CERTIFICATE OF INSURANCE

A complete explanation of Your vision plan

Custom UC Post Docs Supreme 010-2
Vision PPO Certificate

Important benefit information – please read

CD5301(CA1/25)

INSURANCE PLAN 1B

HEALTH NET VISION PPO CERTIFICATE

ISSUED BY

HEALTH NET LIFE INSURANCE COMPANY

Los Angeles, California

HEALTH NET LIFE INSURANCE COMPANY (herein called HNL) agrees to provide Benefits as described in this *Certificate* to the principal Covered Person (herein called "You" or "Your") and Your eligible Dependents.

This *Certificate* describes the vision coverage, which is provided by HNL, under the Policy between HNL and the principal Covered Person.

The Benefits described under this *Certificate* do not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, and are not subject to any pre-existing condition or exclusion period. PLEASE CONTACT OUR CUSTOMER CONTACT CENTER BEFORE SERVICES ARE RECEIVED WITH QUESTIONS ABOUT THE COVERAGE.

HEALTH NET LIFE INSURANCE COMPANY OR "HNL" IS A LIFE AND DISABILITY INSURANCE COMPANY REGULATED BY THE CALIFORNIA DEPARTMENT OF INSURANCE.

THE TERMS "YOU" OR "YOUR," WHEN THEY APPEAR IN THIS *CERTIFICATE*, REFER TO THE PRINCIPAL COVERED PERSON. THE TERMS "WE," "OUR" OR "US," WHEN THEY APPEAR IN THIS *CERTIFICATE*, REFER TO HNL.

Important Notice To California Certificate Holders

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

Health Net Life Insurance Company
P.O. Box 9103
Van Nuys, CA 91410-9103
1-866-392-6058

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

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

Table of Contents

VISION PLAN SCHEDULE OF BENEFITS

Health Net PPO
Supreme 010-2

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

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.

To receive maximum Benefits, You must utilize Participating Vision Providers. A list of Participating Vision Providers is available at www.healthnet.com or by calling our Customer Contact Center at the number on your vision care plan identification card.

Note: Copayments and any expenses paid by You for Benefits covered under this vision plan will not be applied to your medical plan's Out-of-Pocket Maximum. You must continue to pay charges for the vision care Benefits under this plan even after the Out-of-Pocket Maximum has been reached in your medical plan. "Out-of-Pocket Maximum" is defined in your medical plan's certificate.

Exam	Participating Vision Provider	Nonparticipating Vision Provider
Exam with dilation as necessary	$0 Copayment, Covered Services are paid in full by the plan.	You are reimbursed up to $40 of the cost for Covered Services.

Exam Options (fit and follow-up)	Participating Vision Provider	Nonparticipating Vision Provider
Standard contact lenses	After you pay up to $55, Covered Services are paid in full by the plan.	You receive no discount.
Premium contact lenses	You receive 10% off retail cost.	You receive no discount.

Eyewear (lenses and frame)	Participating Vision Provider	Nonparticipating Vision Provider
Single vision lenses	Covered in full after a $10 Copayment.	You are reimbursed up to $40.
Lined bifocal lenses	Covered in full after a $10 Copayment.	You are reimbursed up to $60.
Lined trifocal lenses	Covered in full after a $10 Copayment.	You are reimbursed up to $80.
Lenticular lenses	Covered in full after a $10 Copayment.	You are reimbursed up to $80.

Eyewear (lenses and frame)	Participating Vision Provider	Nonparticipating Vision Provider
Standard progressive lenses	Covered in full after a $75 Copayment.	You are reimbursed up to $60.
Premium progressive lenses	$75 Copayment, then 80% of total charge less $120 allowance.	You are reimbursed up to $60.
Frame	Covered up to $160 allowance. You will receive a 20% discount on the balance over your allowance.	You are reimbursed up to $45.

Lens Options	Participating Vision Provider	Nonparticipating Vision Provider
UV Coating	Covered in full after a $15 Copayment. **	You receive no discount.
Tint, solid and gradient	Covered in full after a $15 Copayment. **	You receive no discount.
Standard scratch-resistance	Covered in full after a $15 Copayment. **	You receive no discount.
Standard polycarbonate	Covered in full after a $40 Copayment. **	You receive no discount.
Standard anti-reflective	Covered in full after a $45 Copayment. **	You receive no discount.
Other add-ons and services	You receive 20% off retail cost. **	You receive no discount.

** Your Copayment or eyewear discount applies to any optional items purchased with your lenses and/or frames from a Participating Vision Provider. Listed items are examples of optional items.

Contact lenses (instead of spectacle lenses and frame) – Materials	Participating Vision Provider	Nonparticipating Vision Provider
Conventional	$0 Copayment. You receive a maximum allowance of $160, plus a discount of 15% over your allowance.	You are reimbursed up to $105 of the cost for Covered Services.

Contact lenses (instead of spectacle lenses and frame) – Materials	Participating Vision Provider	Nonparticipating Vision Provider
Disposables	$0 Copayment. You receive a maximum allowance of $160, you are responsible for remaining balance over your allowance.	You are reimbursed up to $105 of the cost for Covered Services.
Medically Necessary Contact Lenses	Paid in full.	You are reimbursed up to $210 of the cost for Covered Services.

Frequency of Service	
Examination	Once every 12 months from the last date of service.
Lenses	Once every 12 months from the last date of service.
Frame	Once every 24 months from the last date of service.
Contact lenses in lieu of lenses	Once every 12 months from the last date of service.

Value Added Discounts

In addition to the Benefits described above, there are discounts available for services or Materials as shown below.

Contact Lenses: Participating Vision Providers offer preferred pricing and direct delivery on annual supplies of select brands of disposable contact lenses.

Lasik or PRK: You may have a discount available for these services. Please contact our Customer Contact Center for more information.

Continued Eyewear Savings: After your initial Benefits have been utilized, you may be able to receive ongoing discounts on additional eyewear purchases at Participating Provider locations. Please contact our Customer Contact Center for more information.

BENEFITS AND LIMITATIONS

Vision services are covered as shown in the "Vision Plan Schedule of Benefits" section. Covered Services can be provided by both Preferred Vision and non-Preferred Vision Providers. However, if a Covered Person receives vision services and Materials from a Preferred Vision Provider, covered expenses will usually be paid at a higher level, as shown in the "Vision Plan Schedule of Benefits". Certain services or Materials may be payable under this *Certificate* only if the service or Material is furnished by a Preferred Vision Provider. If this is the case, it will be indicated in the "Vision Plan Schedule of Benefits". It is the Covered Person's responsibility to determine if a Vision Care Provider is a Preferred Vision Provider at the time the service or Material is provided.

When the Covered Person receives Benefits from a Preferred Vision Provider they will pay a percentage of covered expenses or any amount in excess of the Maximum Benefit Allowance as stated in the "Vision Plan Schedule of Benefits" in this *Certificate*. HNL pays the Preferred Vision Provider without You having to submit a claim. HNL arranges for the provision of vision services by contracting with Preferred Vision Providers to serve the Covered Persons in an organized and cost-effective manner.

When the Covered Person receives Benefits from a non-Preferred Vision Provider they are responsible for the difference in the Maximum Benefit Allowance and the provider's normal fee. The Covered Person is required to pay the full cost for the Covered Services, then submit a claim for reimbursement. Payment will be made directly to the Covered Person unless otherwise directed by the Covered Person.

If You have any questions regarding the Benefits described in this section, please contact the Customer Contact Center at **1-866-392-6058**.

Covered Services and Supplies

Medically Necessary services, including consultation, diagnosis and treatment, for vision care provided appropriately as Telehealth Services are covered on the same basis and to the same extent as Covered Services delivered in-person.

Examination

The vision examination includes an analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities.

If You request or require contact lenses, there is an additional examination for contact lens fit and follow-up as stated under the "Exam Options (fit and follow-up)" portion of the "Vision Plan Schedule of Benefits" section. Follow-up exam(s) for contact lenses include subsequent visit(s) to the same provider who provided the initial contact lens fit exam.

Standard contact lens fit and follow–up applies to routine application soft, spherical (astigmatism less than .75D), daily wear contact lenses for single vision prescriptions. Standard Contact Lens fit and follow-up does not include extended or overnight wear for any prescription

Premium contact lens fit and follow-up applies to complex applications, including but not limited to toric (astigmatism .75D or higher), bifocal, multifocal, cosmetic color, post-surgical and gas permeable. Premium Contact Lens fit and follow-up includes extended and overnight wear for any prescription.

Frames

If an examination indicates the necessity of eyeglasses, this vision Benefit will cover a frame as specified in the "Vision Plan Schedule of Benefits" section.

Eyeglass Lenses

If an examination results in corrective lenses being prescribed for the first time or if a current wearer of corrective lenses needs new lenses, this vision plan will cover a pair of lenses as specified in the "Vision Plan Schedule of Benefits" section.

Lens Options (In Addition to Standard Lenses)

You may select lenses with additional eyeglass lens option as described under "Lens Options" in the "Vision Plan Schedule of Benefits" section.

Contact Lenses

You may elect contact lenses in lieu of eyeglass lenses and frames.

Procedures For Using Vision Benefits

To obtain Covered Services under this vision plan, the Covered Person must follow the steps below:

1. **Schedule an appointment.** The Covered Person calls the vision provider to schedule an appointment for a Comprehensive Eye Examination. Preferred Vision Providers are listed in the Health Net Vision PPO Directory. The names of Participating Vision Providers and their locations and hours of practice may also be obtained by contacting Health Net's Customer Contact Center at **1-866-392-6058**.
2. **Attend appointment and receive Comprehensive Eye Examination.** The Covered Person presents their Vision identification card to the vision provider at the time of the scheduled appointment. In accordance with professionally recognized standards of practice, the Covered Person will receive a Comprehensive Eye Examination, including an analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities. The vision provider will provide a diagnosis and treatment plan, as appropriate.
3. **Obtain corrective eyeglass lenses, if necessary.** If the examination results in corrective lenses being prescribed for the first time, or if the Covered Person is a current wearer of corrective lenses and needs new lenses, the Covered Person may obtain the correctives lenses from either the examining vision provider or another vision provider of their choice. The dispensing vision provider will provide quality eyeglasses in accordance with the prescription of the examining vision provider. The vision provider will assist in the selection of a frame, verify the accuracy of the finished lenses and fit and adjust the frame. The Covered Person will be required to pay all charges in excess of the allowances shown in the "Vision Plan Schedule of Benefits" for Materials at this time.

   Coverage for prescriptions for contact lenses is subject to Medical Necessity and all applicable exclusions and limitations. Generally, coverage for contact lenses will only be authorized for the following circumstances:

   1. Keratoconus where the Covered Person is not correctable to 20/30 in either or both eyes using standard spectacle lenses, or the Provider attests to the specified level of visual improvement;

2. High Ametropia exceeding -10D or +10D in spherical equivalent in either eye;
3. Anisometropia of 3D in spherical equivalent or more; or
4. Vision for a Covered Person can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle.

A Covered Person may elect non-Medically Necessary contact lenses in lieu of all other Materials Benefits. Refer to the Vision Plan Schedule of Benefits for Benefits, exclusions and limitation information.

Choice of Preferred Vision Provider

The Directory of *Health Net Vision PPO Directory* is a listing of Preferred Vision Providers currently contracting with HNL in Your area. However, it is subject to change as new providers contract with HNL and some Preferred Vision Providers contract ends. The current participation status of any provider can be determined by calling HNL's Customer Contact Center at **1-866-392-6058**.

HNL compensates its Preferred Vision Providers on a discounted "fee-for-service" basis. HNL does not compensate Preferred Vision Providers with bonuses or financial incentives in connection with the amount of services the Covered Person may receive under this *Certificate*. Therefore, there are no inducements to delay, reduce, limit or deny necessary and appropriate care. If further information is needed the Covered Person may contact HNL's Customer Contact Center or their Preferred Vision Provider.

Covered Person's Liability For Payment

Covered Persons are responsible for any applicable charges and for payment for non-Covered Services and Materials in excess of specified Benefit limitations. If HNL does not pay a Preferred Vision Provider for Covered Services, the Covered Person will not be liable to the provider for any sums owed by HNL. But if HNL does not pay a non-Preferred Vision Provider, the Covered Person may be liable for payment.

Upon termination of any Preferred Vision Provider contract, HNL shall be liable for payment of Covered Services rendered by such Preferred Vision Provider (other than any Covered Charges in excess of the Maximum Benefit Allowance) to a Covered Person who retains eligibility under this *Certificate* or by operation of law who is under the care of such Preferred Vision Provider at the time of such termination, until the Covered Services being rendered to the Covered Person by such Preferred Vision Provider are completed, unless HNL makes reasonable and medically appropriate provision for the assumption of such services by another Preferred Vision Provider. A Covered Person may elect to continue care with the provider whose contract was terminated by HNL if at the time of termination, the Covered Person was receiving care for an acute or serious chronic condition or if the performance of a scheduled surgery or other procedure that has been recommended and documented by the provider is to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a new Covered Person. If a Covered Person has questions about or wishes to request continuity of care, they should contact HNL's Customer Contact Center.

Non–Assignability of Benefits

The coverage and Benefits of this vision plan may not be assigned without the prior written consent of HNL, which consent may be withheld for any reason. HNL reserves the right to make payment of Benefits, directly to the attending provider or to the Covered Person.

Exclusions and Limitations

Except as otherwise provided in the Vision Plan Schedule of Benefits, the following are excluded from coverage:

1. Fees charged by a Provider for services other than a covered Benefit must be paid in full by the Covered Person to the Provider. Such fees or Materials are not covered under the *Certificate*;
2. Benefit allowances provide no remaining balance for future use within the same Benefit Frequency;
3. Expenses for any non-Standard Corrective Lens Materials, including but not limited to the following: Coated, dyed, glass lens tints or laminated lenses, or Oversize lenses, occupational or recreational lenses, polycarbonate, safety glasses, scratch resistant, UV protection, anti-reflective, or Photochromic Lenses/photosensitive lenses;
4. Plano (non-prescription) lenses;
5. Non-prescription sunglasses;
6. Two pair of glasses in lieu of bifocals;
7. Orthoptic or vision training, Subnormal Vision Aids and associated supplemental testing;
8. Aniseikonic lenses;
9. Medical or surgical treatment of the eye, eyes or supporting structures including, but not limited to, Laser In Situ Keratomileusis (LASIK) and Photorefractive Keratectomy (PRK);
10. Prescription or non-prescription medications;
11. Any eye examination or any corrective eye wear required as a condition of employment; safety eyewear;
12. Services or Materials which HNL determines to be Experimental, cosmetic or not Medically Necessary;
13. Any service or Material not prescribed by an ophthalmologist, optometrist or registered dispensing optician;
14. Services and Materials furnished in conjunction with excluded services and Materials;
15. Services and Materials for repair or replacement of broken, lost or stolen lenses, contact lenses or frames. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available;
16. Services and Materials that a Covered Person received during a Service Interval under any other plan offered by HNL or one of HNL's affiliates;
17. Services or Materials provided by any other group benefit plan providing vision care;

18. Charges incurred before a Covered Person's Effective Date of coverage under this *Certificate* or after such coverage terminates. Services rendered after the date a Covered Person ceases to be covered under the *Certificate*, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Covered Person are within 31 days from the date of such order;
19. Services or Materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony;
20. Services and Materials obtained while outside the United States, except for Emergency Vision Care;
21. Services or Materials that have been paid under any Workers' Compensation Law, Employer's Liability Law or similar law. The Covered Person must promptly claim and notify HNL of all such Benefits;
22. As follows:
    a. Charges payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, HNL will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and Materials.
    b. Charges are not imposed against the person or for which the person is not liable; or
23. Services, procedures, or Materials for which a charge would not have been made in the absence of insurance.

ELIGIBILITY AND ENROLLMENT

Who Is Eligible For Coverage

The Covered Services and Supplies of this plan are available to the following individuals, as long as the principal Covered Person lives in California, all other Covered Persons live in the United States, and all Covered Persons meet the additional eligibility requirements set forth by California State law, applicable Federal law and as defined by the Group:

- The principal Covered Person (employee);
- Spouse: Your lawful spouse as defined by California law;
- Domestic Partner: The registered Domestic Partner, as defined by California law;
- Children: The children (up to the age of 26 unless the child is disabled) of the principal Covered Person or their spouse or Domestic Partner (including legally adopted children, stepchildren and wards, as defined in the following provision);
- Wards: Children for whom the principal Covered Person or their spouse or Domestic Partner is a court-appointed guardian; and
- Other child: Any child that You have assumed a parent-child relationship, in lieu of a parent-child relationship described above, as indicated by intentional assumption of parental status, or assumption of parental duties by You, as certified by You at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled.

Children of the principal Covered Person or their spouse or Domestic Partner who are the subject of a Medical Child Support Order, according to state or federal law, are also eligible. Coverage of care received outside the United States will be limited to services provided in connection with Emergency Care.

Disabled Child

Children who reach age 26 are eligible to continue coverage or initiate new Dependent coverage if all of the following conditions apply:

- The child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and
- The child is chiefly dependent upon the principal Covered Person for support and maintenance.

If You are *enrolling* a disabled child for new coverage, You must provide HNL with proof of incapacity and dependency within 60 days of the date You receive a request for such information about the dependent child from HNL.

HNL must provide You notice at least 90 days prior to the date Your enrolled child reaches the age limit that coverage will terminate on the child's 26th birthday unless You provide documentation of disability and dependency. You must provide HNL with proof of Your child's incapacity and dependency within 60 days of receipt of the notice. Coverage will continue until HNL makes a determination as to the child's disability and dependency.

You must provide the proof of incapacity and dependency at no cost to HNL.
CD5301(CA1/25)

Health Net may require proof of continuing incapacity and dependency. If so, Health Net will follow these guidelines:

- Within the first two years following the child's reaching the age limit, you may be asked to provide proof as may be required by Health Net.
- After this two-year period, Health Net may require proof no more frequently than once a year.

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

How to Enroll for Coverage

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

Employee

Each new employee entering employment subsequent to the Effective Date of the Group's initial enrollment period shall be permitted, without proof of insurability, to apply for coverage for themselces and eligible Dependents within 60 days of becoming eligible, subject to the enrollment regulations in effect with the Group. Such enrollments, if accepted by HNL, become effective when any waiting or probationary period (of up to 60 days) required by the Group is completed.

When the employee is not subject to a probationary period, the enrollment becomes effective, in accordance with established Group eligibility rules, either on the date of hire or on the first day of the calendar month following the month in which the employee was hired.

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

A person cannot be denied coverage due to present medical conditions at enrollment.

Newly Acquired Dependents

You are entitled to enroll newly acquired Dependents as follows:

Spouse: If You marry while You are covered by this plan, You may enroll Your new spouse (and Your spouse's eligible children) within 60 days of the date of marriage. Coverage begins on the first day of the month following the date the application for coverage is received.

Domestic Partner: If You are the principal Covered Person and You enter into a domestic partnership while You are covered by this plan, You may enroll Your new Domestic Partner (and their eligible children) within 60 days of the date a Declaration of Domestic Partnership is filed with the Secretary of State or other recognized state or local agency, or within 60 days of the formation of the domestic partnership according to Your Group's eligibility rules. Coverage begins on the first day of the month following the date the application for coverage is received.

Newborn Child: Newborn children will be automatically covered for 31 days (including the date of birth). If You do not enroll the newborn within 31 days (including the date of birth), they are are covered for only the 31 days-starting on and including the date of birth.

Adopted Child: A newly adopted child, or a child who is being adopted, becomes eligible on the date of adoption or the date You or Your spouse or Domestic Partner receive physical custody of the child or the first day of the following month after the date of adoption or receiving physical custody, if requested by the principal Covered Person.

Coverage begins automatically and will continue for 31 days from the date of eligibility. You must enroll the child within 60 days for coverage to continue beyond the first 31 days. HNL will require written proof of the right to control the child's health care when such child is enrolled. If an adopted child is enrolled within 60 days following adoption or date of placement for adoption (date of physical custody), coverage will be continuous from the date of adoption or date of placement for adoption (date of physical custody).

Legal Ward (Guardianship): If You or Your spouse or Domestic Partner becomes the legal guardian of a child, the child is eligible to enroll on the effective date of the court order, but coverage is not automatic. The child must be enrolled within 60 days of the effective date of the guardianship. Coverage will begin on the first day of the month after HNL receives the enrollment request.

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

Other Child: Any child that You have assumed a parent-child relationship, in lieu of a parent-child relationship described above, as indicated by court order, intentional assumption of parental status, or assumption of parental duties by You, as certified by You at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled.

The child must be enrolled within 60 days of the effective date of the assumption of parental status. Coverage will begin on the first day of the month after HNL receives the enrollment request.

Open Enrollment Period

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

When Coverage Ends

You must notify the Group of changes that will affect Your eligibility. The Group will send the appropriate request to HNL according to current procedures.

All Covered Persons

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

Principal Covered Person and All Dependents

The principal Covered Person and all their Dependents will become ineligible for coverage at the same time if the principal Covered Person establishes primary residency outside of California, or otherwise loses eligibility for this plan.

Individual Covered Persons

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

- The Covered Person no longer meets the eligibility requirements established by the Group and HNL.

  This will include a child subject to a Medical Child Support Order, according to state or federal law, who becomes ineligible on the earlier of:

  1. The date established by the order; or
  2. The date the order expired;

- The Covered Person establishes primary residency outside the continental United States; or
- Your marriage or domestic partnership ends by divorce, annulment, or some other form of dissolution. Eligibility for Your enrolled spouse or Domestic Partner (now former spouse or Domestic Partner) and that spouse's or Domestic Partner's enrolled Dependents, who were related to You only because of the marriage, will end.

Notice of Ineligibility

It shall be Your responsibility to notify the Group of any changes that will affect Your eligibility or that of Your Dependents for services or Benefits under this *Certificate*. HNL shall provide notification of ineligibility or termination of coverage to individual Covered Persons.

CLAIMS AND DISPUTES RESOLUTION

Claims

A. **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 Health Net Vision Claims, P.O. Box 8504, Mason, OH 45040-7111. Notice should include information sufficient for Us to identify the Covered Person.

B. **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. We will not pay legal fees or interest due on claims that the Covered Person fails to submit in a timely manner.

C. **PROOF OF LOSS:** Written proof of loss must be furnished to Us at P.O. Box 9040, Farmington, MO 63640-9040, in case of claim for loss for which this *Certificate* provides any periodic payment contingent upon continuing loss, within 90 days after the 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.

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

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

E. CLAIMS DENIAL:

1. **DENIAL:** If the Covered Person submits a fully completed claim to HNL, and it is partially or totally denied, they should be notified in writing of the denial within 30 days from the date the claim was submitted. The Covered Person will be given the specific reasons for the denial. If the claim might be paid with more information, the Covered Person will be told what additional information is necessary and why.

2. **APPEAL:** The Covered Person or their authorized representative has the right to appeal the denial or partial denial of any claim made under the *Certificate* by requesting a review of the claim. The request must be made in writing to HNL within 365 days of the date that appears on the claims denial.

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

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

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

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

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

Grievance and Appeals Process

Appeal, complaint or grievance means any dissatisfaction expressed by You or Your representative concerning a problem with HNL, a medical provider or Your coverage under this *Certificate*, including an adverse benefit determination as set forth under the Affordable Care Act (ACA). An adverse benefit determination means a decision by HNL to deny, reduce, terminate or fail to pay for all or part of a benefit including on the basis of:

- A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review;

- Any reduction or termination of an approved ongoing course of treatment to be provided over a period of time or number of treatments before the end of such period of time or number of treatments. If there is an adverse benefit determination, the Covered Person will be notified sufficiently in advance of the reduction or termination to allow time to appeal and obtain a determination on review of that adverse benefit determination before the Benefit is reduced or terminated;
- Rescission of coverage, even if it does not have an adverse effect on a particular Benefit at that time;
- Determination of an individual's eligibility to participate in this HNL plan;
- Determination that a Benefit is not covered;
- An exclusion or limitation of an otherwise covered benefit based on a source-of-injury exclusion; or
- Determination that a Benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

If You are not satisfied with efforts to solve a problem with HNL or a medical provider, before filing an arbitration proceeding, You must file a grievance or appeal against HNL by calling the Customer Contact Center at **1-866-392-6058** or by submitting a Covered Person grievance form through HNL website at www.healthnet.com. You must file Your grievance or appeal with HNL within 365 calendar days following the date of the incident or action that caused Your grievance. You may also file a complaint in writing by sending information to:

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

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

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

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

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

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

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

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

Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an Independent Medical Review (IMR) of Disputed Health Care Services from the California Department of Insurance (CDI) at 1-800-927-4357, TDD: 800-482-4833, or on their website at www.insurance.ca.gov, if You believe that health care services eligible for coverage and payment under Your HNL plan have been improperly denied, modified or delayed by HNL. A "Disputed Health Care Service" is any health care service eligible for coverage and payment under Your HNL plan that has been denied, modified or delayed by HNL or one of its contracting providers, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available. You will not pay any application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. HNL will provide You with an IMR application form and HNL's grievance response letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause You to forfeit any statutory right to pursue legal action against HNL regarding the Disputed Health Care Service.

Eligibility

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

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

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

For non-urgent cases, the IMR organization designated by the Department must provide its determination within 30 days of receipt of the application for review and the supporting documents.

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

For more information regarding the IMR process or to request an application form, please call the Customer Contact Center at the telephone number on Your Vision 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;
- Either (a) Your contracting Physician has recommended a drug, device, procedure, or other therapy that the Physician certifies in writing is likely to be more beneficial to You than any available standard therapies, or (b) You, or the Your Physician who is a licensed, board-certified or board-eligible Physician qualified to practice in the area of practice appropriate to treat Your condition, has requested a therapy that, based on two documents from the medical and scientific evidence, as defined below, is likely to be more beneficial for You than any available standard therapy. The Physician certification shall include a statement of the evidence relied upon by the Physician in certifying their recommendation. Nothing in this provision shall be construed to require HNL to pay for the services of a noncontracting Physician that are not otherwise covered pursuant to the contract.
- You have been denied coverage by HNL for the recommended or requested therapy; and

- If not for HNL's determination that the recommended or requested treatment is Experimental or Investigational, it would be covered.

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

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

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

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

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

If there is an imminent and serious threat to the health of the Covered Person, including, but not limited to, serious Pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the Covered Person's health, all necessary information and documents shall be delivered to an Independent Medical Review organization within 24 hours of approval of the request for review.

In reviewing a request for review, the Department of Insurance may waive the requirement that the Covered Person follow the insurer's grievance process in extraordinary and compelling cases, where the commissioner finds that the Covered Person has acted reasonably.

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

Arbitration

As a condition to becoming a HNL Covered Person, **YOU AGREE TO SUBMIT ALL DISPUTES RELATING TO OR ARISING OUT OF YOUR HNL MEMBERSHIP TO INDIVIDUAL, FINAL AND BINDING ARBITRATION, EXCEPT DISPUTES CONCERNING ADVERSE BENEFIT DETERMINATIONS AS DEFINED IN 45 CFR 147.136, AND YOU AGREE NOT TO PURSUE CLASS ARBITRATION. Likewise, HNL agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both You and HNL are bound to use binding bilateral 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.

Sometimes disputes or disagreements may arise between You (including Your enrolled Dependents, heirs or personal representatives) and HNL regarding the construction, interpretation, performance or breach of this *Certificate*, or regarding other matters relating to or arising out of Your HNL membership. Typically such disputes are handled and resolved through the HNL Grievance, Appeal and Independent Medical Review process described above, and you must attempt to resolve your dispute by utilizing that process before instituting arbitration. However, in the event that a dispute is not resolved in that process, HNL uses binding bilateral 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. However, You are not required to participate in final, binding arbitration to resolve disputes concerning Adverse Benefit Determinations and are entitled to pursue any remedies available under the law. In addition, disputes with HNL involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

HNL's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is $500,000 or less ($50,000 or less with respect to

disputes with HNL involving alleged professional liability or medical malpractice), the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $500,000 or $50,000, whichever is applicable. In the event that total amount of damages is over $500,000 or $50,000, whichever is applicable, the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

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

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

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

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

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

Medical Malpractice Disputes

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

SPECIFIC PROVISIONS

Right of Recovery

Whenever HNL has made payments in excess of the Benefits payable under this *Certificate*, HNL has the right to recover the excess from any person to, or for, or with respect to whom, such payments were made, or from any other insurers, health care service plans or other organizations.

If HNL pays Benefits for expenses incurred on account of a Covered Person, the principal Covered Person or any other person that was paid must make a refund to HNL if:

- All or some of the expenses were not paid by the principal Covered Person or their Dependents or did not legally have to be paid.
- All or some of the payment made by HNL exceeded the Benefits under this *Certificate*.
- All or some of the expenses were recovered from or paid by a source other than this *Certificate*. This includes payments made as a result of claims against a third party of negligence, wrongful acts or omissions.

The refund equals the amount HNL 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 HNL paid.

If the refund is due from another person or organization that was paid, the principal Covered Person and their Dependents agree to help HNL get the refund when requested.

If the principal Covered Person, or any other person or organization that was paid, do not promptly refund the amount, HNL may reduce the amount of any future Benefits that are payable under this *Certificate*. The reduction will equal the amount of the required refund.

Health Care Plan Fraud

Principal Covered Person Responsibility

The principal Covered Person must:

- File accurate claims. If someone else, such as the principal Covered Person's spouse, Domestic Partner or another Dependent, files claims on Your behalf, You should review the form before You sign it;
- Review the Explanation of Benefits (EOB) form when it is returned to You. Make certain that Benefits have been paid correctly based on Your knowledge of the expenses incurred and the services rendered;
- Never allow another person to seek medical treatment under Your identity. If Your Vision 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 the number shown on Your Vision ID card. All calls are strictly confidential.

CONFIDENTIALITY OF MEDICAL RECORDS

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

GENERAL PROVISIONS

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

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

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

Notice of Cancellation: If this *Certificate* terminates for any reason, HNL will send the notice of cancellation to the principal Covered Person.

Modifications to Plan and Notice Obligations: If the plan is modified in accordance with the terms and provisions of this *Certificate*, HNL will send notice of such modification to the principal Covered Person.

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 principal Covered Person, at the address appearing on the records of HNL; and, if notice is required of the principal Covered Person, it will be sufficient if mailed to the HNL office at the address listed on the back cover of this *Certificate*.

Regulation and Interpretation of Certificate: This *Certificate* is issued with and is governed by the state of California. The laws of the state of California shall be applied to interpretations of this *Certificate*.

Nondiscrimination: HNL hereby agrees that no person who is otherwise eligible for coverage under this *Certificate* shall be refused enrollment nor shall their coverage be canceled solely because of race, color, national origin, ancestry, religion, sex, gender identity, gender expression, marital status, sexual orientation, age, health status, or physical or mental handicap.

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

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

DEFINITIONS

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

Anisometropia: A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.

Basic Lenses: Standard single vision, bifocal, trifocal or lenticular clear glass or plastic lenses that are Medically Necessary to correct vision.

Benefit Frequency: The period of time in which a Benefit is payable. The Benefit Frequency begins on the later of the Covered Person's Effective Date or last date services were provided to the Covered Person. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

Benefits: Vision services and Materials which are specified in this *Certificate* and Vision Plan Schedule of Benefits as being eligible for Benefits under this vision plan.

Blended Lenses (Progressive Lenses): Bifocals or trifocals which do not have a visible dividing line.

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

Coated Lenses: A substance which is added to a finished lens on one or both surfaces.

Comprehensive Eye Examination: A comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination, biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Copayment: A fixed dollar fee charged to a Covered Person for Covered Services and Supplies. The amount of each Copayment is indicated in "Vision Plan Schedule of Benefits" and is due and payable by the Covered Person to the provider of care at the time services are rendered.

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

Covered Services: Vision services and Materials rendered by Preferred Vision and non-Preferred Vision Providers which are specified in this *Certificate* and “Vision Plan Schedule of Benefits as being eligible for Benefits under this vision plan.

Dependent includes:

1. a principal Covered Person’s legally married spouse or Domestic Partner as defined by California law;
2. a principal Covered Person’s child who is:
   (a) under the age of 26; or

(b) over the age of 26 and incapable of self-sustaining employment by reason of physical or mental disability incurred prior to attainment of age 26 and who is chiefly dependent upon the principal Covered Person or principal Covered Person's spouse or Domestic Partner for support;

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

In order for a child to remain insured after age 26, You must provide proof of the child's incapacity and dependency to Us within 60 days of the child becoming 26 years of age. We will notify you at least 90 days prior to the date of the child becoming 26 years of age.

Domestic Partner: For the purposes of this *Certificate*, is a person eligible for coverage as a Dependent provided that the partnership is with the principal Covered Person and who is a registered domestic partner and meets all domestic partnership requirements under specified by section 297 or 299.2 of the California Family Code.

Effective Date: The date on which You become covered or entitled to Benefits under this *Certificate*. Enrolled Dependents may have a different Effective Date than the principal Covered Person if they are added later to the plan.

Experimental: Medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time HNL makes a determination regarding coverage in a particular case, is determined to be:

A. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or

B. Subject to review and approval by any institutional review board for the proposed use; or

C. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or

D. Not demonstrated through peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Health Net Life Insurance Company (HNL or Health Net): 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.

Keratoconus: A development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area.

Materials: Lenses, frames and contact lenses.

Maximum Benefit Allowance: The Maximum Benefit Allowance as shown in the Vision Plan Schedule of Benefits is the maximum amount HNL will pay for Covered Services. The Covered Person will be responsible for any charges in excess of the Maximum Benefit Allowance.

Medical Information: Any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health application information, reproductive or sexual health application information, mental or physical condition, or treatment. "Individually identifiable" means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual.

Medically Necessary (or Medical Necessity): Medically Necessary services are Covered Services which are generally recognized by the relevant medical community for treatment of a Covered Person's visual acuity. Attending Preferred Vision Providers are exclusively responsible for making all vision determinations and treatment decisions. The fact that a Preferred Vision Provider may prescribe, order, recommend or approve a service or Material does not, in itself, make it Medically Necessary, or make it a Covered Service.

Orthoptics: The teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular lenses.

Oversized Lenses: Larger than standard (i.e., 61 millimeter) lens blanks to accommodate a prescription.

Preferred Provider Agreement: An agreement between the PPO and a Provider that contains the rates and reimbursement methods for services and supplies provided by such Provider.

Preferred Provider Organization ("PPO"): A network of Providers and retail chain stores within the PPO Service Area that has signed a Preferred Provider Agreement.

Preferred Vision Provider: An optometrist, ophthalmologist or optician licensed to provide Covered Services and who, or which, at the time care is rendered to a Covered Person, has a contract in effect with HNL to furnish care to Covered Persons. The names of Preferred Vision Providers can be found forth in the *Health Net Vision PPO Directory*. The names of Preferred Vision Providers and their locations and hours of practice may also be obtained by contacting the HNL's Customer Contact Center. This vision plan does not guarantee the initial or continued availability of any particular Preferred Vision Provider.

Photochromic Lenses: Lenses which change color with intensity of sunlight.

Professional Service: Examination, Material selection, fitting of eyeglasses or contact lenses and, related adjustments, or instructions related to these services.

Progressive Lenses: Bifocals or trifocals which do not have a visible dividing line.

Protected Individual means any adult covered by the principal Covered Person's health care service plan or a minor who can consent to a health care service without the consent of a parent or legal guardian, pursuant to state or federal law. "Protected Individual" does not include an individual that lacks the capacity to give informed consent for health care pursuant to Section 813 of the Probate Code. A health care service plan shall not require a protected individual to obtain the Group, principal Covered Person's, or other enrollee's authorization to receive Sensitive Services or to submit a claim for Sensitive Services if the protected individual has the right to consent to care.

Sensitive Services means all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6929, 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

Subnormal or Low Vision Aids: Devices (optical and non-optical) to assist those individuals who are partially sighted.

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

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

Tinted Lenses: Lenses which have additional substance added to produce constant tint, (e.g., pink, green, gray, blue, etc.).

Vision Materials: Those Materials shown in the Vision Plan Schedule of Benefits.

IMPORTANT NOTICES

Covered Persons' Rights and Responsibilities, and Obligations Statement

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

Covered Persons have the right to:

- Receive information about HNL, its services, its practitioners and providers and Covered Persons' rights and responsibilities;
- Be treated with respect and recognition of their dignity and right to privacy;
- Participate with practitioners in making decisions about their health care;
- A candid discussion of appropriate or Medically Necessary treatment options for their conditions, regardless of cost or benefit coverage;
- Request an interpreter at no charge to You;
- Use interpreters who are not Your family members or friends;
- File a grievance in Your preferred language by using the interpreter service or by completing the translated grievance form that is available on www.healthnet.com;
- File a complaint if Your language needs are not met;
- Voice complaints or appeals about the organization or the care it provides; and
- Make recommendations regarding HNL's Covered Person's rights and responsibilities policies.

Covered Persons have the responsibility and obligation to:

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

Notice of Privacy Practices

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

PLEASE REVIEW IT CAREFULLY.

Covered Entities Duties:

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

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

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

- Uses or disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice

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

Internal Protections of Oral, Written and Electronic PHI:

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

**This Notice of Privacy Practices also applies to enrollees in any of the following Health Net entities: Health Net of California, Inc., Health Net Community Solutions, Inc., Managed Health Network, LLC and Health Net Life Insurance Company, which are subsidiaries of Health Net, LLC. and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. Rev. 04/01/2022

CD5301(CA1/25)

These are some of the ways we protect your PHI.

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

Permissible Uses and Disclosures of Your PHI:

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

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

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

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

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

Other Permitted or Required Disclosures of Your PHI:

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

- ***Judicial and Administrative Proceedings*** - We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:
  - an order of a court
  - administrative tribunal
  - subpoena
  - summons
  - warrant
  - discovery request, or
  - similar legal request
- ***Law Enforcement*** - We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:
  - court order
  - court-ordered warrant
  - subpoena
  - summons issued by a judicial officer
  - grand jury subpoena

  We may also disclose your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.
- ***Coroners, Medical Examiners and Funeral Directors*** - We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.
- ***Organ, Eye and Tissue Donation*** - We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:
  - cadaveric organs
  - eyes
  - tissues
- ***Threats to Health and Safety*** - We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
- ***Specialized Government Functions*** - If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:
  - to authorized federal officials for national security and intelligence activities
  - the Department of State for medical suitability determinations
  - for protective services of the President or other authorized persons

- ***Workers' Compensation*** - We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide Benefits for work-related injuries or illness without regard to fault.
- ***Emergency Situations*** - We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- ***Inmates*** - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care,; to protect your health or safety, or the health or safety of others; or for the safety and security of the correctional institution.
- ***Research*** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

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

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

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

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

Impermissible Use of PHI - We will not use your language, race, ethnic background, sexual orientation, and gender identity information to deny coverage, services, Benefits, or for underwriting purposes.

Individual's Rights

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

The State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. and Health Net Life Insurance Company (Health Net, LLC) comply with applicable federal civil rights laws and do not discriminate, exclude people or treat them differently on

the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, gender affirming care, sexual orientation, age, disability, or sex.

- ***Right to Revoke an Authorization*** - You may revoke your authorization at any time, the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.
- ***Right to Request Restrictions*** - You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment or health care operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.
- ***Right to Request Confidential Communications*** - You have the right to request that We communicate with You about your PHI by alternative means or to alternative locations. We must accommodate Your request if it is reasonable and specifies the alternative means or location where Your PHI should be delivered. A confidential communications request shall be implemented by the health insurer within seven 7 calendar days of the receipt of an electronic transmission or telephonic request or within 14 calendar days of receipt by first-class mail. We shall not disclose medical information related to Sensitive Services provided to a Protected Individual to the Group, principal Covered Persons, or any plan enrollees other than the Protected Individual receiving care, absent an express written authorization of the Protected Individual receiving care. Refer to the customer service phone number on the back of your Covered Person identification card or the plan's website for instructions on how to request confidential communication.
- ***Right to Access and Receive a Copy of your PHI*** - You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.
- ***Right to Amend your PHI*** - You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

- ***Right to Receive an Accounting of Disclosures*** - You have the right to receive a list of instances within the last 6 years period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.
- ***Right to File a Complaint*** - If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

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

  WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.
- ***Right to Receive a Copy of this Notice*** - You may request a copy of our Notice at any time by using the contact information list at the end of the Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.

Contact Information

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

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

Telephone: 1-866-392-6058
Fax: 1-818-676-8314
Email: Privacy@healthnet.com

Financial Information Privacy Notice

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

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

Information We Collect

We collect personal financial information about you from the following sources:

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

- Information from consumer reports.

Disclosure of Information

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

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

Confidentiality and Security

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

Questions About this Notice

If You have any questions about this notice, please **call the toll-free phone number on the back of Your ID card** or contact HNL at **1-866-392-6058.**

NONDISCRIMINATION NOTICE

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net Life Insurance Company (Health Net) complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, gender affirming care, sexual orientation, age, disability, or sex.

Health Net:

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

If you need these services, contact Health Net's Customer Contact Center at:
Group Plans through Health Net 1-866-392-6058 (TTY: 711)

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

Health Net of California, Inc./Health Net Life Insurance Company Appeals & Grievances
PO Box 10348,
Van Nuys, CA 91410-0348

Fax: 1-877-831-6019
Email: Member.Discrimination.Complaints@healthnet.com (Members)
Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

You may submit a complaint by calling the California Department of Insurance at 1-800-927-4357 or online at https://www.insurance.ca.gov/01-consumers/101-help/index.cfm.

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

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

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Language Assistance Services

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

Notice of Language Services

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

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

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

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

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

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

Japanese

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

Khmer

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

Korean

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

Navajo

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

Persian (Farsi)

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

Panjabi (Punjabi)

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

Russian

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

Spanish

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

Tagalog

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

Thai

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

Vietnamese

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

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

FLY017549EH00 (12/17)

Contact us

Health Net Vision PPO
Post Office Box 9103
Van Nuys, California 91410-9103

Customer Contact Center
1-866-392-6058

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