Summary *of* Benefits

Large Business Group (51-100)
SALUD CON HEALTH NET EPO • Plan ABZ

DELIVERING CHOICES

When it comes to your health care, the best decisions are made with the best choices. **Health Net Life** (herein, called HNL) offers an Exclusive Provider Organization (EPO) insurance plan called Salud Primero EPO, an insurance plan that provides you with ways to help you receive the care you deserve. *This Summary of Benefits (SB/)* answers basic questions about this versatile insurance plan. This health insurance plan is specifically designed for Latino employers located in the Los Angeles and Ventura Counties. Health Net Life Salud Network, with locations in Los Angeles and Ventura Counties, has been selected to provide services to enrollees of this plan who live in California. A network of physicians contracting with Sistemas Medicos Nacionales Sociedad Anonima (SIMNSA) has been selected to provide services to enrolled dependents who reside in Mexico. If you have further questions, just contact the Customer Contact Center at **1-800-676-6976** (English) or **1-800-331-1777** (Spanish). Our friendly, knowledgeable representatives will be glad to help. For enrollees who reside in Mexico, please contact SIMNSA at **(011-52-664) 683-29-02** or **(011-52-664) 683-30-05**.

If you have further questions, contact us:

By phone at 1-800-676-6976,

Or write to: Health Net Life Insurance Company
P.O. Box 10196
Van Nuys, CA 91410-0196

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

This *Summary of Benefits* (SB/) is only a summary of your health insurance plan. Your *Certificate of Insurance (Certificate)*, which you will receive after you enroll, contains the exact terms and conditions of your Health Net Life Salud Primero EPO 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 1-800-676-6976 (English) or 1-800-331-1777 (Spanish). You should also consult the *Health Net EPO Group Insurance Policy (Policy)* (issued to your employer) to determine governing contractual provisions. It is important for you to carefully read this SB and the plan's *Certificate* thoroughly once received, especially those sections that apply to those with special health care needs. This SB includes a matrix of benefits in the section titled "Schedule of benefits and coverage."

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How the insurance plan works

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

DESIGNATED SALUD PRIMERO EPO PROVIDERS IN THE UNITED STATES

- The Health Net Salud Network (HNSN) consists of hospitals, physicians, pharmacies and other providers contracted with HNL. Employees and eligible dependents who live or work in the approved Health Net Life Salud Primero EPO service area, which includes Los Angeles County, Ventura County and adjoining areas from where there is reasonable access to medical care from a Health Net Salud Network facility, will receive care from a HNSN provider.

DESIGNATED SALUD PRIMERO EPO PROVIDERS IN MEXICO

- The SIMNSA network consists of hospitals, physicians, pharmacies and other providers that contract with Sistemas Medicos Nacionales Sociedad Anomia de C.V. Eligible dependents who reside in the approved Health Net Life Salud Primero EPO Service Area in Mexico, which includes an area extending 50 miles into Baja California from the Mexico-U.S. border, will receive care from a SIMNSA provider.
- All care (except for emergency and urgently needed care) must be performed or authorized by a Health Net Salud Network participating physician or SIMNSA. Copayments, benefits and certain legal remedies available to enrollees who receive care in Mexico may differ from those available to enrollees receiving care in the United States.

SELECTION OF PHYSICIANS

- The Salud Primero EPO insurance plan allows you to seek health care in the United States or in Mexico. When you receive care in the United States, you may select any doctor from the Health Net Salud Network who provides care in the approved HNL Salud Primero EPO service area. If you receive care in Mexico, you may go to any contracting physician from the SIMNSA Provider Directory. (See your Directory for a list of HNSN and SIMNSA providers in your area and for detailed information about participating providers in the HNL Salud Primero EPO network.)

HOW TO CHOOSE A PHYSICIAN

Selecting a physician is important to the quality of care you receive. To ensure you are comfortable with your choice, we suggest the following:

- Discuss any important health issues with your selected HNSN or SIMNSA physician.
- To ensure that you and your eligible dependents have adequate access to medical care, select a doctor located within reasonable access from your place of employment or residence.

HOW TO ENROLL

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

Some Hospitals and other providers do not provide one or more of the following services that may be covered under the plan's Certificate and that you or your eligible dependents 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 doctor, medical group, independent practice association, or clinic, or call the Customer Contact Center at 1-800-676-6976 (English) or 1-800-331-1777 (Spanish) to ensure that you can obtain the health care services that you need.

This Plan provides benefits required by the Newborns' and Mothers' Health Protection Act of 1996 and the Women's Health and Cancer Rights Act of 1998.

Schedule of benefits and coverage

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

SERVICES AND COPAYMENTS/COINSURANCE

Copayments, coinsurance, benefits and certain legal remedies available to enrollees who reside in Mexico and obtain care through SIMNSA may differ from those available for enrollees who reside in the United States and obtain care through the Health Net Salud Network (HNSN).

There are two levels of copayments listed for each covered service or supply. The SIMNSA copayments apply to enrollees who reside in Mexico. These enrollees must use a contracting provider affiliated with SIMNSA operating in approved regions of Mexico. The Health Net Salud Network (referred to as HNSN throughout this section) copayments apply to enrollees who reside in California within the designated service area of this plan. You must use a participating physician operating within the approved HNSN service area. You are responsible for the copayment levels applicable to either a HNSN or SIMNSA provider.

Principal benefits and coverage matrix

Deductibles & plan maximums	SIMNSA	HNSN
Calendar year deductible		
For each person	None	None
Additional deductibles		
Emergency room deductible (waived if admitted to a hospital)	$10	$100
Urgent care facility deductible (waived if admitted to a hospital)	$10	$15
Lifetime maximum	None	None

Calendar Year Out-of-Pocket Maximum (OOPM)

Once your payment for covered services and supplies equals the amount shown below in any one calendar year, no additional copayments or coinsurance for covered services and supplies are required for the remainder of that calendar year. Once an individual member in a family satisfies the individual out-of-pocket maximum, the remaining enrolled family members must continue to pay copayments for covered services until the total amount of copayment paid by the family reaches the family out-of-pocket maximum or each enrolled family member individually satisfies the individual out-of-pocket maximum. Payments for any supplemental benefits or services not covered by this insurance plan will not be applied to this calendar year out-of-pocket maximum. You will need to continue making payments for any additional benefits as described in the "Additional insurance plan benefits information" section of this SB.

Out-of-Pocket Maximum (OOPM)	SIMNSA	Salud Network
For each covered individual	$1,500	$1,500
For each family	$4,500	$4,500

Type of services, benefit maximums & what you pay	SIMNSA	HNSN
Professional Services		
Visit to a primary care physician (general practitioner, internal medicine practitioner, OB/GYN, or pediatrician)■	$5	$15
Specialist consultations (any physician who is not a primary care physician)	$5	$35
Prenatal and postnatal office visits	Covered in full	Covered in full
Normal delivery, cesarean section, newborn inpatient professional care*	Covered in full	Covered in full
Treatment of complications of pregnancy, including medically necessary abortions*	See note below**	See note below**
Surgeon or assistant surgeon services▲**	Covered in full	Covered in full
Administration of anesthetics	Covered in full	Covered in full
Laboratory procedures and diagnostic imaging (including x-ray) services *	Covered in full	Covered in full
Rehabilitative therapy (includes physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)*	$5	$15
Organ and stem cell transplants (non-experimental and non-investigational)*	Covered in full	Covered in full
Chemotherapy	Covered in full	Covered in full
Radiation therapy	Covered in full	Covered in full
Vision and hearing examinations (for diagnosis or treatment, including refractive eye examinations), (birth through age 17)	Covered in full	Covered in full

Vision and hearing examinations (for diagnosis or treatment, including refractive eye examinations) (age 18 and older, including refractive eye examinations) ..... Not covered $35

■ *Self-referrals are allowed for obstetrics and gynecological services including preventive care, pregnancy and gynecological ailments. Copayment requirements may differ depending on the services provided.*

▲ *Surgery includes surgical reconstruction of a breast incident to mastectomy, including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema. While Health Net or SIMNSA will determine the most appropriate services, the length of hospital stay will be determined solely by your participating physician.*

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

***** *These services may require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB/. Routine care for condition of pregnancy do not require prior certification. However, notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced, both in-network and out-of-network, to 50% of covered expenses. In addition, a $250 penalty will also be charged for inpatient admissions and a $50 penalty for outpatient visits.*

Preventive care

Preventive services ..... Covered in full ..... Covered in full

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

Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA.

Allergy treatment and other injections (except for infertility injections)

Allergy testing ..... Covered in full ..... Covered in full

Allergy serum ..... Covered in full ..... Covered in full

Allergy injection services ..... $5 ..... $15

Immunizations (to meet foreign travel requirements) ..... Not covered ..... Not covered

Immunizations (to meet occupational requirements) ..... Not covered ..... Not covered

Injections (except for infertility)

Injectable drugs administered by a physician (per dose) ..... Covered in full ..... Covered in full

Self-injectable drugs* ..... Covered in full ..... Covered in full

***** *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. If certification is required but not obtained, your benefit reimbursement level will be reduced, both in-network and out-of-network, to 50% of covered expenses. In addition, a $250 penalty will also be charged for inpatient admissions and a $50 penalty for outpatient visits.*


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

Outpatient services

Outpatient services (other than surgery, except for infertility services)*	Covered in full	20%
Outpatient surgery (surgery performed in a hospital or outpatient surgery center only, except for infertility services)*	Covered in full	20%

***** *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced, both in-network and out-of-network, to 50% of covered expenses. In addition, a $250 penalty will also be charged for inpatient admissions and a $50 penalty for outpatient visits*


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

Hospitalization services

Semi-private hospital room or special care unit with ancillary services, including maternity care (per admission; unlimited days)	Covered in full	$250
Skilled nursing facility stay (limited to 100 days each calendar year)	Not covered	20%
Physician visit to hospital or skilled nursing facility (excluding care for substance abuse and mental disorders)	Covered in full	Covered in full

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

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


These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced, both in-network and out-of-network, to 50% of covered expenses. In addition, a $250 penalty will also be charged for inpatient admissions and a $50 penalty for outpatient visits.

Emergency health coverage		
Emergency room (professional and facility charges)	Covered in full	Covered in full
Urgent care center (professional and facility charges)	Covered in full	Covered in full

Copayments for emergency room or urgent care center visits will not apply if the member is admitted as an inpatient directly from the emergency room or urgent care center.

Ambulance services		
Ground ambulance	Covered in full	$50
Air ambulance*	Not covered	$50

** These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced, both in-network and out-of-network, to 50% of covered expenses. In addition, a $250 penalty will also be charged for inpatient admissions and a $50 penalty for outpatient visits*

Prescription drug coverage	SIMNSA Participating Pharmacy (for drugs prescribed in Mexico)	Health Net Participating Pharmacy (for drugs prescribed in California)

\+ *Please refer to the "Prescription drug program" section of this SB for applicable definitions, benefit descriptions and limitations. Copayments for prescription drugs do not apply to the out-of-pocket maximum, except copayments for peak flow meter and inhaler spacers used for the treatment of asthma, and diabetic supplies.*

SIMNSA Participating Pharmacies (up to a 30-day supply in Mexico)		
Prescription drugs dispensed through a SIMNSA Participating Pharmacy	$5	Not applicable
Lancets	Covered in full	Not applicable
Preventive drugs and women's contraceptives*	Covered in full	Not applicable

Retail pharmacy (up to a 30-day supply in California)		
Level I drugs listed on the Health Net Recommended Drug List (primarily generic)	Not applicable	$10
Level II drugs listed on the Health Net Recommended Drug List (primarily brand name), peak flow meters, inhaler spacers and diabetic supplies (including insulin)◆	Not applicable	$35
Level III drugs listed on the Health Net Recommended Drug List (or drugs not listed on the Health Net Recommended Drug List)◆	Not applicable	50%
Appetite Suppressants	Not applicable	Covered in full
Oral infertility drugs[9]	Not applicable	50%

Preventive drugs and women's contraceptives*	Not applicable	Covered in full

Specialty Pharmacy Vendor

	Specialty Pharmacy
Specialty Drugs when listed in the Recommended Drug List	30%
Maximum amount payable by covered person per prescription	$250

Maintenance Drugs through the Mail-order program (up to a 90-day supply) Available only in California

Level I drugs listed on the Health Net Recommended Drug List (primarily generic)	Not applicable	$20
Level II drugs listed on the Health Net Recommended Drug List (primarily brand name) and diabetic supplies (including insulin)◆	Not applicable	$70
Level III drugs listed on the Health Net Recommended Drug List (or drugs not listed on the Health Net Recommended Drug List)◆	Not applicable	50%
Lancets	Not applicable	Covered in full
Preventive drugs and women's contraceptives*	Not applicable	Covered in full

For information about Health Net's Recommended Drug List, please call the Customer Contact Center at the telephone number on the back cover.

** Preventive drugs and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the Member. Preventive drugs are prescribed over-the-counter drugs or Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations.*

If a Brand Name Drug is dispensed, and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the Generic and Brand Name Drug. However, if a Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from Health Net, then the Brand Name Drug will be dispensed at no charge.

Infertility drugs have a lifetime maximum of $1000

◆ Generic drugs will be dispensed when a generic drug equivalent is commercially available. When a brand name drug is dispensed and a generic equivalent is available, the member must pay the difference between the generic equivalent and the brand name drug plus the Level I drug copayment.

However, if the prescription drug order states "dispense as written," "do not substitute" or words of similar meaning in the physician's handwriting, only the Level II or Level III drug copayment as appropriate will be applicable.

This limitation only applies to members residing in California. Members residing in Mexico will pay the same copayment for all prescription drugs.

[9] Must be approved by Health Net.

Copayments for prescription drugs do not apply to the out-of-pocket maximum, except copayments for peak flow meters, inhaler spacers used for the treatment of asthma and diabetic supplies.

This plan uses the Recommended Drug List. The Health Net Recommended Drug List (the List) is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. The List also shows which drugs are Level I, Level II or Level III, so you know which copayment applies to the covered drug. Drugs that are not on the List (that are not excluded or limited from coverage) are also covered at the Level III drug copayment.

Some drugs require prior authorization from Health Net. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 72 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 5 days, as appropriate and medically necessary, for the nature of the member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination.. For a copy of the Essential Rx Drug List, call the Customer Contact Center at the number listed on the back cover of this booklet or visit our website at www.healthnet.com.

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Medical Supplies

Durable medical equipment (including nebulizers, face masks and tubing for the treatment of asthma)*	Covered in full	Covered in full
Orthotics (such as bracing, supports and casts)	Covered in full	Covered in full
Corrective footwear	Covered in full	Covered in full
Diabetic equipment. (See the "Prescription drug program" section of this SB for diabetic supplies benefit information.)	Covered in full	Covered in full
Diabetic footwear	Covered in full	Covered in full
Prostheses*	Covered in full	Covered in full

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

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

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

***** *These services may require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy do not require prior certification. However, notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced, both in-network and out-of-network, to 50% of covered expenses. In addition, a $250 penalty will also be charged for inpatient admissions and a $50 penalty for outpatient visits.*

Mental disorders and chemical dependency benefits

Severe Mental Illness and Serious Emotional Disturbances of a Child

Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting) ⌖	$5	$15
Inpatient services⌖	Covered in full	$250

Other Mental Disorders

Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting)	$5	$15
Inpatient services⌖	Covered in full	Covered in full

Chemical Dependency

Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting)	$5	$15
Inpatient services⌖	Covered in full	Covered in full
Acute care (detoxification) ⌖	Covered in full	$250

***** *Each group therapy session requires only one half of a private office visit copayment. If two or more Members in the same family attend the same outpatient treatment session, only one copayment will be applied.*

⌖ *These services may require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy do not require prior certification. However, notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced, both in-network and out-of-network, to 50% of covered expenses. In addition, a $250 penalty will also be charged for inpatient admissions and a $50 penalty for outpatient visits.*

Home health services

Home health visits*	$5	$10

**These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB.*

Other services

Sterilizations --Vasectomy	$50	$150
Sterilizations --Tubal ligation	Covered in full	Covered in full
Blood, blood plasma, blood derivatives and blood factors	Covered in full	Covered in full
Renal dialysis*****	Covered in full	Covered in full
Hospice services*****	Not Covered	Covered in full


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

***** *These services may require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy do not require prior certification. However, notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced, both in-network and out-of-network, to 50% of covered expenses. In addition, a $250 penalty will also be charged for inpatient admissions and a $50 penalty for outpatient visits.*

Infertility services		
Infertility services and supplies (all covered services that diagnose, evaluate or treat infertility)	50%	50%

Notes:

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

Limits of coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS) UNDER YOUR MEDICAL BENEFIT INSURANCE PLAN

- Acupuncture;
- Air ambulance in Mexico;
- Air or ground ambulance and paramedic services that are not emergency care or which do not result in a patient's transportation will not be covered unless certification is obtained and services are medically necessary.
- Artificial insemination;
- Care for mental health care as a condition of parole or probation, or court-ordered testing for mental disorders, except when such services are medically necessary;
- Conception by medical procedures (IVF, GIFT and ZIFT);
- Corrective footwear is not covered unless medically necessary and custom made for the covered person;
- Cosmetic services and supplies;
- Custodial or live-in care;
- Dental services. However, medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures are covered. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate;
- Dietary or nutritional supplements, except when prescribed for the treatment of Phenylketonuria (PKU);
- Disposable supplies for home use;
- Elective abortion in Mexico;
- Experimental or investigational procedures, except as set out under the "Clinical trials" and "If you have a disagreement with our insurance plan" sections of this SB;
- Genetic testing is not covered except when determined by Health Net Life to be medically necessary. The prescribing physician must request prior authorization for coverage;
- Hearing aids;
- Hypnosis
- Home health care for Mexico residents;
- Hospice care for Mexico residents;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder;
- Non-eligible institutions. This insurance plan only covers services or supplies provided by a legally operated hospital, Medicare-approved skilled nursing facility or other properly licensed facility as specified in the *Certificate*. Any institution that is primarily a place for the aged, a nursing home or similar institution, regardless of how it is designated, is not an eligible institution. Services or supplies provided by such institutions are not covered;
- Orthoptics (eye exercises);
- Nontreatable disorders;
- Outpatient prescriptions drugs or medications (except as noted under "Prescription drug program");
- Orthotics (such as bracing, supports and casts) that are not custom made to fit the member's body. Refer to the "corrective footwear" bullet above for additional foot orthotic limitations.;
- Personal or comfort items;
- Physician self treatment;
- Physician treating immediate family members;
- Private rooms when hospitalized, unless medically necessary;
- Private-duty nursing;
- Refractive eye surgery unless medically necessary, recommended by the treating physician and authorized byHNL;

- Reversal of surgical sterilization;
- Routine physical examinations for insurance, licensing, employment, school, camp or other nonpreventive purposes;
- Services and supplies determined not to be medically necessary as defined in the *Certificate*;
- Services and supplies not specifically listed in the plan's *Certificate* as covered expenses;
- Services and supplies that do not require payment in the absence of insurance;
- Services for an injury incurred in the commission (or attempted commission) of a crime unless the condition was an injury resulting from an act of domestic violence or and injury resulting from a medical condition;
- Services for conditions of pregnancy for a surrogate pregnancy are covered when the surrogate parent is the covered person under this HNL plan. However, when compensation is obtained for the surrogacy, the HNL shall have a lien on such compensation to recover its medical expense. A surrogate parent is a woman who agrees to become pregnant with the intent of surrendering custody of the child to another person
- Services not related to a covered illness or injury, except as provided under preventive care and annual routine exams;
- Services and supplies for the collection, preservation and storage of umbilical cord blood, cord blood stem cells and adult stem cells;
- Services and supplies not authorized according to procedures HNL or SIMNSA have established;
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of benefits" section of your *Certificate;*
- Sex change services;
- Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary;
- Treatment of obesity, weight reduction or weight management, except for treatment of morbid obesity.

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

Benefits and coverage

WHAT YOU PAY FOR SERVICES

The comprehensive benefits of your HNL Salud Primero EPO insurance plan are described in the "Schedule of benefits and coverage" section. Please take a moment to look it over.

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

The Children's Health Insurance Program (CHIP) is a joint federal and state funded program that provides comprehensive health care coverage for qualified uninsured children under the age of 19. In California, the CHIP plans are known as the Healthy Families Program and the Access for Infants and Mothers Program (AIM). The Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) creates a special enrollment period in which individuals and their dependent(s) are eligible to request enrollment in this plan within 60 days of becoming ineligible and losing coverage from the Healthy Families Program, Access for Infants and Mothers Program (AIM) or a Medi-Cal plan.

NOTICE OF REQUIRED COVERAGE

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

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

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

SERVICES REQUIRING CERTIFICATION

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

Services that require certification include:

All inpatient admissions, any facility[1]

- Acute rehabilitation center
- Chemical dependency care facility

- Hospice
- Hospital
- Mental health facility
- Skilled nursing facility

Ambulance

- Non-emergency, air or ground ambulance services
- Ambulance services not resulting in patient transport

Bariatric-related services:

- Non-surgical bariatric-related consultations
- All bariatric-related surgical services

Certain physician-administered drugs, whether administered in a physician office, free-standing infusion center, 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.

Clinical trials

Durable medical equipment:

- Power wheelchairs
- Scooters
- Hospital beds
- Custom-made items
- Continuous positive airway pressure (CPAP)

Experimental/investigational services and new technologies.

Home health agency services including nursing, physical therapy, occupational therapy, speech therapy, home IV therapy and home uterine monitoring

Hospice care

Occupational and speech therapy.

Organ, tissue and stem cell transplant services, including pre-evaluation and pre-treatment services and the transplant procedure

Outpatient Diagnostic Imaging:

- CT (Computerized Tomography)
- MRA (Magnetic Resonance Angiography)
- MRI (Magnetic Resonance Imaging)
- PET (Positron Emission Tomography)
- Nuclear cardiology procedures, including SPECT (Single Photon Emission Computed Tomography)

Outpatient pharmaceuticals

- Self-injectables
- Intravenous immunoglobulin (IVIG)

Outpatient physical and rehabilitation therapy, chiropractic care and acupuncture] (exceeding 12 visits)

subject to any benefit limitations stated in the "Schedule of benefits and coverage" section.

Prosthesis and orthotics over $2,500

Surgical Procedures including:

- Abdominal, ventral, umbilical, incisional hernia repair
- Bariatric procedures
- Blepharoplasty
- Breast reductions and augmentations
- Mastectomy for gynecomastia
- Orthognathic procedures (includes TMJ treatment)
- Rhinoplasty
- Sclerotherapy
- Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
- Reconstructive surgery for medically necessary 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.

Tocolytic services (intravenous drugs used to decrease or stop uterine contraction in premature labor)

[1]Certification is not required for the length of a hospital stay for reconstructive surgery incident to a mastectomy or for renal dialysis. Certification is also not required for the length of stay for the first 48 hours following a normal delivery or 96 hours following cesarean delivery.

COVERAGE FOR NEWBORNS

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

- Coverage will end the 31st day after birth; and
- You will have to pay for all medical care provided after the 30th day of your baby's life.

EMERGENCIES

HNL covers emergency and urgently needed care throughout the world. If you are injured, feel severe pain, begin active labor or experience an unexpected illness that a reasonable person with an average knowledge of health and medicine would believe requires immediate treatment to prevent serious threat to your health (including severe mental illness and serious emotional disturbances of a child), seek care where it is immediately available. Depending on your circumstances, you may seek this care by going to an HNSN or SIMNSA physician , to the nearest emergency facility or by calling **911**.

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

You are encouraged to use appropriately the **911** emergency response system, in areas where the system is established and operating, when you have an emergency medical condition (including severe mental illness and serious emotional disturbances of a Child) that requires an emergency response. All ambulance and ambulance transport services provided as a result of a **911** call will be covered, if the request is made for an emergency medical condition (including severe mental illness and serious emotional disturbances of a child). Please note, the **911** emergency response system is not available in Mexico.

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

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

Please note that for members who live in Mexico, only emergency or urgently needed care is covered in California.

All follow-up care (including severe mental illness and serious emotional disturbances of a child) after the urgency has passed and your condition is stable, must be provided or authorized by a HNSN physician or SIMNSA.

MEDICALLY NECESSARY CARE

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

SECOND OPINIONS

You have the right to request a second opinion when:

- Your physician gives a diagnosis or recommends a treatment plan that you are not satisfied with;
- You are not satisfied with the result of treatment you have received;
- You are diagnosed with, or a treatment plan is recommended for, a condition that threatens loss of life, limb, or bodily function, or a substantial impairment, including but not limited to a serious chronic condition; or
- Your physician is unable to diagnose your condition, or test results are conflicting.

To obtain a copy of HNL's second opinion policy, contact the Health Net Life Customer Contact Center at **1-800-676-6976**.

CLINICAL TRIALS

Routine patient care costs for patients diagnosed with cancer who are accepted in to phase I, II, III or IV clinical trials are covered when medically necessary, recommended by the covered person's treating physician and authorized by HNL. The physician must determine that participation has a meaningful potential to benefit you and the trial has therapeutic intent. For further information, please refer to the plan's *Certificate*.

CONTINUITY OF CARE

Transition of Care for New Enrollees

You may request continued care from a provider who does not contract with HNL or SIMNSA if at the time of your enrollment with HNL you were receiving care for the conditions listed below. You must make this request within 15 days of your effective date.

Continuity of Care Upon Termination of Provider Contract

If HNL's contract with a HNSN EPO or SIMNSA provider is terminated, HNL will transfer any affected covered individuals to another contracted HNSN EPO or SIMNSA provider to ensure that care continues. HNL will provided a written notice to affected covered person at least 60-days prior to termination of a contract with a HNSN EPO physician or an acute care hospital. In addition, the covered individual may request continued care from a provider whose contract is terminated if at the time of termination you were receiving care from such a provider for the conditions listed below.

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable copayments and any other exclusions and limitations of your plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider's contract termination. You must request continued care within 30 days upon receiving notification of the provider's date of termination.

EXTENSION OF BENEFITS

If you are totally disabled when your employer ends its group service agreement with HNL, we will cover the treatment for the disability until one of the following occurs:

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

Your application for an extension of benefits for disability must be made to HNL 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 YOUR INFORMATION

HNL knows that personal information in your medical records is private. Therefore, we protect your personal health information in all setting (including oral, written and electronic information). The only time we would release your confidential information without your authorization is for payment, treatment, health care operations (including but not limited to utilization management, quality improvement, disease or case management programs) or when permitted or required to do so by law such as for things such as a court order or

subpoena. We will not release your confidential claims details to your employer or their agent. Often, HNL 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 enrollees.

PRIVACY PRACTICES

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

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

TECHNOLOGY ASSESSMENT

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

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

The expert medical reviewer also advises HNL when patients require quick determinations of coverage, when there is no guiding principle for certain technologies or when the complexity of a patient's medical condition requires expert evaluation.

Utilization management processes

Utilization Management is an important component of health care management. Through the processes of pre-authorization, concurrent and retrospective review and care management, we evaluate the services provided to covered persons to be sure they are medically necessary and appropriate for the setting and time. This oversight helps to maintain HNL's high quality medical management standards.

PRE-AUTHORIZATION

Certain proposed services may require an assessment prior to approval. Evidence-based criteria are used to evaluate that the procedure is medically necessary and planned for the appropriate setting (i.e., inpatient, ambulatory surgery, etc.).

CONCURRENT REVIEW

This process continues to authorize inpatient and certain outpatient conditions on a concurrent basis while following 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 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 pre-authorization was required but not obtained.

CARE OR CASE MANAGEMENT

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

If you would like additional information regarding HNL's utilization management process, please call the Customer Contact Center at **1-800-676-6976** (**English**) or **1-800-331-1777** (**Spanish**). If you reside in Mexico, please call SIMNSA at (**011-52-664**) **683-29-02** or (**011-52-664**) **683-30-05** for additional information.

Payment of premiums and charges

YOUR PORTION OF COINSURANCE, COPAYMENT AND DEDUCTIBLES

The comprehensive benefits of your Heath Net Life Salud Primero EPO insurance plan are described in the "Schedule of benefits and coverage" section. Please take a moment to look it over.

Prepayment of PREMIUMS

Your employer will pay HNL your monthly premiums for all enrolled family members. Check with your employer regarding any share that you may be required to pay. If your share ever increases, your employer will inform you in advance.

Other charges

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

When the total amount of deductibles and copayments you pay equals the annual out-of-pocket maximum shown in the "Schedule of benefits and coverage," you will not have to pay additional copayments for the rest of the year for most services provided or authorized by your HNSN or SIMNSA provider.

Payment for services not covered by this plan will not count toward the calendar year out-of-pocket maximum. Additionally, certain deductibles and copayments will not count toward the out-of-pocket maximum as shown in the "Schedule of benefits and coverage" section. For further information please refer to the Certificate.

CONTRACTED RATE

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

MAXIMUM ALLOWABLE AMOUNT

The maximum allowable amount is the amount on which HNL bases its reimbursement for covered services and supplies provided by an Out-of-Network Provider, which may be less than the amount billed for those services and supplies. Health Net Life calculates Maximum allowable amount as the lesser of the amount billed by the out-of-network provider or the amount determined as set forth herein. Maximum allowable amount is not the amount that Health Net Life pays for a Covered Service; the actual payment will be reduced by applicable coinsurance, copayments, deductibles and other applicable amounts. Please refer to the insurance plan's *Certificate* for additional information .

- Maximum allowable amount for physician services is determined by applying a designated percentile from the database of physician charges from the OptumInsight MDR Payment System (MDR) or a similar type of database of physician charges.
- For hospital services, maximum allowable amount is calculated using a method developed by Viant, Inc., a data service that applies a hospital profit margin factor for hospitals, to the estimated costs of the services rendered by the out-of-network hospital or a similar type of hospital data service.
- For all other types of services, Maximum Allowable Amount is determined by applying a percentage of what Medicare would allow (known as the Medicare allowable amount). The Maximum Allowable Amount for such services is [190 – 240%] of the Medicare allowable amount.

- In the event the applicable service or database does not include an amount for the service or supply provided, maximum allowable amount shall be deemed to be 75% of the covered charges billed by the provider for the same services or supplies. The maximum allowable amount determined under the databases described above may be more or less than 75% of the amount normally charged by the provider for the same services or supplies.

- The maximum allowable amount may also be subject to other limitations on covered expenses. See the insurance plan's *Certificate* under "Schedule of Benefits," "Plan Benefits" and "General Limitations and Exclusions" sections for specific benefit limitations, maximums, pre-certification requirements and payment policies that limit the amount HNL pays for certain covered services and supplies. HNL uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement.

In addition to the above, from time to time, HNL also contracts with vendors that have contracted fee arrangements with providers ("Third Party Networks"). In the event HNL contracts with a Third Party Network that has a contract with the out-of-networkprovider, HNL may, at its option, use the rate agreed to by the Third Party Network as the maximum allowable amount, in which case you will not be responsible for the difference between the maximum allowable amount and the billed charges. You will be responsible for any applicable deductible, copayment and/or coinsurance at the out-of-network provider level.

In addition, HNL may, at its option, refer a claim for out-of-network services to a fee negotiation service to negotiate the maximum allowable amount for the service or supply provided directly with the out-of-network provider. In that situation, if the out-of-network provider agrees to a negotiated maximum allowable amount, You will not be responsible for the difference between the maximum allowable amount and the billed charges. You will be responsible for any applicable deductible, copayment and/or coinsurance at the out-of-network level.

In the event that the billed charges for the out-of-network provider are more than the maximum Allowable Amount, You are responsible for any amounts charged in excess of the maximum allowable amount, except where the out-of-network provider's fee is determined by reference to a Third Party Network agreement or the out-of-network provider agrees to a negotiated maximum allowable amount.

Please note that whenever You obtain covered services and supplies from anout-of-network provider, you are responsible for applicable deductibles, copayments and coinsurance.

For more information on the determination of maximum allowable amount, or for information, services and tools to help you further understand your potential financial responsibilities for covered out-of-network services and supplies] please log on to www.healthnet.com or contact HNL's Customer Contact Center at the number on Your member identification card.

Liability of enrollee for payment

If you receive health care services from doctors without receiving required authorization from your HNSN or SIMNSA provider (medical), you are responsible for payment of expenses for these services. Remember services are only covered when provided or authorized by a HNSN or SIMSNA provider, except for emergency or out-of-area urgent care. Consult the Salud Primero EPO Salud Network or SIMNSA Directory for a full listing of HNL Salud Primero EPO-contracted physicians.

Reimbursement provisions

Payments that are owed by HNL for services provided by or through your HNSN or SIMNSA provider will never be your responsibility.

If you have out-of-pocket expenses for covered services, call the HNL Customer Contact Center for a claim form and instructions. You will be reimbursed for these expenses less any required copayment or deductible. (Remember: you do not need to submit claims for medical services provided by your HNSN or SIMNSA provider.)

If you receive emergency services not provided or directed by your HNSN or SIMNSA provider, you may have to pay at the time you receive service. To be reimbursed for these charges, you should obtain a complete statement of the services received and, if possible, a copy of the emergency room report.

Please contact the HNL Customer Contact Center at **1-800-676-6976** (**English**) or **1-800-331-1777** (**Spanish**) to obtain claim forms and to find out whether you should send the completed form to HNL. Claims must be received by HNL within one year of the date of service to be eligible for reimbursement.

If you need to file a claim for emergency medical services or for services authorized by your physician, please send a completed claim form within one year of the date of service to:

Health Net Commercial Claims
P.O. Box 14702
Lexington, KY 40512

If you need to file a claim for outpatient prescription drugs, please send a completed prescription drug claim form to:

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

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

Facilities

Health care services for you and eligible dependents will be provided at:

- The facilities of the HNSN or SIMNSA provider; or
- A nearby HNL Salud Primero EPO contracted hospital, if hospitalization is required.

Health care will be provided at the facilities used by the doctor you choose at the time you seek care. These are also listed in the Health Net Life Salud Primero Directory.

Continuity of Care

Transition of Care for New Enrollees

You may request continued care from a provider who does not contract with Health Net Life or SIMNSA if at the time of your enrollment with Health Net Life you were receiving care for the conditions listed below. You must make this request within 15 days of your effective date.

Continuity of Care Upon Termination of Provider Contract

If HNL's contract with a HNSN EPO or SIMNSA provider is terminated, HNL will transfer any affected covered individuals to another contracted HNSN EPO or SIMNSA provider to ensure that care continues. HNL will provided a written notice to affected covered person at least 60-days prior to termination of a contract with a HNSN EPO physician or an acute care hospital. In addition, the covered individual may request continued care from a provider whose contract is terminated if at the time of 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;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- A newborn (up to 36 months of age with a maximum duration of coverage of twelve months);
- A terminal illness; and
- A surgery or other procedure that has been authorized by HNL as part of a documented course of treatment.

If you would like more information on how to request continued care, please contact the Customer Contact Center at **1-800-676-6976 (English)** or **1-800-331-1777 (Spanish)**.

Renewing, continuing or ending coverage

Renewal provisions

The contract between HNL 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. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or your could be denied coverage entirely.

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.
- **Cal-COBRA Continuation Coverage.** If you have exhausted COBRA and you live in the Health Net Service Area, you may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if you began receiving federal COBRA coverage on or after January 1, 2003, have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage, and you are not entitled to Medicare. If you are eligible, you have the opportunity to continue group coverage under

the *Certificate* through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.

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

- **HIPAA:** The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people covered under existing group health insurance plans to maintain coverage regardless of Pre-Existing Conditions when they change jobs or are unemployed for brief periods of time. California law provides similar and additional protections. Applicants who meet the following requirements are eligible to enroll in a guaranteed issue individual health insurance plan from any health insurance plan that offers individual coverage without medical underwriting. A health insurance plan cannot reject Your application for guaranteed issue individual health coverage if You meet the following requirements, agree to pay the required premiums and live or work in the insurance plan's service area. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance. To be considered an eligible individual:

1. The applicant must have a total of 18 months of coverage (including COBRA, if applicable) without a significant break (excluding any employer-imposed waiting periods) in coverage of more than 63 days.
2. The most recent coverage must have been under a group health plan. COBRA and Cal-COBRA coverage are considered group coverage.
3. The applicant must not be eligible for coverage under any group health insurance plan, Medicare or Medicaid, and must not have other health insurance coverage.
4. The individual's most recent coverage could not have been terminated due to fraud or nonpayment of premiums.
5. If COBRA or Cal-COBRA coverage was available, it must have been elected and such coverage must have been exhausted.

For more information regarding guarantee issue coverage through HNL, please call Our Individual Sales Department at **1-800-909-3447.** If you believe your rights under HIPAA have been violated, please contact the Department of Insurance at 1-**888-927-HELP.**

Also, if you become ineligible for group coverage, you may convert from group coverage to a type of individual coverage called conversion coverage (not available to Mexico residents). Application must be made within 63 days of the date group coverage ends. Please contact the Customer Contact Center at **1-800-676-6976** (**English**) or **1-800-331-1777** (**Spanish**) for information about conversion insurance plan coverage. Furthermore, you may be eligible for continued coverage for a disabling condition (for up to 12 months) if your employer terminates its agreement with HNL. Please refer to the "Extension of benefits" section of this brochure for more information.

Termination of benefits

HNL can terminate your coverage when:

- The agreement between the employer covered under this HNL Salud Primero EPO insurance plan and HNL ends;
- The employer covered under this HNL Salud Primero EPO insurance plan fails to pay subscription charges;
- You cease to either live or work within HNL Salud Primero EPO's service area; or
- You no longer work for the employer covered under this Health Net Salud Primero EPO insurance plan.

The Policy specifies the date and time such termination becomes effective.


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

If the employer covered under this HNL Salud Primero EPO insurance plan does not pay appropriate subscription charges, benefits will end on the last day for which subscription charges have been made, unless:

- You apply for conversion coverage within 31 days of that date (not available to Mexico residents); or
- You are totally disabled and apply for an extension of benefits for the disabling condition within 90 days.

If you have a disagreement with our insurance plan

The California Department of Insurance (DOI) is responsible for regulating disability insurance carriers (HNL is a disability insurance carrier). The DOI has a toll-free telephone number (**1-800-927-HELP**) to receive complaints regarding 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
Office of the Ombudsman
300 South Spring Street
South Tower
Los Angeles, CA 90013
1-800-927-HELP or 1-800-927-4357
www.insurance.ca.gov

GRIEVANCE AND APPEALS PROCESS

Enrollees who obtain care through SIMNSA in Mexico have certain grievance rights, as described below, but do not have access to the same legal rights and remedies regarding grievance processing as those enrollees who obtain care through the Health Net Salud Network in the United States. The differences are noted below.

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.

+ *How to file a grievance or appeal:*

You must file your grievance or appeal with HNL within 365 calendar days following the date of the incident or action that caused your grievance. To file a grievance or appeal you may call or write to HNL, P.O. Box 10348, Van Nuys, CA 91410, 1-800-676-6976 (English) or 1-800-331-1777 (Spanish) or submit a Member Grievance Form through the Health Net website at www.healthnet.com.

You may also write to:

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

If your concern involves services provided by SIMNSA provider, please contact:

SIMNSA
206 Paseo Rio Tijuana
1 er Piso-Edificio Allen Lloyd
Tel. (011-52-664) 683-29-02 and 683-30-05

Please include all the information from your HNL identification card as well as the detail of your concern or problem.

HNL will acknowledge your grievance or appeal within five calendar days, review the information and tell you of our decision in writing within 15 days of receiving the grievance if the grievance pertains to a claims dispute or within 30 days of receiving the grievance for all other grievances. You may also file an emergency appeal for conditions where there is an immediate and serious threat to your health, including severe pain or, the potential for loss of life, limb or major bodily function. HNL must notify you of the status of your grievance no later than three days from receipt of all the required information.

 *In addition, if you obtain your care through the Health Net Salud Network in the United States, you can request an independent medical review of disputed health care services from the DOI if you believe that health care services eligible for coverage and payment under the insurance plan was improperly denied, modified or delayed by HNL or one of its participating providers.*

Also, if HNL 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 HNL's decision from the DOI if you meet eligibility criteria set out in the Certificate. An independent medical review from the Department of Managed Health Care is not available to individuals who access care through SIMNSA.

HNL has established and administers the member grievance procedure. This process includes a detailed description of the roles and responsibilities that HNL, the participating provider and SIMNSA have in resolving HNL member grievances. This includes a detailed description of any and all delegation and oversight that HNL monitors or SIMNSA. HNL does not delegate to SIMNSA any appeals or grievance resolution for any HNL member seeking care through SIMNSA.

SIMNSA and HNL shall establish and maintain grievance policies and procedures and shall make a written summary of such policies and procedures available to HNL, to the participating provider, to SIMNSA and to members. Such summary shall include the current address and telephone number for registering a complaint first through the primary care physician or SIMNSA's grievance procedures in accordance with the HNL standards.

The participating provider or SIMNSA shall report to HNL all HNL member appeals by type of appeal or grievance and timeliness of appeal or grievance resolution on a quarterly basis. HNL will periodically audit all delegated appeals and grievances to ensure that the appeals and grievances are being handled in a timely and appropriate manner.

In the event any complaint or grievance of a HNL member cannot be settled through the appeal or grievance process, such matter shall be submitted to binding arbitration in accordance with the terms of the member's Benefits Disclosure and *Certificate*. In that event, the parties hereto agree to cooperate and, at the request of a party, participate in any arbitration proceedings arising therefrom and, subject to either party's right to seek judicial review thereof in **accordance** with the terms of the HNL Benefits Disclosure and *Certificate*, to abide by all provisions of any final award rendered as a result of such proceedings.

Arbitration

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

Additional insurance plan benefit information

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

Prescription drug program

HNL and SIMNSA are contracted with many major pharmacy chains, supermarket based pharmacies and privately owned neighborhood pharmacies For a complete and up-to-date list participating pharmacies, call the Customer Contact Center at **1-800-676-6976** (**English**) or **1-800-331-1777** (**Spanish**). Members residing in Mexico, please visit our website at www.healthnet.com under the pharmacy information or contact SIMNSA for a complete list of participating pharmacies at (**011-52-664**) **683-29-02** or (**011-52-664**) **683-30-05**.

Prescriptions By Mail Drug Program (Available in the United States only)

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period), you have the option of filling it through our convenient Prescriptions By Mail Drug Program. This program allows you to receive a 90-consecutive-calendar-day supply of maintenance medications. For complete information, call the Customer Contact Center at **1-800-676-6976** (**English**) or **1-800-331-1777** (**Spanish**). The mail order prescription drug coverage is limited to enrollees residing or working in the U.S. Drugs dispensed through the Mail Drug Program are not covered for dependents residing in Mexico.

Schedule II narcotic drugs are not covered through mail order. For further information, please refer to the Certificate.

The health net Recommended Drug List:

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

We specifically suggest to all Salud Primero EPO contracted physicians that they refer to this list when choosing drugs for patients who are HNL Salud Primero EPO enrollees. When your physician prescribes medications listed in the Recommended Drug List, it ensures that you are receiving a high quality prescription medication that is also of high value.

The Recommended Drug List is updated regularly, based on input from the Health Net Pharmacy and Therapeutics (P&T) Committee. The committee members are actively practicing physicians of various medical specialties and clinical pharmacists. Voting members are recruited from contracting physicians 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 Recom-

mended Drug List are made as new clinical information and new drugs become available. The drug usage guidelines are reviewed and updated as new clinical information becomes 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
- Physician recommendations

To obtain a copy of HNL's most current Recommended Drug List, please visit our web site at www.healthnet.com, under the pharmacy information or call the Customer Contact Center at **1-800-676-6976** (**English**) or **1-800-331-1777** (**Spanish**).

The Health Net Recommended Drug List is applicable to drugs (1) prescribed for those enrolled with HNL who reside in the U.S. and (2) purchased at Health Net participating pharmacies.

What is "prior authorization?"

Some prescription medications require prior authorization. This means that your doctor must contact HNL in advance to provide the medical reason for prescribing the medication.

+ *How to request prior authorization:*

Requests for prior authorization may be submitted by telephone or facsimile. Upon receiving your physician's request for prior authorization, HNL will evaluate the information submitted and make a determination as based on established clinical criteria for the particular medication.

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

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

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

To submit an appeal:

- Call the Customer Contact Center at **1-800-676-6976** (English) or **1-800-331-1777** (Spanish).
- Visit www.healthnet.com for information on e-mailing the Customer Contact Center; or

Write to:

Health Net

Customer Contact Center

P.O. Box 10348

Van Nuys, CA 91410

What's covered

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

Outpatient prescription medication:

- For enrollees residing in Mexico, drugs covered by SIMNSA;
- Level I drugs for enrollees residing in the U.S. listed on the Recommended Drug List (primarily generic);
- Level II drugs for enrollees residing in the U.S. listed on the Recommended Drug List (primarily brand name) and diabetic supplies (including insulin); and
- Level III drugs listed on the Recommended Drug List for enrollees residing in the U.S. (or drugs not listed on the Health Net Recommended Drug List).

Specialty Drugs:

Specialty Drugs listed in the Health Net Recommended Drug List are covered when prior authorization is obtained from HNL and the drugs are dispensed through HNL's Specialty Pharmacy Vendor. These drugs include self-administered injectable and other drugs that have significantly higher cost than traditional pharmacy benefit drugs. Please note that needles and syringes required to administer the self-injected medications are covered only when obtained through the Specialty Pharmacy Vendor.

Self-administered injectable medications are defined as drugs that are:

- Medically necessary
- Administered by the patient or family member; either subcutaneously or intramuscularly
- Deemed safe for self-administration as determined by Health Net's Pharmacy and Therapeutics Committee
- Included in the Health Net Recommended Drug List
- Shown on the Recommended Drug List as requiring prior authorization.

MORE INFORMATION ABOUT DRUGS THAT WE COVER

- Prescription drug covered expenses are the lesser of HNL's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.
- Prescription drug refills are covered, up to a 30-consecutive-day supply per prescription at a HNL EPO or SIMNSA contracted pharmacy for one copayment.
- If the pharmacy's retail price is less than the applicable copayment, you will only pay the pharmacy's retail price.
- Percentage copayments will be based on Health Net's contracted pharmacy rate.
- For Level III Drugs, you will pay the greater of the Level II Drug copayment or the Level III coinsurance.
- 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 HNL as the retail pharmacy copayment. Mail prescription drug coverage is limited to enrollees residing or working in the U.S. Drugs dispensed through the mail order program are not covered for dependents residing in Mexico.
- Vaginal, oral and emergency contraceptives are covered. Vaginal contraceptives include diaphragms and cervical caps and are only covered when a physician performs a fitting examination and prescribes the device. Such devices are only available through a prescription from a pharmacy and are limited to one fitting and prescription per calendar year, unless additional fittings or devices are medically necessary. [For a complete list of contraceptive products covered by Health Net Life, please refer to the Recommended Drug List.] Injectable contraceptives are covered when administered by a physician. If your physician determines that the covered methods are not appropriate, then another FDA approved contraceptive method will be provided. Refer to your insurance plan's *Certificate* for more information on contraceptives covered under the medical benefit.
- Diabetic supplies (blood glucose testing strips, lancets, needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (i.e. opened in order to dispense the product in quantities oth-

er 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. See diabetic equipment under the "Schedule of benefits and coverage" section of this SB for additional benefit 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. Consult your insurance plan's Certificate for more information. In addition to the exclusion and limitations listed below, prescription drug benefits are subject to the insurance plan's general exclusions and limitations.*

- Allergy serum. Allergy serum is covered as a medical benefit. See "allergy serum " benefit in the "Schedule of Benefits and Coverage" for details;
- Coverage for devices or appliances is limited to vaginal contraceptive devices and diabetic supplies. No other devices are covered;
- Drugs prescribed for routine dental treatment;
- Drugs used for diagnostic purposes;
- Drugs that are appetite suppressants or are indicated for and prescribed for body weight reduction, except when prescribed for the treatment of obesity are covered, when medically necessary for the treatment of morbid obesity. In such cases the drugs will be subject to prior authorization by Health Net Life;
- Drug products that help you reduce or quit smoking or for nicotine addiction (for example, nicotine patches);
- Drugs or medicines administered by a physician or physician's staff member;
- Drugs (including injectable medications) prescribed for the treatment of sexual dysfunction are not covered;
- Drugs when prescribed to shorten the duration of the common cold;
- Drugs prescribed by a physician who is not a member physician or an authorized specialist are not covered, except when the physician's services have been authorized or because of medical emergency condition, illness or as specifically stated;
- Experimental drugs (those that are labeled "Caution - Limited by Federal Law to investigational use only"). If you are denied coverage of a drug because the drug is investigational or experimental you will have a right to independent medical review. See "If you have a disagreement with our insurance plan" section of this SB for additional information;
- Hypodermic needles or syringes, except for specific brands of disposable insulin needles, syringes and specific brands of pen devices. Needles and syringes required to administer self-injected medications (other than insulin) will be provided through Our Specialty Pharmacy Vendor. All other devices, syringes and needles are not covered;
- Immunizing agents, injections (except for insulin and self-administered injectable drugs are described in the recommended drug list), agents for surgical implantation, biological sera, blood, blood derivatives or blood plasma obtained through a prescription;
- Individual doses of medication dispensed in plastic, unit dose or foil packages unless medically necessary or only available in that form;
- Irrigation solutions and saline solutions;
- Level III drugs if you reside in Mexico;
- Limits on quantity, dosage and treatment duration may apply to some drugs. Medications taken on an "as-needed" basis may have a copayment based on a 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;
- Mail order drug program if you reside in Mexico;
- Medical equipment and supplies (including insulin), that are available without a prescription are covered when prescribed by a physician for the management and treatment of diabetes. Any other nonprescription

drug, 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 However, if a higher dosage form of a prescription drug or over-the counter (OTC) drug is only available by prescription, that higher dosage drug will be covered. If a drug that was previously available by prescription becomes available in an over-the-counter (OTC) from in the same prescription strength, then any prescription drugs that are similar agents and have comparable clinical effect(s) will only be covered when prior authorization is obtained from HNL. In addition, if a higher dosage form of a nonprescription drug or an OTC drug is only available by prescription, that higher dosage drug will be covered when medically necessary and prior authorization is obtained from Health Net Life;

- Prescription drugs filled at pharmacies that are not in the HNL or SIMNSA pharmacy network or are not in California except in emergency or urgent care situation;
- Prescription drugs prescribed by a physician who is not a member physician or an authorized specialist are not covered, except when the physician's services have been authorized or because of a medical emergency condition, illness or injury, or as specifically stated;
- Replacement of lost, stolen or damaged medications;
- Services or supplies for which there is no charge or for which you are not legally required to pay;
- Supply amounts for prescriptions that exceed the FDA's or Health Net Life's indicated usage recommendation are not covered unless medically necessary and prior authorization is obtained from Health Net Life; 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.
- Sexual dysfunction drugs which are drugs that establish, maintain or enhance sexual functioning are not covered

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

Notice of language services

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 us at the number on your ID card. For Individual and Family or Farm Bureau members please call 800-839-2172. Employer group members please call 800-522-0088. PPO members: for more help call the CA Dept. of Insurance at 1-800-927-4357. HMO members: for more help call the Department of Managed Health Care HMO Help Line at 1-888-HMO-2219. **English**

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que una persona le lea los documentos y que algunos se envíen en su idioma. Para solicitar ayuda, llámenos al número que aparece en su tarjeta de identificación. Para los afiliados de Individual y Familiar o de la Oficina Agrícola, llame al número 800-839-2172. Los afiliados de un grupo del empleador deben llamar al 800-522-0088. Afiliados de PPO: para obtener más ayuda llame al Departamento de Seguros de CA al 1-800-927-4357. Afiliados de HMO: para obtener más ayuda llame a la Línea de Ayuda del Departamento de Cuidado Médico de HMO al 1-888-HMO-2219. **Spanish**

免費語言服務。您可以取得口譯員服務，我們可以把文件朗讀給您聽，部分文件可以翻譯成您的語言並寄送給您。欲取得協助，請撥打您會員卡上的電話號碼與我們聯絡。個人與家庭計畫或農業協會的會員請撥打 800-839-2172。僱主團體會員請撥打 800-522-0088。PPO 會員：欲取得更多協助，請致電加州保險局 1-800-927-4357。HMO 會員：欲取得更多協助，請致電醫療保健計畫管理局 HMO 協助專線 1-888-HMO-2219。 **Chinese**

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, xin gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị. Các hội viên Individual and Family hoặc Farm Bureau có thể gọi số 800-839-2172. Các hội viên trong chương trình bảo hiểm theo nhóm của hãng sở xin gọi số 800-522-0088. Các hội viên PPO: để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Các hội viên HMO: để được giúp đỡ thêm, xin gọi Đường Dây Trợ Giúp HMO của Sở Điều Quản Y Tế tại số 1-888-HMO-2219. **Vietnamese**

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 경우, 본인 ID 카드 상의 안내번호로 전화해 주십시오. 개인 및 가족 회원 혹은 Farm Bureau 회원께서는 800-839-2172번으로 전화해 주십시오. 고용주 그룹 회원께서는 800-522-0088번으로 전화해 주십시오. PPO 가입자: 보다 많은 도움이 필요하신 분은 캘리포니아 보험 담당국, 안내번호 1-800-927-4357번으로 문의하십시오. HMO 가입자: 보다 많은 도움이 필요하신 분은 보건관리부 (the Department of Managed Health Care)의 HMO 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오. **Korean**

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card. Para sa Individual at Family members, mangyaring tumawag sa 800-839-2172. Para sa employer group members, mangyaring tumawag sa 800-522-0088. Para sa PPO members: para sa karagdagang tulong, tumawag sa CA Dept. of Insurance sa 1-800-927-4357. Para sa HMO members: para sa karagdagang tulong, tumawag sa Department of Managed Health Care HMO Help Line sa 1-888-HMO-2219. **Tagalog**

Անվճար Լեզվական ծառայություններ: Դուք կարող եք թարգմանիչ ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեր լեզվով: Օգնության համար, մեզ զանգահարեք ձեր ինքնության տոմսի վրա նշված համարով: Եթե անդամ եք Անհատական և Ընտանեկան կամ Ագարակային Գրասենյակի (Farm Bureau), զանգահարեք 800-839-2172 համարով: Գործատիրոջ Խմբի անդամներից խնդրվում է զանգահարել 800-522-0088 համարով: PPO-ի անդամներ՝ լրացուցիչ տեղեկության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: HMO-ի անդամներ՝ լրացուցիչ տեղեկության համար 1-888-HMO-2219 համարով զանգահարեք Կառավարված Առողջական Խնամքի Օգնության Գծին: **Armenian**

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочесть документы на вашем языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте; участники планов индивидуального или семейного страхования, а также планов страхования Фермерского бюро могут позвонить по телефону 800-839-2172. Участники плана группового страхования по месту работы могут позвонить по телефону 800-522-0088. Участники системы предпочтительного выбора (Preferred Provider Organization, PPO): для получения дополнительной помощи звоните в Министерство страхования штата Калифорния по телефону 1-800-927-4357. Участники организаций медицинского обслуживания (Health Maintenance Organizations, HMO): для получения дополнительной помощи звоните в справочную службу HMO Департамента организованного медицинского обслуживания по телефону 1-888-HMO-2219. **Russian**

無料の言語サービス。日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号までお問い合わせください。個人、家族会員、または、ファーム・ビューロー会員の方は、800-839-2172 まで、雇用者団体会員の方は、800-522-0088 までご連絡ください。PPO会員の方：更なるお問い合わせは、カリフォルニア州保険庁、 1-800-927-4357 までご連絡ください。HMO会員の方：更なるお問い合わせは、カリフォルニア州管理医療庁のHMO相談窓口、 1-888-466-2219 までご連絡ください。 **Japanese**

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید مدارک به زبان خودتان برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است تماس بگیرید. اعضاء «طرح افراد و خانواده ها» یا «طرح اداره مزارع» لطفاً به شماره 800-839-2172 تلفن کنند. اعضاء گروههای کارفرمایان لطفاً با شماره 800-522-0088 تماس بگیرند. اعضاء PPO: برای کسب اطلاعات بیشتر لطفاً با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. اعضاء HMO: برای کسب اطلاعات بیشتر به خط کمکی HMO در Department of Managed Health Care به شماره 1-888-HMO-2219 تلفن کنید. **Farsi**

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਜਾਂ ਫਾਰਮ ਬਿਊਰੋ ਮੈਂਬਰ ਕਿਰਪਾ ਕਰਕੇ 800-839-2172 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਇੰਪਲਾਇਰ ਗਰੁੱਪ ਦੇ ਮੈਂਬਰ ਕਿਰਪਾ ਕਰਕੇ 800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। PPO ਮੈਂਬਰ: ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। HMO ਮੈਂਬਰ: ਵਧੇਰੇ ਮਦਦ ਲਈ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਮੈਨੇਜਡ ਹੈਲਥ ਕੇਅਰ ਦੀ HMO ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। **Punjabi**

ការបកប្រែភាសាដោយឥតគិតថ្លៃ ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងឲ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន ។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក ។ សំរាប់សមាជិក បុគ្គលខ្លួន និងគ្រួសារ ឬសមាជិក Farm Bureau សូមទូរស័ព្ទទៅលេខ 800-839-2172 ។ សមាជិកក្រុមម្ចាស់ក្រុមហ៊ុននិយោជក សូមទូរស័ព្ទមកលេខ 800-522-0088 ។ សមាជិក PPO : សំរាប់ជំនួយបន្ថែម សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រង នៃរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 ។ សមាជិក HMO : សំរាប់ជំនួយបន្ថែម សូមទូរស័ព្ទទៅក្រសួងគ្រប់គ្រងសុខាភិបាល ខ្សែជំនួយ HMO តាមលេខ 1-888-HMO-2219 ។ **Khmer**

خدمات ترجمة بدون تكلفة. يمكنك الاستعانة بمترجم. يمكنك طلب قراءة وثائق وإرسال بعضها لك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك (ID). بالنسبة للأفراد وأعضاء الأسرة أو أعضاء Farm Bureau رجاء الاتصال بالرقم 800-839-2172. وبالنسبة لأعضاء مجموعات صاحب العمل رجاء الاتصال بالرقم 800-522-0088. أعضاء PPO: للحصول على المساعدة الإضافية، يرجى الاتصال بالخط الخاص بإدارة التأمين الصحي لولاية كاليفورنيا على الرقم 1-800-827-4357. أعضاء HMO: للحصول على المساعدات الإضافية يرجى الاتصال بخط المساعدة لـ Department of Managed Health Care على الرقم 1-888-HMO-2219. **Arabic**

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi. Koj kom muaj ib tug neeg txhais lus rau koj los tau. Koj kom nyeem cov ntaub ntawv thiab xa ib co ntaub ntawv ua koj hom lus tuaj rau koj los tau. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID. Rau cov tswv cuab hauv pawg Tus Kheej thiab Tsev Neeg los sis Farm Bureau thov hu rau 800-839-2172. Cov tswv cuab hauv pawg tom chaw ua hauj lwm thov hu rau 800-522-0088. Cov tswv cuab hauv PPO: yog xav tau kev pab ntxiv hu rau CA Lub Koom Haum Saib Xyuas Txog Kev Tuav Pov Hwm ntawm 1-800-927-4357. Cov tswv cuab hauv HMO: yog xav tau kev pab ntxiv hu rau Lub Caj Meem Fai Saib Xyuas Txog Kev Tswj Txoj Kev Kho Mob (Department of Managed Health Care) HMO Tus Xov Tooj Muab Kev Pab ntawm 1-888-HMO-2219. **Hmong**

ບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດໄດ້ຮັບບໍລິການແປພາສາແລະມີຜູ້ອ່ານເອກກະສານໃຫ້ທ່ານຟັງເປັນພາສາຂອງທ່ານເອງ. ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມໝາຍເລກທີ່ລະບຸໄວ້ໃນບັດປະກັນໄພຂອງທ່ານ. ຂໍໃຫ້ສະມາຊິກລາຍບຸກຄົນແລະຄອບຄົວຫລືສະມາຊິກ Farm Bureau ໂທຕາມໝາຍເລກ 800-839-2172. ຂໍໃຫ້ສະມາຊິກກຸ່ມລູກຈ້າງໂທຕາມໝາຍເລກ 800-522-0088. ສະມາຊິກ PPO: ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອເພີ່ມຕື່ມ ໃຫ້ໂທໄປຫາກົມປະກັນໄພແຫ່ງລັດຄາລີຟໍເນຍຕາມໝາຍເລກ 1-800-927-4357. ສະມາຊິກ HMO: ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອເພີ່ມຕື່ມ ໃຫ້ໂທຕາມສາຍດ່ວນ HMO ແຫ່ງກົມກຳກັບລະບົບຄຸ້ມຄອງການຮັກສາສຸຂະພາບ (Department of Managed Health Care) ຕາມໝາຍເລກ 1-888-HMO-2219. **Laotian**

Contact us

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