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

Large Business Group (51-100)
SALUD MEXICO HMO (SIMNSA only plan)• Plan AAK

Health Net®
A BETTER DECISION

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 Salud Mexico plan.

A network of physicians contracting with Sistemas Medicos Nacionales S.A. de C.V. (SIMNSA) has been selected to provide services to enrolled dependents who reside in the Salud Mexico Service Enrollment Area which is the area in California and Mexico within 50 miles of the U.S. - Mexico Border. If you have further questions, just contact the Health Net Customer Contact Center at 1-800-522-0088 or SIMNSA at (011-52-664) 683-29-02 or 683-30-05. Our friendly, knowledgeable representatives will be glad to help.

If you have further questions, contact us:

☎ **By phone at 1-800-522-0088,**

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 have the right to view the Evidence of Coverage (EOC) prior to enrollment. To obtain a copy of the EOC, contact the Health Net Customer Contact Center at 1-800-522-0088. You should also consult the Group Hospital and Professional Group Service Agreement (issued to your employer) to determine governing contractual provisions. It is important for you to carefully read this document and your EOC thoroughly once received especially those sections that apply to those with special health care needs. This Summary of benefits and disclosure form (SB/DF) includes a matrix of benefits in the section titled "Schedule of Benefits and coverage."

Table of contents

HOW THE PLAN WORKS

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

WHO CAN ENROLL

THE FOLLOWING CATEGORIES OF INDIVIDUALS ARE ELIGIBLE TO ENROLL IN THIS PLAN:

IN CALIFORNIA

- Employee and eligible dependents who live or work within 50 miles of the U.S.- Mexico border.

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IN MEXICO

¥ Employee and eligible dependents who live or work in Mexico, which includes an area extending 50 miles into Baja California from the U.S.- Mexico border.

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SELECTION OF SIMNSA PHYSICIANS

- When you enroll with Health Net, you must obtain all health care services from any contracting physician from the SIMNSA Provider Directory. (See your SIMNSA Directory of Participating Physician Groups for detailed information about physicians in the SIMNSA network.)
- Whenever you or a covered family member needs health care, your SIMNSA provider will provide the medically necessary treatment. Specialist care is also available through your Health Net plan, when authorized in advance through your SIMNSA provider.
- Members and eligible dependents residing in the Salud Mexico service enrollment area may go to any contracting PCP 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 in Mexico.

SPECIALISTS AND REFERRAL CARE

If you need medical care that your SIMNSA provider cannot provide, you may be referred by SIMNSA 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.

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 SIMNSA Provider Directory. The SIMNSA Provider 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.

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 your Evidence of Coverage 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**

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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 Centerat 1-800-522-0088 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.

Principal benefits and coverage matrix

Deductibles ..... **None**

Lifetime maximums ..... **None**

Out-of-Pocket Maximum (OOPM)

One member $1,500

Two members $3,000

Family (three members or more) $4,500

Once your payments for covered services equals the amount shown below in any one calendar year, no additional copayments for covered services 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 for covered services 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 any supplemental benefits or services not covered by this plan will not count toward 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 service & what you pay for services (medical benefits)[1]

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

Specialist consultations ▪ $5

Prenatal and postnatal office visits	Covered in full
Normal delivery, cesarean section, newborn inpatient care	Covered in full
Treatment of complications of pregnancy, including medically necessary abortions	See note below*
Surgeon or assistant surgeon services▲	Covered in full
Administration of anesthetics	Covered in full
Laboratory procedures and diagnostic imaging (including x-ray) services	Covered in full
Rehabilitative therapy (includes physical, speech, occupational, and respiratory therapy)	$5
Organ and stem cell transplants (non-experimental and non-investigational)	Covered in full
Chemotherapy	Covered in full
Radiation therapy	Covered in full
Vision and hearing examinations (for diagnosis or treatment, including refractive eye examinations)	$5

■ *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.*

** 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 will apply.*

◢ *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 will determine the most appropriate services, the length of hospital stay will be determined solely by your PCP.*

Preventive care

Preventive care services	Covered in full

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

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

Allergy treatment and other injections (except for infertility injection)

Allergy testing ..... Covered in full

Allergy serum ..... Covered in full

Allergy injection services $5

Immunizations -- To meet foreign travel requirements ..... Not Covered

Immunizations -- To meet occupational requirements ..... Not Covered

Injections (except for infertility)

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

Self injectable drugs■ ..... Covered in full

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

■ *Certain self-injectable drugs (other than insulin) are considered specialty drugs and must be obtained through Health Net's contracted Specialty Pharmacy Vendor. The Specialty Pharmacy Vendor will charge you the appropriate copayment as shown above. Specialty drugs require prior authorization from Health Net. Please refer to the plan's EOC for additional information.*

Outpatient services

Outpatient services (other than surgery) ..... Covered in full

Outpatient surgery (surgery performed in a hospital or outpatient surgery center only) ..... Covered in full

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

Hospitalization services

Semi-private hospital room or intensive care unit with ancillary services, including maternity care (per admission; unlimited days) ..... Covered in full

Skilled nursing facility stay (limited to 100 days each calendar year) ..... Covered in full

Physician visit to hospital or skilled nursing facility (excluding care for substance abuse and mental disorders) ..... 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 or Urgent care center in Mexico (facility charges) $10

Emergency room in the U.S. or in countries other than Mexico (facility charges) $50

Professional services in an Emergency room or Urgent care facility ..... Covered in full

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

Air ambulance ..... Not Covered

Prescription drug coverage

+ *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.*

Drugs dispensed through SIMNSA $5

Lancets ..... Covered in full

Oral infertility drugs 50%

Preventive drugs and women's contraceptives* ..... Covered in full

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

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

Medical Supplies

Durable medical equipment (including nebulizers, face masks and tubing for the treatment of asthma) ..... Covered in full

Orthotics (such as bracing, supports and casts) ..... Covered in full

Diabetic Equipment ..... Covered in full

Diabetic footwear ..... Covered in full

Prostheses ..... Covered in full

Diabetic equipment covered under the medical benefit (through "Diabetic Equipment"), includes blood glucose monitors designed for the visually impaired, insulin pumps and related supplies. In addition, the following supplies are covered under the medical benefit as specified: diabetic footwear, visual aids (excluding eyewear) to assist the visually impaired with the proper dosing of insulin are provided through the prostheses benefit; Glucagon is provided through the self-injectable benefit. Self-management training, education and medical nutrition therapy will be covered only when provided by licensed health care professionals with expertise in the management or treatment of diabetes (provided through the patient education benefit). Diabetic equipment and supplies covered under the prescription drug benefit include insulin, specific brands of blood glucose monitors and testing strips, Ketone urine testing strips, lancets and lancet puncture devices, specific brands of pen delivery systems for the administration of insulin (including pen needles) and specific brands of insulin syringes.

Mental disorders and chemical dependency benefits

+ *SIMNSA contracts with behavioral health providers practicing in the enrollment service area in Mexico. For information on these providers, please contact SIMNSA at (011-52-644) 683-29-02 or 683-30-05.)*

+ *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

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 ..... Covered in full

Other Mental Disorders

Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting) * $5

Inpatient services ..... Covered in full

Chemical Dependency

Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting) *

Individual session $5

Inpatient services ..... Covered in full
Acute care (detoxification) ..... Covered in full

Home health services

Home health services ..... Not Covered

Other services

Sterilizations --Vasectomy $50

Sterilizations --Tubal ligation ..... Covered in full

Blood, blood plasma, blood derivatives and blood factors ..... Covered in full

Renal dialysis ..... Covered in full

Hospice services ..... Not Covered

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%

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

Infertility services and all covered services that prepare the member to receive this procedure, 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 and limited to a maximum of three treatment courses per calendar year.

Limits of coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- Air ambulance in Mexico;
- Artificial insemination for reasons not related to infertility;
- Conception by medical procedures (IVF, GIFT and ZIFT);
- Except for the management and treatment of diabetes, 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;
- Elective abortions in Mexico;
- 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;
- 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 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 foot orthotic limitations;
- Outpatient prescription drugs (except as noted under "Prescription drug program");
- Personal or comfort items;
- Physician self-treatment;
- Physician treating immediate family members;
- Private rooms when hospitalized, unless medically necessary;
- Private-duty nursing;
- Refractive eye surgery unless medically necessary, recommended by the member's treating physician and authorized by Health Net;
- Reversal of surgical sterilization;
- 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, SIMNSA or the physician group according to Health Net's procedures;
- Services for a surrogate pregnancy are covered. 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 member's Evidence of Coverage;
- Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary; and

- Treatment of obesity, weight reduction or weight management, except for treatment of morbid obesity.
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder;
- Nontreatable disorders;
- Services related to educational or training, including for employment and professional purposes, except for behavioral health treatment for pervasive developmental disorder or autism;
- Stress, except when rendered in connection with services provided for a treatable mental disorder;
- 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;

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

NOTICE OF REQUIRED COVERAGE

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

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

All follow-up care (including severe mental illness and serious emotional disturbances of a child), after the urgency has passed must be provided or authorized by a SIMNSA provider, otherwise it will not be covered by Health Net.

Emergency care *means any otherwise covered service for an acute illness, a new injury or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or, if a minor, to the minor's parent or guardian that a reasonable person with an average knowledge of health and medicine (a prudent layperson) would believe requires immediate treatment (including severe mental illness and serious emotional disturbances of a child), and without immediate treatment, any of the following would occur: (a) his or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger); (b) his or her bodily functions, organs or parts would become seriously damaged; or (c) his or her bodily organs or parts would seriously malfunction. Emergency Care also includes treatment of severe pain or active labor. Active labor means labor at the time that either of the following would occur: (a) there is inadequate time to effect safe transfer to another Hospital prior to delivery; or (b) a transfer poses a threat to the health and safety of the Member or her unborn child. Emergency Care will also include additional screening, examination and evaluation by a Physician (or other health care provider acting within the scope of his or her license) to determine if a Psychiatric Emergency Medical Condition exists and the care and treatment necessary to relieve or eliminate such condition, either within the capacity of the facility or by transferring the Member to another facility as Medically Necessary to treat the Psychiatric Emergency Medical Condition.*

Ground 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).

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 your Evidence of Coverage; any other services or supplies are not covered.

SECOND OPINIONS

You have the right to request a second opinion when:

- Your SIMNSA provider or a referral Physician gives a diagnosis or recommends a treatment plan that you are not satisfied with, or
- You are not satisfied with the result of treatment you have received, or
- 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 SIMNSA provider 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, call the Health Net Customer Contact Center at: **1-800-522-0088.**

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 EOC.

EXTENSION OF BENEFITS

If you or a covered family member is totally disabled when your employer ends its 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.

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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. Also, 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 operation (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 your plan's EOC, at www.healthnet.com under "Privacy" or you may contact the Customer Contact Center at 1-800-522-0088 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.

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. This oversight helps 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 that the procedure is medically necessary and planned for the appropriate setting (i.e., inpatient, ambulatory surgery, etc.).

CONCURRENT REVIEW

This process continues to authorize inpatient and certain outpatient conditions on a concurrent basis while following 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 and 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 **1-800-522-0088** or SIMNSA at **(011-52-664) 683-29-02 or 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 all enrolled family members. Check with your employer regarding any share that you may be required to pay. If your share ever increases, your employer will inform you in advance.

OTHER CHARGES

You are responsible for payment of your share of the cost of services covered by this plan. Amounts paid by you are called copayments or coinsurance, which are described, in the "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 "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 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, such as prescription drugs, chiropractic, or acupuncture 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. Please read the Evidence of Coverage for more information.

You will be required to notify Health Net when you have paid the maximum copayment liability amount. You should keep all receipts or canceled checks and then contact the Health Net Customer Contact Center at 1-800-522-0088 for instructions about how to proceed.

LIABILITY OF SUBSCRIBER OR ENROLLEE FOR PAYMENT

If you receive covered health care services from doctors without receiving required authorization from SIMNSA, you are responsible for payment of expenses for these services. Remember, services are covered only when provided or authorized by a SIMNSA provider, except for emergency or out-of-area urgent care. Consult the SIMNSA Directory of Contracting Physician Groups for a full listing of SIMNSA participating physicians.

REIMBURSEMENT PROVISIONS

Payments that are owed by Health Net for covered services provided by or through SIMNSA will never be your responsibility.

If you have out-of-pocket expenses for covered services (such as an out-of-area emergency), call the Health Net Member Customer Contact Center at **1-800-522-0088** 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 SIMNSA provider.)

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

Please call Health Net Customer Contact Center at **1-800-522-0088** to obtain claim forms, and to find out whether you should send the completed form to your SIMNSA provider. Medical claims must be received by Health Net within one year of the date of service to be eligible for reimbursement.

+ How to file a claim:

If you need to file a claim for emergency medical services or for services authorized by SIMNSA with Health Net, 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

SIMNSA
c/o International Healthcare, Inc.
303 H. Street, Suite 390
Chula Vista, CA 90910
1-619-407-4082

or

SIMNSA
206 Paseo Rio Tijuana 406
1er Piso-Edificio Allen Lloyd
Tijuana, Baja California
Mexico, 22320
Tel. (011-52-664) 683-29-02 and 683-30-05

 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 receive literature, please contact Health Net Customer Contact Center at 1-800-522-0088 or SIMNSA at (011-52-664) 683-29-02 or 683-30-05 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 at:

- The facilities of the SIMNSA provider; or
- A nearby SIMNSA–contracted hospital, if hospitalization is required.

SIMNSA has a physician on call 24 hours a day or an urgent care center available to offer access to care at all times. SIMNSA has a contractual relationship with local hospitals (for acute, subacute and transitional care) and skilled nursing facilities in Mexico. These are listed in your *SIMNSA Directory of Contracting Physician Groups*.

CONTINUITY OF CARE

Transition of Care For New Enrollees

You may request continued care from a provider 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 you can show that it was not reasonably possible to make the request within 60 days of the group's effective date and you make the request 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 30-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 five 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 you can show that it was not reasonably possible to make the request within 30 days of the provider's date of termination and you make the request 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.

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 **1-800-522-0088**. Members in Mexico, please call SIMNSA at **(011-52-664) 683-29-02 or 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):** For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they

live outside of California. Please check with your group to determine if you and your covered dependents are eligible.

- **Cal-COBRA Continuation Coverage:** If you have exhausted COBRA and you live in the Health Net Service Area, you may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if you began receiving federal COBRA coverage on or after January 1, 2003, have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage, and you are not entitled to Medicare. If you are eligible, you have the opportunity to continue group coverage under 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.
- **HIPAA Guaranteed Issue Coverage:** The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people covered under existing group health plans to maintain coverage regardless of pre-existing conditions when they change jobs or are unemployed for brief periods of time. California law provides similar and additional protections. Applicants who meet the following requirements are eligible to enroll in a guaranteed issue individual health plan from any health plan that offers individual coverage, including Health Net's Guaranteed HMO Plans, without medical underwriting. A health plan cannot reject your application for guaranteed issue individual health coverage if you meet the following requirements, agree to pay the required premiums and live or work in the plan's service area. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance. To be considered an eligible individual:

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

  For more information regarding guarantee issue coverage through Health Net please call the Individual Sales Department at 1-800-909-3447. If you believe your rights under HIPAA have been violated, please contact the Department of Managed Health Care at 1-888-HMO-2219 or visit the Department's website at www.hmohelp.ca.gov.

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

If we terminate your membership for cause, you will not be allowed to enroll in a Health Net health plan in the future. We may also 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 end 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 or SIMNSA, you should first telephone Health Net in California or SIMNSA in Mexico at **1-800-522-0088** or SIMNSA at (**011-52-664**) **683-29-02** or **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.

MEMBER GRIEVANCE AND APPEALS PROCESS

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

+ ***How to file a grievance or appeal:***

To file a grievance or appeal you may call the Customer Contact Center at the phone number on the back cover1-800-522-0088 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 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.

 In addition, 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 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 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 SIMNSA.

SIMNSA 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 SIMNSA and to members. Such summary shall include the current address and telephone number for registering a complaint first through SIMNSA's grievance procedures in accordance with the Health Net standards.

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, 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 the copayments required for behavioral health services and prescription benefits available with your plan. For a more complete description of copayments and exclusions and limitations of service, please see your plan's *Evidence of Coverage*.

Behavioral health services

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 683-30-05.

TRANSITION OF CARE FOR NEW ENROLLEES

If you are receiving ongoing care for an acute, serious, or chronic mental health condition from a non-participating mental health professional at the time you enroll with Health Net, we may temporarily cover services from a provider not affiliated with SIMNSA, subject to applicable copayments and any other exclusions and limitations of this plan.

Your non-participating mental health professional must be willing to accept SIMNSA'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 1-800-522-0088.

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, 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; and/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 the most recent edition the Diagnostic and Statistical Manual for Mental Disorders), autism, anorexia nervosa, and bulimia nervosa.

CONTINUATION OF TREATMENT

If you are in treatment for a mental disorder, 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 copayments.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

+ Services or supplies excluded under behavioral health services may be covered under the medical benefits portion of your plan.

In addition to the exclusion and limitations listed below, mental health and detoxification are subject to the plan's general exclusions and limitations. Consult your plan's EOC for more information.

- Congenital or organic disorders, including organic brain disease and mental retardation, except for some conditions when the level of severity meets the criteria of severe mental illness or serious emotional disturbances of a child as described in the EOC;
- Experimental or investigational therapies;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder;
- Nontreatable mental disorders;
- Private-duty nursing;
- Services related to educational and professional purposes;
- Smoking cessation, weight reduction, obesity, stammering, sleeping disorders or stuttering;
- 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 detoxification in newborns;
- Treatment, testing or screening of learning disabilities, except for some conditions when the level of severity meets the criteria of severe mental illness or serious emotional disturbances of a child as described in the EOC; and
- 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 and subject to the plan's day or visit limits.

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

Prescription drug program

SIMNSA is contracted with many major pharmacies within Mexico. For a complete and up to date list of participating pharmacies, call the Health Net Customer Contact Center at 1-800-522-0088. Members residing in Mexico, please contact SIMNSA for a complete list of participating pharmacies at (011-52-664)-683-29-02 or 664-683-30-05.

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.

WHAT IS "PRIOR AUTHORIZATION?"

Some prescription medications require prior authorization. This means that your doctor must contact SIMNSA in advance to provide the medical reason for prescribing the medication. You may obtain a list of drugs requiring prior authorization by visiting our website at www.healthnet.com or call the Health Net Customer Contact Center at the phone number on the back cover.

+ How to request prior authorization:

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

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

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

The appeal may be submitted in writing, by telephone or through e-mail. We must receive the appeal within 60 days of the date of the denial notice. Please refer to your Health Net Evidence of Coverage for details regarding your right to appeal.

TO SUBMIT AN APPEAL:

- Call the Health Net Customer Contact Center at 1-800-522-0088

- Visit **www.healthnet.com** for information on e-mailing the Health Net Customer Contact Center

  Write to:

  Health Net Customer Contact Center
  P.O. Box 10348
  Van Nuys, CA 91410-0348

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. Outpatient prescription medication are dispensed by SIMNSA.

There is an out-of-pocket maximum copayment of $10 for prescriptions written on the same day by the same Physician.

Note:

- Prescription drug covered expenses are the lesser of SIMNSA's contracted pharmacy rate or the pharmacy's retail price for covered Prescription Drugs.
- If the pharmacy's retail price is less than the applicable Copayment, the member will pay the pharmacy's retail price.
- Prescription drugs for the treatment of asthma are covered. Inhaler spacers and peak flow meters under the pharmacy benefit are covered when medically necessary. Nebulizers (including face masks and tubing) are covered under "Durable Medical Equipment" and educational programs for the management of asthma are covered under "Patient Education" through the medical benefit. For information about copayments required for these benefits, please see the "Schedule of benefits and coverage" section of this SB/DF.
- Oral drugs prescribed for treating infertility are subject to a 50% copayment.
- Vaginal, oral and emergency contraceptives are covered. Vaginal contraceptives include diaphragms and cervical caps and are only covered when a member physician performs a fitting examination and prescribes the device. Such devices are only available through a prescription from a pharmacy and are limited to one fitting and prescription per calendar year, unless additional fittings or devices are medically necessary. For a complete list of contraceptive products, please contact SIMNSA. Injectable contraceptives are covered when administered by a physician. Refer to your plan's Evidence of Coverage for information on contraceptives covered under the medical benefit. If your physician determines that none of the methods specified as covered by the plan are medically appropriate, then the plan will provide coverage for another FDA approved prescription or method as prescribed by your physician.
- Diabetic supplies (blood glucose testing strips, lancets, needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (i.e. opened in order to dispense the product in quantities other than those packaged). When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times your physician has prescribed for a 30-day period.
- For more information about diabetic equipment and supplies, please see "Endnotes" in the "Schedule of benefits and coverage" section of this SB/DF.

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 your plan's EOC for more information.

- Allergy serum. Allergy serum is covered as a medical benefit. See "allergy serum" benefit in the "Schedule of benefits and coverage" for details;
- Cosmetics, health or beauty aids, or drugs prescribed for cosmetic reasons, including drugs prescribed for baldness or to eliminate wrinkles;
- Coverage for devices includes vaginal contraceptive devices, peak flow meters, spacer inhalers and diabetic supplies. No other devices are covered even if prescribed by a member physician;
- Drugs prescribed for the treatment of obesity are covered, when medically necessary for the treatment of morbid obesity. In such cases, the drugs will be subject to prior authorization from SIMNSA and Health Net;
- Drug products that help you reduce or quit smoking or for nicotine addiction(e.g., nicotine patches);
- Drugs or medicines administered by a physician or physician's staff member1;
- Drugs prescribed for routine dental treatment;
- Drugs prescribed to shorten the duration of the common cold;
- Drugs (including self-injectable medications) prescribed for sexual dysfunction, including drugs that establish, maintain, or enhance sexual function or satisfaction;
- Drugs prescribed by a Physician who is not a Member Physician or an authorized specialist are not covered, except when the Physician's services have been authorized, or because of medical emergency condition, illness, or injury, or as specifically stated;
- Experimental drugs (those that are labeled "Caution - Limited by the 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;
- Hypodermic needles or syringes, except for insulin needles, syringes and specific brands of pen devices;
- Immunizing agents, injections (except for insulin), agents for surgical implantation, biological sera, blood, blood derivatives or blood plasma obtained through a prescription;
- Individual doses of medication dispensed in plastic, unit dose, or foil packages unless medically necessary or only available in that form;
- Limits on quantity, dosage and treatment duration may apply to some drugs. Medications taken on an "as-needed" basis may have a copayment based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If medically necessary, your physician may request a larger quantity from SIMNSA or Health Net;
- Mail Order Drug Program;

- Medical equipment and supplies (including insulin), that are available without a prescription are covered when prescribed by a physician for the management and treatment of diabetes. Any other nonprescription drug, medical equipment or supply that can be purchased without a prescription drug order is not covered even if a physician writes a prescription drug order for such drug, equipment or supply. However, if a higher dosage form of a prescription drug or over-the-counter (OTC) drug is only available by prescription, that higher dosage drug will be covered. If a drug that was previously available by prescription becomes available in an OTC form in the same prescription strength, then any prescription drugs that are similar agents and have comparable clinical effect(s) will only be covered when medically necessary and prior authorization is obtained from SIMNSA or Health Net;
- Prescription drugs filled at pharmacies that are not in the SIMNSA pharmacy network except in emergency or urgent care situations;
- Replacement of lost, stolen or damaged medications;
- Services or supplies for which there is no charge, or for which you are not legally required to pay;
- Supply amounts for prescriptions that exceed the FDA's or Health Net'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.

[1]*Must be approved by Health Net or SIMNSA.*
[2]*These items are covered under the medical coverage portion of your plan*

This is only a summary. Consult your 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 보건관리루 (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 թարգմանի ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեր լեզվով: Օգնության համար, մեզ զանգահարեք ձեր իքնության 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 بگیرید. اعضاء HMO: برای کسب اطلاعات بیشتر به خط کمکی HMO در Department of Managed Health Care به شماره 1-888-HMO-2219 تلفن کنید. **Farsi**

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

ការបកប្រែភាសាដោយឥតគិតថ្លៃ ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងឲ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន ។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក ។ សំរាប់សមាជិក បុគ្គលខ្លួន និងគ្រួសារ ឬសមាជិក Farm Bureau សូមទូរស័ព្ទទៅលេខ 800-839-2172 ។ 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 rau CA Lub Koom Haum Saib Xyuas Txog Kev Tuav Pov Hwm ntawm 1-800-927-4357. Cov tswv cuab hauv HMO: yog xav tau kev pab ntxiv hu rau Lub Caj Meem Fai Saib Xyuas Txog Kev Tswj Txoj Kev Kho Mob (Department of Managed Health Care) HMO Tus Xov Tooj Muab Kev Pab ntawm 1-888-HMO-2219. **Hmong**

ບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າ. 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

For more information, please contact us at:

Health Net
Post Office Box 10348
Van Nuys, California 91409-10348

Customer Contact Center

Large Group:
1-800-522-0088
(for companies with 51 or
more employees)

Optimizer HMO HRA
Dedicated Customer Contact Center:
1-800-431-9059

Small Business Group:
1-800-522-0088
(for companies with 2-50 employees)

Individual & Family Plans:
1-800-839-2172

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

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