emergency Care only.

Telephone Consultations

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

EXTENSION OF BENEFITS

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

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

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

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

COORDINATION OF BENEFITS

Your coverage is subject to the same limitations, exclusions and other terms of this Certificate whether HNL is the Primary Plan or the Secondary Plan.

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

B. **PURPOSE**: "Coordination of Benefits" determines responsibility for payment of eligible expenses among insurers providing Group coverage to You, so that the total of all reasonable expense for Covered Services and Supplies will be paid up to the stated limits of all such coverages, but not to exceed total expense incurred for those services and supplies.

C. **ADMINISTRATION**: If You are known to have group coverage through any other health plan or insurer, responsibility for payment of benefits is determined by following the Rules Establishing the Order of Benefits Determination, formulated by the Insurance Commissioner of the State of California and incorporated in this *Certificate*. Such rules determine the order of payment responsibilities between HNL and any other applicable group insurer, by establishing which is the PRIMARY PLAN and which is the SECONDARY PLAN.

1. **PRINCIPAL COVERED PERSON**: This *Certificate* is the PRIMARY PLAN with responsibility for first payment, except when (i) You are covered by another group health plan or insurer as the employee and that plan has covered him or her longer than the HNL plan, or (ii) the group plan or insurer does not contain a Coordination of Benefits provision similar to this one.

2. **SPOUSE**: This *Certificate* is the PRIMARY PLAN with responsibility for first payment, except when (i) the spouse is covered under another group health plan or insurer as the employee or (ii) the other group plan or insurer does not contain a Coordination of Benefits provision similar to this one.

3. **CHILD**: Determination of the PRIMARY PLAN will be based on the following:

   a. The insurer, under whom the child is covered as a principal Covered Person, employee or primary individual, shall be the PRIMARY PLAN for that child.

   b. If the child is not covered as specified in Section 3.a. above, and is covered as a dependent under the insurers of both parents, then the insurer of the parent whose date of birth, but not year of birth, occurs earlier in a Calendar Year shall be the PRIMARY PLAN for dependent children covered under their group health plan. The insurer of the parent whose birthday occurs later in the Calendar Year shall be the SECONDARY PLAN for dependent children covered under their group health plan.

   HNL is the PRIMARY PLAN with responsibility for first payment, unless the Order of Benefit Determination is affected because of a divorce and assignment of legal custody of the child. IF THE MOTHER HAS LEGAL CUSTODY, her group plan or insurer pays first; the stepfather's (if any) group plan or insurer pays second; and the natural father's third. IF THE FATHER HAS LEGAL CUSTODY, his group plan or insurer pays first; the stepmother's (if any) pays second, and the natural mother's third.

   The above paragraphs of this Subsection 3.b. notwithstanding, if the child's parents are separated or divorced and there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses of that child, then the insurer of the parent with such court-ordered financial responsibility shall be the PRIMARY PLAN. The insurer of the other parent shall be the SECONDARY PLAN.

4. When numbers 1-3 above do not establish an order of benefit determination, the insurer or group health plan who has covered the person for the longer period of time shall be the PRIMARY PLAN and the other insurer shall be the SECONDARY PLAN provided that:

    a. The benefits of a group health plan or insurer covering the person as a laid off or retired employee or dependent of such person, shall be determined after the benefits of any other insurer or Group health plan covering such person as an employee, other than a laid off or retired employee or dependent of such person; and

    b. If either group health plan does not have a provision regarding laid off or retired employees, which results in each insurer or group health plan determining its benefits after the other, then the provisions of 4.a. shall not apply.

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

E. **RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION**: HNL may obtain or release any information considered to be necessary for Coordination of Benefits with respect to any person claiming benefits under this *Certificate* without consent of, or notice to, You or any other person or organization. However, HNL shall not be required to determine the existence of any other group plan or insurer or the benefits payable under such plan or insurer when computing benefits due You covered under this *Certificate*.

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

G. **RIGHT OF RECOVERY**: Whenever HNL's payment for Covered Expenses exceeds the maximum amount of payment necessary to satisfy the intent of this provision, HNL shall have the right to recover those excessive amounts from any insurer, any organization or any persons.

H. **GOVERNMENT COVERAGE**

MEDICARE COORDINATION OF BENEFITS (COB): When You or Your spouse reach age 65, You may become eligible for Medicare based on age. You may also become eligible for Medicare before reaching age 65 due to disability or end stage renal disease.

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

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

If either You or Your spouse is over the age of 65 and You are actively employed, neither You or Your spouse is eligible for Medicare Coordination of Benefits. For answers to questions regarding Medicare, contact:

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

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

SPECIFIC PROVISIONS

Grievance And Appeals Process

If You are not satisfied with efforts to solve a problem with HNL or a Participating Provider, You must first file a grievance or appeal against HNL by calling Member Services at **1-800-539-4072** or by submitting a Member Grievance Form through the HNL website at www.healthnet.com/uc. You must file Your grievance or appeal with HNL within 365 calendar days following the date of the incident or action that caused Your grievance. You may also file a complaint in writing by sending information to:

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

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

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

Independent Medical Review Of Grievances Involving A Disputed Health Care Service

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

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

Eligibility

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

1.(A) Your provider has recommended a health care service as Medically Necessary, or

(B) You have received urgent or Emergency Care that a provider determined to have been Medically Necessary

(C) In the absence of the provider recommendation described in 1. (A) above, or the receipt of urgent or Emergency Care described in 1. (B) above, You have been seen by a Physician for the diagnosis or treatment of the medical condition for which You seek IMR;

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

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

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

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

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

Independent Medical Review Of Investigational Or Experimental Therapies

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

Eligibility

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

If You obtain care through the HNL EPO network, and HNL denies coverage of the recommended or requested therapy and You meet the eligibility requirements, HNL will notify You within five business days of its decision and Your opportunity to request an external review of HNL's decision through IMR. HNL will provide You with an application form to request an IMR of HNL's decision. The IMR process is in addition to any other procedures or remedies that may be available. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of Your request for IMR. If Your Physician determines that the proposed therapy should begin promptly, You may request expedited review and the experts on the IMR panel will render a decision within seven days of the request. If the IMR panel recommends that HNL covers the recommended or requested therapy, coverage for the services will be subject to the terms and conditions generally applicable to other benefits You are entitled to. A decision not to participate in the IMR process may cause You to forfeit any statutory right to pursue legal action against HNL regarding the denial of the recommended or requested therapy. For more information, You may call the Member Services Department at the telephone number on Your HNL ID Card.

Arbitration

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

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

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

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

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

Health Net Life
Attention: Litigation Administrator
P.O. Box 4504
Woodland Hills, CA 91365-4505

If your concern involves the Mental Health Disorders and Substance Abuse, please call United Behavior Health (UBH) at 1-888-440-8225.

You may write to:

United Behavior Health
Appeals & Grievances
P.O Box 32040
Oakland, CA 94604

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

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

Effective July 1, 2002, Covered Persons who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are *not* required to submit disputes about certain "adverse benefit determinations" made by HNL to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by HNL to deny, reduce, terminate or not pay for all or a part of a benefit. However, You and HNL may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Medical Malpractice Disputes

HNL and the health care providers that provide services to You through this Plan are each responsible for their own acts or omissions and are ordinarily not liable for the acts or omissions of others nor for the costs of defending others.

When A Third Party Causes The Covered Person's Injuries:

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

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

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

1. **STEPS THE COVERED PERSON MUST TAKE**

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

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

   a. Telling HNL, and the medical providers, the name and address of the third party, if You know it, the name and address of Your lawyer, if You are using a lawyer and describing how the injuries were caused;

   b. Completing any paperwork that HNL or the medical providers may reasonably require to assist in enforcing the lien;

   c. Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions;

   d. Notifying the lienholders immediately upon You or Your lawyer receiving any money from the third parties or their insurance companies; and

   e. Holding any money that You receive from the third parties or their insurance companies in Group, and reimbursing HNL, and the medical providers for the amount of the lien as soon as You are paid by the third party.

2. **HOW THE AMOUNT OF THE COVERED PERSON'S REIMBURSEMENT IS DETERMINED**

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

   a. The amount of the reimbursement owed to HNL, or the medical provider will be reduced by the percentage that the recovery is reduced if a judge, jury or arbitrator determines that You were responsible for some portion of his or her injuries.

   b. The amount of the reimbursement owed HNL, or the medical provider will also be reduced by a pro rata share for any legal fees or costs paid from money You received.

   c. The amount You will be required to reimburse HNL or the medical provider for services received under this plan will not exceed one-third of the money You received if You engage a lawyer or one-half of the money received if a lawyer is not engaged.

Refund To HNL of Overpayment Of Benefits

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

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

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

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

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

Termination Of Membership For Cause:

HNL may terminate Your coverage under this *Certificate* if You:

- Knowingly omit or misrepresent a material fact on the application for membership.
- Utilize fraud or deception in the use of benefits or knowingly permit such fraud or deception by another.
- Fail to pay any required fee, Coinsurance, Copayment and, if applicable, premium required under this *Certificate*.

If You are terminated for any of the above reasons, You and all Dependents forfeit all rights to enroll in the Conversion Plan or reenroll in Health Net EPO or HNL at any future time. A termination for cause shall be effective immediately upon mailing of notice of termination, or upon any later date set forth in the notice. However, in relation to item 1 above, such termination may extend back to the beginning of coverage.

Second Medical Opinion

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

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

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

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

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

GENERAL PROVISIONS

Member Services Department Interpreter Services

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

Form Or Content Of Certificate

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

Benefits Not Transferable

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

Time Limit On Certain Defenses

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

Cash Benefits

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

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

Notice Of Claim

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

If You need to file a claim for outpatient Prescription Drugs, please send a completed prescription drug claim form to:

Health Net
C/O Caremark
P.O. Box 52136
Phoenix, AZ 85072

Please call the Member Services Department at **1-800-539-4072** or visit our website at www.healthnet.com/uc to obtain a prescription drug claim form.

Claim Forms

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

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

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

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

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

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

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

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

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

Notice
Any notice required of HNL shall be sufficient if mailed to the holder of the Group Agreement, at the address appearing on the records of HNL; and, if notice is required of You or the employer, it will be sufficient if mailed to the HNL office at the address listed on the back cover of this *Certificate*.

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

Legal Actions
No legal action may be brought to recover under this *Certificate* after three years from the time the Notice of Claim was required to be sent to HNL. This means that legal action must occur no later than four years after performance of the disputed medical service.

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

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

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

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

Your Responsibility

As a Covered Person, You must:

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

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

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

If You are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if You know of or suspect any illegal activity, call Our toll-free hotline at **1-800-977-3565**. All calls are strictly confidential.

Privacy Statement

At HNL, maintaining Our customers' and insureds' ("Covered Persons") Group and confidence is a top priority. We want You to understand how We protect Your privacy when We collect and use information about Covered Persons and the measures that We take to safeguard that information. These provisions apply to both current and former Covered Persons, unless We state otherwise.

Information Security

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

Information We Collect

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

1. Information We receive from the Covered Person on applications or other forms (such as the Covered Person's name, address, telephone number, social security number, account information, employment, health status and other personal information relevant to the Covered Person's coverage); and

2. Information about the Covered Person's transactions with Us, Our affiliates or others (such as information about premium payment history, Copayments, claims payments, Coinsurance and Deductibles).

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

Disclosures

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

Additional Information about this Privacy Statement

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

**Information We collect through Our Internet web site is subject to Our Web Privacy Statement, which is available on Our web site at www.healthnet.com/uc.

Notice of Privacy Practices

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

This notice, effective August 10, 2006, tells You about the ways in which HNL (referred to as "We" or "the Plan") may collect, use and disclose Your protected health information and Your rights concerning Your protected health information. "Protected health information" is information about You, including demographic information, that can reasonably be used to identify You and that relates to Your past, present or future physical or Behavioral Health or condition, the provision of health care to You or the payment for that care.

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

How We May Use And Disclose Your Protected Health Information

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

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

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

Other Permitted Or Required Disclosures

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

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

Other Uses Or Disclosures With An Authorization

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

Your Rights Regarding Your Protected Health Information

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

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

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

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

within the same time period, We may charge for providing the accounting, but We will tell You the cost in advance.

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

Health Information Security

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

Changes To This Notice

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

Complaints

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

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

Contact The Plan

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

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

You may also contact Us at:

Telephone: **1-800-539-4072**
Fax: **1-818-676-8981**
Email: Privacy@healthnet.com

Continuity of Care

If HNL's contract with a Participating Provider is terminated, HNL will transfer any affected Covered Persons to another contracted Participating Provider to ensure that care continues.

In addition, You may request continued care with a terminated provider if at the time of termination You were receiving care from such a provider for:

- An acute condition
- A serious chronic condition
- A pregnancy
- A newborn
- A terminal illness
- A scheduled surgery

If You would like more information on how to request continued care You may contact the Member Services Department at the telephone number on Your HNL ID Card.

Providing Of Care

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

Non-Regulation Of Provider Charges This HNL EPO plan does not regulate the amounts charged by providers of medical care, except to the extent that the amounts charged for Covered Services and Supplies by Participating Providers are based on Allowable Charges.

OUTPATIENT PRESCRIPTION DRUG BENEFITS

The following section describes covered services, exclusions and limitations of additional plan benefits available under this *Certificate*. Please refer to the "Schedule of Benefits and Copayments" section of this *Certificate* for information on the applicable Copayments, Coinsurance, Deductibles and benefit maximums.

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

The following benefits are provided for Prescription Drugs and diabetic supplies. The Recommended Drug List (also referred to as "the List") includes Generic Drugs and Brand Name Drugs which this plan covers at the Copayment levels shown in the "Schedule of Benefits and Copayments." It was developed to identify the safest and most effective medications for HNL Covered Persons while attempting to maintain affordable pharmacy benefits. We specifically suggest to all HNL contracting Physicians and specialists that they refer to this List when choosing drugs for patients who are HNL Covered Persons. When Your Physician prescribes medications listed in the Recommended Drug List, it is ensured that You are receiving a high quality and high value prescription medication.

A. DEFINITIONS

The following definitions apply to the coverage provided under this "Outpatient Prescription Drug Benefits" section. Other "Definitions" appearing within this *Certificate* also apply to the coverage provided under the outpatient prescription drug benefits.

Average Wholesale Price ("AWP") is the accepted amount for pharmaceutical products from one of the following: Medi-Span, First Data Bank or Micro-Medics as determined by HNL.

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

Compounded Drugs are Prescription Drug Orders that are combined or manufactured by the pharmacist and placed in an ointment, capsule, solution or cream using FDA approved drugs, with the primary drug being on the Recommended Drug List and used for a FDA approved indication.

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

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

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

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

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

Some Level III Drugs may require Prior Authorization from HNL in order to be covered. Please refer to the “Recommended Drug List” definition in this section for more details.

Maintenance Drugs are Prescription Drugs taken continuously to manage chronic or long term conditions where Covered Persons respond positively to drug treatment, and dosage adjustments are either no longer required or are made infrequently.

Maximum Allowable Cost for any Prescription Drug is the maximum charge HNL will allow for Generic Drugs, or for Brand Name Drugs which have a generic equivalent. A list of Maximum Allowable Costs is maintained, and may be revised periodically, by HNL.

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

Off-Label is a term of classification for Prescription Drugs that are approved by the Food and Drug Administration, but that are used for indications other than those stated in the marketing label. A Prescription Drug prescribed for a use that is not stated in the indications and usage information published by the manufacturer is covered only if the drug is:

a. Approved by the Food and Drug Administration (FDA).

b. Prescribed or administered by a licensed health care professional for the treatment of:

   i. A life-threatening condition, or

   ii. A chronic and seriously debilitating condition in which the drug is determined to be Medically Necessary to treat such condition.

c. Recognized for treatment of the life-threatening or chronic and seriously debilitating conditions by one of the following:

   i. The American Medical Association Drug Evaluations

   ii. The American Hospital Formulary Service Drug Information

   iii. The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional"

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

d. Otherwise Medically Necessary.

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

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

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

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

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

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

Prescription Drug is a drug or medicine which, according to federal law, can be obtained only by a Prescription Drug Order and is required to bear a label which says, "Caution, Federal Law Prohibits Dispensing Without a Prescription," or is restricted to prescription dispensing by state law. An exception is insulin and other diabetic supplies which are considered to be a covered Prescription Drug.

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

Prescription Drug Allowable Charge is the lesser of pharmacy's usual and customary charge or is the charge that Participating Pharmacies and the mail service program have agreed to charge Covered Persons, based on a contract between HNL and such provider.

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

Prior Authorization is the approval process for certain Generic Drugs and Brand Name Drugs that are listed on the Recommended Drug List or not on the List. Physicians must obtain Prior Authorization before certain List or non-List Drugs will be covered.

Recommended Drug List (also known as the **List)** is a list of the Prescription Drugs that are covered under this *Certificate.* You may contact the Member Services Department at the telephone number on Your HNL ID Card to find out if a particular drug is on the HNL list. You may also request a copy of the current List to be mailed to them. The current List for is also available on the internet at www.healthnet.com/uc under the pharmacy information. It is prepared by HNL and given to all Participating Providers and Participating Pharmacies. These lists may be revised periodically.

B. BENEFITS

Outpatient Prescription Drug Benefits shall be provided if You, while covered under this *Certificate*, incurs an expense for Prescription Drugs which were prescribed by any Physician who has been designated as a Participating EPO Provider for this benefit plan or by an Out-of-Network Physician in connection with a medical emergency.

Diabetic Drugs and Supplies

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

Drugs and Equipment for the Treatment of Asthma

Prescription Drugs for the treatment of asthma are covered as stated in the Recommended Drug List. Inhaler spacers and peak flow meters used for the management and treatment of asthma are covered when Medically Necessary. Nebulizers (including face masks and tubing) are covered under the medical benefit. Please refer to the "Medical Services and Supplies" portion of this section for additional information.

Contraceptives

Oral contraceptives and emergency contraceptives are covered. Vaginal contraceptives include diaphragms and cervical caps, when a Member Physician performs a fitting examination and prescribes the device. Such devices are only available through a prescription from a pharmacy and limited to one fitting and prescription per Calendar Year unless additional fittings or devices are Medically Necessary. For a complete list of contraceptive products covered by HNL, please refer to the Recommended Drug List. Injectable contraceptives are covered as a medical benefit when administered by a Physician. Refer to the "Schedule of Benefits and Copayments" section for details about the supply amounts that are covered.

Smoking Cessation Coverage

Drugs that require a prescription in order to be dispensed for the relief of nicotine withdrawal symptoms are covered for the course of therapy stated in the "Outpatient Prescription Drug Benefits" portion of "General Limitations and Exclusions," and if the Covered Person is concurrently enrolled in a comprehensive smoking cessation behavioral support program. The prescribing Physician must request Prior Authorization for coverage. For information regarding smoking cessation behavioral support programs available through HNL, contact Member Services at the telephone number on Your HNL ID Card or visit Our website at www.healthnet.com/uc.

1. GENERIC DRUGS AND BRAND NAME DRUGS INCLUDED ON THE RECOMMENDED DRUG LIST AND DRUGS THAT ARE NOT ON THE LIST

The List is created and maintained by the HNL Pharmacy and Therapeutics Committee. Before deciding whether to include a drug on the List, the committee reviews medical and scientific publications, relevant utilization experience and Physician recommendations to assess the drug for its safety, effectiveness, cost-effectiveness (when there is a choice between two drugs having the same effect, the less costly drug will be listed), side effect profile and therapeutic outcome. The committee has quarterly meetings to review medications and to establish policies and procedures for drugs included in the List. The Recommended Drug List is updated as new clinical information and medications are approved by the FDA. The committee is made up of actively practicing Physicians of various medical specialists from HNL Physician Groups, as well as clinical pharmacists. Voting members are recruited from contracting Physician Groups throughout California based on their experience, knowledge and expertise. In addition, the Pharmacy and Therapeutics Committee frequently consults with other medical experts to provide additional input to the Committee. A vote is taken before a drug is added to the List. The voting members are not employees of HNL. This ensures that decisions are unbiased and without conflict of interest.

Prescription Drugs listed on the Recommended Drug List are covered, when dispensed by Participating Pharmacies and prescribed by a Physician. Subject to the benefits maximums shown in the "Schedule of Benefits and Copayments" section, Prescription Drugs not listed in the Recommended Drug List that are not excluded from coverage are considered non-List drugs and are covered under the HNL Pharmacy only. When a non-List Prescription Drug is dispensed, You will be responsible for the Coinsurance amount shown in the "Schedule of Benefits and Copayments" section. Some List and non-List Prescription Drugs may require Prior Authorization to be covered.

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

2. PRIOR AUTHORIZATION PROCESS

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

Urgent requests from Physicians are handled in a timely fashion not to exceed 72 hours, as appropriate and Medically Necessary, for the nature of the Covered Person's condition after HNL's receipt of the information reasonably necessary and requested by HNL to make the determination. Routine requests from Physicians are processed in a timely fashion, not to exceed 5 days, as appropriate and Medically Necessary, for the nature of the Covered Person's condition after HNL's receipt of the information reasonably necessary and requested by HNL to make the determination. Requests may be submitted by telephone or facsimile. HNL will evaluate the submitted information upon receiving the Physician's request for Prior Authorization and make a determination based on established clinical criteria for the particular medication. The criteria used for Prior Authorization is developed and based on input from the HNL Pharmacy and Therapeutics Committee as well as Physician experts. Your Physician may contact HNL to obtain the usage guidelines for specific medications.

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

3. PRESCRIPTION DRUGS DISPENSED BY A PARTICIPATING PHARMACY

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

HNL is contracted with many major pharmacy chains, supermarket based pharmacies and privately owned neighborhood pharmacies in California. To find a conveniently located Participating Pharmacy, please visit Our website at www.healthnet.com/uc or call the Member Services Department at the telephone number on Your HNL ID Card. Present the HNL ID Card and pay the appropriate Copayment when the drug is dispensed.

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

You, upon presentation of a valid HNL ID Card which indicates coverage for Prescription Drugs, shall be entitled to have a Prescription Order filled by a Participating Pharmacy for up to a 30 consecutive calendar day supply per prescription or for each refill at the appropriate time interval, subject to the following:

(If the HNL ID Card has not been received or if it has been lost, refer to Subsections 4 and 6 below.)

a. **IF A GENERIC DRUG IS DISPENSED** by a Participating Pharmacy, You must pay the Participating Pharmacy the Copayment specified in the "Schedule of Benefits and Copayments" section of this *Certificate* for each Generic Drug dispensed.

b. **IF A BRAND NAME DRUG IS DISPENSED** by a Participating Pharmacy and there is an equivalent Generic Drug commercially available, You must pay the pharmacy the difference between the cost of the Generic Drug and the cost of Brand Name Drug, as well as the Copayment specified in the "Schedule of Benefits and Copayments" section of this *Certificate* unless the Physician has specified "do not substitute," "dispense as written" or words of similar meaning on the Prescription Order.

   You may avoid paying this additional amount by requesting that the Generic Drug be substituted.

If a Participating Pharmacy dispenses a Brand Name Drug not listed in or not dispensed according to the Recommended Drug List, the Copayment or Coinsurance for Level III drugs as shown in the "Schedule of Benefits and Copayments" section of this Certificate will apply.

4. PRESCRIPTION DRUGS DISPENSED BY A NONPARTICIPATING PHARMACY

Prescription drugs dispensed by a Nonparticipating Pharmacy are covered for emergency or urgent care. A new Covered Person who has not yet received the HNL ID Card may also fill the Prescription Order at a Nonparticipating Pharmacy during the first 30 days of coverage. The Covered Person must pay the full cost of the Prescription Drug dispensed and submit a claim to HNL for partial reimbursement.

The maximum charge HNL will allow for a Prescription Order is the Prescription Drug Covered Expense, as defined in Section A above. It is not necessarily the amount a Nonparticipating Pharmacy will charge. You are financially responsible for any amount charged by a Nonparticipating Pharmacy which exceeds the amount of Prescription Drug Covered Expense in addition to the appropriate Deductible and Copayment.

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

a. **IF A GENERIC DRUG IS DISPENSED** by a Non-Participating Pharmacy, You must pay the Non-Participating Pharmacy the full cost of the drug and then file a claim for reimbursement. HNL will first determine the amount of Prescription Drug Covered Expense for the drug, then subtract the applicable Copayment or Coinsurance. You will be reimbursed for the remaining portion of Prescription Drug Covered Expense.

b. **IF A BRAND NAME DRUG IS DISPENSED** at Your request by a Non-Participating Pharmacy, You must pay the Non-Participating Pharmacy the full cost of the drug and then file a claim for reimbursement. HNL will determine the Prescription Drug Covered Expense for the drug, and subtract the applicable Copayment or Coinsurance.

If there is an equivalent Generic Drug commercially available, HNL will also subtract the difference in the amount of cost of the Generic Drug and the cost of the Brand Name Drug, unless the Physician has specified "do not substitute," "dispense as written" or words of similar meaning on the Prescription Order. You must include a copy of the Prescription Order with the claim form.

You will be reimbursed for the remaining portion of Prescription Drug Covered Expense.

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

Claim forms will be provided by HNL upon request.

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

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

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

When a Brand Name Drug is dispensed at You request, but there is an equivalent Generic Drug commercially available, You will be billed the difference between the cost of the Generic Drug and the cost of the Brand Name Drug as well as any Copayment specified in the "Schedule of Benefits and Copayments" section of this *Certificate* unless the Physician has indicated "do not substitute," "dispense as written" or words of similar meaning on the Prescription Order.

You may avoid paying this additional amount by requesting that the Generic Drug be substituted.

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

6. WHEN THE HNL EPO IDENTIFICATION CARD IS NOT IN YOUR POSSESSION

If You need to have a Prescription Order filled by a Participating Pharmacy and have not received an HNL ID Card, or it has been lost, or eligibility cannot be determined, You must pay for the drug(s). You may then be entitled to partial reimbursement. After the HNL ID Card has been received, You must file a claim. Claim forms will be provided by HNL upon request.

C. GENERAL PROVISIONS

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

1. Expense must be incurred on or after Your Effective Date of coverage under this *Certificate* and prior to termination of such coverage. An expense will be considered to have been incurred on the date that the Prescription Drug is dispensed.
2. The amount of Prescription Drugs (including insulin) which may be dispensed per Prescription Order or refill at a pharmacy will be in quantities normally prescribed by a Physician up to and including a 30-consecutive calendar day supply. In some cases, a 30-consecutive-calendar-day supply may not be an appropriate drug treatment plan according to the Food and Drug Administration (FDA), or HNL usage recommendations. If this is the case, the amount of medication may be less than a 30-day supply.
3. Up to a 90-consecutive-calendar-day supply of Maintenance Drugs (see "Definitions" in Section A) may be dispensed through the Mail Service Prescription Drug Program. Prescription Drugs that are not Maintenance Drugs will also be dispensed by the mail order program, but the quantity dispensed may be less than a 90-day quantity. For information, You should call the mail order program at **1-888-858-2951**. In some cases, a 90-consecutive-calendar-day supply may not be an appropriate drug treatment plan according to the Food and Drug Administration (FDA) or HNL's usage recommendations. If this is the case, the amount of medication may be less than a 90-day supply.
4. Any Participating Pharmacy furnishing benefits to You does so as an independent contractor and HNL shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by You.
5. HNL shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with the manufacturing, compounding, dispensing or use of any Prescription Drug covered under this *Certificate*.
6. HNL retains the right to replace any third-party contracting agency through which You may be required to obtain Prescription Drugs. If HNL should replace any such third-party contracting agency, You would be notified of all new procedures. HNL also retains the right to modify the program with due notice to Covered Persons.

D. EXCLUSIONS:

In addition to any applicable "General Limitations" contained elsewhere in this *Certificate*, the following "Exclusions" shall apply to the coverage described under this section.

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

Allergy Serum: Allergy desensitization products, whether administered by injection or drops placed in the nose or mouth (transmucosal absorption), to lessen or end the person's allergic reactions are not covered. These products are sometimes described as "allergy serum." Allergy serum is covered as a medical benefit. See the "Allergy, Immunizations and Injections" portion of the "Schedule of Benefits and Copayments" section.

Appetite Suppressants Or Drugs For Body Weight Reduction: Drugs for the treatment of obesity are not covered unless Medically Necessary.

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

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

Devices: Coverage is limited to vaginal contraceptive devices, peak flow meters, inhaler spacers, and those devices listed under "Diabetic drugs and supplies" in this section. No other devices are covered even if prescribed by a Physician.

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

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

Drugs Prescribed by a Dentist: Drugs prescribed for routine dental treatment are not covered.

Drugs Covered By Another Section: Prescription Drugs covered in whole or in part elsewhere in this Plan are not covered.

Drugs Prescribed for Common Cold: Drugs when prescribed to shorten the duration of the common cold are not covered.

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

Food And Drug Administration (FDA): Supply amounts for prescriptions that exceed the FDA's or HNL's indicated usage recommendation are not covered, unless Medically Necessary and Prior Authorization is obtained from HNL.

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

Injectable Drugs: Injectable drugs obtained through a prescription are limited to insulin and sexual dysfunction drugs when prescribed by a Physician. Other injectable medications are covered under the medical benefit (see the "Immunizations and Injections" portion of the "Medical Benefits" section). Surgically implanted drugs are covered under the medical benefit (see the "Surgically Implanted Drugs" portion of the "Medical Benefits" section.

Irrigation Solutions: Irrigation solutions and saline solutions are not covered.

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

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

Lost, Stolen Or Damaged Drugs: Drugs that are lost, stolen, or damaged are not covered. The Covered Person will have to pay the retail price for replacing them.

Nonparticipating Pharmacies: Drugs dispensed by Nonparticipating Pharmacies are not covered, except as specified in the "Drugs Dispensed by a Nonparticipating Pharmacy" provision this section.

Nonprescription (Over-the-Counter) Drugs, Equipment And Supplies: Medical equipment and supplies (including insulin), that are available without a prescription, are covered when prescribed by a Physician for the management and treatment of diabetes.

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

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

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

Schedule II Narcotic Drugs: Schedule II narcotic drugs are not covered through mail order. Schedule II drugs are drugs classified by the Federal Drug Enforcement Administration as having a high abuse risk but also safe and accepted medical uses in the United States.

Smoking Cessation: Drugs that require a prescription in order to be dispensed for the relief of nicotine withdrawal symptoms are covered up to a twelve-week course of therapy per Calendar Year if You are concurrently enrolled in a comprehensive smoking cessation behavioral support program. The prescribing Physician must request Prior Authorization for coverage. For information regarding smoking cessation behavioral support programs available through HNL, contact Member Services at the telephone number on Your HNL ID card or visit the HNL website at www.healthnet.com/uc.

Unit Dose Or "Bubble" Packaging: Individual doses of medication dispensed in plastic, unit dose, or foil packages and dosage forms used for convenience as determined by HNL, are only covered when Medically Necessary or when the medication is only available in that form.

Compounded Drugs: Compounded drugs are Prescription Drug Orders that are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form using FDA approved drugs and are covered at the Level III Drug Copayment only when Medical Necessity is verified through Prior Authorization and the prescription is being used for a FDA approved indication. Compounded drugs are not covered if there is a similar proprietary product available.

PLAN ADMINISTRATION

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this Plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the Group Hospital and Professional Service Agreement. What is written in this document and/or the Group Insurance Contracts does not constitute a guarantee of plan coverage or benefits--particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plan is administered and what your rights are.

Sponsorship and Administration of the Plan
The University of California is the Plan sponsor for the Plan described in this booklet. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
Health & Welfare Administration
300 Lakeside Drive, 12th Floor
Oakland, CA 94612
(800) 888-8267

Retirees may also direct questions to the University's Customer Service Center at the above phone number.

Claims under the Plan are processed by Health Net at the following address and phone number:

Health Net Commercial Claims
PO Box 14702
Lexington, KY 40512
1-800-539-4072

Group Contract Number
The Group Contract Number for this Plan is: 92-2557406

Type of Plan
This Plan is a health and welfare plan that provides group medical care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

Plan Year
The plan year is January 1 through December 31.

Continuation of the Plan
The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premiums that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California’s annual budget appropriation.

Financial Arrangements
The benefits under the Plan are provided by Health Net under a UC Standardized Contract . The monthly cost of the premiums are currently shared between you and the University of California.

Agent for Serving of Legal Process
Legal process may be served on Health Net at the address listed above.

Your Rights under the Plan
As a participant in a University of California medical plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the UC Standardized Contract , at a time and location mutually convenient to the participant and the Plan Administrator.

Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims under the Plan
To file a claim or to appeal a denied claim, refer to pages 55 and 67 of this document.

Nondiscrimination Statement
In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Please send inquiries regarding the University’s affirmative action and equal opportunity policies for staff to Director of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

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Contact us

HNL EPO
Post Office Box 10196
Van Nuys, California 91410-0196

Customer Contact Center
1-800-539-4072

1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

Telecommunications Device for the Hearing and Speech Impaired
1-800-995-0852

www.healthnet.com/uc