Summary *of* Benefits

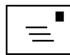
Large Business Group (51-100)
Value PPO 20• Insurance Plan ADB

DELIVERING CHOICES

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

If you have further questions, contact us:

By phone at 1-800-676-6976,



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

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

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

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How the insurance plan works

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

SELECTION OF PHYSICIANS

This insurance plan allows you to:

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

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

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

Your choice of doctors and hospitals may determine which services will be covered, as well as how much you will pay. In many instances, certification is required for full benefits (see "Schedule of benefits and coverage" section of this brochure). Preferred providers are listed on the HNL website at www.healthnet.com or you can contact the Customer Contact Center at the telephone number listed on the back cover to obtain a copy of the Preferred Provider Directory.

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

HOW TO ENROLL

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

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

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

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

Schedule of benefits and coverage

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

Principal benefits and coverage matrix

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

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

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

Deductibles	PPO	OON (out-of network)

You must pay this amount for covered services before HNL begins to pay. However, PPO services to which a copayment applies are not subject to the calendar year deductible.

Calendar year deductible

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

Any amount applied toward the deductible for covered services provided by a PPO provider will apply toward the OON deductible; any amount applied toward the deductible for covered services provided by an OON provider will apply to the PPO deductible.

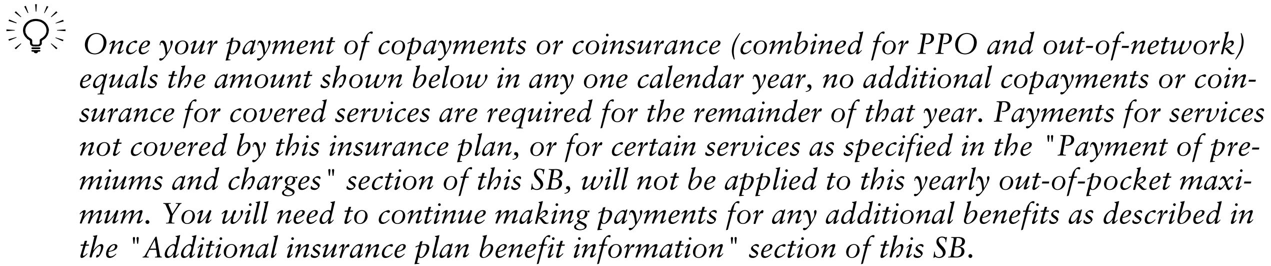
Deductibles	PPO	OON (out-of network)
For each covered person	$1250	$2500
For a family	$2500	$5000
Additional deductibles		
Inpatient deductible (applies each calendar year to the first admission)◈	$250	$250
Outpatient surgery deductible (per calendar year)	$250	$250
Skilled nursing facility deductible (applies each calendar year to the first admission)	$250	$250
Infertility services deductible (per calendar year, continues to apply after)ঝ	$500	$500
Ambulance deductible	$50	$50
Emergency room deductible (waived if admitted to a hospital)	$100	$100
Urgent care center deductible (waived if admitted to a hospital)	$50	$50

ঝ *Combined for PPO and out-of-network.*

◈*Does not apply to detoxification, non-severe Mental Disorders or Chemical Dependency.*

Insurance Plan maximums	PPO	OON (out-of network)

Yearly Out-of-pocket maximum (OOPM)



Once your payment of copayments or coinsurance (combined for PPO and out-of-network) equals the amount shown below in any one calendar year, no additional copayments or coinsurance for covered services are required for the remainder of that year. Payments for services not covered by this insurance plan, or for certain services as specified in the "Payment of premiums and charges" section of this SB, will not be applied to this yearly out-of-pocket maximum. You will need to continue making payments for any additional benefits as described in the "Additional insurance plan benefit information" section of this SB.

	PPO	OON
For each covered person	$3500	$7000
For a family	$7000	$14000

Type of services, benefit maximums & what you pay

Professional services	PPO	OON
Visit to physician	$20	50%
Annual routine physical exam (age 17 and older)	$20	Not covered
Calendar year maximum	*$250*	*Not applicable*
Specialist consultations	$20	50%
Prenatal and postnatal office visits♦	20%	50%
Normal delivery, cesarean section, newborn inpatient professional care★	20%	50%
Treatment of complications of pregnancy, including medically necessary abortions★	See note below**	See note below**
Physician visit to hospital or skilled nursing facility	20%	50%
Surgeon or assistant surgeon services▲, ★	20%	50%
Administration of anesthetics	20%	50%
Rehabilitative therapy (including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)★	20%	50%
Maximum visits per calendar year✎, ◘	*12*	*12*
Organ and stem cell transplants (nonexperimental and noninvestigational)★	20%	50%
Chemotherapy	20%	50%

Radiation therapy	20%	50%
Vision and hearing examinations (for diagnosis or treatment, including refractive eye examinations) (birth through age 16)	$20	Not covered

♦*Prenatal, postnatal and newborn care office visits for preventive care are covered in full for preferred providers. If the primary purpose of the office visit is unrelated to a preventive service or if other non-preventive services are received during the same office visit, the above copayment or coinsurance will apply for the non-preventive services.*

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

Combined for PPO and out-of-network.

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

▲*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.*

◘*Benefits for up to 12 additional visits are payable if precertified as medically necessary following neurological and orthopedic surgery, cerebral cardiovascular accident, third degree burns, head trauma or spinal cord injuries. All visit maximums will be combined for covered services and supplies provided by preferred providers and out-of-network providers. Medically Necessary rehabilitative services following post-mastectomy lymphedema syndrome are not subject to such visit limitations* In addition, medically necessary rehabilitative or habilitative services for autism or pervasive developmental disorder are not subject to such visit limitations.*

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

Allergy treatment and other injections (except for infertility injections)	**PPO**	**OON**
Allergy testing	$20	50%
Allergy serum	20%	50%
Allergy injection services	$20	50%
Injections (except for infertility)		

Injectable drugs administered by a physician	$20	50%

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

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

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

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

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

Hospital services	PPO	OON
Semi-private hospital room or special care unit with ancillary services, including delivery and maternity care (unlimited days) *	20%	50%
Skilled nursing facility stay*	20%	50%
Maximum days per calendar year	*100*	*100*
Confinement for bariatric (weight loss) surgery*	20%	Not covered

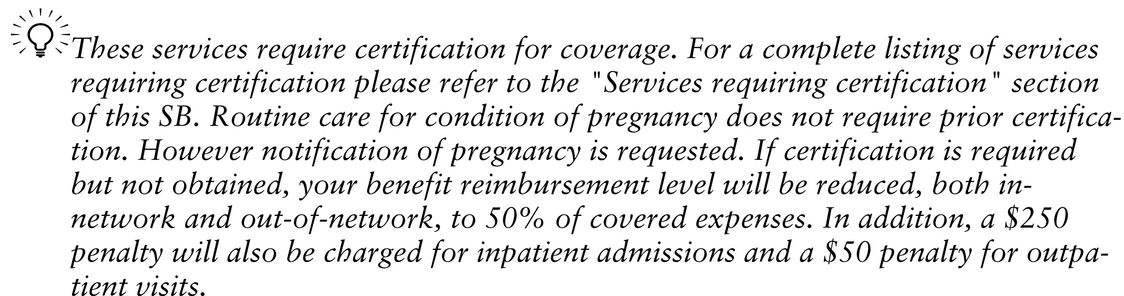
* *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is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

ª *Combined for PPO and out-of-network.*

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

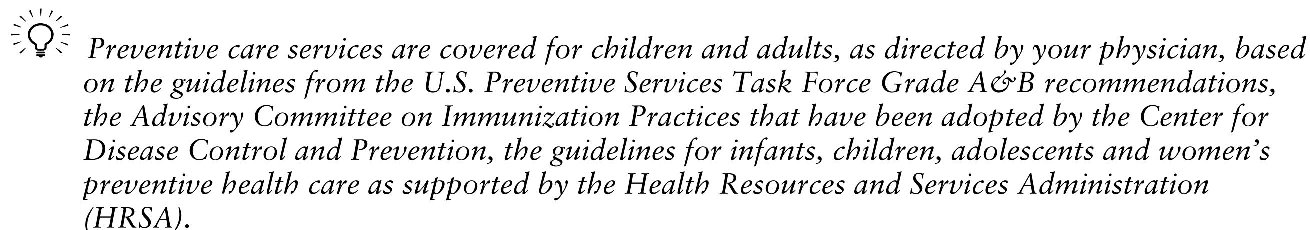
Inpatient care for infertility is described below in the "Infertility services" section.

Radiological services	PPO	OON
Laboratory procedures and diagnostic imaging (including x-ray)	20%	50%



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

Preventive Care	PPO	OON
Preventive care services	Covered in full	Not covered



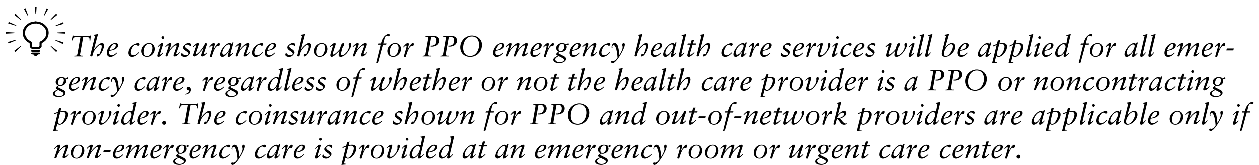
Preventive care services are covered for children and adults, as directed by your physician, based on the guidelines from the U.S. Preventive Services Task Force Grade A&B recommendations, the Advisory Committee on Immunization Practices that have been adopted by the Center for Disease Control and Prevention,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

Preventive care services 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.

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

Emergency health coverage	PPO	OON
Emergency room or urgent care professional services (in an emergency)	$20	$20
Emergency room or urgent care professional services (non-emergency)	20%	50%
Emergency room or urgent care facility services (non-emergency)	20%	50%

Emergency room or urgent care facility services (in an emergency)	20%	20%



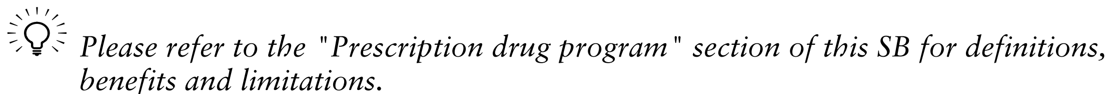
The coinsurance shown for PPO emergency health care services will be applied for all emergency care, regardless of whether or not the health care provider is a PPO or noncontracting provider. The coinsurance shown for PPO and out-of-network providers are applicable only if non-emergency care is provided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

Ambulance services	PPO	OON
Ground ambulance	20%	50%
Air ambulance*	20%	50%

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

Outpatient prescription drug plan

Prescription drugs	Participating pharmacy	Nonparticipating pharmacy



Please refer to the "Prescription drug program" section of this SB for definitions, benefits and limitations.

Retail pharmacy (up to a 30-day supply)

Level I drugs listed on the Recommended Drug List (primarily generic)	$15	50%
Level II drugs listed on the Recommended Drug List (primarily preferred brand name) and diabetic supplies (including insulin)◆	$30	50%
Level III drugs listed on the Recommended Drug List (or non-preferred drugs not listed on the Recommended Drug List)◆	$50	50%
Preventive drugs and women's contraceptives) *	Covered in full	Not covered

Specialty Pharmacy Vendor

	Specialty Pharmacy
Specialty Drugs when listed in the Recommended Drug List	30%

Maximum amount payable by covered person per prescription		$250

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

Level I drugs listed on the Recommended Drug List (primarily generic)	$30	Not Covered
Level II drugs listed on the Recommended Drug List (primarily preferred brand name) and diabetic supplies (including insulin) ◆	$60	Not Covered
Level III drugs listed on the Recommended Drug List (or non-preferred drugs not listed on the Recommended Drug List)◆	$100	Not Covered
Preventive drugs and women's contraceptives) *	Covered in full	Not covered

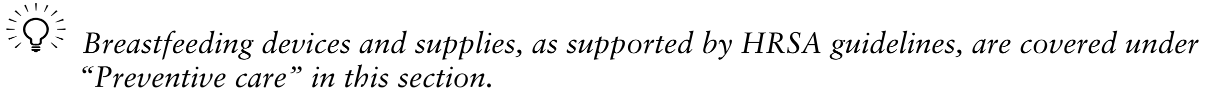
◆ *Generic drugs will be dispensed when a generic drug equivalent is commercially available. When a brand name drug is dispensed and a generic equivalent is commercially available, the covered person must pay the difference between the generic equivalent and the brand name drug in addition to the listed copayments or coinsurance.*
However, if the prescription drug order states "dispense as written," "do not substitute" or words of similar meaning in the physician's handwriting, only the listed drug copayment will be applicable.

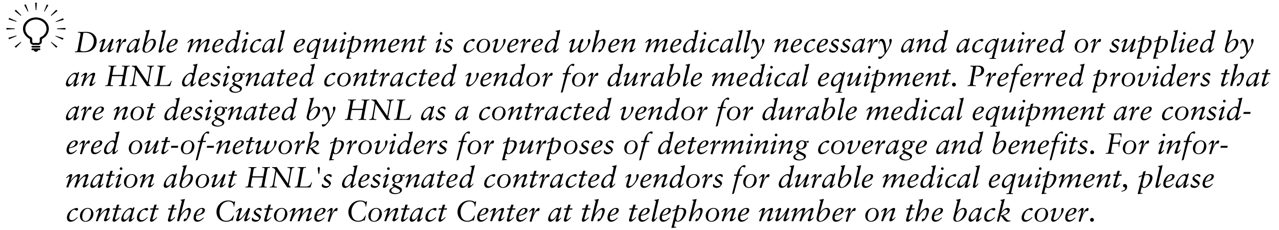
* *Preventive drugs and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the covered person. Preventive drugs are prescribed over-the-counter drugs or Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services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

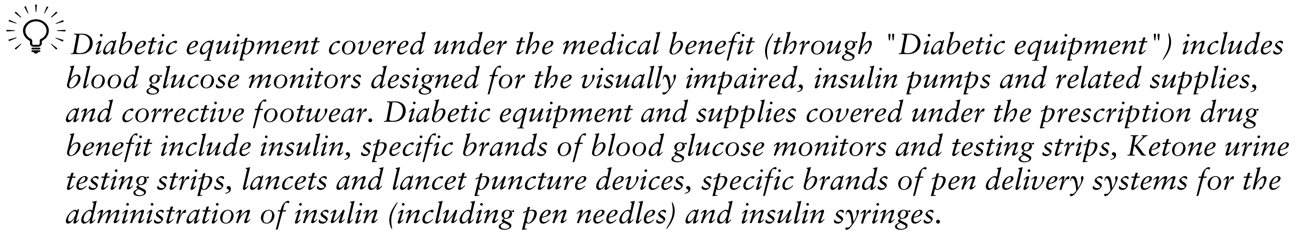
If a brand name drug is dispensed, and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand name drug. However, if a brand name drug is medically necessary and the physician obtains prior authorization from Health Net Life, then the brand name drug will be dispensed at no charge.

Medical supplies	PPO	OON
Durable medical equipment *	20%	50%
Diabetes education	20%	50%
Orthotics (such as bracing, supports and casts) *	20%	50%
Corrective footwear*	20%	50%
Diabetic equipment (See the "Prescription Drug Program" section of this SB for diabetic supplies benefit information)	20%	50%
Diabetic footwear	20%	50%

Prostheses* .... 20% 50%


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

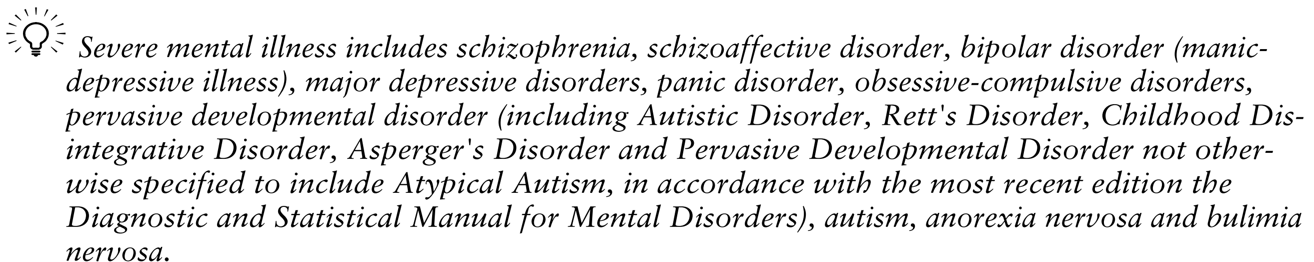

Durable medical equipment is covered when medically necessary and acquired or supplied by an HNL designated contracted vendor for durable medical equipment. Preferred providers that are not designated by HNL as a contracted vendor for durable medical equipment are considered out-of-network providers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


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

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

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

Mental disorders and chemical dependency benefits	PPO	OON


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

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

Severe Mental Illness and Serious Emotional Disturbances of a Child		
Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting) ◆	$20	50%
Outpatient professional consultation (psychological evaluation or therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day) ◆	$20	50%
Inpatient services*	20%	50%
Other Mental Disorders		
Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting) ◆	$20	50%
Inpatient services*	20%	50%
Chemical Dependency		
Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting) ◆	$20	50%
Inpatient services*	20%	50%
Acute detoxification*	20%	50%

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

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

Home Health Services	PPO	OON
Home health visits*	20%	50%
*Maximum visits per calendar year*ᛟ	*100*	*100*

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

ᛟ *Combined for PPO and out-of-network.*

Other services	PPO	OON
Sterilization - Vasectomy	20%	50%
Sterilization - Tubal ligation	Covered in full	Not covered
Blood, blood plasma, blood derivatives and blood factors **	20%	50%
Renal dialysis	20%	50%
Hospice services*	20%	50%
Infusion therapy (home or physician's office) *	20%	50%
Number of days for each supply of injectable prescription drugs and other substances, for each delivery	*14*	*14*

ᛟ *Combined for PPO and out-of-network.*

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

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

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

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

Infertility services	PPO	OON
Infertility services and supplies (all covered services that diagnose, evaluate or treat infertility)	20%	50%
Lifetime benefit maximum (applies to all covered infertility services, including oral infertility drugs)	$2000	$2000

Notes:

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

All calculations of the lifetime benefit maximum for Infertility services for each covered person are based on the total aggregate amount of benefits paid under this plan and all other Health Net or HNL plans sponsored by the same employer.

Chiropractic care	PPO	OON
Office visits*	$20	Not covered
Maximum visits per calendar year	12	*Not applicable*

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

Acupuncture care	PPO	OON
Office visits*	20%	50%
*Maximum visits per calendar year*ឱ	12	*12*

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

ឱ *Combined for PPO and out-of-network.*

Limits of coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- Air or ground ambulance and paramedic services that are not emergency care or which do not result in a patient's transportation will not be covered unless certification is obtained and services are medically necessary.
- Artificial insemination;
- Care for mental health care as a condition of parole or probation, or court-ordered treatment and testing for mental disorders, except when such services are medically necessary;
- Charges in excess of rate negotiated between any organization and the physician, hospital or other provider;
- Conception by medical procedures (IVF, GIFT and ZIFT);
- Conditions resulting from the release of nuclear energy when government funds are available;
- Corrective footwear is not covered unless medically necessary and custom made for the covered person or is a podiatric device to prevent or treat diabetes-related complications;
- Cosmetic services or supplies;
- Custodial or live-in care;
- Dental services. However, medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures are covered. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate;
- Disposable supplies for home use;
- Experimental or investigational procedures, except as set out under the "Clinical trials" and "If you have a disagreement with our insurance plan" sections of this SB;
- Genetic testing is not covered except when determined by Health Net Life to be medically necessary. The prescribing physician must request prior authorization for coverage;
- Hearing aids;
- Hearing examination (age 17 and older);
- Hypnosis;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder;
- Non-eligible institutions. This insurance plan only covers services or supplies provided by a legally operated hospital, Medicare-approved skilled nursing facility or other properly licensed facility as specified in the *Certificate*. Any institution, regardless of how it is designated, is not an eligible institution. Services or supplies provided by such institutions are not covered;
- Nontreatable disorders;
- Orthoptics (eye exercises);
- Orthotics (such as bracing, supports and casts) that are not custom made to fit the covered person's body. Refer to the "corrective footwear" bullet above for additional foot orthotic limitations;
- Outpatient prescriptions drugs or medications (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 covered person's treating physician and authorized by Health Net Life;
- Reversal of surgical sterilization;
- Routine foot care for treatment of corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes;
- Services and supplies determined not to be medically necessary as defined in the *Certificate*;
- Services and supplies not specifically listed in the plan's *Certificate* as covered expenses;
- Services and supplies that do not require payment in the absence of insurance;
- Services for an injury incurred in the commission (or attempted commission) of a crime unless the condition was an injury resulting from an act of domestic violence or an injury resulting from a medical condition;
- Services for conditions of pregnancy for a surrogate pregnancy are covered when the surrogate parent is the covered person under this HNL plan. However, when compensation is obtained for the surrogacy, Health Net Life shall have a lien on such compensation to recover its medical expense. A surrogate parent is a woman who agrees to become pregnant with the intent of surrendering custody of the child to another person;
- Services not related to a covered illness or injury, except as provided under preventive care and annual routine exams;
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the plan's *Certificate*;
- Services related to educational and 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 the jaw, unless medically necessary;
- Treatment of obesity, weight reduction or weight management, except for treatment of morbid obesity;
- Vision examination (age 17 and older).

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

Benefits and coverage

WHAT YOU PAY FOR SERVICES

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

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

- You must pay a deductible before the insurance plan begins to pay for covered services.
- You pay less when you receive care from doctors contracted with our PPO, since they have agreed in advance to provide services for a specific fee.
- When you receive care from out-of-network doctors and hospitals, you will be responsible for the applicable coinsurance, plus payment of any charges that are in excess of the covered expenses as defined in the *Certificate*.
- For some services, certification is necessary to receive full benefits. Please see the "Services requiring Certification" section of this brochure for details.
- To protect you from unusually high medical expenses, there is a maximum amount, or out-of-pocket maximum, that you will be responsible for paying in any given year. Once you have paid this amount, the insurance plan will pay 100% of covered expenses. (There are exceptions, see the *Certificate* for details.)

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

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

NOTICE OF REQUIRED COVERAGE

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

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

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

SERVICES REQUIRING CERTIFICATION[1]

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

Services that require certification include:

All inpatient admissions, any facility:

- Acute rehabilitation center
- Chemical dependency care facility
- Hospice
- Hospital
- Mental health facility
- Skilled nursing facility

Ambulance

Non-emergency air or ground ambulance services

Chondrocyte implants

Cochlear implants

Clinical trials

Custom orthotics

Durable medical equipment:

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

Experimental/investigational services and new technologies.

Genetic testing

Home Health Care Services including home uterine monitoring, hospice, nursing, occupational therapy, physical therapy, speech therapy, and tocolytic services.

Neuro or spinal cord stimulator

Occupational and speech therapy.

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

Outpatient Diagnostic Procedures:

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

Outpatient pharmaceuticals

- Self-injectables
- Hemophilia factors and intravenous immunoglobulin (IVIG)
- Certain physician-administered drugs, whether administered in a physician office, free-standing infusion center, outpatient surgery center, outpatient dialysis center, or outpatient hospital. Refer to the Health Net Life website, www.healthnet.com, for a list of physician-administered drugs that require Certification.

Outpatient physical, chiropractic care and acupuncture (exceeding 12 visits), subject to any benefit limitations stated in the "Schedule of benefits and coverage" section.

Outpatient surgical procedures including:

- Bariatric procedures
- Blepharoplasty
- Breast reductions and augmentations
- Mastectomy (including lumpectomy) for gynecomastia
- Orthognathic procedures (including TMJ treatment)
- Rhinoplasty
- Septoplasty
- Treatment of varicose veins
- Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
- Reconstructive surgery for medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

Prosthesis and orthotics over $2,500 in billed charges.

Radiation therapy

- Intensity modulated radiation therapy (IMRT)
- Proton beam therapy

Stereotactic radiosurgery and stereotactic body radiotherapy (SBRT).

X-Stop

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

COVERAGE FOR NEWBORNS

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

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

EMERGENCIES

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

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

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

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

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

MEDICALLY NECESSARY CARE

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

CLINICAL TRIALS

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

CONTINUITY OF CARE

If our contract with a PPO health care provider is terminated, you may be able to elect continued care by that provider if you are receiving care for an acute condition, serious chronic condition, pregnancy, new born, terminal illness or scheduled surgery. If you would like more information on how to request continued care, please call the Customer Contact Center at the telephone number listed on the back cover.

EXTENSION OF BENEFITS

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

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

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

OUT OF STATE PROVIDERS

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

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

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

CONFIDENTIALITY AND RELEASE OF COVERED PERSON INFORMATION

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

PRIVACY PRACTICES

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

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

TECHNOLOGY ASSESSMENT

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

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

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

Utilization management

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

PRIOR CERTIFICATION

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

CONCURRENT REVIEW

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

DISCHARGE PLANNING

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

RETROSPECTIVE REVIEW

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

CARE OF CASE MANAGEMENT

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

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

Payment of premiums and charges

YOUR COINSURANCE, COPAYMENT AND DEDUCTIBLES

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

PREPAYMENT OF PREMIUMS

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

OTHER CHARGES

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

When the total amount of deductibles, copayments and coinsurance you pay equals the annual out-of-pocket maximum amount shown in the "Schedule of benefits and coverage" section, you will not have to pay additional copayments or coinsurance for the rest of the year for most services provided, unless your doctor charges an amount that Health Net Life considers to be in excess of covered expenses. Additionally, deductibles, coinsurance and copayments for any covered supplemental benefits purchased by your employer, such as prescription drugs (with the exception of copayments for diabetic supplies) or vision care will also not be applied to the limit, as well as:

- Charges applied to the calendar year deductible;
- Charges applied to the infertility deductible;
- Charges in excess of covered expenses;
- Charges for services or supplies not covered by this insurance plan;
- Services for which certification was required but not obtained.

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

CONTRACTED RATE

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

MAXIMUM ALLOWABLE AMOUNT

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

- Maximum allowable amount for physician services is determined by applying a designated percentile from the database of physician charges from the FAIR Health RV Benchmarks or a similar type of database of physician charges.
- For all other types of services, Maximum Allowable Amount is determined by applying a percentage of what Medicare would allow (known as the Medicare allowable amount). The Maximum Allowable Amount for such services is 190% of the Medicare allowable amount.
- In the event the applicable service or database does not include an amount for the service or supply provided, maximum allowable amount shall be deemed to be 75% of the covered charges billed by the provider for the same services or supplies. The maximum allowable amount determined under the databases described above may be more or less than 75% of the amount normally charged by the provider for the same services or supplies.
- The maximum allowable amount may also be subject to other limitations on Covered Expenses. See the insurance plan's *Certificate* under "Schedule of Benefits," "Plan Benefits" and "General Limitations and Exclusions" sections for specific benefit limitations, maximums, pre-certification requirements and payment policies that limit the amount HNL pays for certain covered services and supplies. HNL uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement.

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

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

In the event that the billed charges for the out-of-network provider are more than the maximum allowable amount, you are responsible for any amounts charged in excess of the maximum allowable amount, except where the out-of-network provider's fee is determined by reference to a Third Party

Network agreement or the out-of-network provider agrees to a negotiated maximum allowable amount.

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

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

LIABILITY OF ENROLLEE FOR PAYMENT

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

REIMBURSEMENT PROVISIONS

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

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

How to file a claim:

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

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

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

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

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

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

Renewing, continuing or ending coverage

RENEWAL PROVISIONS

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

INDIVIDUAL CONTINUATION OF BENEFITS

Please examine your options carefully before declining coverage.

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

- **COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985).** For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside of California. Please check with your group to determine if you and your covered dependents are eligible.
- **Cal-COBRA Continuation Coverage.** If you have exhausted COBRA and you live in the United States, you may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if you have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage and you are not entitled to Medicare. If you are eligible, you have the opportunity to continue group coverage under the *Certificate* through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.

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

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

TERMINATION OF BENEFITS

Your coverage under this insurance plan ends when:

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

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

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

- You apply for conversion coverage within 63 days of that date; or
- You are totally disabled and apply for an extension of benefits for the disabling condition within 90 days.

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

If you have a disagreement with our insurance plan

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

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

California Department of Insurance
Office of the Ombudsman
300 South Spring Street
South Tower
Los Angeles, CA 90013
1-800-927-HELP or 1-800-927-4357
www.insurance.gov

GRIEVANCE AND APPEALS PROCESS

If you are dissatisfied with the quality of care that you have received or feel that you have been incorrectly denied a service or claim, you may file a grievance or appeal. You must file your grievance or appeal with HNL within 365 calendar days following the date of the incident or action that caused your grievance.

How to file a grievance or appeal:

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

You may also write to:

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

Please include all the information from your Health Net Life identification card as well as the details of your concern or problem. Health Net Life will acknowledge your grievance or appeal within five calendar days, review the information and tell you of our decision in writing within 15 days of receiving the grievance if the grievance pertains to a claims dispute or within 30 days of receiving the grievance for all other grievances. 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 Life will notify you of the status of your grievance no later than three days from receipt of all the required information.

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

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

ARBITRATION

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

Additional insurance plan benefit information

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

Prescription drug program

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

PRESCRIPTIONS BY MAIL DRUG PROGRAM

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

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

THE HEALTH NET RECOMMENDED DRUG LIST

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

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

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

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

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

WHAT IS "PRIOR AUTHORIZATION?"

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

How to request prior authorization:

Requests for prior authorization may be submitted by telephone or facsimile. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 72 hours, after Health Net Life's receipt of the request and any additional information requested by Health Net Life that is reasonably necessary to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 5 days, as appropriate and medically necessary, for the nature of the covered person's condition after Health Net Life's receipt of the information reasonably necessary and requested by Health Net Life to make the determination. Upon receiving your physician's request for prior authorization, Health Net Life will evaluate the information submitted and make a determination based on established clinical criteria for the particular medication.

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

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

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

To submit an appeal:

a. • Call the Customer Contact Center at the telephone number listed on the back cover
b. • Visit www.healthnet.com for information on e-mailing the Customer Contact Center; or
c. • Write to: Health Net Life
Customer Contact Center
P.O. Box 10196
Van Nuys, CA 91410-0348

WHAT'S COVERED

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

This insurance plan covers the following:

- Level I drugs listed on the Recommended Drug List (primarily generic);
- Level II drugs listed on the Recommended Drug List (primarily brand name) and diabetic supplies (including insulin); and
- Level III drugs listed on the Recommended Drug List (or drugs that are not listed on the Recommended Drug List).
- Preventive drugs and women's contraceptives
- Specialty Drugs
  Specialty Drugs listed in the Health Net Recommended Drug List are covered when prior authorization is obtained from HNL and the drugs are dispensed through HNL's Specialty Pharmacy Vendor. These drugs include self-administered injectable and other drugs that have significantly higher cost than traditional pharmacy benefit drugs. Please note that needles and syringes required to administer the self-injected medications are covered only when obtained through the Specialty Pharmacy Vendor.

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

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

MORE INFORMATION ABOUT DRUGS THAT WE COVER

- Prescription drug covered expenses are the lesser of Health Net Life's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs;
- If a prescription drug deductible (per covered person each calendar year) applies, you must pay this amount for prescription drug covered expenses before Health Net Life begins to pay. Diabetic supplies, preventive drugs and women's contraceptives are not subject to the deductible. After the deductible is met the copayments or coinsurance amounts apply;
- Prescription drug refills are covered, up to a 30-consecutive-day supply per prescription at a Health Net Life contracted pharmacy for one copayment;
- If the pharmacy's retail price is less than the applicable copayment, the covered person will only pay the pharmacy's retail price;
- Mail order drugs are covered up to a 90-consecutive-calendar-day supply. When the retail pharmacy copayment is a percentage, the mail order copayment is the same percentage of the cost to Health Net Life as the retail pharmacy copayment;
- Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over-the-counter or are only available with a prescription. Vaginal, oral, transdermal and emergency contraceptives are covered under this pharmacy benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit. Refer to the plan's Certificate for more information.
- Diabetic supplies (blood glucose testing strips, lancets, needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (that is, opened in order to dispense the product in quantities other than those packaged). When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times

your physician has prescribed for a 30-day period. For more information about diabetic equipment and supplies, please see "Endnotes" in the "Schedule of benefits and coverage" section of this SB.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

Services or supplies excluded under pharmacy services may be covered under the medical benefits portion of your insurance plan. In addition to the exclusion and limitations listed below, prescription drug benefits are subject to the insurance plan's general exclusions and limitations. Consult your insurance plan's Certificate 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;
- Coverage for devices is limited to FDA approved vaginal contraceptive devices, peak flow meters, spacer inhalers and diabetic supplies. No other devices are covered;
- Drugs that are appetite suppressants or are indicated for and prescribed for body weight reduction;
- Drug products that help you reduce or quit smoking or for nicotine addiction (for example, nicotine patches);
- Drugs or medicines administered by a physician or physician's staff member;
- Drugs prescribed to shorten the duration of the common cold;
- Drugs (including self-injectable medications) prescribed for the treatment of sexual dysfunction are not covered;
- Drugs prescribed for a condition or treatment not covered by this insurance plan are not covered. However, the insurance plan does cover drugs for medical conditions that result from nonroutine complications of a noncovered service.
- Drugs prescribed for routine dental treatment;
- Drugs used for diagnostic purposes;
- Experimental drugs (those that are labeled "Caution - Limited by Federal Law to investigational use only"). If you are denied coverage of a drug because the drug is investigational or experimental you will have a right to independent medical review. See "If you have a disagreement with our insurance plan" section of this SB for additional information;
- Hypodermic needles or syringes, except for specific brands of disposable insulin needles and syringes and specific brands of pen devices.
- 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;
- Irrigation solutions and saline solutions;
- Limits on quantity, dosage and treatment duration may apply to some drugs. Medications taken on an "as-needed" basis may have a copayment based on a standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If medically necessary, your physician may request a larger quantity from Health Net Life;
- Medical equipment and supplies (including insulin), that are available without a prescription are covered when prescribed by a physician for the management and treatment of diabetes, or for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations or for female contraception as approved by the FDA. Any other nonprescription drug, medical equipment or supply that can be purchased without a prescription drug order is not cov-

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

- Prescription drugs prescribed by an unlicensed physician;
- Replacement of lost, stolen or damaged medications;
- Services or supplies which are covered in full or for which you are not legally required to pay;
- Supply amounts for prescriptions that exceed the FDA's or Health Net Life's indicated usage recommendation are not covered unless Medically Necessary and prior authorization is obtained from Health Net Life;

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

Notice of language services

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or please call 800-522-0088. PPO members: for more help call the CA Dept. of Insurance at 1-800-927-4357. HMO members: call the DMHC Helpline at 1-888-HMO-2219.
English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o llame al 800-522-0088. Afiliados a PPO: para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Afiliados a HMO: llame a la Línea de Ayuda del Departamento de Atención Médica Administrada de California (DMHC, por sus siglas en inglés) 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。如需協助，請撥您會員卡所列的電話號碼或撥 800-522-0088 與我們聯絡。PPO 會員：如需其他協助，請致電 CA 保險局，電話 1-800-927-4357。HMO 會員：請撥 DMHC 協助專線 1-888-HMO-2219。
Chinese

Dịch vụ ngôn ngữ miễn phí. Quý vị có thể được cấp thông dịch viên. Quý vị có thể được cấp người đọc văn bản cho quý vị hoặc nhận tài liệu, văn bản bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi cho chúng tôi tại số điện thoại trên thẻ hội viên của quý vị hoặc gọi số 800-522-0088. Hội viên chương trình PPO: Để được trợ giúp thêm, vui lòng gọi cho Sở Bảo hiểm CA tại số 1-800-927-4357. Hội viên chương trình HMO: xin gọi Đường dây trợ giúp của Sở DMHC tại 1-888-HMO-2219.
Vietnamese

무료 언어 지원 서비스. 귀하는 통역사 서비스를 받으실 수 있습니다. 본인에게 편한 언어로 서류 낭독 서비스 및 번역 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상의 안내번호로 전화하시거나 800-522-0088 번으로 연락해 주십시오. PPO 가입자: 더 많은 도움이 필요하신 분은 캘리포니아 보험 담당국, 안내번호 1-800-927-4357 번으로 문의하십시오. HMO 가입자: DMHC 헬프라인, 안내번호 1-888-HMO-2219 번으로 문의해 주십시오.
Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin. Maaari mong ipabasa sa iyo ang mga dokumento, at maaaring ipadala sa iyo ang ilan sa mga ito sa iyong wika. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o kaya mangyaring tumawag sa 800-522-0088. Para sa PPO members: para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Para sa HMO members: tawagan ang DMHC Helpline sa 1-888-HMO-2219.
Tagalog

Անվճար Լեզվական Ծառայություններ: Կարող եք թարգմանիչ ստանալ: Փաստաթղթերը կարող են ձեզ համար ընթերցվել կամ ձեզ ուղարկվել ձեր լեզվով: Օգնության համար զանգահարեք մեզ ձեր ինքնության (ID) տոմսի վրա նշված համարով կամ խնդրում ենք զանգահարել 800-522-0088 համարով: PPO անդամներ՝ լրացուցիչ օգնության համար զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք (CA Dept. of Insurance) 1-800-927-4357 համարով: HMO անդամներ՝ զանգահարեք DMHC-ի Օգնության գծին՝ 1-888-HMO-2219 համարով:
Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика. Вам могут прочесть ваши документы, а также выслать вам некоторые из них на вашем языке. Для получения помощи звоните нам по номеру телефона, указанному в вашей карточке-удостоверении, или по номеру 800-522-0088. Просим участников плана PPO для получения дополнительной помощи звонить в Министерство страхования (Department of Insurance) штата Калифорния по номеру 1-800-927-4357. Участников организаций медицинского обслуживания (HMO) просим обращаться в телефонную службу помощи Департамента организованного медицинского обслуживания (DMHC) по телефону 1-888-HMO-2219.
Russian

無料の言語サービス。通訳がご利用になれ、書類を日本語でお読みします。また、書類によっては日本語版をお届けできるものもあります。サービスをご希望の方は、IDカード記載の番号または 800-522-0088 までご連絡ください。PPO加入者: その他の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加入者: DMHCヘルプライン、1-888-HMO-2219 までご連絡ください。
Japanese

خدمات بی هزینه مربوط به زبان. می توانید از خدمات یک مترجم شفاهی برخوردار شوید. می توانید بگوئید تا نوشته ها به زبان خودتان برایتان خوانده شده و بعضی از آنها به زبان خودتان برایتان ارسال شوند. برای دریافت کردن کمک، به ما به شماره ای که روی کارت هویتتان قید شده است تلفن کنید و یا با شماره 800-522-0088 تماس بگیرید. اعضاء PPO: برای دریافت کمک بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. اعضاء HMO : با خط تلفنی کمکی DMHC به شماره 1-888-HMO-2219 تماس بگیرید.
Farsi

ਭਾਸ਼ਾ ਦੀਆਂ ਮੁਫਤ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ। ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ ਅਤੇ ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਕਿਸੇ ਵੀ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ ਕਿਰਪਾ ਕਰਕੇ 800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। PPO ਮੈਂਬਰ: ਹੋਰ ਸਹਾਇਤਾ ਲਈ CA ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। HMO ਮੈਂਬਰ: DMHC ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ।
Punjabi

ការបកប្រែភាសាដោយឥតអស់ថ្លៃ។ អ្នកអាចទទួលជំនួយពីអ្នកបកប្រែបាន។ អ្នកអាចឲ្យគេអានឯកសារជូនអ្នក និងផ្ញើឯកសារខ្លះ ទៅឲ្យអ្នក ជាភាសាខ្មែរបាន។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខដែលមានកត់នៅលើប័ណ្ណ ID របស់អ្នក ឬសូមទូរស័ព្ទ ទៅលេខ 800-522-0088។ សមាជិក PPO: សំរាប់ជំនួយបន្ថែម សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357។ សមាជិក HMO: សូមទូរស័ព្ទទៅខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219។
Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم. يمكنك طلب قراءة وثائق وإرسال بعضها إليك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك (ID) أو رجاء الاتصال بالرقم 800-522-0088. أعضاء PPO: للحصول على المساعدة الإضافية يمكنهم الاتصال بـ CA Dept. of Insurance على الرقم 1-800-927-4357. أعضاء برنامج HMO: يمكنهم الاتصال بخط المساعدة التابع لـ DMHC بواسطة الرقم 1-888-HMO-2219.
Arabic

Kev Pab Lus Tsis Muaj Nqi Them. Koj txais tau tus neeg txhais lus. Koj muab tau cov ntawv nyeem rau koj thiab ib co xa tuaj rau koj ua koj hom lus. Kom tau kev pab, hu rau peb ntawm tus xovtooj sau rau koj daim npav ID lossis thov hu 800-522-0088. Cov tswv cuab PPO: kom tau kev pab ntxiv hu rau lub CA Dept. of Insurance ntawm 1-800-927-4357. Cov tswv cuab HMO: hu rau lub DMHC Helpline ntawm 1-888-HMO-2219.
Hmong

Doo bąąh hiliní da hazaad bee haká'adoowołgo. Ata' halne'é ła' áka'adoolwołígíí jóki'. Naaltsoos binahjį' éé dahózinígíí hach'į' yíidooltah áádóó ła' hach'į' adoolyįįł t'áá hó hazaad k'ehjí. Aká'adoowoł biniiyé, nihich'į' hódíílnih béésh bee hane'é binumber bee néé hó'dolzin biniiyé nanitinígíí bikáá' éí doodaií kojį' hodíílnih 800-522-0088. PPO atah jiljįgo: t'áá náás bee shiká'anáá'doowoł ninizingo kojį' hodíílnih CA Dept of Insurancejį' éí 1-800-927-4357. HMO atah jiljįgo: kojį' hodíílnih DMHC béésh bee hane'é bee aká'a'áyeedjį' éí 1-888-HMO-2219.
Navajo

Contact us

Health Net
Post Office Box 9103
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

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