Summary *of* Benefits

Small Business Group
Silver 70 PPO 2000/45 + Child Dental • Insurance Plan F5V

Health Net®
LIFE INSURANCE COMPANY

DELIVERING CHOICES

When you need health care, it's nice to have options. That's why Health Net Life* offers a Preferred Provider Organization (PPO) insurance plan (called "Health Net PPO") — an insurance plan that offers you flexibility and choice. This SB answers basic questions about Health Net PPO. Please contact the Customer Contact Center at the telephone number listed on the back cover and talk to one of our friendly, knowledgeable representatives if you have additional questions.

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

The benefits described under this SB/DF do not discriminate on the basis of race, ethnicity, color, nationality, ancestry, gender, gender identity, gender expression, age, disability, sexual orientation, genetic information, marital status, domestic partner status or religion, and are not subject to any pre-existing condition or exclusion period.

If you have further questions, contact us:

By phone at 1-800-522-0088

Or write to: Health Net Life Insurance Company
P.O. Box 9103
Van Nuys, CA 91409-9103

This insurance plan is underwritten by Health Net Life Insurance Company and administered by Health Net of California, Inc. (Health Net).

This *Summary of benefits* (SB) is only a summary of your health insurance plan. The plan's *Certificate of Insurance (Certificate)*, which you will receive after you enroll, contains the exact terms and conditions of your Health Net Life coverage. You have the right to view the *Certificate* prior to enrollment. To obtain a copy of *Certificate,* contact the Customer Contact Center at 1-888-926-5133. You should also consult the *Health Net PPO Group Insurance Policy (Policy)* (issued to your employer) to determine governing contractual provisions. It is important for you to carefully read this SB and the plan's *Certificate* thoroughly once received, especially those sections that apply to those with special health care needs. This SB includes a matrix of benefits in the section titled "Schedule of benefits and coverage." In case of conflict, the *Certificate* will control. State mandated benefits may apply depending upon your state of residence.

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How the insurance plan works

Please read the following information so you will know from whom or what group of providers health care may be obtained.

SELECTION OF PHYSICIANS

This insurance plan allows you to:

- Choose your own doctors and hospitals for all your health care needs; and
- Take advantage of significant cost savings when you use doctors contracted with our PPO.

Like most PPO insurance plans, Health Net PPO offers two different ways to access care:

- In-network, meaning you choose a doctor (or hospital) contracted with our PPO.
- Out-of-network, meaning you choose a doctor (or hospital) not contracted with our PPO.

Your choice of doctors and hospitals may determine which services will be covered, as well as how much you will pay. In many instances, certification is required, except in the case of an emergency. For full benefits, see "Schedule of benefits and coverage" section of this brochure. Preferred providers are listed on the HNL website at www.healthnet.com or you can contact the Customer Contact Center at the telephone number listed on the back cover to obtain a copy of the Preferred Provider Directory at no cost.

WHEN YOU USE AN OUT-OF-NETWORK PROVIDER, BENEFITS ARE SUBSTANTIALLY REDUCED AND YOU WILL INCUR A SIGNIFICANTLY HIGHER OUT-OF-POCKET EXPENSE. TO MAXIMIZE THE BENEFITS RECEIVED UNDER THIS HEALTH NET PPO INSURANCE PLAN, YOU MUST USE PREFERRED PROVIDERS.

HOW TO ENROLL

Complete the enrollment form found in the enrollment packet and return the form to your employer. If a form is not included, your employer may require you to use an electronic enrollment form or an interactive voice response enrollment system. Please contact your employer for more information

Some hospitals and other providers do not provide one or more of the following services that may be covered under the plan's *Certificate* and that you or your dependents might need:

- **Family planning;**
- **Contraceptive services; including emergency contraception;**
- **Sterilization, including tubal ligation at the time of labor;**
- **Infertility treatments; or**
- **Abortion.**

You should obtain more information before you enroll. Call your prospective doctor, participating or preferred provider or clinic, or call the Customer Contact Center at the telephone number listed on the back cover to ensure that you can obtain the health care services that you need.

Schedule of benefits and coverage

The services covered and amount you pay depend upon the doctor or hospital you choose when you need health care. The following charts summarize what is covered and what you pay with Health Net PPO.

Principal benefits and coverage matrix

Benefit levels	PPO	OON (Out of Network)
Features	**(Preferred providers)** Care provided by doctors and hospitals contracted with our PPO	**(All other providers)** Care provided by licensed doctors and hospitals not contracted with our PPO
	• Lower out-of-pocket costs • Great freedom of choice • Certification from Health Net Life required for certain services • Claim forms usually not required for reimbursement • Must meet annual deductible (and coinsurance, if applicable to this insurance plan) • Coverage for preventive care services available	• Higher out-of-pocket costs • Greatest freedom of choice • Certification from Health Net Life required for certain services • Claim forms required for reimbursement • Must meet annual deductible and coinsurance

For the PPO level of benefits, the percentages that appear in this chart are based on contracted rates with providers. See the "Payment of premiums and charges" section, under "Contracted Rate" for additional details.

For the out-of-network level of benefits, the percentages that appear in this chart are based the maximum allowable amount. The covered person is responsible for charges in excess of this amount in addition to the coinsurance shown. See the "Payment of premiums and charges" section, under "Maximum Allowable Amount" for additional details.

Deductibles	PPO	OON (Out of Network)

You must pay this amount for covered services before HNL begins to pay.

Calendar year deductible *You must pay a deductible before the insurance plan begins to pay for covered services. Once an individual member of a family satisfies the individual deductible, the remaining enrolled family members must continue to pay a deductible until each enrolled family member individually meets the individual deductible or the total amount paid by the family reaches the family deductible.*

Any amount applied toward the deductible for covered services provided by a PPO provider will not apply toward the OON deductible; any amount applied toward the deductible for covered services provided by an OON provider will not apply to the PPO deductible.

For each covered person	$2,000	$4,000
For a family	$4,000	$8,000

Insurance Plan maximums	PPO	OON (Out of Network)

Yearly Out-of-pocket maximum (OOPM)

Once your payment of deductibles, copayments and coinsurance (combined for PPO and out-of-network) for the medical and prescription drug benefits equals the amount shown below in any one calendar year, no further copayment, coinsurance or additional deductibles for covered services, supplies or prescription drugs are required for the remainder of that year. Payments for services not covered by this insurance plan or for certain services as specified in the "Payment of premiums and charges" section of this SB, will not be applied to this yearly out-of-pocket maximum.

For each covered person	$7,550	$15,100
For each family	$15,100	$30,200

Type of services, benefit maximums & what you pay

Professional services	PPO	OON
Visit to physician	$45, Deductible waived	50%
Specialist consultations	$80, Deductible waived	50%
Urgent Care services	$45, Deductible waived	50%
Prenatal office visits*	$0, Deductible waived	50%
Preventive postnatal office visits	$0, Deductible waived	50%
Non-Preventive postnatal office visits	$45, Deductible waived	50%
Normal delivery, cesarean section, newborn inpatient professional care*	20%	50%
Treatment of complications of pregnancy*	See note below**	See note below**
Physician visit to hospital or skilled nursing facility	20%	50%
Surgeon or assistant surgeon services▲,*,◘	20%	50%
Administration of anesthetics	20%	50%

Rehabilitative therapy (including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)*	$45, Deductible waived	Not covered
Habilitative therapy (including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)*	$45, Deductible waived	Not covered
Organ and stem cell transplants (non-experimental and non-investigational)*	20%, Deductible waived	Not covered
Chemotherapy	20%, Deductible waived	50%
Radiation therapy	20%, Deductible waived	50%
Hearing examinations (for diagnosis or treatment)	$45, Deductible waived	Not covered
Vision examinations (for refractive eye exams at an ophthalmologist) (age 19 and over)	$80, Deductible waived	Not covered
Vision examinations (for refractive eye exams at an optometrist) (age 19 and over)	$45, Deductible waived	Not covered
Teladoc consultation telehealth services***	$0, Deductible waived	Not covered

** Prenatal, postnatal and newborn care office visits for preventive care are covered in full for preferred providers and the calendar year deductible does not apply.*

*** Applicable deductible, copayment or coinsurance requirements apply to any services and supplies required for the treatment of an illness or condition, including but not limited to, complications of pregnancy. For example, if the complication requires an office visit, then the office visit copayment or coinsurance will apply.*

**** HNL contracts with Teladoc to provide telehealth services for medical, mental disorders and chemical dependency conditions. Teladoc services are not intended to replace services from your physician, but are a supplemental service. Teladoc consultations provide primary care services by telephone or secure online video. Teladoc physicians may be used when your physician's office is closed or you need quick access to a physician. Teladoc consultation services may be obtained by calling 1-800-TELADOC (800-835-2362) or visiting www.teladoc.com/hn. Before Teladoc services may be accessed, you must complete a Medical History Disclosure (MHD) form, which can be completed online at Teladoc's website at no charge or printed, completed and mailed or faxed to Teladoc.*

***** *These services require certification for coverage, except in the case of an emergency. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $250 for in-network and $500 for out-of-network penalty will be charged.*

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

▪ *The coverage described above in relation to medically necessary rehabilitative services for post-mastectomy lymphedema syndrome complies with requirements under the Women's Health and Cancer Rights Act of 1998. In compliance with the Women's Health Cancer Rights Act of 1998, this Plan provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.*

Allergy treatment and other injections (except for infertility injections)	**PPO**	**OON**
Allergy testing	$80, Deductible waived	50%
Allergy serum	20%, Deductible waived	Not covered
Allergy injection services	$45, Deductible waived	50%
Injections (except for infertility)		
Injectable drugs administered by a physician	20%, Deductible waived	50%

Note:

Certain injectable drugs which are considered self-administered are covered on the specialty drug tier under the pharmacy benefit. Specialty drugs are not covered under the medical benefits even if they are administered in a physician's office. If you need to have the provider administer the specialty drug, you will need to obtain the specialty drug through the Specialty Pharmacy Vendor and bring it with you to the provider office. Alternatively, you can coordinate delivery of the specialty drug directly to the provider office through the Specialty Pharmacy Vendor. Please refer to the "Specialty Pharmacy Vendor" portion of this "Schedule of benefits and coverage" section for the applicable copayment or coinsurance.

Injections for the treatment of infertility are described below in the "Infertility services" section.

Outpatient services	**PPO**	**OON**
Outpatient facility services (other than surgery, except for infertility services)*	20%, Deductible waived	50%
Outpatient surgery (hospital or outpatient surgery center charges only, except for infertility services)*	20%, Deductible waived	50%

* *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $250 for in-network and $500 for out-of-network penalty will be charged.*

Outpatient care for infertility is described below in the "Infertility services" section.

Hospital services	**PPO**	**OON**
Semi-private hospital room or special care unit with ancillary services, including delivery and maternity care (unlimited days)	20%	50%
Skilled nursing facility stay	20%	50%
Confinement for bariatric (weight loss) surgery	20%	Not covered

These services require certification for coverage, except in the case of an emergency. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $250 for in-network and $500 for out-of-network penalty will be charged.

The above coinsurance for inpatient hospital or special care unit services is applicable for each admission for the hospitalization of an adult, pediatric or newborn patient. If a newborn patient requires admission to a special care unit, a separate coinsurance for inpatient hospital services will apply.

Inpatient care for infertility is described below in the "Infertility services" section.

Radiological services	**PPO**	**OON**
Laboratory procedures	$40, Deductible waived	50%
X-ray and diagnostic imaging	$75, Deductible waived	50%
Imaging (CT/PET scans, MRIs)	20%, Deductible waived	50%

These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $250 for in-network and $500 for out-of-network penalty will be charged.

Preventive Care	**PPO**	**OON**
Preventive care services	$0, Deductible waived	Not covered

Preventive care services are covered for children and adults, as directed by your physician, based on the guidelines from the U.S. Preventive Services Task Force Grade A&B recommendations, the Advisory Committee on Immunization Practices that have been adopted by the Center for Disease Control and Prevention, the guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA).

Preventive care services are not subject to the calendar year deductible and include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, and preventive vision and hearing screening examinations, diabetes screening including intensive behavioral counseling intervention for individuals who test positive for abnormal levels of blood glucose, tobacco cessation intervention services, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA.

One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the covered person. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it. Breast pumps can be obtained by calling the Customer Contact Center at the phone number listed on the back cover of this booklet.

Emergency health coverage	**PPO**	**OON**
Emergency room (facility services)	$350, Deductible waived	$350, Deductible waived
Emergency room (professional services)	$0, Deductible waived	$0, Deductible waived

The coinsurance shown for PPO emergency health care services will be applied for all emergency care, regardless of whether or not the health care provider is a PPO or noncontracting provider. The coinsurance shown for PPO and out-of-network providers are applicable only if non-emergency care is provided at an emergency room or urgent care center.

Ambulance services	PPO	OON
Ground ambulance	$250	$250
Air ambulance	$250	$250

These services require certification for coverage, except in the case of an emergency. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $250 for in-network and $500 for out-of-network penalty will be charged.

The coinsurance shown for PPO emergency health care services will be applied for all emergency care, regardless of whether or not the health care provider is a PPO or noncontracting provider. The coinsurance shown for PPO and out-of-network providers are applicable only if non-emergency care is provided at an emergency room or urgent care center.

Outpatient prescription drug plan

Prescription drugs	Participating pharmacy	Nonparticipating pharmacy

The prescription drug benefit is subject to the OOPM as described at the beginning of this section. Please also refer to the "Prescription drug program" section of this SB for definitions, benefits and limitations.

Deductible

Prescription drug deductible required for brand name drugs including specialty drugs (per covered individual)	$200	Not applicable
Prescription drug deductible required for brand name drugs including specialty drugs (per family)	$400	Not applicable

The prescription drug deductible required for brand name drugs (per covered person or family each calendar year) must be paid for prescription drug covered expenses before Health Net Life begins to pay. Diabetic supplies, preventive drugs (including smoking cessation drugs) and women's contraceptives are not subject to the deductible. After the deductible is met the copayments or coinsurance amounts apply.

Retail pharmacy (up to a 30-day supply)

Tier 1 drugs	$15	Not covered
Tier 2 drugs◆	$55	Not covered
Tier 3 drugs◆	$85	Not covered
Preventive drugs, including smoking cessation drugs, and women's contraceptives *	$0, Deductible waived	Not covered

Specialty Pharmacy Vendor

	Specialty Pharmacy
Tier 4 drugs (specialty drugs)	20% up to $250 per prescription

Mail-order program (up to a 90-day supply of maintenance drugs)

Tier 1 drugs	$30	Not covered
Tier 2 drugs◆	$110	Not covered
Tier 3 drugs◆	$170	Not covered
Preventive drugs, including smoking cessation drugs, and women's contraceptives*	$0, Deductible waived	Not covered

Orally administered anti-cancer drugs will have a deductible, copayment and coinsurance maximum of $200 for an individual prescription of up to a 30-day supply or $600 for a 90-day supply through mail order.

Generic or brand name drugs not listed in the Essential Rx Drug List which are prescribed by your physician and not excluded or limited from coverage are covered as an exception and are subject to the tier 3 drug copayment or coinsurance, as applicable. Specialty drugs not listed on the Essential Rx Drug List that are covered as an exception would be subject to the tier 4 (specialty drug) coinsurance.

◆ *Generic drugs will be dispensed when a generic drug equivalent is commercially available. When a brand name drug is dispensed and a generic equivalent is commercially available, the covered person must obtain prior authorization for the brand name drug to be covered.*

* *Preventive drugs, including smoking cessation drugs, and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the covered person and are not subject to the deductible. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations.*

Up to a 12-consecutive -calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single Prescription Drug Order.

Medical supplies	**PPO**	**OON**
Durable medical equipment✱	20%, Deductible waived	Not covered
Diabetes education	$0, Deductible waived	50%
Orthotics (such as bracing, supports and casts)✱	20%, Deductible waived	Not covered
Corrective footwear✱	20%, Deductible waived	Not covered
Diabetic equipment (See the "Prescription Drug Program" section of this SB for diabetic supplies benefit information)	20%, Deductible waived	50%
Diabetic footwear	20%, Deductible waived	50%
Prostheses✱	20%, Deductible waived	50%

Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under "Preventive care" in this section.

Durable medical equipment is covered when medically necessary and acquired or supplied by an HNL designated contracted vendor for durable medical equipment. Preferred providers that are not designated by HNL as a contracted vendor for durable medical equipment are considered out-of-network providers for purposes of determining coverage and benefits. Durable medical equipment is not covered if provided by an out-of-network provider. For information about HNL's designated contracted vendors for durable medical equipment, please contact the Customer Contact Center at the telephone number on the back cover.

Diabetic equipment covered under the medical benefit (through "Diabetic equipment") includes blood glucose monitors designed for the visually impaired, insulin pumps and related supplies, and corrective footwear. Diabetic equipment and supplies covered under the prescription drug benefit include insulin, specific brands of blood glucose monitors and testing strips, Ketone urine testing strips, lancets and lancet puncture devices, specific brands of pen delivery systems for the administration of insulin (including pen needles) and insulin syringes.

In addition, the following supplies are covered under the medical benefit as specified: visual aids (excluding eyewear) to assist the visually impaired with the proper dosing of insulin are provided through the prosthesis benefit; Glucagon is provided through the self-injectable benefit. Self-management training, education and medical nutrition therapy will be covered only when provided by licensed health care professionals with expertise in the management or treatment of diabetes (provided through the patient education benefit).

***** *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $250 for in-network and $500 for out-of-network penalty will be charged.*

Mental disorders and chemical dependency benefits	**PPO**	**OON**

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

Serious emotional disturbances of a child is when a child under the age of 18 has one or more mental disorders identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary chemical dependency disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one of the following: (a) as a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home or (ii) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year; (b) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; and/or (c) the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Severe Mental Illness and Serious Emotional Disturbances of a Child		
Outpatient office visits (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring)	$0, Deductible waived	50%
Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care program, day treatment, partial hospitalization and other outpatient procedures including behavioral health treatment for pervasive developmental disorder or autism)	$0, Deductible waived	50%
Inpatient facility*	20%	50%
Other Mental Disorders		
Outpatient office visits (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring)	$0, Deductible waived	50%
Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care program, day treatment, partial hospitalization and other outpatient services)	$0, Deductible waived	50%
Inpatient facility*	20%	50%
Chemical Dependency		
Outpatient office visits (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring)	$0, Deductible waived	50%
Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care program, day treatment, partial hospitalization, medical treatment for withdrawal symptoms, and other outpatient services)	$0, Deductible waived	50%
Inpatient facility *	20%	50%
Inpatient detoxification*	20%	50%

***** *These services require certification for coverage, except in the case of an emergency. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $250 penalty will be charged. for in-network and a $500 penalty will be charged for out-ot-network.*

Note:

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

Home Health Services	**PPO**	**OON**
Home health visits*	20%, Deductible waived	Not covered
Maximum visits per calendar year	*100*	*Not applicable*

***** *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $250 for in-network and $500 for out-of-network penalty will be charged.*

Other services	**PPO**	**OON**
Sterilization - Vasectomy	20%, Deductible waived	50%
Sterilization - Tubal ligation	$0, Deductible waived	50%
Blood, blood plasma, blood derivatives and blood factors (except for drugs used to treat hemophilia, including blood factors)**	20%, Deductible waived	50%
Renal dialysis	20%, Deductible waived	50%
Hospice services*	$0, Deductible waived	50%
Infusion therapy (home or physician's office) *	20%, Deductible waived	Not covered

***** *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. If certification is required but not obtained, a $250 for in-network and $500 for out-of-network penalty will be charged.*

*** Drugs used to treat hemophilia, including blood factors, are covered on the specialty drug tier under the pharmacy benefit. Specialty drugs are not covered under the medical benefit even if they are administered in a physician's office. If you need to have the provider administer the specialty drug, you will need to obtain the specialty drug through the Specialty Pharmacy Vendor and bring it with you to the provider's office. Alternatively, you may be able to coordinate delivery of the specialty drug directly to the provider's office through the Specialty Pharmacy Vendor.*

Infertility services and supplies are described below in the "Infertility services" section.

Sterilization of females and women's contraception methods and counseling, as supported by HRSA guidelines, are covered under "Preventive Care Services" in this section.

Infertility services	PPO	OON
Infertility services and supplies (all covered services that diagnose, evaluate or treat infertility)	Not covered	Not covered

***Notes*:**

Infertility services include prescription drugs, professional services, inpatient and outpatient care and treatment by injections.

Acupuncture care	PPO	OON
Office visits	$45, Deductible waived	Not covered

Note:

Acupuncture Services are provided by HNL. HNL contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage. With this program, you may obtain care by selecting a contracted acupuncturist from the ASH Plans Contracted Acupuncturist Directory.

Pediatric Vision care (birth through age 18)

Pediatric vision benefits are administered by EyeMed Vision Care, LLC, a contracted vision services provider panel. Refer to the "Pediatric Vision Care Program" section later in this SB/DF for the benefit information which includes the Eyewear Schedule.

Pediatric dental (birth through age 18) (in California only)

Pediatric dental benefits are underwritten by Unimerica Life Insurance Company and administered by Dental Benefit Administrative Services. Unimerica Life Insurance Company and Dental Benefit Adminstrative Services are not affliliated with Health Net Life. Refer to the "Pediatric dental program" section later in this SB/DF for the benefit information which includes the Dental Schedule See the Certificate for additional details.

Limits of coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- Air or ground ambulance and paramedic services that are not emergency care or which do not result in a patient's transportation will not be covered unless certification is obtained and services are medically necessary.
- Artificial insemination;
- Care for mental health care as a condition of parole or probation, or court-ordered treatment and testing for mental disorders, except when such services are medically necessary;
- Charges in excess of rate negotiated between any organization and the physician, hospital or other provider;
- Conception by medical procedures (IVF, GIFT and ZIFT);
- Conditions resulting from the release of nuclear energy when government funds are available;
- Corrective footwear is not covered unless medically necessary and custom made for the covered person or is a podiatric device to prevent or treat diabetes-related complications;
- Cosmetic services or supplies;
- Custodial or live-in care;
- For covered persons age 19 and over, dental services. However, medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures are covered. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate;
- Disposable supplies for home use;
- Experimental or investigational procedures, except as set out under the "Clinical trials" and "If you have a disagreement with our insurance plan" sections of this SB;
- Prenatal genetic testing is not covered except when determined by Health Net Life to be medically necessary. The prescribing physician must request prior authorization for coverage;
- Hearing aids;
- Hypnosis;
- Immunizations and injections for foreign travel or occupational purposes;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder;
- Non-eligible institutions. This insurance plan only covers services or supplies provided by a legally operated hospital, Medicare-approved skilled nursing facility or other properly licensed facility as specified in the *Certificate*. Any institution, regardless of how it is designated, is not an eligible institution. Services or supplies provided by such institutions are not covered;
- Nontreatable disorders;
- Outpatient prescriptions drugs or medications (except as noted under "Prescription drug program");
- Orthotics (such as bracing, supports and casts) that are not custom made to fit the covered person's body. Refer to the "corrective footwear" bullet above for additional foot orthotic limitations;
- Personal or comfort items;
- Physician self-treatment;
- Physician treating immediate family members;
- Private rooms when hospitalized, unless medically necessary;
- Private-duty nursing;
- Refractive eye surgery unless medically necessary, recommended by the covered person's treating physician and authorized by Health Net Life;
- Reversal of surgical sterilization;
- Routine foot care for treatment of corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes, except when medically necessary;

- Services and supplies determined not to be medically necessary as defined in the *Certificate*;
- Services and supplies not specifically listed in the plan's *Certificate* as covered expenses;
- Services and supplies that do not require payment in the absence of insurance;
- Services for an injury incurred in the commission (or attempted commission) of a crime unless the condition was an injury resulting from an act of domestic violence or an injury resulting from a medical condition;
- Services for conditions of pregnancy for a surrogate pregnancy are covered when the surrogate parent is the covered person under this HNL plan. However, when compensation is obtained for the surrogacy, Health Net Life shall have a lien on such compensation to recover its medical expense. A surrogate parent is a woman who agrees to become pregnant with the intent of surrendering custody of the child to another person;
- Services not related to a covered illness or injury, except as provided under preventive care and annual routine exams;
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the plan's *Certificate*;
- Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary;
- Services related to educational and professional purposes, except for behavioral health treatment for pervasive developmental disorder or autism;
- Stress, except when rendered in connection with services provided for a treatable mental disorder.

The above is a partial list of the principal exclusions and limitations applicable to the medical portion of your Health Net PPO insurance plan. The *Certificate,* which you will receive if you enroll in this insurance plan, will contain the full list.

Benefits and coverage

WHAT YOU PAY FOR SERVICES

The "Schedule of benefits and coverage" section explains your coverage and payment for services. Please take a moment to look it over.

With Health Net PPO, you are responsible for paying a portion of the costs for your care. The amount you pay can vary from a flat amount to a significant percentage of the costs. It all depends on the doctor (and hospital) you choose.

- You must pay a deductible before the insurance plan begins to pay for covered services.
- You pay less when you receive care from doctors contracted with our PPO, since they have agreed in advance to provide services for a specific fee.
- If you choose to receive care from out-of-network doctors and hospitals, you will be responsible for the applicable out-of-network coinsurance, plus payment of any charges that are in excess of the covered expenses as defined in the *Certificate*.

  Exceptions: In the following circumstances, the in-network level of coverage applies and you will not be responsible for any amounts in excess of the covered expenses:
  1) If we authorize medically necessary services through an out-of-network provider because such services are not available through a preferred provider; or
  2) When non-emergent out-of-network services are received at an in-network health facility.

  For further details and necessary requirements, see the *Certificate.*
- For some services, certification is necessary to receive full benefits. Please see the "Services requiring Certification" section of this brochure for details.
- To protect you from unusually high medical expenses, there is a maximum amount, or out-of-pocket maximum, that you will be responsible for paying in any given year. Once you have paid this amount, the insurance plan will pay 100% of covered expenses. (There are exceptions, see the *Certificate* for details.)

SPECIAL ENROLLMENT RIGHTS UNDER CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

The Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) creates a special enrollment period in which individuals and their dependent(s) are eligible to request enrollment in this plan within 60 days of becoming ineligible and losing coverage from the Access for Infants and Mothers Program (AIM) or a Medi-Cal plan.

NOTICE OF REQUIRED COVERAGE

Benefits of this insurance plan provide coverage required by the Federal Newborns' and Mothers' Health Protection Act of 1996 and Women's Health and Cancer Right Act of 1998.

The Newborns' and Mothers' Health Protection Act of 1996 sets requirements for a minimum Hospital length of stay following delivery. Specifically, Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Women's Health and Cancer Right Act of 1998 applies to medically necessary mastectomies and requires coverage for prosthetic devices and reconstructive surgery on either breast provided to restore and achieve symmetry.

SERVICES REQUIRING CERTIFICATION[1]

The following services require certification for both PPO and OON coverage. If you do not contact Health Net Life prior to receiving certain services, your benefit reimbursement level will be reduced as shown in the "Schedule of benefits and coverage" section of this SB. A penalty will also be charged for uncertified inpatient admissions, and uncertified outpatient services as shown in the "Schedule of benefits and coverage" section. These penalties do not apply to your out-of-pocket maximum. (Note: after the OOPM has been reached if certification is not obtained, benefits for service(s) will not be paid at 100%.) Services provided as a result of an emergency do not require certification.

Services that require certification include:

1. **Inpatient admissions**
   Any type of facility, including but not limited to:
   - Acute rehabilitation center
   - Chemical dependency care facility, except in an emergency
   - Hospice
   - Hospital, except in an emergency
   - Mental health facility, except in an emergency
   - Skilled nursing facility

2. **Outpatient procedures, services or equipment**
   - Ambulance: Non-emergency air or ground ambulance services
   - Capsule endoscopy
   - Clinical trials
   - Custom orthotics
   - Diagnostic Procedures
     - Advanced Imaging
       - CT (Computerized Tomography)
       - MRA (Magnetic Resonance Angiography)
       - MRI (Magnetic Resonance Imaging)
       - PET (Positron Emission Tomography)
     - Cardiac Imaging
       - Coronary computed tomography angiography (CCTA)
       - Echocardiography
       - Myocardial perfusion imaging (MPI)
       - Multigated acquisition (MUGA) scan
     - Sleep studies.
   - Durable Medical Equipment (DME)
   - Enhanced External Counterpulsation (EECP)
   - Experimental/investigational services and new technologies
   - Genetic testing
   - Injections for intended use of steroid and/or pain management including epidural, nerve, nerve root, facet joint, trigger point and Sacroiliac (SI) joint injection
   - Occupational therapy (includes home setting)
   - Organ, tissue and stem cell transplant services, including pre-evaluation and pre-treatment services and the transplant procedure.
   - Outpatient pharmaceuticals:

  - Most self-injectables, excluding insulin, require prior authorization. Please refer to the Essential Rx Drug List to identify which drugs require prior authorization.
  - All hemophilia factors and intravenous immunoglobulin (IVIG) through the outpatient prescription drug benefit require prior authorization and must be obtained through the Specialty Pharmacy Vendor.
  - Certain physician-administered drugs require prior authorization, including newly approved drugs whether administered in a physician office, free-standing infusion center, home infusion, ambulatory surgery center, outpatient dialysis center or outpatient hospital. Refer to the Health Net Life website, www.healthnet.com, for a list of physician-administered drugs that require Certification for medical necessity review or to coordinate delivery through our contracted Specialty Pharmacy Vendor.
  - Most specialty drugs must have prior authorization through the outpatient prescription drug benefit and must be obtained through the Specialty Pharmacy Vendor. Please refer to the Essential Rx Drug List to identify which drugs require prior authorization. Urgent or emergent drugs that are medically necessary to begin immediately may be obtained at a retail pharmacy.
  - Other outpatient prescription drugs, as indicated in the Essential Rx Drug List, may require prior authorization. Refer to the Essential Rx Drug List to identify which drugs require prior authorization.
- Outpatient surgical procedures:
  - Ablative techniques for treating Barrett's esophagus and for treatment of primary and metastatic liver malignancies
  - Balloon sinuplasty
  - Bariatric procedures
  - Cochlear implants
  - Neuro or spinal cord stimulator
  - Orthognathic procedures (includes TMJ treatment)
  - Spinal surgery including, but not limited to, laminotomy, fusion, discectomy, vertebroplasty, nucleoplasty, stabilization and X-Stop
  - Total joint replacements (hip, knee, shoulder, or ankle)
  - Uvulopalatopharyngoplasty (UPPP) and laser-assisted UPPP
  - Vestibuloplasty
- Physical therapy (includes home setting)
- Potentially cosmetic services, devices or procedures including but not limited to:
  - Bone alteration or reshaping such as Osteoplasty
  - Breast reduction and augmentation except when following a mastectomy (includes gynecomastia or macromastia).
  - Dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
  - Dermatology such as Chemical exfoliation and electrolysis, Dermabrasions and chemical peels, Laser treatment or Skin injections and implants
  - Excision, excessive skin and subcutaneous tissue (including lipectomy and panniculectomy) of the abdomen, thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad, and other areas.
  - Eye or brow procedures such as blepharoplasty, brow ptosis or canthoplasty
  - Gynecologic or urology procedures such as clitoroplasty, labiaplasty, vaginal rejuvenation, scrotoplasty, testicular prosthesis, vulvectomy
  - Hair electrolysis, transplantation or laser removal
  - Lift such as arm, body, face, neck, thigh
  - Liposuction
  - Nasal surgery such as rhinoplasty or septoplasty
  - Otoplasty

  - Treatment of varicose veins
  - Vermilionectomy with mucosal advancement
- Prosthesis and corrective appliances
- Radiation therapy
- Speech therapy (includes home setting)

[1]*Certification is not required for the length of a hospital stay for mastectomies, lymph node dissections and reconstructive surgery incident to a mastectomy (including lumpectomy). Certification is also not required for the length of stay for the first 48 hours following a normal delivery or 96 hours following cesarean delivery; however, please notify HNL within 24 hours following birth or as soon as reasonably possible; no penalty will apply if notification is not received.*

COVERAGE FOR NEWBORNS

Children born after your date of enrollment are automatically covered at birth. To continue coverage, the child must be enrolled through your employer before the 30th day of the child's life. If the child is not enrolled within 30 days of the child's birth:

- Coverage will end the 31st day after birth; **and**
- You will have to pay for all medical care provided after the 31st day of your baby's life.

EMERGENCIES

Health Net Life covers emergency and urgently needed care throughout the world. If you need emergency or urgently needed care, seek care where it is immediately available.

You are encouraged to use appropriately the **911** emergency response system, in areas where the system is established and operating, when you have an emergency medical condition (including severe mental illness and serious emotional disturbances of a child) that requires an emergency response. All ambulance and ambulance transport services provided as a result of a **911** call will be covered, if the request is made for an emergency medical condition (including severe mental illness and serious emotional disturbances of a child).

If you go to an emergency facility for condition that is not of an urgent or emergency nature, it will be covered at whichever level (PPO or OON) it qualifies for, subject to your insurance plans exclusions and limitations.

Emergency care *means any otherwise covered service for an acute illness, a new injury or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or, if a minor, to the minor's parent or guardian that a reasonable person with an average knowledge of health and medicine (a prudent layperson) would believe requires immediate treatment (including severe mental illness and serious emotional disturbances of a child), and without immediate treatment, any of the following would occur: (a) his or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger); (b) his or her bodily functions, organs or parts would become seriously damaged; or (c) his or her bodily organs or parts would seriously malfunction. Emergency care also includes treatment of severe pain or active labor. Active labor means labor at the time that either of the following would occur: (a) there is inadequate time to effect safe transfer to another hospital prior to delivery; or (b) a transfer poses a threat to the health and safety of the covered person or her unborn child.*

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

A "psychiatric emergency medical condition" means a mental disorder that manifests itself by acute

symptoms of sufficient severity that it renders the patient as being either of the following:

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

***Urgently Needed Care** means any otherwise covered medical service that a reasonable person with an average knowledge of health and medicine would seek for treatment of an injury, unexpected illness or complication of an existing condition, including pregnancy, to prevent the serious deterioration of his or her health, but which does not qualify as Emergency Care, as defined in this section. This may include services for which a person should reasonably have known an emergency did not exist.*

MEDICALLY NECESSARY CARE

All services that are medically necessary will be covered by your Health Net Life insurance plan (unless specifically excluded under the insurance plan). All covered services or supplies are listed in the plan's *Certificate*; any other services or supplies are not covered.

CLINICAL TRIALS

Routine patient care costs for patients diagnosed with cancer or other life-threatening disease or condition who are accepted into phase I, II, III, or IV clinical trials are covered when medically necessary, either recommended by the covered person's treating physician or the covered person provides medical and scientific information establishing eligibility for the trial, and authorized by Health Net Life. For further information, please refer to the plan's *Certificate*.

CONTINUITY OF CARE

If our contract with a PPO health care provider is terminated, you may be able to elect continued care by that provider if you are receiving care for an acute condition, serious chronic condition, pregnancy, new born, terminal illness or scheduled surgery. To request continued care, you will need to complete a Continuity of Care Assistance Request Form. For more information on how to request continued care or request a copy of the Continuity of Care Assistance Request Form or of our continuity of care policy, please call the Customer Contact Center at the telephone number listed on the back cover.

EXTENSION OF BENEFITS

If you or a covered dependent is totally disabled when your employer ends its agreement with Health Net Life, we will cover the treatment for the disability until one of the following occurs:

- A maximum of 12 consecutive months elapses from the termination date;
- Available benefits are exhausted;
- The disability ends; or
- You become enrolled in another insurance plan that covers the disability.

Your application for an extension of benefits for disability must be made to Health Net Life within 90 days after your employer ends its agreement with us. We will require medical proof of the total disability at specified intervals.

OUT-OF-STATE PROVIDERS

Health Net PPO allows covered persons access to participating providers outside their state of residence. These providers participate in a network, other than the HNL PPO network, that agrees to provide discounted health care services to HNL covered persons. This program is through the out-of-state provider network shown on your HNL ID card and is limited to covered persons traveling outside their state of residence.

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

When you obtain services outside your state of residence through the out-of-state provider network, you will be subject to the same copayments, coinsurances, deductibles, maximums and limitations as you would be if you obtained services from a preferred provider in your state of residence. There is the following exception: covered expenses will be calculated based on the lower of (i) the actual billed charges or (ii) the charge that the out-of-state provider network is allowed to charge, based on the contract between HNL and the network. In a small number of states, local statutes may dictate a different basis for calculating your covered expenses.

CONFIDENTIALITY AND RELEASE OF COVERED PERSON INFORMATION

Health Net Life knows that personal information in your medical records is private. Therefore, we protect your personal health information in all setting (including oral, written and electronic information). The only time we would release your confidential information without your authorization is for payment, treatment, health care operations (including but not limited to utilization management, quality improvement, disease or case management programs) or when permitted or required to do so by law, such as for court order or subpoena. We will not release your confidential claims details to your employer or their agent. Often, Health Net Life is required to comply with aggregated measurement and data reporting requirements. In those cases, we protect your privacy by not releasing any information that identifies our covered persons.

PRIVACY PRACTICES

Once you become a Health Net Life covered person, Health Net Life uses and discloses a covered person’s protected health information and nonpublic personal financial information* for purposes of treatment, payment, health care operations, and where permitted or required by law. Health Net Life provides covered persons with a Notice of Privacy Practices that describes how it uses and discloses protected health information; the individual’s rights to access, to request amendments, restrictions, and an accounting of disclosures of protected health information; and the procedures for filing complaints. Health Net Life will provide you the opportunity to approve or refuse the release of your information for non-routine releases such as marketing. Health Net Life provides access to covered persons to inspect or obtain a copy of the covered person’s protected health information in designated record sets maintained by Health Net Life. Health Net Life protects oral, written and electronic information across the organization by using reasonable and appropriate security safeguards. These safeguards include limiting access to an individual's protected health information to only those who have a need to know in order to perform payment, treatment, health care operations or where permitted or required by law. Health Net Life releases protected health information to insurance plan sponsors for administration of self-funded plans but does not release protected health information to plan sponsors/employers for insured products unless the plan sponsor is performing a payment or health care operation function for the plan. Health Net Life's entire Notice of Privacy Practices can be found in the plan's *Certificate*, at www.healthnet.com under "Privacy" or you may call the Customer Contact Center at the telephone number listed on the back cover to obtain a copy.

** Nonpublic personal financial information includes personally identifiable financial information that you provided to us to obtain health plan coverage or we obtained in providing benefits to you. Examples include Social Security numbers, account balances and payment history. We do not disclose any nonpublic personal information about you to anyone, except as permitted by law.*

TECHNOLOGY ASSESSMENT

New technologies are those procedures, drugs or devices that have recently been developed for the treatment of specific diseases or conditions, or are new applications of existing procedures, drugs or devices. New technologies are considered investigational or experimental during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to be considered investigational or experimental if clinical study has not shown safety or effectiveness or if they are not considered standard care by the appropriate medical specialty. Approved technologies are integrated into Health Net Life benefits.

Health Net Life determines whether new technologies should be considered medically appropriate, or investigational or experimental, following extensive review of medical research by appropriately specialized physicians. Health Net Life requests review of new technologies by an independent, expert medical reviewer in order to determine medical appropriateness or investigational or experimental status of a technology or procedure.

The expert medical reviewer also advises Health Net Life when patients require quick determinations of coverage, when there is no guiding principle for certain technologies, or when the complexity of a patient's medical condition requires expert evaluation. If Health Net Life denies, modifies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational, you may request an independent medical review (IMR) of Health Net Life's decision from the Department of Insurance. Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" in the Certificate for additional details.

Utilization management

Utilization management is an important component of health care management. Through the processes of prior certification, concurrent and retrospective review and care management, we evaluate the services provided to our covered persons to be sure they are medically necessary and appropriate for the setting and time. These processes help to maintain Health Net Life's high quality medical management standards.

PRIOR CERTIFICATION

Certain proposed services may require an assessment prior to approval. Evidence-based criteria are used to evaluate whether or not the procedure is medically necessary and planned for the appropriate setting (that is, inpatient, outpatient surgery, etc.).

CONCURRENT REVIEW

This process continues to authorize inpatient and certain outpatient conditions on a concurrent basis while following a covered person's progress, such as during inpatient hospitalization or while receiving outpatient home care services.

DISCHARGE PLANNING

This component of the concurrent review process ensures that planning is done for a covered person's safe discharge in conjunction with the physician's discharge orders and to authorize post-hospital services when needed.

RETROSPECTIVE REVIEW

This medical management process assesses the appropriateness of medical services on a case-by-case basis after the services have been provided. It is usually performed on cases where prior certification was required but not obtained.

CARE OR CASE MANAGEMENT

Nurse care managers provide assistance, education and guidance to covered persons (and their families) through major acute and/or chronic long-term health problems. The care managers work closely with covered persons, their physicians and community resources.

If you would like additional information regarding Health Net Life utilization management process, please call the Customer Contact Center at the telephone number listed on the back cover.

Payment of premiums and charges

YOUR COINSURANCE, COPAYMENT AND DEDUCTIBLES

The "Schedule of benefits and coverage" section explains your coverage and payment for services. Please take a moment to look it over.

PREPAYMENT OF PREMIUMS

Your employer will pay Health Net Life your monthly premiums for you and all enrolled dependents. Check with your employer regarding any share that you may be required to pay. If your share ever increases, your employer will inform you in advance.

OTHER CHARGES

You are responsible for payment of your share of the cost of services covered by this insurance plan. Amounts paid by you are called copayments, coinsurance or deductibles, which are described in the "Schedule of benefits and coverage" section of this SB. Beyond these charges the remainder of the cost of covered services will be paid by Health Net Life.

When the total amount of deductibles, copayments and coinsurance you pay equals the annual out-of-pocket maximum amount shown in the "Schedule of benefits and coverage" section, you will not have to pay additional copayments or coinsurance for the rest of the year for most services provided, unless your doctor charges an amount that Health Net Life considers to be in excess of covered expenses. Additionally, the following expenses will not be applied to the limit:

- Charges in excess of covered expenses;
- Charges for services or supplies not covered by this insurance plan;
- Penalties for services for which certification was required but not obtained.

For further information please refer to the *Certificate*. Covered expenses for out-of-network providers are limited to the maximum allowable amount.

CONTRACTED RATE

The contracted rate is the rate that preferred providers are allowed to charge you, based on a contract between Health Net Life and such provider. Covered expenses for services provided by a preferred provider will be based on the contracted rate.

MAXIMUM ALLOWABLE AMOUNT (MAA)

The maximum allowable amount (MAA) is the amount on which HNL bases its reimbursement for covered services and supplies provided by an out-of-network provider, which may be less than the amount billed for those services and supplies. HNL calculates Maximum Allowable Amount as the lesser of the amount billed by the out-of-network provider or the amount determined as set forth below. Maximum Allowable Amount is not the amount that HNL pays for a covered service; the actual payment will be reduced by applicable coinsurance, copayments, deductibles and other applicable amounts set forth in this *Certificate*.

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

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

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

The Maximum Allowable Amount for facility services, including but not limited to hospital, skilled nursing facility, and outpatient surgery, is determined by applying 150% of the Medicare Allowable Amount.

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

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

a. Maximum Allowable Amount for professional and ancillary services shall be 100% of FAIR Health's Medicare gapfilling methodology. Services or supplies not priced by gapfilling methodology shall be the lesser of: (1) the average amount negotiated with preferred providers within the geographic region for the same covered services or supplies provided; (2) 50th percentile of FAIR Health database of professional and ancillary services not included in FAIR Health Medicare gapfilling methodology; (3) 100% of Medicare Allowable Amount for the same covered services or supplies under alternative billing codes published by Medicare; or (4) 50% of the out-of-network provider's billed charges for covered services. A similar type of database or valuation service will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination.

b. Maximum Allowable Amount for facility services shall be the lesser of: (1) the average amount negotiated with preferred providers within the geographic region for the same covered services or supplies provided; (2) 100% of the derived amount using a method developed by Data iSight for facility services (a data service that applies a profit margin factor to the estimated costs of the services rendered), or a similar type of database or valuation service, which will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination; (3) 150% of the Medicare Allowable Amount for the same covered services or supplies under alterna-

tive billing codes published by Medicare; or (4) 50% of the out-of-network provider's billed charges for covered services.

- ***Maximum Allowable Amount for Out-of-Network Emergency Care*** will be the greatest of: (1) the median of the amounts negotiated with preferred providers for the emergency service provided, excluding any in-network copayment or coinsurance; (2) the amount calculated using the same method HNL generally uses to determine payments for out-of-network providers, excluding any in-network copayment or coinsurance; or (3) the amount paid under Medicare Part A or B, excluding any in-network copayment or coinsurance.
- ***Maximum Allowable Amount for non-emergent services at an in-network (PPO network) health facility, at which, or as a result of which, you receive non-emergent covered services by an out-of-network provider, the non-emergent services provided by the out-of-network provider*** will be payable at the greater of the average contracted rate or 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered unless otherwise agreed to by the noncontracting individual health professional and HNL.
- ***Maximum Allowable Amount for covered outpatient pharmaceuticals*** (including but not limited to injectable medications) dispensed and administered to the patient, in an outpatient setting, including, but not limited to, physician office, outpatient hospital facilities, and services in the patient's home, will be the lesser of billed charges or the average wholesale price for the drug or medication.
- ***Maximum Allowable Amount for pediatric Dental Services*** is calculated by HNL based on available data resources of competitive fees in that geographic area and must not exceed the fees that the dental provider would charge any similarly situated payor for the same services for each covered dental service. The data resources of competitive fees are supplied by FAIR Health, which are updated twice a year. HNL reimburses non-network dental providers at 55% of FAIR Health rates. You must pay the amount by which the non-network provider's billed charge exceeds the eligible dental expense.

The Maximum Allowable Amount may also be subject to other limitations on covered expenses. See "Schedule of Benefits," "Plan Benefits" and "General Limitations and Exclusions" sections for specific benefit limitations, maximums, pre-certification requirements and payment policies that limit the amount HNL pays for certain covered services and supplies.

In addition to the above, from time to time, HNL also contracts with vendors that have contracted fee arrangements with providers ("Third Party Networks"). In the event HNL contracts with a Third Party Network that has a contract with the out-of-network provider, HNL may, at its option, use the rate agreed to by the Third Party Network as the Maximum Allowable Amount. Alternatively, HNL may, at its option, refer a claim for out-of-network services to a fee negotiation service to negotiate the Maximum Allowable Amount for the service or supply provided directly with the out-of-network provider. In either of these two circumstances, You will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable deductible, copayment and/or coinsurance at the out-of-network level.

NOTE: When the Centers for Medicare and Medicaid Services (CMS) adjusts the Medicare Allowable Amount, HNL will adjust, without notice, the Maximum Allowable Amount based on the CMS schedule currently in effect. Claims payment will be determined according to the schedule in effect at the time the charges are incurred. Claims payment will also never exceed the amount the out-of-network provider charges for the service or supply. You should contact the Customer Contact Center if You wish to confirm the covered expenses for any treatment or procedure you are considering.

For more information on the determination of Maximum Allowable Amount, or for information, services and tools to help you further understand your potential financial responsibilities for out-of-network services and supplies please log on to *www.healthnet.com* or contact HNL Customer Service at the number on your member identification card.

LIABILITY OF ENROLLEE FOR PAYMENT

If you receive health care services from doctors outside our network, covered services will be paid at the out-of-network benefit level. You are responsible for any copayments, coinsurance amounts and amounts in excess of the maximum allowable amount.

REIMBURSEMENT PROVISIONS

If you have out-of-pocket expenses for covered services, call the Customer Contact Center for a claim form and instructions. You will be reimbursed for these expenses less any required copayment, coinsurance or deductible.

Please call the Customer Contact Center at the telephone number listed on the back cover to obtain claim forms, and to find out whether you should send the completed form to your doctor, hospital or to Health Net Life. Claims must be received by Health Net Life within one year of the date of service to be eligible for reimbursement.

How to file a claim:

For medical services*, please send a completed claim form to:*

Health Net Commercial Claims
P.O. Box 9040,
Farmington, MO 63640-9040

For mental health disorders and chemical dependency services, please send completed claim form to:

MHN Services
P.O. Box 14621
Lexington, KY 40512-4621

MHN Services will give you claim forms on request. For more information regarding claims for covered mental disorders and chemical dependency services, you may call MHN Services at 1-800-444-4281 or you may write MHN Services at the address given immediately above.

For covered Acupuncture Services provided upon referral by American Specialty Health Plans of California, Inc. (ASH Plans*), you must file the claim with ASH Plans within one year after receiving those services. You must use ASH Plans' forms in filing the claim and you should send the claim to ASH Plans at the address listed in the claim form or to ASH Plans at:*

American Specialty Health Plans of California, Inc.
Attention: Customer Contact Center
P.O. Box 509002
San Diego, CA 92150-9002

ASH Plans will give you claim forms on request. For more information regarding claims for covered Acupuncture Services, you may call ASH Plans at 1-800-678-9133 or you may write ASH Plans at the address given immediately above.

For outpatient prescription drugs *please send a completed prescription drug claim form to:*

Health Net
C/O Caremark

P.O. Box 52136
Phoenix, AZ 85072

Please call the Customer Contact Center at the telephone number listed on the back cover or visit our website at www.healthnet.com to obtain a prescription drug claim form.

Claims for covered expenses filed more than 20 days from the date of service will not be paid unless you can show that it was not reasonably possible to file your claim within that time limit and that you have filed as soon as was reasonably possible.

Renewing, continuing or ending coverage

RENEWAL PROVISIONS

The contract between Health Net Life and your employer is usually renewed annually. If your contract is amended or terminated, your employer will notify you in writing.

SMALL EMPLOYER CAL-COBRA COVERAGE

When the group is a small employer (as defined in the Certificate), state law provides that members who enroll in this plan and later lose eligibility may be entitled to continuation of group coverage. More information regarding eligibility for this coverage is provided in your Certificate.

INDIVIDUAL CONTINUATION OF BENEFITS

Please examine your options carefully before declining coverage.

If your employment with your current employer ends, you and your covered dependents may qualify for continued group coverage under:

- **COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)**: For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside of California. Please check with your group to determine if you and your covered dependents are eligible.

- **Small Employer Cal-COBRA Continuation Coverage:** For employers with fewer than 20 employees who were eligible to enroll in the employer's health plan on 50% of the employer's business days in the preceding year, Health Net Life is required by state law to offer continuation coverage.

- **Cal-COBRA Continuation Coverage:** If you have exhausted COBRA and you live in the United States, you may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if you have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage and you are not entitled to Medicare. If you are eligible, you have the opportunity to continue group coverage under the *Certificate* through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.

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

Also, you may be eligible for continued coverage for a disabling condition (for up to 12 months) if your employer terminates its agreement with Health Net Life. Please refer to the "Extension of benefits" section of this SB for more information.

TERMINATION OF BENEFITS

Your coverage under this insurance plan ends when:

- The agreement between the employer covered under this insurance plan and Health Net Life ends;
- The employer covered under this insurance plan fails to pay premium charges; or
- You no longer work for the employer covered under this insurance plan.

If the employer covered under this insurance plan does not pay appropriate premium charges, benefits will end on the last day for which premium charges have been made, unless you are totally disabled and apply for an extension of benefits for the disabling condition within 90 days.


If the person involved in any of the above activities is the enrolled employee, coverage under this insurance plan will end as well for any covered dependents.

If you have a disagreement with our insurance plan

The California Department of Insurance (CDI) is responsible for regulating disability insurance carriers (Health Net Life is a disability insurance carrier). The CDI has a toll-free telephone number (**1-800-927-HELP**) to receive complaints about carriers.

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

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

GRIEVANCE AND APPEALS PROCESS

If you are dissatisfied with the quality of care that you have received or feel that you have been incorrectly denied a service or claim, you may file a grievance or appeal. 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.


How to file a grievance or appeal:

You may call the telephone number listed on the back cover or submit the covered person grievance form through the HNL website at ***www.healthnet.com*** **.**

You may also write to:

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

If your concern involves the Mental Disorders and Chemical Dependency program, call MHN Services at 1-888-426-0030 or write to:

MHN Services
Attention: Appeals and Grievances
P.O. Box 10697
San Rafael, CA 94912

Please include all the information from your Health Net Life identification card as well as the details of your concern or problem. For a grievance or appeal of our benefit determination, we shall notify you 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.

In addition, you can request an independent medical review of disputed health care services from the Department of Insurance, if you believe that health care services eligible for coverage and payment under the insurance plan was improperly denied, modified or delayed by Health Net Life or one of its participating providers.

Also, if Health Net Life denies your appeal of a denial for lack of medical necessity, or denies or delays coverage for requested treatment involving experimental or investigational drugs, devices, procedures or therapies, you can request an independent medical review of Health Net Life's decision from the Department of Insurance if you meet the eligibility criteria set out in the Certificate.

ARBITRATION

If you are not satisfied with the result of the grievance hearing and appeals process, you may submit the problem to binding arbitration. Health Net Life uses binding arbitration to settle disputes, including medical malpractice. When you enroll in Health Net Life, you agree to submit any disputes to arbitration, in lieu of a jury or court trial.

Additional insurance plan benefit information

The following insurance plan benefits show benefits available with your insurance plan. For a more complete description of copayments, and exclusions and limitations of service, please see your insurance plan's *Certificate*.

Prescription drug program

Health Net Life contracts with many major pharmacy chains, supermarket based pharmacies and privately owned neighborhood pharmacies. For a complete and up-to-date list of participating pharmacies, please visit our website at www.healthnet.com or call the Customer Contact Center at the telephone number listed on the back cover.

PRESCRIPTIONS BY MAIL DRUG PROGRAM

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period), you have the option of filling it through our convenient Prescriptions by Mail Drug Program. This program allows you to receive up to a 90-consecutive-calendar-day supply of maintenance medications. For complete information, call the Customer Contact Center at the telephone number listed on the back cover.

Schedule II narcotic drugs (which are drugs that have a high abuse risk as classified by the Federal Drug Enforcement Administration) are *not covered through mail order. For further information, please refer to the Certificate*.

THE HEALTH NET ESSENTIAL RX DRUG LIST

This insurance plan uses the Essential Rx Drug List. The Health Net Essential Rx Drug List (or the List) is the approved list of medications covered for illnesses and conditions. It was developed to identify the safest and most effective medications for Health Net Life covered persons while attempting to maintain affordable pharmacy benefits.

We specifically suggest to all Health Net Life contracted participating providers and specialists that they refer to this List when choosing drugs for patients who are Health Net Life covered persons. When your physician prescribes medications listed in the Essential Rx Drug List, it ensures that you are receiving a high quality prescription medication that is also of high value.

The Essential Rx Drug List is updated regularly, based on input from the Health Net Pharmacy and Therapeutics (P&T) Committee. The committee members are actively practicing physicians of various medical specialties and clinical pharmacists. Voting members are recruited from participating physician groups throughout California based on their experience, knowledge and expertise. In addition, the P&T Committee frequently consults with other medical experts to provide additional input to the Committee. Updates to the Essential Rx Drug List and drug usage guidelines are made as new clinical information and new drugs become available. In order to keep the List current, the P&T Committee evaluates clinical effectiveness, safety and overall value through:

- Medical and scientific publications;
- Relevant utilization experience; and
- Physician recommendations.

To obtain a copy of Health Net Life most current Essential Rx Drug List, please visit our web site at www.healthnet.com under the pharmacy information, or call the Customer Contact Center at the telephone number listed on the back cover.

WHAT IS "PRIOR AUTHORIZATION?"

Some drugs require prior authorization. This means that your doctor must contact Health Net Life in advance to provide the medical reason for prescribing the medication.

 How to request prior authorization:

Requests for prior authorization may be submitted electronically or by telephone or facsimile. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 2 business days or 72 hours, whichever is less, after Health Net Life's receipt of the request and any additional information requested by Health Net Life that is reasonably necessary to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 2 business days, as appropriate and medically necessary, for the nature of the covered person's condition after Health Net Life's receipt of the information reasonably necessary and requested by Health Net Life to make the determination. Upon receiving your physician's request for prior authorization, Health Net Life will evaluate the information submitted and make a determination based on established clinical criteria for the particular medication.

If a drug is not on the Essential Rx Drug List, and is not specifically excluded from coverage, your physician can ask for an exception. To request an exception, your Physician can submit a prior authorization request along with a statement supporting the request. Requests for prior authorization may be submitted electronically or by telephone or facsimile. If we approve an exception for a drug that is not on the Essential Rx Drug List, the non-preferred brand name drug tier (tier 3) or specialty copayment applies. If you are suffering from a condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug that is not on the Essential Rx Drug List, then You, Your designee or your physician can request an expedited review. Expedited requests for prior authorization will be processed within 24 hours after HNL's receipt of the request and any additional information requested by HNL that is reasonably necessary to make a determination.

The criteria used for prior authorization are developed and based on input from the Health Net P&T Committee as well as physician specialist experts. Your physician may contact Health Net Life to obtain the usage guidelines for specific medications.

If authorization is denied by Health Net Life, you will receive written communication including the specific reason for denial. If you disagree with the decision, you may appeal the decision.

The appeal may be submitted in writing, by telephone or through e-mail. We must receive the appeal within 60 days of the date of the denial notice. Please refer to the plan's *Certificate* for details regarding your right to appeal.

To submit an appeal:

- Call the Customer Contact Center at the telephone number listed on the back cover
- Visit www.healthnet.com for information on e-mailing the Customer Contact Center; or
- Write to:

  Health Net Life
  Customer Contact Center
  P.O. Box 9103
  Van Nuys, CA 91409-9103

WHAT'S COVERED

 *Please refer to the "Schedule of benefits and coverage" section of this SB for the deductibles and copayments.*

This insurance plan covers the following:

- Tier 1 drugs – Tier 1 drugs are most generic drugs and low-cost preferred brand name drugs;
- Tier 2 drugs – Tier 2 drugs are higher cost generic drugs and preferred brand name drugs; and
- Tier 3 drugs – Prescription drugs that are non-preferred brand name drugs, brand name drugs with generic equivalent on a lower tier, or drugs that have a preferred alternative on a lower tier.
- Preventive drugs and women's contraceptives
- Tier 4 (specialty drugs)- Includes drugs that are made using biotechnology; drugs that are distributed through a specialty pharmacy; drugs that require special training for self-administration; drugs that require regular monitoring of care by a specialty pharmacy; and drugs that cost more than six hundred dollars for a one-month supply. Note, insulin and other self-administered injectable drugs that do not meet the above specialty drugs criteria are covered on a lower drug tier as specified in the Essential Rx Drug List.

MORE INFORMATION ABOUT DRUGS THAT WE COVER

- Prescription drug covered expenses are the lesser of Health Net Life's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs;
- If a prescription drug deductible (per covered person each calendar year) applies, you must pay this amount for prescription drug covered expenses before Health Net Life begins to pay. Diabetic supplies, preventive drugs and women's contraceptives are not subject to the deductible. After the deductible is met the copayments or coinsurance amounts apply;
- Prescription drug refills are covered, up to a 30-consecutive-day supply per prescription at a Health Net Life contracted pharmacy for one copayment;
- If the pharmacy's retail price is less than the applicable copayment, the covered person will only pay the pharmacy's retail price;
- Mail order drugs are covered up to a 90-consecutive-calendar-day supply. When the retail pharmacy copayment is a percentage, the mail order copayment is the same percentage of the cost to Health Net Life as the retail pharmacy copayment;
- Preventive drugs, including smoking cessation drugs, are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over-the-counter or are only available with a prescription. Vaginal, oral, transdermal and emergency contraceptives are covered under this pharmacy benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit. Refer to the plan's *Certificate* for more information.
- Diabetic supplies (blood glucose testing strips, lancets, needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (that is, opened in order to dispense the product in quantities other than those packaged). When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times your physician has prescribed for a 30-day period. For more information about diabetic equipment and supplies, please see "Endnotes" in the "Schedule of benefits and coverage" section of this SB.
- Sexual dysfunction drugs which are drugs that establish, maintain or enhance sexual functioning are covered for sexual dysfunction when medically necessary. Sexual dysfunction drugs are covered when prior authorization is obtained from HNL. Injectable sexual dysfunction drugs must be dispensed through HNL's Specialty Pharmacy Vendor. These prescription drugs are covered for up to the number of doses or tablets specified in the Essential Rx Drug List. For information about the Essential Rx Drug List, please call the Customer Contact Center at the telephone number on your ID card.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

Services or supplies excluded under pharmacy services may be covered under the "plan benefits" portion of your insurance plan. In addition to the exclusion and limitations listed below, prescription drug benefits are subject to the insurance plan's general exclusions and limitations. Consult your insurance plan's Certificate for more information.

- Allergy serum;
- Coverage for devices is limited to FDA approved vaginal contraceptive devices and diabetic supplies. No other devices are covered;
- Drugs that are appetite suppressants or are indicated for and prescribed for body weight reduction;
- Drugs or medicines administered by a physician or physician's staff member;
- Drugs prescribed to shorten the duration of the common cold;
- Drugs prescribed for routine dental treatment;
- Drugs used for diagnostic purposes;
- Experimental drugs (those that are labeled "Caution - Limited by Federal Law to investigational use only"). If you are denied coverage of a drug because the drug is investigational or experimental you will have a right to independent medical review. See "If you have a disagreement with our insurance plan" section of this SB for additional information;
- Hypodermic needles or syringes, except for specific brands of disposable insulin needles and syringes and specific brands of pen devices. Needles and syringes required to administer self-injected medications (other than insulin) will be provided through Our Specialty Pharmacy Vendor. All other devices, syringes and needles are not covered;
- Immunizing agents, injections (except for insulin and self-administered injectable drugs as described in the Essential Rx Drug List), agents for surgical implantation, biological sera, blood, blood derivatives or blood plasma obtained through a prescription;
- Individual doses of medication dispensed in plastic, unit dose or foil packages unless medically necessary or only available in that form;
- Irrigation solutions and saline solutions;
- Limits on quantity, dosage and treatment duration may apply to some drugs. Medications taken on an "as-needed" basis may have a copayment based on a standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If medically necessary, your physician may request a larger quantity from Health Net Life;
- Medical equipment and supplies (including insulin), that are available without a prescription are covered when prescribed by a physician for the management and treatment of diabetes or for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations or for female contraception as approved by the FDA. Any other nonprescription drug, medical equipment or supply that can be purchased without a prescription drug order is not covered even if a physician writes a prescription drug order for such drug, equipment or supply. However, if a higher dosage form of a prescription drug or over-the counter (OTC) drug is only available by prescription, that higher dosage drug will be covered. If a drug that was previously available by prescription becomes available in an OTC form in the same prescription strength, then any prescription drugs that are similar agents and have comparable clinical effect(s) will only be covered when medically necessary and prior authorization is obtained from Health Net Life;
- Prescription drugs prescribed by an unlicensed physician;
- Replacement of lost, stolen or damaged medications, once you have taken possession of the drugs;
- Services or supplies which are covered in full or for which you are not legally required to pay;
- Supply amounts for prescriptions that exceed the FDA's or Health Net Life's indicated usage recommendation are not covered unless medically necessary and prior authorization is obtained from Health Net Life; Drugs that are not approved by the FDA are not covered.

- Drugs prescribed for a condition or treatment not covered by this insurance plan are not covered. However, the insurance plan does cover drugs for medical conditions that result from nonroutine complications of a noncovered service.

This is only a summary. Consult your insurance plan's *Certificate* to determine the exact terms and conditions of your coverage.

Pediatric vision care program

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

Professional Services ***Copayment***

Routine eye examination with dilation, as medically necessary.....$0, Deductible waived

Limitation:

In accordance with professionally recognized standards of practice, this Plan covers one complete vision examination once every calendar year.

Materials (including frames and lenses) ***Copayment***

Provider selected Frames (one every calendar year).....$0, Deductible waived

Standard Plastic Eyeglass Lenses (one pair every calendar year).....$0, Deductible waived

- Single vision, bifocal, trifocal, lenticular
- Glass or plastic
- Oversized and glass-grey #3 prescription sunglass lenses

Optional Lenses and Treatments including:.....$0, Deductible waived

- UV Treatment
- Tint (Fashion & Gradient & Glass-Grey)
- Standard Plastic Scratch Coating
- Standard Polycarbonate –
- Photochromic / Transitions Plastic
- Standard, Premium and Ultra Anti-Reflective Coating
- Polarized
- Standard, Premium, Select, and Ultra Progressive Lens
- Hi-Index Lenses
- Blended segment Lenses
- Intermediate vision Lenses
- Select or ultra- progressive lenses

Premium Progressive Lenses .....$0, Deductible waived

Provider selected Contact Lenses, a one year supply every calendar year (In lieu of eyeglass lenses).....$0, Deductible waived

- Disposables
- Conventional
- Medically Necessary*

Subnormal or Low Vision Services and Aids - one comprehensive low vision evaluation every 5 years; low vision aids, including high-power spectacles, magnifiers or telescopes (limited to one aid per year) and follow-up care (limited to 4 visits every 5 years) .....$0, Deductible waived

* Contact Lenses may be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, Contact Lenses may be medically necessary and appropriate when the use of Contact

Lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

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

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

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

 Services or supplies excluded under the vision care program may be covered under the medical benefits portion of your plan. Consult the plan's Certificate for more information.

In addition to the limitations described above, the plan does not cover the following:

- Eye examinations required for work or school;
- Medical or surgical treatment of the eyes;
- Nonprescription eyewear, vision devices or nonprescription sunglasses; and
- Replacement of lost, stolen or broken frames or lenses, unless benefits are otherwise available.
- Orthoptics (eye exercises);

LIABILITY FOR PAYMENT

If you go to a care provider not affiliated with Health Net Life, you will be responsible for payment of your eye exam, glasses or contact lenses.

You may also have to pay additional fees when you use an affiliated provider if you choose lenses, frames or contact lenses that cost more than the covered expense. Health Net Life will seek reimbursement for vision and eyewear services that are covered under Workers' Compensation or required by occupational disease law.

This is only a summary. Consult the plan's *Certificate* to determine the exact terms and conditions of your coverage.

Pediatric dental program

Benefits

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Calendar Year basis unless otherwise specifically stated.

Benefit Description	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Benefits	$0, Deductible waived	10%, Deductible waived
Preventive Benefits	$0, Deductible waived	10%, Deductible waived
Restorative Benefits	20%, Deductible waived	30%, Deductible waived
Periodontal Maintenance Services	20%, Deductible waived	30%, Deductible waived
Endodontics	50%, Deductible waived	50%, Deductible waived
Periodontics (other than Periodontal Maintenance)	50%, Deductible waived	50%, Deductible waived
Maxillofacial Prosthetics	50%, Deductible waived	50%, Deductible waived
Implant Services	50%, Deductible waived	50%, Deductible waived
Prosthodontics (Removable)	50%, Deductible waived	50%, Deductible waived
Fixed Prosthodontics	50%, Deductible waived	50%, Deductible waived
Oral and Maxillofacial Surgery	50%, Deductible waived	50%, Deductible waived
Medically Necessary Orthodontics	50%, Deductible waived	50%, Deductible waived
Adjunctive Services	50%, Deductible waived	50%, Deductible waived

Pediatric Dental Exclusions and Limitations:

Periodic Oral Evaluations
Periodic oral evaluations are limited to 1 every 6 months.

Prophylaxis
Prophylaxis services (cleanings) are limited to 1 every 6 months.

Fluoride treatment
Fluoride treatment is covered once 1 every 6 months.

Intraoral radiographic images
Intraoral - complete series of radiographic images are limited to once every 24 months.
intraoral - occlusal radiographic image are limited to 2 every 6 months.

Bitewing x-rays
Bitewing x-rays in conjunction with periodic examinations are limited to one series of 4 films in any 6-month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.

Full mouth x-rays
Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 months.

Panoramic film x-rays
Panoramic film x-rays are limited to once every 24 months.

Dental Sealant
Dental sealant treatments are limited to the first, second and third permanent molars that occupy the second molar position.

Replacement of a restoration
Replacement of a restoration is covered only when it is defective, as evidenced by conditions such a recurrent caries or fracture, and replacement is medically necessary.

Crowns
Prefabricated Crowns – primary teeth are covered once every 12 months.
Prefabricated Crowns – permanent teeth are covered once every 36 months.
Replacement prefabricated crowns necessary in primary teeth within the first 12 months and permanent teeth within the first 36 months are covered.

Only acrylic crowns and stainless crowns are benefit for children under 12 years of age. If other types of crowns are chosen the covered person will pay the difference in cost for children under 12 years of age. The covered dental benefit level will be that of an acrylic crown.

Gingivectomy or gingivoplasty and osseous surgery
Gingivectomy or gingivoplasty and osseous surgery are limited to once per quadrant every 36 months.

Periodontics (other than Maintenance)
Periodontal scaling and root planning, and subgingival curettage are limited to once per quadrant every 24 months.

Periodontal Maintenance
Periodontal maintenance is covered once every 12 months per quadrant.

Fixed bridgework
Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment (that is, it is an upgrade) and HNL will only pay for the partial; the covered person is responsible for the difference in cost to upgrade to a fixed bridge. A fixed bridge is covered once in a 5-year period when it is necessary to replace a missing permanent anterior tooth. Fixed bridges used to replace missing posterior teeth are considered optional (that is, it is an upgrade) when the abutment teeth are dentally sound and would be crowned only for the purpose of

supporting a pontic. HNL will only pay for the partial; the covered person is responsible for the difference in cost to upgrade to a fixed bridge.

Fixed bridges are optional (that is, it is an upgrade) when provided in connection with a partial denture on the same arch. HNL will only pay for the partial; the covered person is responsible for the difference in cost to upgrade to a fixed bridge. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair. The benefit allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment (that is, it is an upgrade). HNL will only pay for the partial; the Covered Person is responsible for the difference in cost to upgrade to a fixed bridge. Fixed bridges are also covered when medical conditions or employment preclude the use of a removable partial denture.

Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair. Also covered one in a 5-year period when medical conditions or employment preclude the use of a removable partial denture.

Full upper and/or lower dentures
Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair. The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. It a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.

Relines and Tissue Conditioning
Office or laboratory relines covered six months after the date of service for immediate dentures an immediate overdenture and cast metal partial dentures that required extractions.

Office or laboratory relines covered 12 months after the date of service for complete dentures, a complete (remote) overdenture and cast metal partial dentures that do not require extractions.

Tissue conditioning is limited to two per denture.

Medically Necessary Orthodontia:

- Orthodontic care is covered when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

Adjunctive Services:

Adjunctive services, including anesthesia, professional visits and consults, behavior management, post-surgical complications, and occlusal guards, are covered:

a. Palliative treatment (relief of pain).
b. Palliative (emergency) treatment, for treatment of dental pain, limited to once per day, per covered person.
c. House/extended care facility calls, once per member per date of service.
d. One hospital or ambulatory surgical center call per day per provider per covered person.
e. The following anesthesia services are covered in conjunction with oral surgery, as well as for other purposes when medically necessary:
    i. deep sedation/general anesthesia, each 15 minute increment
    ii. intravenous moderate (conscious) sedation/analgesia – each 15 minute increment
    iii. non-intravenous conscious sedation
    iv. inhalation of nitrous oxide/analgesia, anxiolysis

f. Occlusal guards when medically necessary for covered persons from 12 to 19 years of age when covered person has permanent dentition.

Pediatric Dental Exclusions

1. Services which, in the opinion of the attending dentist, are not necessary to the covered person's dental health.
2. Cosmetic dental care.
3. Experimental procedures or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or devices usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficiency have not been determined for use in the treatment for which the item in service in question is recommended or prescribed. Denial of Experimental procedures or Investigational services is subject to Independent Medical Review (please refer to the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "Specific Provisions" section of the *Certificate* for more information).
4. Services that were provided without cost to the covered person by State government or an agency thereof, or any municipality, county or other subdivisions.
5. Hospital charges of any kind.
6. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the covered person become eligible for such services.
7. Dispensing of drugs not normally supplied in a dental office.
8. The cost of precious metals used in any form of dental benefits.
9. Dental Services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonable should have known that an Emergency Care situation did not exist.

Notice of Nondiscrimination

Nondiscrimination Notice

In addition to 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) 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, 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:
Individual & Family Plan (IFP) Members On Exchange/Covered California 1-888-926-4988 (TTY: 711)
Individual & Family Plan (IFP) Members Off Exchange 1-800-839-2172 (TTY: 711)
Individual & Family Plan (IFP) Applicants 1-877-609-8711 (TTY: 711)
Group Plans through Health Net 1-800-522-0088 (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) or
Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

For HMO, HSP, EOA, and POS plans offered through Health Net of California, Inc.: If your health problem is urgent, if you already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

For PPO and EPO plans underwritten by Health Net Life Insurance Company: 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.

FLY018690EP00 (6/18)

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 bą́ą́h 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 (IFP) Off Exchange 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

CONTACT US

For more information, please contact us at:

Health Net PPO
Post Office Box 9103
Van Nuys, California 91409-9103

Customer Contact Center

Small Business Group:
1-800-522-0088 TTY: 711
(for companies with 1-100 employees)

Individual & Family Plans:
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

Online: www.healthnet.com