Summary *of* Benefits *and* Disclosure *Form*

Large Business Group (51-100)
SALUD HMO Y MÁS 35 • Plan AAN

Dear Prospective Health Net member,

Thank you for considering Health Net as your health care plan. We look forward to the opportunity to care for your family should you select our plan. This Health Net Summary of Benefits has all the information you need to learn about receiving care with coverage from Health Net. Please review it carefully.

At Health Net, we work hard to make sure that our members get the care they need when they need it. We are always working to make medical care delivery better through our health plan.

Remember, if you have further questions about Health Net, call the Customer Contact Center at **1-800-400-8987**. For members who reside in Mexico, please contact SIMNSA at **(011-52-664) 683-29-02** or **(011-52-664) 683-30-05**. We're always glad to help.

Thank you for considering Health Net!

DELIVERING CHOICES

When it comes to your health care, the best decisions are made with the best choices. Health Net of California, Inc. (Health Net) provides you with ways to help you receive the care you deserve. This Summary of Benefits and Disclosure Form (SB/DF) answers basic questions about this versatile plan.

This Salud con Health Net plan is specifically designed for employer groups with Latino employees located in California. Providers in the Health Net Salud Network (Salud Network) have been selected to provide services to members of this plan who live in California. A network of physicians contracting with Sistemas Medicos Nacionales S.A. de C.V. (referred to as SIMNSA) has been selected to provide services to enrolled dependents who reside in Mexico.

If you have further questions, contact us:

By phone at 1-800-400-8987

For members who reside in Mexico, please contact SIMNSA at (011-52-664) 683-29-02 or (011-52-664) 683-30-05. Our friendly, knowledgeable representatives will be glad to help.

Or write to: Health Net of California
P.O. Box 10348
Van Nuys, CA 91410-0348

Please examine your options carefully before declining this coverage.

This *Summary of benefits and disclosure form* (SB/DF) is only a summary of your health plan. The plan's *Evidence of Coverage* (EOC), which you will receive after you enroll, contains the exact terms and conditions of your Health Net coverage. You should also consult the *Group Hospital and Professional Service Agreement* (issued to your employer) to determine governing contractual provisions. It is important for you to carefully read this SB/DF and the plan's EOC thoroughly once received, especially those sections that apply to those with special health care needs. This SB/DF includes a matrix of benefits in the section titled "Schedule of benefits and coverage."

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How the plan works

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

This Salud con Health Net Plan is specifically designed for employer groups located in the Health Net Salud service area to provide covered services to members who live in California or Mexico.

If the subscriber and his or her family members live in California, they may receive covered services from:

1. Their selected Salud Network physician group in California; or
2. They may self-refer at any time to a SIMNSA provider in Mexico.

California members must live in the Health Net Salud service area where they have adequate access to medical care from Salud Network providers.

- **If your family members live in Mexico,** they may only receive covered services from a SIMNSA provider, except in the case of emergency or urgently needed care. Family members must live or work within the approved Health Net Salud service area in Mexico.

Please refer to the "Health Net Salud plan service area" section below for more information on the approved areas of California where this Salud Con Health Net plan is available.

SELECTION OF PHYSICIANS AND PHYSICIAN GROUPS

- Health Net requires the designation of a Primary Care Physician. A Primary Care Physician provides and coordinates your medical care. You have the right to designate any Primary Care Physician who participates in our network and who is available to accept you or your family members, subject to the requirements of the physician group. For children, a pediatrician may be designated as the Primary Care Physician. Until you make this Primary Care Physician designation, Health Net designates one for you. For information on how to select a Primary Care Physician and for a list of the participating Primary Care Physicians in the Health Net Service Area, refer to the Provider Directory. The Provider Directory is also available on the Health Net website at www.healthnet.com. You can also call the Customer Contact Center at the number shown on your Health Net I.D. Card to request provider information.
- Whenever you or a covered family member needs health care, your Salud Network primary care physician (PCP) or SIMNSA provider will provide the medically necessary treatment. Specialist care is also available through your plan, when authorized in advance through your Salud Network PCP, the contracting physician group or SIMNSA provider.
- If residing in California, you must select at the time of enrollment a Salud Network physician group close enough to your residence or place of work to allow reasonable access to medical care. You do not have to choose the same physician group location or PCP for all members of your family. Physician group locations, along with names of physicians and specialists are listed in the Provider Directory.
- Members residing in Mexico may go to any contracting provider in the SIMNSA network and will not be required to select a particular SIMNSA physician group or facility for services. All covered services must be received through the selected SIMNSA providers.

HOW TO CHOOSE A PHYSICIAN

Selecting a PCP 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 physician group;
- Do the same with the Health Net Coordinator at the physician group or the SIMNSA and ask for referral specialist policies and hospitals used by the Salud Network physician group or SIMNSA; and
- Ensure that you and your family members have adequate access to medical care, by selecting a physician located within reasonable access from your place of employment or residence.

SPECIALISTS AND REFERRAL CARE

If you are a California member and need medical care that your Salud Network PCP cannot provide, your PCP may refer you to a specialist or other health care provider for that care. Refer to the "Mental Disorders and Chemical Dependency Care" section below for information about receiving care for Mental Disorders and Chemical Dependency.

Members in California and Mexico may self-refer to any provider in the SIMNSA Network in Mexico without prior authorization. You must receive authorization from SIMNSA to receive care from providers outside the SIMNSA Network.

You do not need prior authorization from Health Net or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, refer to your Health Net Group HMO Directory (Health Net HMO Directory). The Health Net HMO Directory is also available on the Health Net website at www.healthnet.com.

MENTAL DISORDERS AND CHEMICAL DEPENDENCY CARE

Health Net contracts with MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator), which administers behavioral health services for mental disorders and chemical dependency conditions. For more information about how to receive care and the Behavioral Health Administrator's prior authorization requirements, please refer to the "Behavioral Health Services" section of this SB/DF.

The Health Net Salud service area

The Health Net Salud service area encompasses regions in southern California and Mexico (Baja California within fifty miles of the California – Mexico Border).

Health Net Salud Plan service area in California

You are eligible to enroll as a subscriber or dependent in this Salud Con Health Net Plan if you live or work in the areas described below, provided that you meet any additional eligibility requirements of the group.

Los Angeles County: You must live or work in Los Angeles County.

Exception: This Salud Con Health Net Plan is **not** available in the following Zip Codes:

91310	91354	91382	91387	93535	93543	93553	93590
91321	91355	91383	91390	93536	93544	93563	93591
91322	91377	91384	93510	93537	93550	93584	93599
91350	91380	91385	93532	93538	93551	93585	
91351	91381	91386	93534	93539	93552	93586	

San Diego County: You must live or work in San Diego County.

Exception: This Salud Con Health Net Plan is **not** available in the following Zip Codes:

91905	92004
91906	92036
91934	92066
91962	92086
91963	
91980	

Orange County: You must live or work in Orange County.

San Bernardino County: You must live or work in the following zip codes:

91701	91761	92318	92336	92359	92391	92410
91708	91762	92321	92337	92369	92399	92411
91709	91763	92322	92344	92373	92401	92412
91710	91764	92324	92345	92374	92402	92413
91729	91784	92325	92346	92375	92403	92414
91730	91786	92326	92350	92376	92404	92415
91737	91798	92331	92352	92377	92405	92418
91739	92313	92334	92354	92378	92406	92423
91743	92316	92335	92357	92382	92407	92424
91758	92317		92358	92385	92408	92427
91759						

Riverside County: You must live or work in the following zip codes:

91752	92501	92507	92516	92551	92557	92878
91766	92502	92508	92517	92552	92570	92879
92320	92503	92509	92518	92553	92571	92880
92324	92504	92513	92519	92554	92599	92882
92373	92505	92514	92521	92555	92860	92883
92399	92506	92515	92522	92556	92877	92881

Kern County: You must live or work in the following zip codes:

93217	93303	93308	93314
93263	93304	93309	
93300	93305	93311	
93301	93306	93312	
93302	93307	93313	

Health Net Salud Plan service area in Mexico

You are eligible to enroll as a dependent in this Salud Con Health Net Plan if you live or work in the approved area in Mexico which extends 50 miles into Baja California from the California - Mexico border.

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 *Evidence of Coverage (EOC)* and that you or your family member might need:

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

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic or call the Health Net Customer Contact Center at 1-800-400-8987 to ensure that you can obtain the health care services that you need.

Schedule of benefits and coverage

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PLAN CONTRACT AND *EVIDENCE OF COVERAGE* (EOC) SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments are usually billed after the service is received.

Copayments, benefits and certain legal remedies available to members who reside in Mexico and obtain care through SIMNSA may differ from those available for members who reside in California and obtain care through the Salud Network.

There are two levels of copayments listed for each covered service or supply. The SIMNSA copayments apply to members receiving care in Mexico. These members must use a contracting provider affiliated with SIMNSA operating in approved regions of Mexico. The Salud Network copayments apply to members who receive care in California within the designated service area of this plan. Members who receive care in California must use their selected Salud Network provider except for emergency or urgent care. Members are responsible for the copayment levels applicable to their selected contracting provider.

Principal benefits and coverage matrix

Deductibles ..... None

Lifetime maximums ..... None

Out-of-Pocket Maximum (OOPM)	SIMNSA	Salud Network
One member	$1500	$4000
Two members	$3000	$8000
Family (three members or more)	$4500	$8000

Once your combined payments for covered services and supplies under both benefit levels equal the amount shown above in any one calendar year, no additional copayments or coinsurance for covered services and supplies are required for the remainder of the 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 or coinsurance for covered services and supplies until the total amount of copayments 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 services not covered by this plan or for certain services as specified in the "Payment of fees and charges" section of this SB/DF, will not be applied to this calendar year out-of-pocket maximum, unless otherwise noted. Also, copayments for prescription drugs do not apply to the out-of-pocket maximum, unless otherwise noted. You must continue to pay copayments for any services and supplies that do not apply to the out-of-pocket maximum.

Type of services, benefit maximums & what you pay	SIMNSA	Salud Network
Professional services		
The copayments below apply to professional services only. Services that are rendered in a hospital or an outpatient center are also subject to the hospital or outpatient center services copayment. See "Hospitalization services" and "Outpatient services" in this section to determine if any additional copayments may apply.		
Visit to physician, physician assistant or nurse practitioner at a contracting physician group	$5	$35
Specialist consultations▪	$5	$35
Prenatal and postnatal office visits*	Covered in full	$35
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
CT, SPECT, MRI, MUGA and PET	Covered in full	$100
Rehabilitative therapy (including physical, speech, occupational cardiac rehabilitation and pulmonary rehabilitation therapy)	$5	$35
Organ and stem cell transplants (nonexperimental and noninvestigational)	Covered in full	Covered in full
Chemotherapy	Covered in full	Covered in full
Radiation therapy	Covered in full	Covered in full

Physician visit to member's home at your physician's discretion and in accordance with criteria set by Health Net	Not covered	Not covered
Vision and hearing examinations (for diagnosis or treatment, including refractive eye examinations) (birth through age 17)	$5	$35
Vision and hearing examinations (for diagnosis or treatment, including refractive eye examinations) (age 18 and older)	$5	Not Covered

- *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. Podiatrist, chiropractor and acupuncturist services may be covered under "Specialist consultation" as authorized by your physician group.*

▲ *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 and your physician group or SIMNSA will determine the most appropriate services, the length of hospital stay will be determined solely by your participating physician.*

** Prenatal, postnatal and newborn care that are preventive care services are covered in full. See copayment listings for Preventive Care services below. If other non-preventive care services are received during the same office visit, the above copayment will apply for the non-preventive care services.*

*** Applicable copayment 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 will apply.*

Preventive care

Preventive care 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.

- *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.*

One breast pump and the necessary supplies to operate it (as prescribed by your physician) will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it. Breast pumps can be ob-

tained by calling the Customer Contact Center at the phone number listed on the back cover of this booklet.

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	$35
Immunizations (to meet occupational or foreign travel 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

▪ *Self-injectable drugs (other than insulin) are considered specialty drugs, which require prior authorization and must be obtained from a contracted specialty pharmacy vendor. Specialty drugs require prior authorization. Please refer to the plan's EOC for additional information.*

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

Outpatient facility services		
Outpatient facility services (other than surgery)	Covered in full	20%
Outpatient surgery (surgery performed in a hospital or outpatient surgery center only)	Covered in full	20%

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 delivery and maternity care (unlimited days)	Covered in full	$500 per day, with a maximun of 4 days per admision.
Skilled nursing facility stay	Covered in full	20%
Calendar year maximum	*100 days*	*100 days*
Physician visit to hospital or skilled nursing facility	Covered in full	Covered in full

The above inpatient hospitalization copayment is applicable for each admission of hospitalization for 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.

Emergency health coverage		
Emergency room (professional and facility charges)	$10	$100
Urgent care center (professional and facility charges)	$10	$35

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. A visit to one of the urgent care centers that is owned and operated by the member's physician group will be considered an office visit and the office visit copayment, if any, will apply.

Ambulance services		
Ground ambulance	Covered in full	$100
Air ambulance	Covered in full	$100

Outpatient prescription drug plan

This plan covers prescription drugs through the SIMNSA Prescription Drug Program which is only available in Mexico. There is limited prescription drug coverage through the Health Net Preventive Pharmacy Program in the United States as shown below.

Refer to the "Outpatient prescription drug plan" section at the end of this SB/DF for the benefits and limitations.

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/DF 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
Smoking cessation drugs	$5	Not applicable
Preventive drugs and womens contraceptives	Covered in full	Not applicable

Retail pharmacy (up to a 30-day supply in California)

Deductible

Prescription drug deductible required for brand name drugs (per member, per calendar year)	Not applicable	$250

The prescription drug deductible (per member, per calendar year) must be paid for prescription drug covered services before Health Net begins to pay.

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 preferred 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 non-preferred drugs not listed on the Health Net Recommended Drug List)◆	Not applicable	$50
Smoking cessation drugs (covered up to a 12-week course of therapy per calendar year if you are currently enrolled in a comprehensive smoking cessation program)■	Not applicable	50%
Appetite Suppressants	Not applicable	50%
Lancets	Not applicable	Covered in full
Oral infertility drugs■	Not applicable	50%
Preventive drugs and women's contraceptives	Not applicable	Covered in full

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 covered	$20
Level II drugs listed on the Health Net Recommended Drug List (primarily preferred brand name) and diabetic supplies (including insulin)◆	Not covered	$70
Level III drugs listed on the Health Net Recommended Drug List (or non-preferred drugs not listed on the Health Net Recommended Drug List)◆	Not covered	$100
Lancets	Not covered	Covered in full
Preventive drugs and women's contraceptives	Not covered	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.

◆ *Generic drugs will be dispensed when a generic drug equivalent is available unless a brand name drug is specifically requested by the physician or the member. 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 or Level III 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 to indicate medical necessity, 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.

▪ *Must be approved by Health Net and the member's physician group.*

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

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.

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.

Percentage copayments will be based on Health Net's contracted pharmacy rate.

If the retail price is less than the applicable copayment, then you will pay the retail price. Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.

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Mental disorders and chemical dependency benefits

For California residents: *Health Net contracts with MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services through a personalized, confidential and affordable mental health and chemical dependency care program. Just call the toll-free number shown on your Health Net ID card before receiving care.*

For Mexico residents: *SIMNSA contracts with behavioral health providers practicing in the enrollment service area in Mexico. For information on these providers, please contact SIMNSA at (011-52-664) 683-29-02 or (011-52-664) 683-30-05.*

MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES THROUGH SIMNSA

Severe Mental Illness and Serious Emotional Disturbances of a Child	**SIMNSA**
Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting) ▣	$5
Outpatient professional consultation (psychological evaluation or therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day) ▣	$5
Inpatient services (unlimited days)	Covered in full
Other Mental Disorders	**SIMNSA**
Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting) ▣	$5
Inpatient services	Covered in full
Chemical Dependency	**SIMNSA**
Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting) ▣	$5
Inpatient services	Covered in full
Acute care detoxification	Covered in full

MENTAL HEALTH and CHEMICAL DEPENDENCY SERVICES THROUGH MHN SERVICES

Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services. For definitions of severe mental illness or serious emotional disturbances of a child, please refer to the Behavioral health section of this SB/DF, or call the Customer Contact Center at the number listed on the back cover of this booklet.

Severe Mental Illness and Serious Emotional Disturbances of a Child	**MHN SERVICES**
Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting)▣	$35
Outpatient professional consultation (psychological evaluation or therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day)▣	$35
Inpatient services (unlimited days)	Covered in full

Other Mental Disorders	**MHN SERVICES**
Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting)▣	$35
Inpatient services	Covered in full

Chemical Dependency	**MHN SERVICES**
Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting)▣	$35
Inpatient services	Covered in full
Acute care detoxification	Covered in full

▣ *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.*

Home health services		
Home health services (copayment required for each day home health visits occur)	Not covered	$10

Calendar year maximum .....*Not applicable* .....*100 visits*

Other services

Sterilizations - Vasectomy	$50	$300
Sterilizations - Tubal ligation	Covered in full	Covered in full
Elective abortions	Not covered	$300
Blood, blood plasma, blood derivatives and blood factors	Covered in full	Covered in full
Renal dialysis	Covered in full	Covered in full
Hospice services	Covered in full	Covered in full

Hospice care is available in Mexico is only in an acute hospital setting. Your copayment for hospice care will be the same as for inpatient hospital services (see "Semiprivate hospital room or intensive care unit with ancillary services" under "Hospital services" in the Schedule of benefits and coverage above).

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

Infertility services

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

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

Infertility services and all covered services are covered only for the Health Net member.

Injections for infertility are covered only when provided in connection with services that are covered by this plan.

Lifetime maximum of $1500 for infertility drug

Limits of coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- Ambulance and paramedic services that do not result in transportation or that do not meet the criteria for emergency care, unless such services are medically necessary and prior authorization has been obtained.
- Artificial insemination for reasons not related to infertility;
- Biofeedback therapy is limited to medically necessary treatment of certain physical disorders such as incontinence and chronic pain;
- 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 artificial means (IVF, GIFT and ZIFT);
- Except for podiatric devices to prevent or treat diabetes-related complications, corrective footwear is not covered unless medically necessary, custom made for the member and permanently attached to a medically necessary orthotic device that is also a covered benefit under this plan;
- 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;
- Disposable supplies for home use;
- Experimental or investigational procedures, except as set out under the "Clinical trials" and "If you have a disagreement with our plan" sections of this SB/DF;
- Genetic testing is not covered except when determined by Health Net to be medically necessary. The prescribing physician must request prior authorization for coverage;
- Hearing aids;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder;
- Non-eligible institutions. This 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 plan's EOC. 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);
- 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;
- Outpatient prescriptions drugs (except as noted under "Prescription drug program");
- Personal or comfort items;

- Physician self-treatment;
- Physician treating immediate family members;
- Physician visit to member's home;
- Private rooms when hospitalized, unless medically necessary;
- Private-duty nursing;
- Refractive eye surgery unless medically necessary, recommended by the member's treating physician and authorized by Health Net;
- Reversal of surgical sterilization;
- Routine foot care for treatment of corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes;
- Routine physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp or other nonpreventive purposes;
- Services and supplies not authorized by Health Net, the Behavioral Health Administrator or the physician group according to Health Net's procedures;
- Services for a surrogate pregnancy are covered when the surrogate is a Health Net member. However, when compensation is obtained for the surrogacy, Health Net shall have a lien on such compensation to recover its medical expense;
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the plan's EOC;
- Services related to education or training, including for employment or professional purposes, except for behavioral health treatment for pervasive developmental disorder or autism;
- State hospital treatment, except as the result of an emergency or urgently needed care;
- Stress, except when rendered in connection with services provided for a treatable mental disorder;
- Treatment of jaw joint disorders or surgical procedures to reduce or realign jaw, unless medically necessary; and
- Treatment of obesity, weight reduction or weight management, except for morbid obesity.

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

Benefits and coverage

WHAT YOU PAY FOR SERVICES

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

TIMELY ACCESS TO NON-EMERGENCY HEALTH CARE SERVICES

The California Department of Managed Health Care (DMHC) has issued regulations (Title 28, Section 1300.67.2.2) with requirements for timely access to non-emergency health care services.

You may contact Health Net at the number shown on the back cover, 7 days per week, 24 hours per day to access triage or screening services. Health Net provides access to covered health care services in a timely manner. For further information, please refer to the plan's EOC or contact the Health Net Customer Contact Center at the phone number on the back cover.

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) plan or a Medi-Cal plan.

NOTICE OF REQUIRED COVERAGE

Benefits of this plan provide coverage required by the Newborns' and Mothers' Health Protection Act of 1996 and the 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.

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 your physician group or SIMNSA for all medical care provided after the 30th day of your baby's life

EMERGENCIES

Health Net covers emergency and urgently needed care throughout the world. If you need emergency or urgently needed care, seek care where it is immediately available. Depending on your circumstances, you may seek this care by going to your physician group (medical) or the Behavioral Health Administrator (mental disorder and chemical dependency) or to the nearest emergency facility or by calling 911 (the 911 emergency response system is not available in Mexico).

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 air and ground ambulance and ambulance transport services provided as a result of a 911 call will be covered, if the request is made for an emergency medical condition (including severe mental illness and serious emotional disturbances of a child).

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, 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 affect safe transfer to another hospital prior to delivery; or (b) a transfer poses a threat to the health and safety of the member or her unborn child. Emergency care will also include additional screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if a psychiatric emergency medical condition exists and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, either within the capability of the facility or by transferring the member to a psychiatric unit within a general acute hospital or to an acute psychiatric hospital as medically necessary.*

All air and ground ambulance and ambulance transport services provided as a result of a ***911*** *call will be covered, if the request is made for an emergency medical condition (including severe mental illness and serious emotional disturbances of a child).*

All follow-up care (including severe mental illness and serious emotional disturbances of a child) after the emergency or urgency has passed and your condition is stable, must be provided or authorized by your Salud Network physician group or SIMNSA (medical) or the Behavioral Health Administrator (mental disorder and chemical dependency); otherwise, it will not be covered by Health Net.

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

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

MEDICALLY NECESSARY CARE

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

SECOND OPINIONS

You have the right to request a second opinion when:

- Your PCP or a referral 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 PCP or a referral physician is unable to diagnose your condition or test results are conflicting.

To obtain a copy of Health Net's second opinion policy, contact Health Net's Customer Contact Center at **1-800-400-8987**. Members in Mexico, please call SIMNSA at **(011-52-664) 683-29-02** or **(011-52-664) 683-30-05** for additional information.

CLINICAL TRIALS

Routine patient care costs for patients diagnosed with cancer or other life-threatening disease or condition who are accepted into phase I, II, III or IV clinical trials are covered when medically necessary, recommended by the member's treating physician and authorized by Health Net. The physician must determine that participation has a meaningful potential benefit to the member and the trial has therapeutic intent. For further information, please refer to the plan's EOC.

EXTENSION OF BENEFITS

If you or a covered family member is totally disabled when your employer ends its group services agreement with Health Net, 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
- The member becomes enrolled in another plan that covers the disability.

Your application for an extension of benefits for disability must be made to Health Net 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 MEMBER INFORMATION

Health Net knows that personal information in your medical records is private. Therefore, we protect your personal health information in all settings (including oral, written and electronic information). The only time we would release your confidential information without your authorization is for payment, treatment, health care operations (including, but not limited to utilization management, quality improvement, disease or case management programs) or when permitted or required to do so by law, such as for court order or subpoena. We will not release your confidential claims details to your employer or their agent. Often, Health Net 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 members.

PRIVACY PRACTICES

Once you become a Health Net member, Health Net uses and discloses a member'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 provides members 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 will provide you the opportunity to approve or refuse the release of your information for non-routine releases such as marketing. Health Net provides access to members to inspect or obtain a copy of the member's protected health information in designated record sets maintained by Health Net. Health Net 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 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's entire Notice of Privacy Practices can be found in the plan's EOC, at www.healthnet.com under "Privacy" or you may call the Customer Contact Center at the phone number on the back cover of this booklet to obtain a copy.

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

TECHNOLOGY ASSESSMENT

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

standard care by the appropriate medical specialty. Approved technologies are integrated into Health Net benefits.

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

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

Utilization management

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 our members to be sure they are medically necessary and appropriate for the setting and time. These processes help to maintain Health Net'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 whether or not the procedure is medically necessary and planned for the appropriate setting (that is, inpatient, ambulatory surgery, etc.).

CONCURRENT REVIEW

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

DISCHARGE PLANNING

This component of the concurrent review process ensures that planning is done for a member'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 members (and their families) through major acute and/or chronic long-term health problems. The care managers work closely with members, their physicians and community resources.

If you would like additional information regarding Health Net's utilization management process, please call the Health Net Customer Contact Center at 1-800-400-8987. Members in Mexico, please call SIMNSA at (011-52-664) 683-29-02 or (011-52-664) 683-30-05 for additional information.

Payment of fees and charges

YOUR COPAYMENT AND DEDUCTIBLES

The comprehensive benefits of your Health Net plan are described in the "Schedule of benefits and coverage" section. Please take a moment to look it over.

PREPAYMENT FEES

Your employer will pay Health Net your monthly subscription charges for you and 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, which are described in the "Schedule of benefits and coverage" section of this SB/DF. Beyond these charges the remainder of the cost of covered services will be paid by Health Net.

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

Certain copayments paid will not be applied to the out-of-pocket maximum as shown in the "Schedule of benefits and coverage" section.

Payment for services not covered by this plan will not be applied to the calendar year out-of-pocket maximum. Additionally, copayments for any covered supplemental benefits purchased by your employer, such as prescription drugs or eyewear will also not be applied to the limit with the exception of copayments for inhaler spacers, peak flow meters used for the treatment of asthma, and diabetic supplies. For further information please refer to the plan's EOC.

LIABILITY OF SUBSCRIBER OR ENROLLEE FOR PAYMENT

If you receive health care services from doctors without receiving required authorization from your Salud Network PCP or physician group or SIMNSA provider (medical) or the Behavioral Health Administrator (mental disorder and chemical dependency), you are responsible for payment of expenses for these services.

Remember, services are only covered when provided or authorized by a PCP or physician group, SIMNSA provider or the Behavioral Health Administrator, except for emergency or out-of-area urgent care. Consult the Salud Network or SIMNSA HMO Directory for a full listing of Health Net-contracted physicians.

REIMBURSEMENT PROVISIONS

Payments that are owed by Health Net for services provided by or through your Salud Network physician group or SIMNSA provider (medical) or the Behavioral Health Administrator (mental disorder and chemical dependency) will never be your responsibility.

If you have out-of-pocket expenses for covered services, call the Health Net Customer Contact Center at **1-800-400-8987** for a claim form and instructions. You will be reimbursed for these expenses less any required copayment. (Remember, you do not need to submit claims for medical services provided by your Salud Network PCP, physician group or SIMNSA provider.)

If you receive emergency services not provided or directed by your physician group or SIMNSA provider (medical) or the Behavioral Health Administrator (mental disorder and chemical dependency), 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 call the Health Net Customer Contact Center **1-800-400-8987** to obtain claim forms and to find out whether you should send the completed form to your physician group or SIMNSA provider (medical) or the Behavioral Health Administrator (mental disorder and chemical dependency) or directly to Health Net. Medical claims must be received by Health Net 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 Salud Network PCP or physician group with Health Net, please send a completed claim form within one year of the date of service to:

 How to file a claim:

***For medical services**, 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 Mental Disorders and Chemical Dependency emergency services or for services authorized by MHN Services (for services provided in California), you must file the claim with MHN Services within one year of the date of service. You must use MHN Services forms in filing the claim, and you should send the claim to MHN Services at the address listed on the claims form or to MHN Services at:

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

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

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

PROVIDER REFERRAL AND REIMBURSEMENT DISCLOSURE

If you are considering enrolling in our plan, you are entitled to ask if the plan has special financial arrangements with our physicians that can affect the use of referrals and other services you may need. Health Net uses financial incentives and various risk sharing arrangements when paying providers. To get this information, call the Health Net Customer Contact Center at **1-800-400-8987** or SIMNSA at **(011-52-664) 683-29-02** or **(011-52-664) 683-30-05**, your physician group or your SIMNSA provider and request information about our physician payment arrangements.

Facilities

Health care services for you and eligible members of your family will be provided as shown below.

- **For members residing in California:** The facilities of the Salud Network physician group you selected at enrollment or a SIMNSA provider. If you require hospitalization, you may receive care at a nearby Salud Network or SIMNSA participating facility.
- **For members residing in Mexico:** The facilities of a SMNSA provider, and a nearby SIMNSA participating facility if hospitalization is required

Many Salud Network physician groups have either a physician on call 24 hours a day or an urgent care center available to offer access to care at all times.

The Salud Network physician group or SIMNSA provider you choose will also have a contractual relationship with local hospitals (for acute, subacute and transitional care) and skilled nursing facilities. These are listed in your Salud Network or SIMNSA HMO Directory.

PHYSICIAN GROUP TRANSFERS

You may switch doctors within the same physician group at any time. You may also transfer to another physician group monthly within the Salud Network when such transfer is appropriate (e.g. if you move). Simply contact Health Net or SIMNSA by the 15th of the month to have your transfer effective by the 1st of the following month. If you call after the 15th, your transfer will be effective the 1st of the second following month.

Transfer requests to another Salud Network facility will generally be honored by Health Net. Members who move to California from Mexico can also request to transfer enrollment from a SIMNSA provider to a provider in the Salud Network. Please call the Health Net Customer Contact Center at 1-800-400-8987. Members in Mexico, please call SIMNSA at (011-52-664) 683-29-02 or (011-52-664) 683-30-05 for additional information.

CONTINUITY OF CARE

Transition of Care for New Enrollees

You may request continued care from a provider, including a hospital, who does not contract with Health Net or SIMNSA if at the time of your enrollment with Health Net you were receiving care for the conditions listed below. Health Net may provide coverage for completion of services from a non-participating provider, subject to applicable copayments and any exclusions and limitations of your plan. You must request the coverage within 60 days of your Group's effective date unless it is shown that it was not reasonably possible to make the request within 60 days of the Group's effective date and the request is made as soon as reasonably possible. The non-participating provider must be willing to accept the same contract terms applicable to providers currently contracted with Health Net, who are not capitated and who practice in the same or

similar geographic region. If the provider does not accept such terms, Health Net is not obligated to provide coverage with that provider.

Continuity of Care Upon Termination of Provider Contract

If Health Net's contract with a physician group or other provider is terminated, Health Net will transfer any affected members to another contracted physician group or provider to ensure that care continues. Health Net will provide a written notice to affected members at least 60-days prior to termination of a contract with a physician group or an acute care hospital to which members are assigned for services. For all other hospitals that terminate their contract with Health Net, a written notice will be provided to affected members within 5 days after the effective date of the contract termination.

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 of the provider's date of termination unless it is shown that it was not reasonably possible to make the request within 30 days of the provider's date of termination and the request is made as soon as it is reasonably possible.

You may request continued care from a provider whose contract is terminated if at the time of termination the member was receiving care from such a provider for the conditions listed below.

The following conditions are eligible for continuation of care:

- An acute condition;
- A serious chronic condition not to exceed twelve months;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- A newborn (up to 36 months of age, not to exceed twelve months);
- A terminal illness (through the duration of the terminal illness);
- A surgery or other procedure that has been authorized by Health Net (or by the member's prior health plan for a new enrollee) as part of a documented course of treatment.

In addition, you may request continued care from a provider, including a hospital, if you have been enrolled in another Health Net Salud y Mas plan that included a larger network than this plan, Health Net will offer the same scope of continuity of care for completion of services, regardless of whether you had the opportunity to retain your current provider by selecting either:

- a Health Net product with an out of network benefit;
- a different Health Net Salud y Mas network product that included your current provider; or
- another health plan or carrier product.

If you would like more information on how to request continued care or to request a copy of Health Net's continuity of care policy, please contact the Health Net Customer Contact Center at **1-800-400-8987**. Members in Mexico, please call SIMNSA at **(011-52-664) 683-29-02** or **(011-52-664) 683-30-05** for additional information.

Renewing, continuing or ending coverage

RENEWAL PROVISIONS

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

INDIVIDUAL CONTINUATION OF BENEFITS

 ***Please examine your options carefully before declining coverage.***

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

- **COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985):** If you are over age 60, an additional period of coverage may be available under state law. For more information, ask your employer. 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 have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage, and you are not entitled to Medicare. If you are eligible, you have the opportunity to continue group coverage under this plan through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.

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

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

TERMINATION OF BENEFITS

The following information describes circumstances when your coverage in this plan may be terminated. For a more complete description of termination of benefits, please see the plan's EOC.

Termination for Nonpayment of Subscription Charges

Your coverage under this plan ends when the agreement between the employer and Health Net terminates due to nonpayment of the subscription charges by the employer. Health Net will provide your employer a 30-day grace period to submit the delinquent subscription charges. If

your employer fails to pay the required subscription charges by the end of the 30-day grace period, the agreement between Health Net and your employer will be cancelled and Health Net will terminate your coverage at the end of the grace period.

Termination for Loss of Eligibility

Your coverage under this plan ends on the date you become ineligible. Some reasons that you may lose eligibility in this plan include, but are not limited to, the following situations:

- The agreement between the employer covered under this plan and Health Net ends;
- You cease to either live or work within Health Net's service area; or
- You no longer work for the employer covered under this plan.

Termination for Cause

Coverage under this Health Net plan may be terminated for good cause with a 30-day written notice for a member who commits any act or practice, which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the agreement, including:

- Misrepresenting eligibility information about yourself or a dependent;
- Presenting an invalid prescription or physician order;
- Misusing a Health Net Member I.D. Card (or letting someone else use it); or
- Failing to notify us of changes in family status that may affect your eligibility or benefits.

We may report criminal fraud and other illegal acts to the authorities for prosecution.

How to Appeal Your Termination

You have a right to file a complaint if you believe that your coverage is improperly terminated or not renewed. A complaint is also called a grievance or an appeal. Refer to the "If You Have a Disagreement With Our Plan" section for information about how to appeal Health Net's decision to terminate your coverage.

If your coverage is terminated based on any reason other than for nonpayment of subscription charges and your coverage is still in effect when you submit your complaint, Health Net will continue your coverage until the review process is completed, subject to Health Net's receipt of the applicable subscription charges. You must also continue to pay copayments for any services and supplies received while your coverage is continued during the review process.

If your coverage has already ended when you submit your request for review, Health Net is not required to continue coverage. However, you may still request a review of Health Net's decision to terminate your coverage by following the complaint process described in the "If You Have a Disagreement With Our Plan" section.

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

If you have a disagreement with our plan

The California Department of Managed Health Care is responsible for regulating health care service plans.

If you have a grievance against Health Net, you should first telephone Health Net at **1-800-400-8987** or SIMNSA at (**011-52-664**) **683-29-02** or (**011-52-664**) **683-30-05** and use the plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency or a grievance that has not been satisfactorily resolved by Health Net or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

GRIEVANCE AND APPEALS PROCESS

Members 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 members who obtain care through the Salud Network in California 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 may call the Customer Contact Center at the phone number on the back cover or submit a Member Grievance Form through the Health Net website at www.healthnet.com:

You may also write to:

Health Net of California
P.O. Box 10348
Van Nuys, CA 91410-0348

Please include all the information from your Health Net identification card as well as details of your concern or problem.

Health Net will acknowledge your grievance or appeal within five calendar days, review the information and tell you of our decision in writing within 30 days of receiving the grievance. For conditions where there is an immediate and serious threat to your health, including severe pain or the potential loss of life, limb or major bodily function, Health Net will notify you of the status of your grievance no later than three days from the receipt of all the required information. For urgent grievances, Health Net will immediately notify you of the right to contact the Department of Managed Health Care. There is no requirement that you participate in Health Net's grievance process prior to applying to the Department of Managed Health Care for review of an urgent grievance.

You can request an independent medical review of disputed health care services from the Department of Managed Health Care if you believe that health care services eligible for coverage and payment under the plan was improperly denied, modified or delayed by Health Net or one of its contracting providers.

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

Health Net has established and administers the Health Net member grievance procedure. This process includes a detailed description of the roles and responsibilities that Health Net, the contracting physician groups and SIMNSA have in resolving Health Net Member grievances. This includes a detailed description of any and all delegation and oversight that Health Net monitors with respect to the contracting physician groups or SIMNSA. Health Net does not delegate to SIMNSA any level of appeals or grievance resolution for any Health Net member seeking care through it in California.

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

The contracting physician groups or SIMNSA shall report to Health Net all Health Net member appeals by type of appeal or grievance and timeliness of appeal or grievance resolution on a quarterly basis. Health Net 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 Health Net 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 Evidence of Coverage. In that event, the parties hereto agree to cooperate and, at the request of a party, participate in any arbitration proceedings arising there from and, subject to either party's right to seek judicial review thereof in accordance with the terms of the Health Net Benefits Disclosure and EOC, 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 hearing and appeals process, you may submit the problem to binding arbitration. Health Net uses binding arbitration to settle disputes, including medical malpractice. When you enroll in Health Net, you agree to submit any disputes to arbitration, in lieu of a jury or court trial.

Additional plan benefit information

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

Behavioral health services

FOR CALIFORNIA RESIDENTS

Health Net contracts with MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator) which administers behavioral health services

through a personalized, confidential and affordable mental health and chemical dependency care program.

Contact the Behavioral Health Administrator by calling the Health Net Customer Contact Center at the phone number on the back cover. The Behavioral Health Administrator will help you identify a participating mental health professional, a participating independent physician or a subcontracted provider association (IPA) within the network, close to where you live or work, with whom you can make an appointment.

Certain services and supplies for mental disorders and chemical dependency may require prior authorization by the Behavioral Health Administrator in order to be covered. No prior authorization is required for outpatient office visits, but a voluntary registration with the Behavioral Health Administrator is encouraged.

Please refer to the plan's EOC for a more complete description of mental disorder and chemical dependency services and supplies, including those that require prior authorization by the Behavioral Health Administrator.

FOR MEXICO RESIDENTS

SIMNSA contracts with behavioral health providers practicing in the enrollment service area in Mexico. For information on these providers, please contact SIMNSA at (011-52-664) 683-29-02 or (011-52-664) 683-30-05.

TRANSITION OF CARE FOR NEW MEMBERS

If you are receiving ongoing care for an acute, serious or chronic mental health condition from a provider not affiliated with the Behavioral Health Administrator when you enroll with Health Net, we may temporarily cover services provided by that provider, subject to applicable copayments and any other exclusions and limitations of this plan.

Your non-participating mental health professional must be willing to accept the Behavioral Health Administrator's standard mental health provider contract terms and conditions and be located in the plan's service area.

If you would like more information on how to request continued care, or to request a copy of our continuity of care policy, please call the Health Net Customer Contact Center at the phone number on the back cover.

SERIOUS EMOTIONAL DISTURBANCES OF A CHILD

Serious emotional disturbances of a child is when a child under the age of 18 has one or more mental disorders identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders,* as amended to date, other than a primary substance use disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following:

- As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home or (ii) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year;
- The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; or
- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

SEVERE MENTAL ILLNESS

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

CONTINUATION OF TREATMENT

If you are in treatment for a mental health or chemical dependency problem, call the telephone number shown on your Health Net ID card to receive assistance in transferring your care to a network provider.

WHAT'S COVERED

Please refer to the "Schedule of benefits and coverage" section of this SB/DF for the explanation of covered services and copayments.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

Services or supplies for the treatment of mental disorder and chemical dependency are subject to the plan's general exclusions and limitations. Please refer to the "Limits of coverage" section of this SB/DF for a list of what's not covered under this plan.

Prescription drug program

This Plan covers Prescription Drugs through the SIMNSA Prescription Drug Program which is only available in Mexico. There is limited prescription drug coverage through the Health Net Preventive Pharmacy Program in the United States as shown below.

Health Net and SIMNSA are contracted with many major pharmacies within California and Mexico. For a complete and up-to-date list of participating pharmacies in California, visit our website at www.healthnet.com or call the Health Net Customer Contact Center at **1-800-400-8987**. Members residing in Mexico, please contact SIMNSA for a complete list of participating pharmacies at **(011-52-664) 683-29-02** or **(011-52-664) 683-30-05**.

To obtain prescription drugs in Mexico, the prescription drug order must be written by a provider in Mexico; to obtain prescription drugs in California, the prescription drug order must be written by a provider in California.

SIMNSA Prescription Drug Program (Available only in Mexico)

Prescription drugs are covered when dispensed by a SIMNSA Participating Pharmacy and prescribed by a SIMNSA Physician or an emergent or urgent care physician. To obtain prescription drugs in Mexico, the prescription drug order must be written by a provider in Mexico.

Health Net Preventive Pharmacy Program (Available only in the U.S.).

The Health Net Preventive Pharmacy Program covers preventive drugs.

The Health Net Preventive Pharmacy Program covers preventive drugs and women's contraceptives at no cost to the member. Such drugs or devices must be prescribed by a physician from your selected physician group, an authorized referral specialist or an emergent or urgent care physician and dispensed through a Health Net contracting retail pharmacy in the U.S.

Covered preventive drugs are over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over-the-counter or are only available with a prescription. Women's contraceptives available through the retail pharmacy include vaginal, oral, transdermal and emergency contraceptives. For the purpose of coverage provided under this provision, "emergency contraceptives" means FDA-approved drugs taken after intercourse to prevent pregnancy.

Over-the-counter preventive drugs and women's contraceptives that are covered under this program require a prescription from your physician. You must present the prescription at a Health Net contracting retail pharmacy to obtain such drugs or contraceptives.

This Preventive Pharmacy Program does not cover brand name drugs that have generic equivalents. However, if a brand name drug is medically necessary and the physician obtains preapproval from Health Net, then the brand name drug will be dispensed at no charge.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

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

- Allergy serum is covered as a medical benefit. See "allergy serum" benefit in the "Schedule of benefits and coverage" for details;
- Outpatient prescription drugs are only covered in the U.S. when they are prescribed by a Physician for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations or for female contraception as approved by the FDA. Such drugs must be dispensed through a Health Net contracting pharmacy. Any other outpatient prescription drugs dispensed in the U.S. are not covered.
- However, diabetic equipment and supplies for the management and treatment of diabetes are covered as medically necessary. Refer to "Diabetic equipment" in the "Schedule of benefits and coverage" section, for additional information.
- Drugs or medicines administered by a physician or physician's staff member;
- Drugs prescribed for routine dental treatment;
- Drugs prescribed to shorten the duration of the common cold;
- 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 plan" section of this SB/DF for additional information;
- Immunizing agents, injections (except for insulin), agents for surgical implantation, biological sera, blood, blood derivatives or blood plasma obtained through a prescription;
- Individual doses of medication dispensed in plastic, unit dose or foil packages unless medically necessary or only available in that form;
- 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, for urgently needed care or as specifically stated;
- Replacement of lost, stolen or damaged medications;

- Supply amounts for prescriptions that exceed the FDA's or Health Net's indicated usage recommendation are not covered unless medically necessary and prior authorization is obtained from Health Net; and
- Drugs prescribed for a condition or treatment not covered by this plan are not covered. However, the plan does cover drugs for medical conditions that result from nonroutine complications of a noncovered service.

This is only a summary. Consult the plan's EOC 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 թարգմանչի 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 2172-839-800 تلفن کنند. اعضاء گروههای کارفرمایان لطفاً با شماره 0088-522-800 تماس بگیرند. اعضاء PPO: برای کسب اطلاعات بیشتر لطفاً با اداره بیمه کالیفرنیا به شماره 4357-927-800-1 تماس بگیرند. 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 សុខភាពបុគ្គល និងក្រុមគ្រួសារ ឬសមាជិក Farm Bureau សូមទូរស័ព្ទទៅលេខ 800-839-2172 ។ សមាជិកក្រុមម្ចាស់ក្រុមហ៊ុនការងារ 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 2172-839-800. وبالنسبة لأعضاء مجموعات صاحب العمل رجاء الاتصال بالرقم 0088-522-800. أعضاء PPO: للحصول على المساعدة الإضافية يرجى الاتصال بالخط الخاص بإدارة التأمين الصحي لولاية كاليفورنيا على الرقم 4357-927-800-1. 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 tau 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. ທ່ານສາມາດໄດ້ຮັບບໍລິການແປພາສາແລະມີຜູ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງເປັນພາສາຂອງທ່ານເອງ. ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມໝາຍເລກທີ່ລະບຸໄວ້ໃນບັດປະກັນໄພຂອງທ່ານ. ຂໍໃຫ້ສະມາຊິກລາຍບຸກຄົນແລະຄອບຄົວຫລືສະມາຊິກ Farm Bureau ໂທຕາມໝາຍເລກ 800-839-2172. ຂໍໃຫ້ສະມາຊິກກຸ່ມລູກຈ້າງໂທຕາມໝາຍເລກ 800-522-0088. ສະມາຊິກ PPO: ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອເພີ່ມຕື່ມ ໃຫ້ໂທໄປຫາກົມປະກັນໄພແຫ່ງລັດຄາລີຟໍເນັຍຕາມໝາຍເລກ 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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Van Nuys, California 91409-9103

Customer Contact Center

Large Group (for companies with 51 or more employees):
1-800-522-0088 – HMO/Elect Open Access
1-800-676-6976 – PPO/Point-of-Service (SELECT/ELECT)

Small Business Group (for companies with 2-50 employees):
1-800-361-3366
1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

Telecommunications Device for the Hearing and Speech Impaired
1-800-995-0852