Health Net Life Insurance Company (Health Net Life)

Insurance Plan Summary

PPO

Small Business Group

Refer to the Summary of Benefits and Coverage (SBC) document to determine your share of costs for services and supplies that are covered by this insurance plan.

HealthNet.com

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 *Insurance Plan Summary* answers basic questions about Health Net PPO.

The coverage described in this *Insurance Plan Summary* 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 *Insurance Plan Summary* 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

By mail at:

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

Online at www.healthnet.com

This *Insurance Plan Summary* and the *SBC* document provide a summary of your health insurance plan. The insurance 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 the *Certificate*, contact the Customer Contact Center at 1-800-522-0088. You should also consult the *Group Insurance Policy (Policy)* (issued to your employer) to determine governing contractual provisions. It is important for you to carefully read this *Insurance Plan Summary*, the *SBC* and, once received, the insurance plan's *Certificate*, especially those sections that apply to those with special health care needs. This *Insurance Plan Summary* includes a matrix of benefits in the section titled "Benefit Matrix." The *SBC*, which is issued in conjunction with this *Insurance Plan Summary*, describes what your insurance plan covers and what you pay for covered services and supplies. 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 health care may be obtained.

CHOICE OF PROVIDERS

When you are insured under the Health Net PPO plan, you (the "covered person") choose your own doctors and hospitals for all your health care needs. Health Net PPO offers two different ways to access care:

- **In-network** - You choose a contracted doctor or hospital within our PPO network. You can take advantage of significant cost savings when you receive care from a provider who is contracted with Health Net PPO.
- **Out-of-network** - You choose a doctor or hospital outside of our PPO network. These providers do not have a contract with Health Net PPO. You will incur higher out-of-pocket costs than when you see a provider within our PPO Network.

Except for emergency care, when you choose to see an out-of-network provider, you will pay the cost-sharing for the out-of-network benefit level, which is typically higher than the in-network benefit level. ***Plus****, you are responsible for the difference between the amount the out-of-network provider bills and the maximum allowable amount (MAA). See "Payment of Premiums and Charges" later in this Insurance Plan Summary for more details.*

Your choice of doctors and hospitals may determine which services will be covered, as well as how much you will pay. Providers who are contracted with Health Net PPO are called "preferred providers" and they are listed on our website at www.healthnet.com. You can also contact the Customer Contact Center at the telephone number listed on the back cover to obtain a copy of the *Health Net PPO Preferred Provider Directory* at no cost.

In some instances, ***certification*** *(also known as preauthorization or treatment review) is required for full benefits to be paid. Refer to the "Certification Requirements" section of this Insurance Plan Summary to find out which services or supplies require certification.*

SPECIALISTS CARE

If you need specialty care, you are free to see any specialist without a referral. Simply call and schedule an appointment. To lower your share of costs, obtain care at the in-network benefit level by seeing a specialist within our PPO network. Refer to the *Health Net PPO Preferred Provider Directory* to locate specialists within our PPO network.

You also do not need approval from Health Net Life or from any other person in order to obtain access to obstetrical, gynecological, reproductive or sexual health care from an in-network health care professional who specializes in obstetrics, gynecology or reproductive and sexual health. The health

care professional, however, may be required to comply with certain procedures, including obtaining certification for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics, gynecology or reproductive and sexual health, refer to your *Health Net PPO Preferred Provider Directory* on the Health Net Life website at www.healthnet.com. A copy of the *Health Net PPO Preferred Provider Directory* may also be ordered online or by calling Health Net Life Customer Contact Center at the phone number on the back cover.

MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Health Net Life contracts with MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator), which administers behavioral health services for mental health and substance use disorders. For more information about how to receive care and the Behavioral Health Administrator's certification requirements, please refer to the "Behavioral Health Services" and “Certification Requirements” sections of this *Insurance Plan Summary*.

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 insurance plan's *Certificate* and that you or your family member might need:

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

You should obtain more information before you enroll. Call your prospective doctors, hospitals or clinics which contract with Health Net Life or any other provider of choice. You may also call the Health Net Life Customer Contact Center at the phone number on the back cover to ensure that you can obtain the health care services that you need.

Benefits Matrix

The matrix below lists examples of services that are provided under this insurance plan. Refer to the *SBC*, which is issued in conjunction with this *Insurance Plan Summary*, for the amount you will pay for covered services and supplies.

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *CERTIFICATE* SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Principal Benefits	What You Pay
Deductible	The *SBC* shows if your insurance plan has a deductible that has to be met before we begin to pay the benefits.
Lifetime maximums	This insurance plan does not have a lifetime maximum.
Professional services	Refer to the *SBC* under "If you visit a health care provider's office or clinic."
Outpatient services	Refer to the *SBC* under "If you have outpatient surgery."
Hospitalization services	Refer to the *SBC* under "If you have a hospital stay."
Emergency health coverage	Refer to the *SBC* under "If you need immediate medical attention."
Ambulance services	Refer to the *SBC* under "If you need immediate medical attention."
Prescription drug coverage	Refer to the *SBC* under "If you need drugs to treat your illness or condition."
Durable medical equipment	Refer to the *SBC* under "If you need help recovering or have other special health needs."
Mental health services	Refer to the *SBC* under "If you need mental health, behavioral health, or substance abuse services."
Substance use disorder services	Refer to the *SBC* under "If you need mental health, behavioral health, or substance abuse services."
Home health services	Refer to the *SBC* under "If you need help recovering or have other special health needs."
Other services	Refer to the *SBC* under "If you have a test" and "If you need help recovering or have other special health needs."
Pediatric vision care	Refer to the "Pediatric Vision Care Program" section later in this *Insurance Plan Summary* for the benefit information which includes the eyewear schedule.
Pediatric dental services	Refer to the "Pediatric Dental Program" section later in this *Insurance Plan Summary* for the benefit information. See the *Certificate* for additional details.

Certification Requirements

For certain covered services, you must obtain certification before receiving the services or you will be required to pay the noncertification penalty as shown in the *SBC* and the *Certificate*. Certifications are performed by Health Net Life (medical), the Behavioral Health Administrator (mental health and substance use disorders) or an authorized designee.

We may revise the certification list from time to time. Any such changes including additions and deletions from the list will be communicated to preferred providers and posted on the www.healthnet.com website.

Certification is NOT a determination of benefits. Some of these services or supplies may not be covered under your insurance plan. Even if a service or supply is certified, eligibility rules and benefit limitations will still apply. However, Health Net Life will not rescind or modify certification after a provider renders health care services in good faith and pursuant to the certification, and will pay benefits under the Certificate for the services certified.

Services provided as the result of an emergency are covered at the in-network benefit level and do not require certification.

SERVICES REQUIRING CERTIFICATION

Inpatient facility admissions

Any type of facility, including but not limited to:

- Acute rehabilitation center
- Hospice
- Hospital, except in an emergency
- Mental health facility, except in an emergency
- Skilled nursing facility
- Substance use disorder facility, except in an emergency

Outpatient procedures, services or equipment

- Acupuncture (after the initial consultation)
- Ambulance: Non-emergency, air or ground ambulance services
- Bronchial thermoplasty
- Capsule endoscopy
- Cardiac procedures
- Chiropractic care
- Clinical trials

- Dermatology such as chemical exfoliation and electrolysis, dermabrasions and chemical peels, laser treatment or skin injections and implants
- Diagnostic procedures:
  1. Advanced imaging
     - Computerized Tomography (CT)
     - Computed Tomography Angiography (CTA)
     - Magnetic Resonance Angiography (MRA)
     - Magnetic Resonance Imaging (MRI)
     - Positron Emission Tomography (PET)
  2. Cardiac imaging
     - Coronary Computed Tomography Angiography (CCTA)
     - Echocardiography
     - Myocardial Perfusion Imaging (MPI)
     - Multigated Acquisition (MUGA) scan
- Durable Medical Equipment
  1. Bilevel Positive Airway Pressure (BiPAP)
  2. Bone growth stimulator
  3. Continuous glucose monitoring
  4. Continuous Positive Airway Pressure (CPAP)
  5. Custom-made items, including custom wheelchairs
  6. Hospital beds and mattresses
  7. Power wheelchairs and accessories
  8. Scooters
  9. Ventilators
- Ear, Nose and Throat (ENT) procedures
- Enhanced External Counterpulsation (EECP)
- Experimental/Investigational services
- Genetic testing
- Implantable pain pumps including insertion or removal
- Injections for intended use of steroid and/or pain management including epidural, nerve, nerve root, facet joint, trigger point and Sacroiliac (SI) joint injections
- Occupational therapy (includes home setting) except when the therapy is medically necessary for treating a mental health diagnosis such as autism
- Organ, tissue and stem cell transplant services, including pre-evaluation and pre-treatment services and the transplant procedure; transplants must be performed through Health Net Life's designated transplantation specialty network.
- Orthotics (custom-made items)
- Outpatient pharmaceuticals:
  1. Most self-injectables, excluding insulin, require prior authorization. Please refer to the Essential Rx Drug List to identify which drugs require prior authorization.

2. All hemophilia factors through the outpatient prescription drug benefit require prior authorization and must be obtained through the Specialty Pharmacy Vendor.
3. Certain physician-administered drugs require prior authorization, including newly approved drugs, whether administered in a physician office, freestanding 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.
4. Most specialty drugs must have prior authorization through the outpatient prescription drug benefit and may need to be dispensed 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.
5. Other 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.
6. Biosimilars are required in lieu of branded drugs.

- Outpatient surgical procedures:
  1. Ablative techniques for treating Barrett's esophagus and for treatment of primary and metastatic liver malignancies
  2. Balloon sinuplasty
  3. Bariatric procedures
  4. Cochlear implants
  5. Joint surgeries
  6. Neuro or spinal cord stimulator
  7. Orthognathic procedures (includes TMJ treatment)
  8. Spinal surgery including, but not limited to, laminotomy, fusion, discectomy, vertebroplasty, nucleoplasty, stabilization and X-Stop
  9. Uvulopalatopharyngoplasty (UPPP) and laser-assisted UPPP
  10. Vestibuloplasty
- Physical therapy (includes home setting) except when the therapy is medically necessary for treating a mental health diagnosis such as autism
- Prosthesis and corrective appliances
- Radiation therapy
- Reconstructive and cosmetic surgery, service and supplies or procedures, including but not limited to:
  1. Bone alteration or reshaping such as osteoplasty
  2. Breast reductions and augmentations except when following a mastectomy (includes gynecomastia and macromastia)
  3. 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

4. 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
5. Eye or brow procedures such as blepharoplasty, brow ptosis or canthoplasty
6. Gynecologic or urology procedures such as clitoroplasty, labiaplasty, vaginal rejuvenation, scrotoplasty, testicular prosthesis, vulvectomy
7. Hair electrolysis, transplantation or laser removal
8. Lift such as arm, body, face, neck, thigh
9. Liposuction
10. Nasal surgery such as rhinoplasty or septoplasty
11. Otoplasty
12. Treatment of varicose veins
13. Vermilionectomy with mucosal advancement

- Speech therapy (includes home setting) except when the therapy is medically necessary for treating a mental health diagnosis such as autism or gender dysphoria

Exceptions: *Certification is not required for the length of a hospital stay for reconstructive surgery incident to a mastectomy (including lumpectomy). Certification is not needed for the first 48 hours of inpatient hospital services following a vaginal delivery, nor the first 96 hours following a cesarean section. However, please notify Health Net Life within 24 hours following birth or as soon as reasonably possible. No penalty will apply if notification is not received. Certification must be obtained if the physician determines that a longer hospital stay is medically necessary either prior to or following birth.*

Limits of Coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- Air or ground ambulance and paramedic services that do not result in transportation or that do not meet the criteria for emergency care, unless such services are medically necessary and certification has been obtained;
- Biofeedback therapy is limited to medically necessary treatment of certain physical disorders (such as incontinence and chronic pain) and mental health and substance use disorders;
- Care for mental health care as a condition of parole or probation, or court-ordered testing for mental health and substance use disorders, except when such services are medically necessary;
- Charges in excess of covered expenses as described in "Covered Expenses" under the "Payment of Premiums and Charges" section of this *Insurance Plan Summary*.
- Chiropractic services, unless shown as covered on your insurance plan's *SBC*;
- Corrective footwear is limited to medically necessary footwear that is custom made for the covered person and permanently attached to a medically necessary orthotic device that is also a covered benefit under this insurance plan, or is a podiatric device to prevent or treat diabetes-related complications. Other corrective footwear is not covered unless specifically described in your *Certificate*;

- Cosmetic services and supplies;
- Custodial or live-in care;
- Dental services for covered persons age 19 and over. 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 except certain disposable ostomy or urological supplies;
- 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 *Insurance Plan Summary*;
- Fertility preservation coverage does not include the following: follow-up assisted reproductive technologies (ART) to achieve future pregnancy such as artificial insemination, in vitro fertilization and/or embryo transfer; pre-implantation genetic diagnosis; donor eggs, sperm or embryos; or gestational carriers (surrogates);
- Genetic testing is not covered except when determined by Health Net Life to be medically necessary. The prescribing physician must request certification for coverage;
- Hearing aids;
- Immunizations and injections for foreign travel or occupational purposes;
- Infertility services and supplies, unless shown as covered on your insurance plan's *SBC*;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental health or substance use disorder;
- Noneligible institutions. This insurance plan only covers medically necessary services or supplies provided by a licensed hospital, hospice, Medicare-approved skilled nursing facility, residential treatment center or other properly licensed medical facility as specified in the *Certificate*. Any institution that is not licensed to provide medical services and supplies, regardless of how it is designated, is not an eligible institution;
- Nontreatable disorders;
- Orthoptics (eye exercises);
- 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;
- Outpatient prescription drugs (except as noted under "Prescription Drug Program");
- 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 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;
- Services and supplies not authorized by Health Net Life or the Behavioral Health Administrator according to Health Net Life's procedures;
- Services for a surrogate pregnancy are covered when the surrogate is a Health Net Life covered person. However, when compensation is obtained for the surrogacy, Health Net Life shall have a lien on such compensation to recover its medical expense;
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the *Certificate*;
- Services related to education or training, including for employment or professional purposes, except for behavioral health treatment for pervasive developmental disorder or autism;
- State hospital treatment, except as the result of an emergency or urgently needed care;
- Stress, except when rendered in connection with services provided for a treatable mental health or substance use disorder;
- Telehealth consultations through the select telehealth services provider do not cover specialist services; and prescriptions for substances controlled by the DEA, non-therapeutic drugs or certain other drugs that may be harmful because of potential for abuse; and
- Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary.

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

Benefits and Coverage

MEDICALLY NECESSARY CARE

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

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. Depending on your circumstances, you may call your physician or the Behavioral Health Administrator (mental health and substance use disorders) or go to the nearest emergency facility or call **911**.

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 mental

health and substance use disorders) that requires an emergency response. All air and ground 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 mental health and substance use disorders).

Emergency care is covered at the in-network benefit level and does not require certification. All follow-up care (including mental health and substance use disorders) after the urgency has passed and your condition is stable will be covered at whichever benefit level (in-network or out-of-network) it qualifies for, subject to any applicable certification requirements, and your insurance plan's 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 seek if he or she was having serious symptoms, and believed that without immediate treatment, any of the following would occur: (1) 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); (2) His or her bodily functions, organs or parts would become seriously damaged; or (3) 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: (1) There is inadequate time to effect safe transfer to another hospital prior to delivery; or (2) A transfer poses a threat to the health and safety of the covered person or 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.

Psychiatric emergency medical condition *means a mental health or substance use disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: (1) An immediate danger to himself or herself or to others, or (2) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental health or substance use disorder.*

Urgent care *is any otherwise covered service for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (by a person applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine) could seriously jeopardize the life or health of the covered person or the covered person's ability to regain maximum function; or, in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment in question.*

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.

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, recommended by the covered person's treating physician and authorized by Health Net Life. The physician must determine that participation has a meaningful potential benefit to the covered person and the trial has therapeutic intent. For further information, please refer to the *Certificate*.

COVERAGE FOR NEWBORNS

Children born after your date of enrollment are automatically covered for 31 days (including the date of birth). To continue coverage, the child must be enrolled through your employer before the 60th day of the child's life. If the child is not enrolled within 60 days (including the date of birth):

- Coverage will end after 31 days (including the date of birth); and
- You will have to pay for all medical care provided after 31 days (including the date of birth).

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 insurance plan within 60 days of becoming ineligible and losing coverage from a Medi-Cal plan.

OUT-OF-STATE PROVIDERS

Health Net PPO allows you access to participating providers outside of California. If you are outside California, require medical care or treatment, and use a provider from the supplemental network (also

known as the “travel network”), your services are covered at the in-network benefit level. If your principle residence is outside of California, all in-network services are through the travel network.

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

The travel network consists of providers who participate in a network as shown on your Health Net Life ID card, that agree to provide health care services to Health Net Life covered persons.

EXTENSION OF BENEFITS

If you or a covered dependent is totally disabled when your employer ends its group *Policy* with Health Net Life, we may 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
- The covered person becomes enrolled in another 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.

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 settings (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 are insured by Health Net Life, 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 the 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 the 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 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 *Certificate*, at www.healthnet.com under "Legal Notices" or you may call the Customer Contact Center at the phone number on the back cover of this *Insurance Plan Summary* 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.*

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

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

Payment of Premiums and Charges

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.

COVERED EXPENSES

Covered expenses are expenses incurred by you for covered services and supplies while enrolled under this insurance plan. You are responsible for payment of your share of the cost of services (i.e., deductibles, copayments or coinsurance). Your share of cost is based on covered expenses.

A covered expense is not necessarily the amount a doctor or provider bills for a service. The amount of covered expenses varies by whether you obtain services from a preferred provider or an out-of-network provider. For a preferred provider, a covered expense is the contracted rate. For an out-of-network provider, a covered expense is the maximum allowable amount. See "Maximum Allowable Amount (MAA) for Out-of-Network Providers" later in this section for more information.

OTHER CHARGES

The *SBC* 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. Amounts paid by you are called **deductible**, **copayment** and **coinsurance**, which are described in the *SBC*. 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. In general:

- If your benefits are subject to a deductible, you must pay the deductible before we begin to pay for those benefits.

- You pay less when you receive care from doctors or hospitals that are contracted with Health Net PPO, since they have agreed in advance to provide services for a specific fee (a contracted rate). You will only pay the applicable in-network deductible, copayment or coinsurance. Preferred providers have agreed to accept the contracted rate as payment in full and may not bill you for charges in excess of the contracted rate.
- If you receive care from out-of-network doctors or hospitals, you will be responsible for the applicable out-of-network deductible, copayment or coinsurance, **plus** any charges that exceed MAA.

  Exceptions: In the following circumstances, the in-network benefit level applies and you will not be responsible for any amounts in excess of MAA:
  - If we authorize medically necessary services through an out-of-network provider because such services are not available through a preferred provider;
  - When non-emergent services are provided by an out-of-network provider at an in-network health facility, and you were not informed prior to receiving the services that the provider is an out-of-network provider; or
  - When emergency services are provided by an out-of-network provider.

  For further details and requirements, see the *Certificate*.
- For some services, certification is necessary to receive full benefits. Please see the "Certification Requirements" section of this *Insurance Plan Summary* 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 your total payment of the deductibles, copayments and coinsurance equals the out-of-pocket maximum shown on your insurance plan's *SBC*, we will pay 100% of covered expenses. (There are exceptions, see the *SBC* and the *Certificate* for details.)

Payment for services not covered by this insurance plan will not count toward the out-of-pocket maximum. Additionally, certain deductibles, copayments and coinsurance will not count toward the out-of-pocket maximum as shown in the SBC. For further information, please refer to the Certificate.

MAXIMUM ALLOWABLE AMOUNT (MAA) FOR OUT-OF-NETWORK PROVIDERS

When you receive care from an out-of-network provider, your share of cost is based on MAA. You are responsible for any applicable deductible, copayments or coinsurance payment, **and** any amounts billed in excess of MAA. You are completely financially responsible for care that this insurance plan does not cover.

MAA may be less than the amount the provider bills for services and supplies. Health Net Life calculates MAA as the lesser of the amount billed by the out-of-network provider or the amount determined as set forth below. MAA is not the amount that Health Net Life pays for a covered service;

the actual payment will be reduced by applicable deductibles, copayments or coinsurance and other applicable amounts set forth in the *Certificate*.

- ***MAA 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.

  For illustration purposes only, Out-of-Network Provider: 70% Health Net Life 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**

  MAA 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.

  MAA 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. MAA 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) the 50th percentile of FAIR Health database of professional and ancillary services not included in FAIR Health Medicare gapfilling methodology (3) 100% of the Medicare allowable amount for the same covered services or supplies under alternative billing codes published by Medicare; or (4) 50% of the out-of-network provider's billed charges for covered services. 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. MAA for facility services shall be the lesser of: (1) the average amount negotiated with preferred providers within the geographic region for the same covered services or supplies provided; (2) 100% of the derived amount using a method developed by Data iSight for facility services (a data service that applies a profit margin factor to the estimated costs of the services rendered), or a similar type of database or valuation service, which will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination; (3) 150% of the Medicare allowable amount for the same covered services or supplies under alternative billing codes published

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

- ***MAA 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 Health Net Life generally uses to determine payments for out-of-network providers, excluding any in-network deductible, copayment or coinsurance; or (3) the amount paid under Medicare Part A or B, excluding any in-network copayment or coinsurance. Emergency care provided by an out-of-network provider is subject to the preferred provider level of cost-sharing (and deductible, if applicable) based on this MAA amount. You are not responsible for any charges in excess of the amount other than the preferred provider level of cost-sharing (and deductible, if applicable).
- ***MAA for non-emergent services at an in-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 an 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 Health Net Life.
- ***MAA 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.
- ***MAA for pediatric dental services*** is calculated by Health Net Life 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. Health Net Life 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 MAA may also be subject to other limitations on covered expenses. See the *Certificate* for specific benefit limitations, maximums, pre-certification requirements and payment policies that limit the amount Health Net Life pays for certain covered services and supplies.

In addition to the above, from time to time, Health Net Life also contracts with vendors that have contracted fee arrangements with providers ("Third Party Networks"). In the event Health Net Life contracts with a Third Party Network that has a contract with the out-of-network provider, Health Net Life may, at its option, use the rate agreed to by the Third Party Network as the MAA. Alternatively, we may, at our option, refer a claim for out-of-network services to a fee negotiation service to negotiate the MAA 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 billed charges and the MAA. You will be responsible for any applicable deductible, copayment and/or coinsurance at the out-of-network benefit level.

NOTE: When the Centers for Medicare and Medicaid Services (CMS) adjusts the Medicare allowable amount, Health Net Life will adjust, without notice, the MAA 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.

LIABILITY OF ENROLLEE FOR PAYMENT

If you receive covered services and supplies, you are responsible for your share of costs as described herein. If you receive services that are not covered by this insurance plan, you are responsible for the entire cost of such services.

*Except in an emergency, when you choose to obtain covered services from an out-of-network provider, you are responsible for your share of cost at the out-of-network benefit level **plus** the amount the provider bills that exceeds MAA.*

REIMBURSEMENT PROVISIONS

Payments that are owed by Health Net Life for covered expenses will never be your responsibility.

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

Please call the Health Net Life Customer Contact Center at the phone number on the back cover to obtain claim forms, and to find out whether you should send the completed form to the Behavioral Health Administrator (mental health and substance use disorders) or directly to Health Net Life. Medical 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 Life Commercial Claims
P.O. Box 9040
Farmington, MO 63640-9040

Please call Health Net Life Customer Contact Center at the phone number on the back cover of this *Insurance Plan Summary* or visit our website at www.healthnet.com to obtain the claim form.

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

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

Please call the Health Net Life Customer Contact Center at the phone number on the back cover of this *Insurance Plan Summary* or visit our website at www.healthnet.com to obtain a prescription drug claim form.

For mental health or substance use disorders emergency services or for services authorized by MHN Services, you must use the CMS (HCFA) - 1500 form. Please send the claim to MHN Claims within one year of the date of service at the address listed on the claim form or to MHN Claims at:

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

Please call MHN Claims at 1-800-444-4281 to obtain a claim form.

For acupuncture services provided by American Specialty Health Plans of California, Inc. (ASH Plans), you must use ASH Plans' forms in filing the claim. Send the claim to ASH Plans at the address listed on the claim form or to ASH Plans at:

American Specialty Health Plans of California, Inc.
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.

Claims for covered expenses filed more than one year 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.

CONTINUITY OF CARE

Continuity of Care upon Termination of Provider Contract

If our contract with a preferred provider ends, Health Net Life will make every effort to ensure that care continues. You may request continued care from an out-of-network provider at the in-network benefit level if, at the time of provider contract termination, you were receiving care from such a provider for the conditions listed below.

The following conditions are eligible for continuation of care:

- An acute condition;

- A serious chronic condition not to exceed twelve months;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- Maternal mental health, not to exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later;
- A newborn (up to 36 months of age, not to exceed twelve months);
- A terminal illness (through the duration of the terminal illness);
- A surgery or other procedure that has been authorized by Health Net Life (or by the covered person's prior health plan for a new enrollee) as part of a documented course of treatment.

To request continued care, you will need to complete a Continuity of Care Request Form. If you would like more information on how to request continued care or to request a copy of the Continuity of Care Request Form or of Health Net Life's continuity of care policy, please call the Health Net Life Customer Contact Center at the phone number on the back cover.

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.

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. Refer to the *Certificate* for more information regarding eligibility for this 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 this insurance plan 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 *Insurance Plan Summary* 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

GRIEVANCES 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 Health Net Life 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 Customer Contact Center at the phone number on the back cover or submit a Grievance Form through our website at www.healthnet.com.

You may also write to:

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

Please include all the information from your Health Net Life identification card as well as details of your concern or problem. Health Net Life will issue a final benefit determination upon receiving a single grievance, or internal appeal request. 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 Health Net Life, 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 Health Net Life, 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 Health Net Life, 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. Refer to the Certificate for more details.

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 plan benefits are available with your insurance plan. For a more complete description of what you pay, and exclusions and limitations of service, please see the *Certificate*.

Behavioral Health Services

Health Net Life contracts with MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator) which administers behavioral health services through a personalized, confidential and affordable mental health and substance use disorder care program.

You may obtain mental health and substance use disorder services from any behavioral health provider. To obtain care at the in-network benefit level, contact the Behavioral Health Administrator by calling the Health Net Life Customer Contact Center at the phone number on the back cover. The Behavioral Health Administrator will help you identify a nearby participating behavioral health professional with whom you can make an appointment.

Certain services and supplies for mental health and substance use disorders require certification by the Behavioral Health Administrator in order to be covered. Refer to the "Certification Requirements" section of this *Insurance Plan Summary* for more details.

Please refer to the *Certificate* for a more complete description of covered mental health and substance use disorder services and supplies.

MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Mental health and substance use disorders means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this definition as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

CONTINUATION OF TREATMENT

If you are in treatment for a mental health or substance use disorder, call the telephone number shown on your Health Net Life ID card to receive assistance in transferring your care to a network provider for covered services to be payable at the in-network benefit level.

WHAT'S COVERED

Please refer to the *SBC* for the explanation of covered services and your share of costs.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

Services or supplies for the treatment of mental health and substance use disorders are subject to the insurance plan's general exclusions and limitations. Please refer to the "Limits of Coverage" section of this *Insurance Plan Summary* for a list of what's not covered under this insurance plan.

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

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 Health Net Life Customer Contact Center at the phone number on the back cover.

THE HEALTH NET ESSENTIAL RX DRUG LIST

This insurance plan uses the Health Net Essential Rx Drug List (or the List). 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 preferred providers that they refer to this List when choosing drugs for patients who are Health Net Life covered persons. When your physician prescribes medications listed in the Essential Rx Drug List, it ensures that you are receiving a high quality prescription medication that is also of high value.

The List is updated regularly, based on input from the Health Net Pharmacy and Therapeutics (P&T) Committee ("Committee"). The Committee members are actively practicing physicians of various medical specialties and clinical pharmacists. Voting members are recruited from contracting 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 the most current Essential Rx Drug List, please visit our website at www.healthnet.com or call the Health Net Life Customer Contact Center at the phone number 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. You may obtain a list of drugs requiring prior authorization by visiting our website at www.healthnet.com or call the Health Net Life Customer Contact Center at the phone number on the back cover.

How to Request Prior Authorization

Drugs on the Essential Rx Drug List - Your physician may submit a request for prior authorization, including a step therapy exception, electronically, by phone or by fax. Requests will be processed within the time frames shown below after Health Net Life's receipt of the request.

Urgent requests: Not to exceed 24 hours.

Routine requests: Not to exceed 72 hours.

Drugs not on the Essential Rx Drug List - If a drug is not on the Essential Rx Drug List, 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, by phone or by fax. 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 drug (tier 4) 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.

Exception requests will be processed within the time frames shown below after Health Net Life's receipt of the request. Exceptions based on your medical condition will be for the duration of your medical condition.

Expedited requests: Within 24 hours.

Standard requests: Within 72 hours.

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. 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. Refer to "Grievance and Appeals Process" under the "If You Have a Disagreement with Our Insurance Plan" section for details on how to file an appeal.

PRESCRIPTIONS BY MAIL PROGRAM

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period), you may fill it through our convenient prescriptions-by-mail program. This program allows you to receive up to a 90-consecutive-calendar-day supply of maintenance drugs from a network mail-order pharmacy. For complete information, visit www.healthnet.com or call the Health Net Life Customer Contact Center at the phone number 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.

WHAT'S COVERED

Please refer to the SBC for the explanation of covered services and *your share of costs.*

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;
- 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;

- 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; 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; and
- Preventive drugs and women's contraceptives.

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 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 copayment or coinsurance amounts will 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. A copayment or coinsurance is required for each prescription. In some cases, a 30-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan according to the Food and Drug Administration (FDA) or Health Net Life's usage guidelines. If this is the case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply.
- Percentage copayments will be based on Health Net Life's contracted pharmacy rate.
- 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.
- Prescription drugs for the treatment of asthma are covered. Inhaler spacers and peak flow meters are covered through the pharmacy benefit when medically necessary. Nebulizers (including face masks and tubing) are covered under "Durable Medical Equipment" and educational programs for the management of asthma are covered under "Patient Education" through the medical benefit.
- 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. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. 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 *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 up to a 30-day period.
- Specialty drugs require prior authorization and upon approval, the specialty pharmacy vendor will arrange for the dispensing of the drugs. Please refer to the *Certificate* for additional information.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

Services or supplies excluded under pharmacy services may be covered under the medical 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 the Certificate for more information.

- Allergy serum is covered as a medical benefit;
- Coverage for devices is limited to FDA-approved vaginal contraceptive devices, peak flow meters, inhaler spacers and diabetic supplies. No other devices are covered even if prescribed by a participating physician;
- Drugs prescribed for the treatment of obesity are covered, when medically necessary or when you meet Health Net Life prior authorization coverage requirements. In such cases, the drugs will be subject to prior authorization from Health Net Life;
- Drugs or medicines administered by a physician or physician's staff member;
- Drugs prescribed for routine dental treatment;
- Drugs prescribed to shorten the duration of the common cold;
- Drugs (including injectable medications) prescribed for sexual dysfunction when not medically necessary, including drugs that establish, maintain, or enhance sexual function or satisfaction;
- 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 *Insurance Plan Summary* for additional information;
- Hypodermic needles or syringes, except for insulin needles, syringes and specific brands of pen devices;
- Immunizing agents, injections (except for insulin), 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;
- Limits on quantity, dosage and treatment duration may apply to some drugs. Medications taken on an "as-needed" basis may have a copayment or coinsurance based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If medically necessary, your physician may request a larger quantity from 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;
- Except in emergency or urgent care situations, prescription drugs filled by an out-of-network pharmacy are not covered;
- Prescription drugs prescribed by an unlicensed physician;
- Once you have taken possession of medications, replacement of lost, stolen or damaged medications is not covered;
- 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, except as described in the *Certificate*; and
- 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 the *Certificate* to determine the exact terms and conditions of your coverage.

Pediatric Vision Care Program

WHAT'S COVERED

Pediatric vision services are covered until the last day of the month in which the individual turns nineteen (19) years of age. Pediatric vision services and supplies, as shown below, must be provided by a participating vision provider in order to be covered. To find a participating eyewear dispenser, call **1-866-392-6058** or visit our website at www.healthnet.com.

Eyewear Schedule

The amounts below are the amounts you pay for benefits, and are not subject to any deductibles.

Professional Services	Copayment
Routine eye examination with dilation, as medically necessary	$0

Limitation:
In accordance with professionally recognized standards of practice, this insurance plan covers one vision examination once every calendar year. However, examination for contact lenses also include contact lens fit and follow up visit.

Materials (including frames and lenses)	Copayment

Provider selected frames (one every calendar year)..... $0

Standard plastic eyeglass lenses (one pair every calendar year) $0

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

Optional lenses and treatments $0

Including:

- 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
- Premium Progressive Lenses

Provider selected contact lenses, a one year supply every calendar year
(In lieu of eyeglass lenses) $0

- Disposables
- Conventional
- Medically necessary

Subnormal or low vision services and aids $0

- 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)

Medically Necessary Contact Lenses

This insurance plan covers contact lenses that are 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 insurance plan. Consult the *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;
- Replacement of lost, stolen or broken frames or lenses, unless benefits are otherwise available; and
- 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 *Certificate* to determine the exact terms and conditions of your coverage.

Pediatric Dental Program

WHAT'S COVERED

Pediatric dental services are covered until the last day of the month in which the individual turns nineteen (19) years of age. Benefits are available for medically necessary dental services. You may see either network or non-network providers.

Eligible Dental Expenses

Eligible dental expenses for covered dental services are determined as shown below.

Network benefits: Eligible dental expenses are based on the contracted fee between us and the network provider. You are not responsible for any amount in excess of the contracted fee.

Non-network benefits: Eligible dental expenses are based on Health Net Life's maximum allowable amounts, which may be more than what non-network providers bill. You are responsible for any amount in excess of the maximum allowable amount. See "Maximum Allowable Amount (MAA) for Out-of-Network Providers" in the "Payment of Premiums and Charges" section for more information.

Benefit Summary

The amounts below are the amounts you pay for benefits, and are not subject to any deductibles. The percentage is based on eligible dental expenses. Refer to the *Certificate* for a complete listing of covered pediatric dental services, benefit limitations and exclusion.

Benefit Description	Network Benefits	Non-Network Benefits
Diagnostic Benefits	$0	10%
Preventive Benefits	$0	10%
Restorative Benefits	20%	30%
Periodontal Maintenance Services	20%	30%
Endodontics	50%	50%
Periodontics (other than Periodontal Maintenance)	50%	50%
Maxillofacial Prosthetics	50%	50%
Implant Services	50%	50%
Prosthodontics (Removable)	50%	50%
Fixed Prosthodontics	50%	50%
Oral and Maxillofacial Surgery	50%	50%
Medically Necessary Orthodontics	50%	50%
Adjunctive Services	50%	50%

Benefit Limitations:

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.

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 36 months.

Intraoral - occlusal radiographic image are limited to 2 every 6 months.

Bitewing x-rays

Bitewing x-rays are limited to four radiographic images once every 6 months.

Panoramic film x-rays

Panoramic radiographic images are limited to once every 36 months.

Dental sealant

Dental sealant, per tooth, is 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.

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 planing, and subgingival curettage are limited to once per quadrant every 24 months.

Periodontal maintenance

Periodontal maintenance is covered once in a calendar quarter only in the 24-month period following the last scaling and root planing.

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:

- Palliative (emergency) treatment, for treatment of dental pain, limited to once per day, per covered person.
- House/extended care facility calls, once per covered person per date of service.
- One hospital or ambulatory surgical center call per day per provider per covered person.
- Teledentistry benefits are limited to twice in a 12 month period.

PEDIATRIC DENTAL EXCLUSIONS

- Services which, in the opinion of the attending dentist, are not necessary to the covered person's dental health.
- Cosmetic dental care.
- 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 "Coverage Decisions and Disputes Resolution" section of the *Certificate* for more information).
- Services that were provided without cost to the covered person by state government or an agency thereof, or any municipality, county or other subdivisions.
- Hospital charges of any kind.
- 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.
- Dispensing of drugs not normally supplied in a dental office.
- The cost of precious metals used in any form of dental benefits.
- Dental Services that are received in an emergency care setting for conditions that are not emergencies if the covered person reasonable should have known that an emergency care situation did not exist.

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

Nondiscrimination Notice

Health Net Life Insurance Company (Health Net) complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

HEALTH NET:

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

If you need these services, contact Health Net's Customer Contact Center at:

Group Plans through Health Net 1-800-522-0088 (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 (Covered Persons)
Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

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

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

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

Notice of Language Services

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

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

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

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

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

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

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

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

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

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

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

Panjabi (Punjabi)

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

Russian

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

Spanish

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

Tagalog

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

Thai

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

Vietnamese

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

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

FLY017549EH00 (12/17)

Contact Us

1-800-522-0088 (English) TTY: 711
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)

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