HMO 40 Conversion Plan
Summary of Benefits

Health coverage made easy

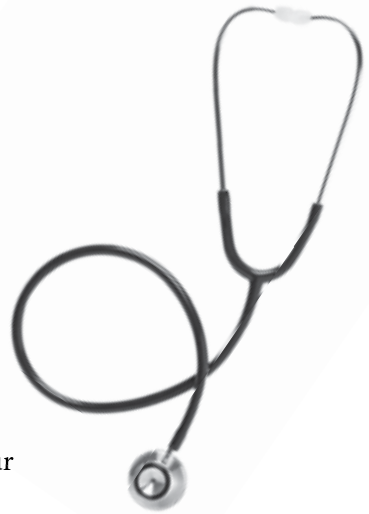
Effective October 2013

Jesus Hao
Health Net

California's Assembly Bill 1180 ends the requirement to offer enrollment in this HMO 40 Conversion plan, effective January 1, 2014. If you choose to enroll in this conversion plan, your coverage will commence on the effective date set forth in the Notice of Acceptance, and will remain in effect through December 31, 2013. On midnight, December 31, 2013, your coverage will be terminated. To ensure you have health coverage effective January 1, 2014, you must apply for other coverage.

Health Net®

Health Net Conversion Plan



Coverage under this nongroup plan is available to members who lose coverage under Health Net group plans, continue to live within the Health Net service area and meet the eligibility of this plan as described later in this guide.

Application for coverage under the Conversion Plan and the first month's payment must be made to Health Net within 63 days after the last day of coverage under a Health Net group plan. Coverage will commence immediately at the end of coverage under the prior Health Net group plan, and subscription charges must be paid to ensure that coverage is continuous. There can be no lapse or break in coverage. There are certain copayment charges that you will be required to pay at the time of service. In addition, the level of benefits and copayments will not be the same as under your Health Net group plan. Please refer to the Principal Benefits and Coverage Matrix in this disclosure form.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

How to enroll

We have enclosed an enrollment application in the enrollment packet. If the form is not included, please contact the Eligibility Department at 1-800-977-2207. Then, just complete the enrollment form and mail it to Health Net at:

Health Net Conversion Plan
PO Box 1150
Rancho Cordova, CA 95741-9847

Also include a check or money order for the first month of coverage. We must receive the application and your initial payment within 63 days of the last day of coverage under your previous Health Net group health plan.

If you have questions, call the Customer Contact Center at 1-800-522-0088.
TTY/TDD users should call 1-800-995-0852.

This document is only a summary of your health coverage. You have the right to view the plan's Plan Contract and Evidence of Coverage (EOC) prior to enrollment. To obtain a copy of this document, contact Health Net's Customer Contact Center at 1-800-522-0088. The plan's Plan Contract and EOC, which you will receive after you enroll, contains the terms and conditions, as well as the governing and exact contractual provisions, of your Health Net coverage. It is important for you to carefully read this document and the plan's Plan Contract and EOC thoroughly once received, especially all sections that apply to those with special health care needs. Health benefits and coverage matrices on pages 4–6 are included to help you compare coverage benefits.

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

If you have additional questions about this plan and would like to speak with a Health Net representative about your coverage options, please contact Health Net at 1-800-977-2207.

How *the Plan Works*

Health Net requires the designation of a primary care physician (PCP). A PCP provides and coordinates your medical care. You have the right to designate any PCP who participates in our Health Net HMO network and who is available to accept you or your family members, subject to the requirements of the physician group. For children, a pediatrician may be designated as the PCP. Until you make your primary care physician designation, Health Net designates one for you. For information about how to select a PCP and for a list of the participating PCPs, refer to your Health Net HMO Directory. The Health Net HMO Directory is also available on the Health Net website at **www.healthnet.com**. Your PCP oversees all your health care and provides the referral/authorization if specialty care is needed. PCPs include general and family practitioners, internists, pediatricians and OB/GYNs. A PCP's office is just like any other private doctor's office. When you need to see your doctor, just call for an appointment. To obtain health care, simply present your ID card and pay the appropriate copayment.

Your PCP must first be contacted for initial treatment and consultation before you receive any care or treatment through a hospital, specialist or other health care provider, except for OB/GYN visits, as explained in the next paragraph below. All treatments recommended by such providers must be authorized by your PCP.

You do not need prior authorization from Health Net or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, refer to your Health Net HMO Directory. The Health Net HMO Directory is also available on the Health Net website at www.healthnet.com. Refer to the "Mental Health and Chemical Dependency Services" section later in this guide for information about receiving care for mental disorders and chemical dependency.

Each member of your family may select a different PCP. Health Net requires that you and your enrolled family members select a PCP whose office is located within a 30-mile radius of your (or your respective family member's) residence or office. If you don't choose a doctor when you complete your enrollment application, we'll assign one to you based on your residential ZIP code. If you need help in selecting a doctor, give us a call at 1-800-522-0088.

Timely Access to Non-Emergency Health Care *Services*

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

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

Out-of-Pocket *Maximum*

See the "Principal Benefits and Coverage Matrix – Conversion Plan" section for specific information about the out-of-pocket maximum and deductibles for the Conversion Plan. The copayments and the calendar year inpatient hospital services deductible that you or your family members pay for covered services and supplies apply toward the individual or family out-of-pocket maximum. After you or your family members meet your individual or family out-of-pocket maximum, you pay no additional amounts for covered services and supplies for the balance of the calendar year, except as otherwise noted. Once an individual member in a family satisfies the individual out-of-pocket maximum, the remaining enrolled family members must continue to pay the copayments and the calendar year deductible for inpatient hospital facility services until either (a) the aggregate of such copayments and deductibles paid by the family reaches the family out-of-pocket maximum, or (b) each enrolled family member individually satisfies the individual out-of-pocket maximum. You are responsible for all charges related to services and supplies not covered by the health plan. Amounts that are paid toward certain covered services and supplies are not applicable to a member's out-of-pocket maximum. See the "Principal Benefits and Coverage Matrix – Conversion Plan" section for specific information about which amounts do not apply toward the out-of-pocket maximum. Payments for services and supplies not covered by this plan will not be applied to this yearly out-of-pocket maximum. In order for the family out-of-pocket maximum to apply, you and your family must be enrolled as a family unit.

Principal Benefits and Coverage Matrix – Conversion Plan

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The plan contract and EOC should be consulted for a detailed description of coverage benefits and limitations.

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

Benefit description	*HMO 40*
Deductibles	$1,500 per calendar year for inpatient hospital services only (prescription drug coverage deductible also applies[1,9])
Lifetime maximums	Unlimited
Out-of-pocket maximum (Payments for services not covered by this plan will not be applied to this yearly out-of-pocket maximum.)	$3,000 single / $6,000 family
Professional services Visit to physician	$40
Specialist consultations	$40
Prenatal and postnatal office visits[2]	$40
Preventive care Preventive care services[3]	Covered in full
Vision exams (for diagnosis or treatment)	$40
Hearing exams (for diagnosis or treatment)	$40
Immunizations – non-preventive care[4]	$40
Immunizations – to meet foreign travel or occupational requirements	20%
Prostate cancer screening and exam	Covered in full
Well-woman exam (breast and pelvic exams, cervical cancer screening and mammography)[5]	Covered in full
Allergy testing	$40
Allergy injection services	$40
All other injections – including self-administered injectable medications[6]	Covered in full
Allergy serum	Covered in full
Outpatient facility services Outpatient services (other than surgery)	Covered in full
Outpatient surgery	$250
Hospitalization services Semiprivate hospital room or special care unit with ancillary services (unlimited, except for nonsevere mental disorders and chemical dependency treatment)	$1,500 deductible applies per calendar year for inpatient services
Surgeon or assistant surgeon services	Covered in full
Skilled nursing facility stay (limited to 100 days per calendar year)	$50 per day
Maternity care in hospital or skilled nursing facility	$0 after inpatient hospital deductible is met

Benefit description	*HMO 40*
Physician visit to hospital or skilled nursing facility (excluding care for substance abuse and mental disorders)	Covered in full
Emergency health coverage Emergency room (professional and facility charges)	$100 (waived if admitted to hospital)
Urgent care center (professional and facility charges)	$40
Ambulance services Ground ambulance	$80
Air ambulance	$80
Prescription drug coverage[7,8,9,10] Prescription drugs filled at a participating pharmacy (up to a 30-day supply)[1]	$100 calendar year deductible per person, then $15 Level I (primarily generic) $25 Level II (primarily brand-name, peak flow meters, inhaler spacers and diabetic supplies, including insulin) $50 Level III drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)
Prescription drugs filled through mail order (up to a 90-day supply)[1]	$100 calendar year deductible per person, then $30 Level I (primarily generic) $50 Level II (primarily brand-name and diabetic supplies, including insulin) $100 Level III drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)
Smoking cessation drugs (covered up to a 12-week course of therapy per calendar year if you are concurrently enrolled in a comprehensive smoking cessation behavioral modification support program. For information regarding smoking cessation behavioral modification support programs available through Health Net, contact the Customer Contact Center at the telephone number on the back of your Health Net ID card, or visit the Health Net website at www.healthnet.com.)[1]	50%
Preventive drugs and women's contraceptives[11]	Covered in full
Durable medical equipment (including nebulizers, face masks and tubing for the treatment of asthma) Durable medical equipment	50%
Prostheses[10]	Covered in full
Mental Health services (Severe mental illness and serious emotional disturbances of a child[12]) Outpatient professional consultation	$40
Inpatient services	Covered in full
Outpatient professional consultation (psychological evaluation or therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day)	$40
Other mental disorders[12] Outpatient professional consultation	$40 (limited to 20 visits per calendar year)
Inpatient services	Covered in full (limited to 30 days per calendar year)
Chemical dependency Chemical dependency treatment	Not covered
Acute care (detoxification)	$100 per day (unlimited)
Home health services Home health services (100 visits per calendar year maximum; limited to three visits per day, four-hour maximum per visit)	$40
Other Diabetic equipment (includes blood glucose monitors, insulin pumps and corrective footwear)[10]	$25
Laboratory procedures and diagnostic imaging (including X-ray) services	Covered in full

Benefit description	*HMO 40*
Rehabilitative therapy (includes physical, speech, occupational and respiratory therapy)	$40
Sterilizations – vasectomy	$150
Sterilizations – tubal ligation[13]	Covered in full
Organ and stem cell transplants (non-experimental and non-investigational)	Covered in full
Hospice services	Covered in full

HMO footnotes

[1]Does not apply to the out-of-pocket maximum, except copayments for peak flow meters, inhaler spacers used for the treatment of asthma, and diabetic supplies.

[2]Prenatal, postnatal and newborn care office visits for preventive care are covered in full. See copayment listing for "Preventive care services." If the primary purpose of the office visit is unrelated to a preventive service, or if other nonpreventive services are received during the same office visit, the above copayment will apply for the nonpreventive services.

[3]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 Centers for Disease Control and Prevention, and 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 member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it. Breast pumps can be obtained by calling the Customer Contact Center at the phone number listed on the back cover of this booklet.

[4]Immunizations that are part of preventive care services are covered under "Preventive care services" in this section.

[5]Women may obtain OB/GYN physician services in their primary care physician's physician group for OB/GYN preventive care, pregnancy and gynecological ailments without first contacting their primary care physician. Mammograms are covered at the following intervals: one for ages 35–39, one every 24 months for ages 40–49, and one every year for age 50 and older.

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

[7]The Health Net Recommended Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net-contracted physicians and participating pharmacies. Some drugs on the List may require prior authorization from Health Net. Drugs that are not listed on the List (previously known as non-formulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the List do require prior authorization from Health Net. Health Net will approve a drug not on the List at the brand-name copayment if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 72 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 5 days, as appropriate and medically necessary, for the nature of the member's condition after Health Net's receipt of the information which is reasonably necessary and requested by Health Net to make the determination. For a copy of the Recommended Drug List, call the Customer Contact Center at the number listed on your ID card or visit our website at www.healthnet.com.

[8]If the pharmacy's retail price is less than the applicable copayment, you will only pay the pharmacy's retail price.

[9]The prescription drug calendar year deductible (per member) must be paid for prescription drug-covered services before Health Net begins to pay. The prescription drug deductible does not apply to peak flow meters, inhaler spacers used for the treatment of asthma, diabetic supplies and equipment dispensed through a participating pharmacy and preventive drugs and women's contraceptives. Prescription drug-covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.

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

[11]Preventive drugs and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the member, and are not subject to the deductible. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over the counter or are only available with a prescription. If a brand-name drug is dispensed and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand-name drug. However, if a brand-name drug is medically necessary and the physician obtains prior authorization from Health Net, then the brand-name drug will be dispensed at no charge. Vaginal, oral, transdermal, and emergency contraceptives are covered under the prescription drug benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit.

[12]Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services. See page 12 for definitions of severe mental illness or serious emotional disturbances of a child.

[13]Sterilization of females and women's contraception methods and counseling, as supported by HRSA guidelines, are covered under "Preventive care services" in this section.

Important *Things to Know*

Who is eligible?

The covered services and supplies of this plan are available to the following people as long as they live or work in the Health Net Service Area and meet any additional eligibility requirements of this Plan Contract.

Subscriber

An employee or member whose coverage under a Health Net group contract has been terminated by an employer is eligible to elect coverage under this plan if he or she applies for this plan and makes the first premium payment no later than 63 days after termination from the group. However, this plan is not available to such employee or member if:

- the group contract terminated and is replaced with similar coverage under another contract within 15 days of the date of termination of group coverage or the subscriber's participation;
- coverage was terminated because the employee or member failed to pay amounts due the plan;
- the employee or member was terminated for good cause as set forth in the EOC;
- the employee or member knowingly furnished incorrect information or otherwise improperly obtained benefits of the plan;
- the employer's insurance coverage is self-insured;
- the employee or member is covered or eligible for benefits under Title XVIII of the United States Social Security Act;
- the employee or member is covered by or eligible for hospital, medical or surgical benefits under any arrangement of coverage for individuals in a group, whether insured or self-insured;
- the employee or member is covered for similar benefits under an individual contract or policy; or
- the employee or member has not been continuously covered during the three-month period immediately preceding termination of coverage.

Spouse upon termination of marriage or domestic partnership

In the event the spouse of a subscriber loses coverage under a group plan due to termination of marriage or domestic partnership, the spouse may elect coverage for himself or herself only.

Spouse and children upon death of subscriber

Since both the spouse and children lose eligibility under a group plan when the subscriber dies, the surviving spouse may elect coverage for himself or herself and the children. All persons covered under the group plan need not be included in the election, but the surviving spouse must be included. If there is no surviving spouse, the children may elect Conversion coverage, or an adult guardian may elect it for them.

Child upon loss of coverage due to ineligibility as a dependent

In the event a child loses his or her coverage due to no longer meeting the eligibility rules of the group plan, such as reaching a limiting age, he or she may elect coverage for himself or herself only. In the event of the death of the subscriber, if there is no surviving spouse, the

children may elect Conversion coverage, or an adult guardian may elect it for them.

Eligible dependents

Subscribers who enroll in this plan may also apply to enroll family members who satisfy the dependent eligibility requirements for enrollment as dependents. To be eligible to enroll as a dependent in this plan, the subscriber's family members must have been covered under the Health Net group contract on the date of the subscriber's coverage termination from the group. The following types of dependents describe those family members who may apply for enrollment as a dependent in this plan:

- **Spouse:** The subscriber's lawful spouse.
- **Children:** The children of the subscriber or his or her spouse (including legally adopted children and stepchildren). Each child is eligible to apply for enrollment as a dependent until the age of 26 (the limiting age).
- **Disabled child:** A child who is over the age limit shown above is eligible for coverage as a dependent if the following conditions apply: (a) the child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; and (b) the child is chiefly dependent upon the subscriber for support and maintenance.
- **Wards:** Children for whom the subscriber or his or her spouse is the court-appointed guardian.
- **Domestic Partner:** A person eligible for coverage as a dependent provided that the partnership with the principal covered person meets all domestic partnership requirements specified by section 297 or 299.2 of the California Family Code.

Children of the subscriber or spouse who are the subject of a Medical Child Support Order, according to state or federal law, are eligible even if they live outside the Health Net Service Area. Coverage of care received outside the Health Net Service Area will be limited to services provided in connection with emergency care or urgently needed care.

When does coverage end?

You must notify Health Net of changes that will affect your eligibility, including no longer residing in the Health Net HMO Service Area. You should direct any such correspondence to us at: Health Net Conversion Plan, PO Box 1150, Rancho Cordova, California 95741-9847.

Individual members

Individual members become ineligible on the date any of the following occurs:

- The Member no longer meets the eligibility requirements established by the plan. This will include a child subject to a Medical Child Support Order, according to state or federal law, who becomes ineligible on the earlier of: (1) the date established by the order, or (2) the date the order expired.
- The Member establishes primary residency outside the Health Net Service Area and does not work inside the Health Net Service Area. However, a child subject to a Medical Child Support Order, according to state or federal law, who moves out of the Health Net Service Area does not cease to be eligible for this plan. But, while that child may continue to be enrolled, coverage of care received outside the Health Net Service Area will be limited to services provided in connection with emergency care or urgently needed care.

  Follow-up care, routine care and all other benefits of this plan are covered only when

authorized by the contracting physician group (medical) or the Behavioral Health Administrator (Mental Disorders and Chemical Dependency).

- The member becomes covered under any other health plan or policy whether on an individual or group basis. In such an instance, until Health Net is able to cancel the member's coverage under this Conversion Plan, the benefits provided hereunder will be reduced by the amount of benefits provided by the other individual or group policy.
- The subscriber's marriage or domestic partnership ends by divorce, annulment or some other form of dissolution. Eligibility for the subscriber's enrolled spouse (now former spouse) and that spouse's enrolled dependents, who were related to the subscriber only because of the marriage or domestic partnership, will end on midnight of the last day of the month in which legal separation occurs, or entry of the final decree of dissolution of marriage or domestic partnership or annulment occurs.

Termination for cause

You may cancel your coverage at any time by giving Health Net written notice. In such event, termination will be effective on the first day of the month following our receipt of your written notice to cancel. Health Net has the right to terminate your coverage for any of the following reasons:

- You do not pay your premium on time. (Health Net will issue a 30-day prior notice of our right to terminate your coverage for nonpayment of premium. The 30-day prior notice will be sent on or before the first day of the month for which premiums are due and will describe the 30-day grace period, which begins after the last day of paid coverage. If you do not pay your premiums by the first day of the month for which premiums are due, Health Net can terminate your coverage after the 30-day grace period.)
- You and/or your family member(s) cease being eligible (see *Who is Eligible?* section).
- You commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the agreement. Some examples include: misrepresenting eligibility information about you or a dependent; presenting an invalid prescription or physician order; or misusing a Health Net member ID card (or letting someone else use it). Members are responsible for payment of any services received after termination of coverage at the provider's prevailing nonmember rates. This is also applicable to members who are hospitalized or undergoing treatment for an ongoing condition on the termination date of coverage.

If you terminate coverage for yourself or any of your family members, you may apply for re-enrollment, but Health Net may decline enrollment at its discretion.

How does the monthly billing work?

Your premium must be received by Health Net by the first day of the coverage month. If there are premium increases after the enrollment effective date, you will be notified at least 60 days in advance. If there are changes to the Health Net Conversion HMO Plan Contract and EOC, including changes in benefits, you will be notified at least 30 days in advance.

Are there any renewal provisions?

Subject to the eligibility and termination provisions discussed, coverage will remain in effect for each month prepayment fees are

received and accepted by Health Net. You will be notified 60 days in advance of any changes in fees. You will be notified 30 days in advance of any changes in benefits or contract provisions.

Does Health Net coordinate benefits?

There are no Coordination of Benefit provisions for individual plans in the state of California.

What is utilization review?

Health Net makes medical care covered under our Conversion Plan subject to policies and procedures that lead to efficient and prudent use of resources and, ultimately, to continuous improvement of quality of care. Health Net bases the approval or denial of services on the following main procedures:

- evaluation of medical services to assess medical necessity and appropriate level of care;
- implementation of case management for long-term or chronic conditions;
- review and authorization of inpatient admission and referrals to noncontracting providers; and
- review of scope of benefits to determine coverage.

If you would like additional information regarding Health Net's Utilization Review System, please call the Customer Contact Center at 1-800-522-0088.

Does Health Net cover the cost of participation in clinical trials?

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

What if I have a disagreement with Health Net?

Members dissatisfied with the quality of care received, or who believe they were denied service or a claim in error, or subject to or received an adverse benefit determination may file a grievance or appeal. An adverse benefit determination includes: (a) rescission of coverage, even if it does not have an adverse effect on a particular benefit at the time; (b) determination of an individual's eligibility to participate in this Health Net plan; (c) determination that a benefit is not covered; (d) an exclusion or limitation of an otherwise covered benefit based on a pre-existing condition exclusion or a source of injury exclusion; or, (e) determination that a benefit is experimental, investigational, or not Medically Necessary or appropriate. In addition, plan members can request an independent medical review of disputed health care services from the Department of Managed Health Care if they believe that health care services eligible for coverage and payment under their Health Net plan were improperly denied, modified or delayed by Health Net or one of its contracting providers.

Also, if Health Net denies a member's 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, members can request an independent medical review of Health Net's decision from the Department of Managed Health Care if they meet eligibility criteria set out in the Plan Contract and EOC.

Members not satisfied with the results of the grievance and appeals process may submit the problem to binding arbitration. Health Net uses binding arbitration to settle disputes, including medical malpractice. As a condition of enrollment, members give up their right to a jury or trial before a judge for the resolution of such disputes.

Health Net

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against Health Net, you should first telephone Health Net at **1-800-522-0088** and use our grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Health Net, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **1-888-HMO-2219** and a TDD line **1-877-688-9891** for the hearing and speech impaired. The Department's website **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

What if I need a second opinion?

Health Net members have the right to request a second opinion when:

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

To obtain a copy of Health Net's second opinion policy, contact the Health Net Customer Contact Center at 1-800-522-0088.

What is the relationship of the involved parties?

Physician groups, contracting physicians, hospitals and other health care providers are not agents or employees of Health Net. Health Net and each of its employees are not the agents or employees of any physician group, contract physician, hospital or other health care provider. All of the parties are independent contractors and contract with each other to provide you the covered services or supplies of your coverage option. Members are not liable for any acts or omissions of Health Net, their agents or employees, physician groups, any physician or hospital, or any other person or organization with which Health Net has arranged or will arrange to provide the covered services and supplies of your plan.

What about continuity of care upon termination of a provider contract?

If Health Net's contract with a physician group or other provider is terminated, Health Net will transfer any affected members to another contracting physician group or provider and make every effort to ensure continuity of care. At least 60 days prior to termination of a contract with a physician group or acute care hospital to which members are assigned for services, Health Net will provide a written notice to affected members. For all other hospitals that terminate their contract with Health Net, a written notice will be provided to affected members within five days after the effective date of the contract termination.

In addition, the member may request continued care from a provider whose contract is terminated if, at the time of termination, the member was receiving care from such a provider for:

- an acute condition;
- a serious chronic condition not to exceed twelve months from the contract termination date;
- a pregnancy (including the duration of the pregnancy and immediate postpartum care);
- a newborn up to 36 months of age, not to exceed twelve months from the contract termination date;
- a terminal illness (for the duration of the terminal illness); or
- a surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment.

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable copayments and any other exclusions and limitations of this plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider's contract termination. You must request continued care within 30 days of the provider's date of termination, unless you can show that it was not reasonably possible to make the request within 30 days of the provider's date of termination and you make the request as soon as reasonably possible.

If you would like more information about how to request continued care, or to request a copy of our continuity of care policy, please contact the Customer Contact Center at the number on your Health Net ID card.

What are Severe Mental Illness and Serious Emotional Disturbances of a Child?

Severe Mental Illness includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with professionally recognized standards including, but not limited to, the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders, as amended to date), 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, as amended to date, other than a primary substance abuse disorder or a developmental disorder, that result in behavior inappropriate to the child's

age according to expected developmental norms. In addition, the child must meet one or more of the following: (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.

Do providers limit services for reproductive care?

Some hospitals and other providers do not provide one or more of the following services that may be covered under the plan's Plan Contract and EOC and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Health Net's Customer Contact Center at 1-800-522-0088 to ensure that you can obtain the health care services that you need.

What is the method of provider reimbursement?

Health Net uses financial incentives and various risk-sharing arrangements when paying providers. Members may request more information about our payment methods by contacting the Customer Contact Center at the telephone number on their Health Net ID card.

When and how does Health Net pay my medical bills?

We will coordinate the payment for covered services when you receive care from your PCP or when you are referred by your PCP to a specialist. We have agreements with these physicians that eliminate the need for claim forms. Simply present your member identification card.

Am I required to see my primary care physician if I have an emergency?

Health Net covers emergency and urgently needed care throughout the world.

If your situation is life-threatening, immediately call 911 if you are in an area where the system is established and operating. If your situation is not so severe, call your PCP or physician group (medical), or the Administrator (mental illness or detoxification). If you are unable to call and you need medical care right away, go to the nearest medical center or hospital.

An emergency means any otherwise covered service for an acute illness, a new injury or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or, if a minor, to the minor's parent or guardian, that a reasonable person with an average knowledge of health and medicine (a prudent layperson) would believe requires immediate treatment, and, without immediate

treatment, any of the following would occur: (a) his or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger); (b) his or her bodily functions, organs or parts would become seriously damaged; or (c) his or her bodily organs or parts would seriously malfunction. Emergency care also includes treatment of severe pain or active labor. Active labor means labor at the time that either of the following would occur: (a) there is inadequate time to effect safe transfer to another hospital prior to delivery, or (b) a transfer poses a threat to the health and safety of the member or her unborn child. Emergency care will also include additional screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition, either within the capacity of the facility or by transferring the member to a psychiatric unit within a general acute hospital or to an acute psychiatric hospital as Medically Necessary.

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

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

Am I liable for payment of certain services?

We are responsible for paying participating providers for covered services. Except for copayments and deductibles, participating providers may not bill you for charges in excess of our payment. You are financially responsible for: (a) services beyond the benefit limitations stated in the plan's Plan Contract and EOC, and (b) services not covered by the Conversion Plan. The Conversion Plan does not cover: prepayment fees, copayments, deductibles, services and supplies not covered by the Conversion Plan, or non-emergency care rendered by a nonparticipating provider.

Under the HMO plans, can I be reimbursed for out-of-network claims?

Some nonparticipating providers will ask you to pay a bill at the time of service. If you have to pay a bill for covered services, submit a copy of the bill, evidence of its payment and the emergency room report to us for reimbursement within one year of the date the service was rendered. Coverage for services rendered by nonparticipating providers is limited to emergency care when a participating provider is not available.

How does Health Net handle confidentiality and release of member information?

Health Net knows that personal information in your medical records is private. Therefore, we protect your personal health information in all settings. As part of the application or enrollment form, Health Net members sign a routine consent to obtain or release their medical information. This consent is used by Health Net to ensure notification to and

consent from members for present and future routine needs for the use of personal health information.

This consent includes the obtaining or release of all records pertaining to medical history, services rendered or treatment given to all subscribers and members under the plan for the purpose of review, investigation or evaluation of an application, claim, appeals (including the release to an independent reviewer organization) or grievance, or for preventive health or health management purposes.

We will not release your medical records or other confidential information to anyone such as employers or insurance brokers, who are not authorized to have that information. We will only release information if you give us special consent in writing. The only time we would release such information without your special consent is when we have to comply with a law, court order or subpoena. Often, Health Net is required to comply with aggregated measurement and data reporting requirements. In those cases, we protect your privacy by not releasing any information that identifies our members.

Privacy practices

For a description of how protected health information about you may be used and disclosed, and how you can get access to this information, please see the Notice of Privacy Practices in the plan's Plan Contract.

How does Health Net deal with new technologies?

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

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

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

What are Health Net's Utilization Management processes?

Utilization Management is an important component of health care management. Through the processes of preauthorization, concurrent and retrospective review and care management, we evaluate the services provided to our members to be sure they are Medically Necessary and appropriate for the setting and time. This oversight helps to maintain Health Net's high quality medical management standards.

Preauthorization

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

Concurrent review

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

Discharge planning

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

Retrospective review

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

Care or case management

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

Exclusions *and* Limitations

No payment will be made under the Health Net Conversion Plan for expenses incurred for, or which are follow-up care to, any of the items below. The following are selective listings only. For comprehensive listings, see the Health Net Individual Conversion Plan Contract and Evidence of Coverage (EOC).

- Services and supplies which Health Net determines are not Medically Necessary, except as set out under *Does Health Net cover the cost of participation in clinical trials?* and *What if I have a disagreement with Health Net?* on pages 10–11.
- Ambulance and paramedic services that do not result in transportation or that do not meet the criteria for emergency care, unless such services are Medically Necessary and prior authorization has been obtained.
- Custodial care is not rehabilitative care and is primarily provided to assist a patient in meeting the activities of daily living such as: help in walking, getting in and out of bed, bathing, dressing, feeding and preparation of special diets, and supervision of medications which are ordinarily self-administered, but not care that requires skilled nursing services on a continuing basis.
- Procedures that Health Net determines to be experimental or investigational, except as set out under *Does Health Net cover the cost of participation in clinical trials?* and *What if I have a disagreement with Health Net?* on pages 10–11.
- Services or supplies provided before the effective date of coverage and services or supplies provided after midnight on the effective date of cancellation of coverage through this plan are not covered.
- Reimbursement for services for which the member is not legally obligated to pay the provider or for which the provider pays no charge.
- Any service or supplies not specifically listed as covered expenses, unless coverage is required by state or federal law.
- Services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include, but are not limited to, collection, storage or purchase of sperm or ova.
- Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.[14]
- Treatment and services for Temporomandibular Joint Disorders are covered when determined to be Medically Necessary, excluding crowns, onlays, bridgework and appliances.
- This plan covers services or supplies provided by a legally operated hospital, Medicare-approved skilled nursing facility, or other properly licensed facility as specified in the plan's Plan Contract and EOC. Any institution that is primarily a place for the aged, nursing home or any similar institution, regardless of how it is

[14]When a Medically Necessary mastectomy has been performed, breast reconstruction surgery and surgery performed on either breast to restore or achieve symmetry (balanced proportions) in the breast are covered. In addition, when surgery is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease, to do either of the following: improve function or create a normal appearance to the extent possible, unless the surgery offers a minimal improvement in the appearance of the member.

designated, is not an eligible institution. Services or supplies that are provided by such institutions are not covered.

- Dental care. However, this plan does cover 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.
- Surgery and related services for the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw, except when such surgery is required due to trauma or the existence of tumors or neoplasms, or when otherwise Medically Necessary. See the "Dental Care" exclusion above for information regarding cleft palate procedures.
- Hearing aids.
- Private duty nursing. Shift care and any portion of shift care services are also not covered.
- Any eye surgery for the purpose of correcting refractive defects of the eye, unless Medically Necessary, recommended by the member's treating physician, and authorized by Health Net.
- Contact or corrective lenses (except an implanted lens that replaces the organic eye lens), vision therapy, and eyeglasses.
- Services to reverse voluntary surgically induced infertility.
- Any services or supplies not related to the diagnosis or treatment of a covered condition, illness or injury. However, the plan does cover Medically Necessary services and supplies for medical conditions directly related to noncovered services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery).
- Any outpatient drugs, medications or other substances dispensed or administered in any setting, except as specifically stated in the plan's Plan Contract and EOC.
- Services for a surrogate pregnancy are covered when the surrogate is a Health Net member. However, when compensation is obtained for the surrogacy, the plan shall have a lien on such compensation to recover its medical expense.
- Although this plan covers durable medical equipment, it does not cover the following items: (a) exercise equipment; (b) hygienic equipment and supplies; (c) surgical dressings other than primary dressings that are applied by your physician group or a hospital to lesions of the skin or surgical incisions; (d) jacuzzis and whirlpools; (e) orthodontic appliances to treat dental conditions related to disorders of the temporomandibular (jaw) joint; (f) support appliances such as stockings, over-the-counter support devices or orthotics, and devices or orthotics for improving athletic performance or sports-related activities; and (g) corrective footwear (except for podiatric devices to prevent or treat diabetes-related complications), unless medically necessary, custom made for the member and permanently attached to a medically necessary orthotic device that is also a covered benefit under this plan
- Personal or comfort items.
- Disposable supplies for home use.
- Home birth, unless the criteria for emergency care have been met.
- Physician self-treatment.
- Treatment by immediate family members.

- Services for the treatment of Chemical Dependency (other than detoxification) are not covered.
- Chiropractic services.
- Home health care (limited to 100 combined visits per calendar year; maximum three visits per day and four hours per visit).
- Services or supplies that are not authorized by Health Net, the Administrator (Mental Disorders or Chemical Dependency) or the physician group (medical) according to Health Net's or the Administrator's procedures.
- Services and supplies rendered by a nonparticipating physician without authorization from Health Net or the physician group.
- Diagnostic procedures or testing for genetic disorders, except for prenatal diagnosis of fetal genetic disorders in cases of high-risk pregnancy.
- Nonprescription drug, medical equipment, or supply that can be purchased without a prescription (except when prescribed by a physician for 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 approved by the FDA). If a drug that was previously available by prescription becomes available in an over-the-counter (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 prior authorization is obtained from Health Net.
- Routine foot care, unless Medically Necessary for a diabetic condition.
- Acupuncture.
- Services to diagnose, evaluate or treat infertility are not covered.
- Treatments which use umbilical cord blood, cord blood stem cells and adult stem cells (nor their collection, preservation and storage) as such treatments are considered to be Experimental or Investigational in nature. For information regarding requesting an Independent Medical Review of a plan denial of coverage on the basis that it is considered Experimental or Investigational, see *What if I have a disagreement with Health Net?* on pages 10–11.
- Drugs (including injectable medications) for the treatment of sexual dysfunction when prescribed for the treatment of sexual dysfunction.
- Bariatric surgery provided for the treatment of morbid obesity is covered when Medically Necessary, authorized by Health Net and performed at a Health Net Bariatric Surgery Performance Center by a Health Net Bariatric Surgery Performance Center network surgeon who is affiliated with the Health Net Bariatric Surgery Performance Center. Health Net has a specific network of bariatric facilities and surgeons, which are designated as Bariatric Surgery Performance Centers to perform weight loss surgery. Your member physician can provide you with information about this network. You will be directed to a Health Net Bariatric Surgery Performance Center at the time authorization is obtained.
- Coverage for rehabilitation therapy is limited to Medically Necessary services provided by a Plan-contracted physician, licensed physical, speech or occupational therapist or other contracted provider, acting within the scope of his or her license, to treat physical or mental health conditions, subject to any required authorization from the Plan or the

member's medical group. The services must be based on a treatment plan authorized as required by the Plan or the member's medical group.

- Therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus (aversion therapy) is not covered.
- Except for services related to behavioral health treatment for pervasive development disorder or autism, all other services related to or consisting of education or training, including for employment or professional purposes, are not covered, even if provided by an individual licensed as a health care provider by the state of California.
- Electroconvulsive therapy is not covered except as authorized by the Administrator.
- The following types of treatment are only covered when provided in connection with covered treatment for a Mental Disorder or Chemical Dependency: (a) treatment for co-dependency; (b) treatment for psychological stress; and (c) treatment of marital or family dysfunction. Treatment of Delirium, Dementia, Amnesic Disorders (as defined in the DSM-IV) and Mental Retardation are covered for Medically Necessary medical services but covered for accompanying behavioral and/or psychological symptoms only if amenable to psychotherapeutic or psychiatric treatment. In addition, Health Net will cover only those Mental Disorder or Chemical Dependency services which are delivered by providers who are licensed in accordance with California law and are acting within the scope of such license or as otherwise authorized under California law.
- Services that do not meet national standards for professional medical or mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, hypnotherapy and crystal healing therapy are not covered. For information regarding requesting an Independent Medical Review of a denial of coverage see *What if I have a Disagreement with Health Net?* on pages 10–11.
- Coverage for biofeedback therapy is limited to Medically Necessary treatment of certain physical disorders such as incontinence and chronic pain, and as otherwise preauthorized by the Administrator.
- Psychological testing except as conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification. Also excluded is coverage for scoring of automated computer-based reports, unless the scoring is performed by a provider qualified to perform them.
- Residential treatment that is not Medically Necessary is excluded. Admissions that are not considered medically appropriate and are not covered include admissions for wilderness center training; for Custodial Care, for a situational or environmental change; or as an alternative to placement in a foster home or halfway house.

- Services in a state hospital are limited to treatment or confinement as the result of an emergency or urgently needed care.
- Treatment or consultations provided by telephone are not covered.
- Medical mental health care or chemical dependency services as a condition of parole or probation, and court-ordered testing are limited to Medically Necessary covered services.
- Methadone maintenance for the purpose of long-term opiate craving reduction is not covered.

Mental Health *and* Chemical Dependency *Services*

Mental Disorders and Chemical Dependency benefits are administered by MHN Services, an affiliate behavioral health administrative services company (the Administrator) which contracts with Health Net to administer these benefits.

When you need to see a participating mental health professional, contact the Administrator by calling Health Net's Customer Contact Center at the phone number on your Health Net ID card. The Administrator will help you identify a participating mental health professional, a participating independent physician or a subcontracted provider association (IPA) within the network, close to where you live or work, with whom you can make an appointment. Certain services and supplies for mental disorders and chemical dependency may require prior authorization by the Administrator in order to be covered. No prior authorization is required for outpatient office visits, but a voluntary registration with the Administrator is encouraged. Please refer to the plan's Individual Conversion Plan Contract and EOC for a more complete description of mental disorder and chemical dependency services and supplies, including those that require prior authorization by the Administrator.

Prescription Drug *Program*

Health Net is contracted with many major pharmacies, supermarket-based pharmacies and privately owned pharmacies in California. To find a conveniently located participating pharmacy, please visit our website at www.healthnet.com or call Health Net's Customer Contact Center.

Specific exclusions and limitations apply to the Prescription Drug Program. See the Conversion Plan Contract and EOC for complete details. Remember that limits on quantity, dosage and treatment duration may apply to some drugs.

Mail-order pharmacy 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 mail-order pharmacy program. This program allows you to receive up to a 90-consecutive-calendar-day supply of maintenance medications. For complete information, call Health Net's Customer Contact Center at 1-800-522-0088.

Note: Schedule II narcotic drugs are not covered through mail order. See the Plan Contract and EOC for additional information.

The Health Net Recommended Drug List: Level I drugs (primarily generic) and Level II drugs (primarily brand)

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

We specifically suggest to all Health Net contracting PCPs and specialists that they refer to this list when choosing drugs for patients who are Health Net members. When your physician prescribes medications listed on 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. This committee's members are actively practicing physicians of various medical specialties and clinical pharmacists. Voting members are recruited from contracting physician groups throughout California based on their experience, knowledge and expertise. In addition, the P&T Committee frequently consults with other medical experts to provide additional input to the Committee. Updates to the 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's most current Recommended Drug List, please visit our website at www.healthnet.com, or call our Customer Contact Center at 1-800-522-0088.

Level III drugs

Level III drugs are prescription drugs that are listed as Level III or not listed on the Recommended Drug List and are not excluded from coverage.

What is prior authorization?

Some Level I, Level II and Level III prescription medications require prior authorization. This means that your doctor must contact Health Net in advance to provide the medical reason for prescribing the medication. Upon receiving your physician's request for prior authorization, Health Net 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 to obtain the usage guidelines for specific medications.

If authorization is denied by Health Net, 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 email. We must receive the appeal within 60 days of the date of the denial notice. Please refer to your Health Net EOC for details regarding your right to appeal.

To submit an appeal:

- call Health Net's Customer Contact Center at 1-800-522-0088;
- visit www.healthnet.com for information about emailing Health Net's Customer Contact Center; or
- write to:
  Health Net Customer Contact Center
  PO Box 10348
  Van Nuys, CA 91410-0348

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 employer group applicants please call Health Net's Commercial Contact Center at 1-800-522-0088. Individual and Family Plan (IFP) or Farm Bureau applicants please call 1-800-909-3447, option 2. For more help call the CA Dept. of Insurance at 1-800-927-4357 if you are enrolling in a PPO plan. If you are enrolling in an HMO plan, call the DMHC Helpline at 1-888-HMO-2219.

English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que una persona le lea los documentos y que algunos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación; los solicitantes de grupo de empleadores deben llamar al Centro de Comunicación Comercial de Health Net al 1-800-522-0088. Los solicitantes del Plan Individual y Familiar (IFP, por sus siglas en inglés) o de la Oficina Agrícola, deben llamar al 1-800-909-3447, opción 2. Para obtener ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357, si desea inscribirse en un plan PPO. Si usted se inscribe en un plan HMO, llame a la Línea de ayuda de DMHC, 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，請撥打您會員卡上所列的電話號碼，雇主團體申請人請致電 Health Net 的商業聯絡中心，電話 1-800-522-0088。個人和家庭計畫 (IFP) 或農業局申請人請撥打 1-800-909-3447，請按 2。若您投保 PPO 計畫，請致電 1-800-927-4357 與加州保險局聯絡，詢求額外協助。若您投保 HMO 計畫，請撥打加州醫療保健計畫管理局 (DMHC) 協助專線，電話 1-888-HMO-2219。

Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được cấp dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu bằng ngôn ngữ của quý vị và cũng có thể được cấp tài liệu phiên dịch sang ngôn ngữ của quý vị. Để được giúp đỡ, xin gọi chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị. Những người muốn xin bảo hiểm theo nhóm do hãng sở đài thọ xin gọi Trung Tâm Liên Lạc Thương Mại của Health Net tại số 1-800-522-0088. Những người muốn xin bảo hiểm của Chương Trình Bảo Hiểm Cá Nhân và Gia Đình (IFP) hoặc Farm Bureau, xin gọi số 1-800-909-3447, bấm số 2. Để được giúp đỡ thêm, xin gọi Bộ Bảo Hiểm California tại số 1-800-927-4357 nếu quý vị đang tham gia một chương trình PPO. Nếu quý vị đang tham gia một chương trình HMO, xin gọi Đường Dây Trợ Giúp của DMHC tại số 1-888-HMO-2219.

Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 적힌 안내 번호로 전화해 주십시오. 고용주 그룹 가입 신청자님의 경우 Health Net 의 상업(Commercial) 고객 서비스 센터, 안내번호 1-800-522-0088 번으로 전화해 주십시오. 개인 및 가족 플랜 (IFP) 혹은 Farm Bureau 가입 신청자님은 안내번호 1-800-909-3447번, 옵션 2를 이용해 주십시오. PPO 플랜에 가입하신 경우, 더 많은 도움이 필요하신 분은 캘리포니아 보험 담당국 안내번호 1-800-927-4357번으로 문의하십시오. HMO 플랜에 가입하신 경우, DMHC(보건관리부) 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오.

Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card, o para sa employer group applicants, mangyaring tumawag sa Commercial Contact Center ng Health Net sa 1-800-522-0088. Para sa Individual and Family Plan (IFP) o Farm Bureau applicants, mangyaring tumawag sa 1-800-909-3447, opsyon 2. Para sa karagdagang tulong, tumawag sa CA Dept. of Insurance sa 1-800-927-4357 kung ikaw ay nag-eenroll sa isang PPO plan. Kung ikaw ay nag-eenroll sa isang HMO plan, tawagan ang DMHC Helpline sa 1-888-HMO-2219.

Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար ձեր լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված համարով, կամ եթե գործատիրոջ խմբի դիմորդ եք, խնդրում ենք 1-800-522-0088 համարով զանգահարել Health Net-ի Հաճախորդի Կապի Կենտրոն: Անհատական և Ընտանեկան Ծրագրի (Individual and Family Plan/IFP) դիմորդներից խնդրվում է զանգահարել 1-800-909-3447 համարով, ընտրանք 2: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք, եթե գրանցվում եք PPO ծրագրում: Եթե գրանցվում եք HMO ծրագրում, 1-888-HMO-2219 համարով զանգահարեք DMHC-ի Օգնության գծին:

Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочесть документы на вашем языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте. Участники плана группового страхования по месту работы могут обратиться в коммерческий контактный центр компании Health Net по телефону 1-800-522-0088. Участники планов индивидуального или семейного страхования (Individual and Family Plan, IFP), а также планов страхования Фермерского бюро: пожалуйста, звоните по номеру 1-800-909-3447, добавочный 2. Если вы участвуете в плане системы предпочтительного выбора (Preferred Provider Organization, PPO), для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по телефону 1-800-927-4357. Если вы состоите в плане организаций медицинского обслуживания (Health Maintenance Organizations, HMO), пожалуйста, звоните в горячую линию Департамента организованного медицинского обслуживания (DMHC) по телефону 1-888-HMO-2219.

Russian

無料の言語サービス。日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号までお問い合わせください。雇用者団体への加入申込の方は、Health Net 民間コンタクト・センター、1-800-522-0088 までご連絡ください。個人・家族プラン (IFP) またはファーム・ビューローへの加入申込の方は、1-800-909-3447（ダイアル後 2 を選択）までお問い合わせください。更なるお問い合わせ事項がある場合、PPO プランにご加入の方は、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プランにご加入の方は、カリフォルニア州管理医療庁 (DMHC) の相談窓口、1-888-HMO-2219 までご連絡ください。

Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید مدارک به زبان خودتان برایتان خوانده شوند. برای دریافت کمک با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است تماس بگیرید. و یا متقاضیان گروههای کارفرمایان لطفاً با مرکز خِارِی Health Net به شماره 1-800-522-0088 تماس بگیرند. متقاضیان «طرح افراد و خانواده ها» (IFP) یا «دفتر مزارع» لطفاً به شماره 1-800-909-3447 گزینه 2 تلفن کنند. برای دریافت کمک بیشتر، به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید اگر در یک طرح PPO ثبت نام میکنید. اگر در یک طرح HMO ثبت نام میکنید، به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید.

Farsi

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ, ਇੰਪਲਾਇਰ ਗਰੁੱਪ ਦੇ ਮੈਂਬਰ ਕਿਰਪਾ ਕਰਕੇ ਹੈਲਥ ਨੈਟ ਦੇ ਵਪਾਰਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਪਲਾਨ (IFP) ਜਾਂ ਫਾਰਮ ਬਿਊਰੋ ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ 1-800-909-3447, ਔਪਸ਼ਨ ੨ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕਿਸੇ ਫਫੋ ਪਲਾਨ ਲਈ ਨਾਂ ਲਿਖਵਾ ਰਹੇ ਹੋ ਤਾਂ ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕਿਸੇ ਪਲਾਨ ਲਈ ਨਾਂ ਲਿਖਵਾ ਰਹੇ ਹੋ ਤਾਂ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਮੈਨੇਜਡ ਹੈਲਥ ਕੇਅਰ (DMHC) ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ।

Punjabi

ការបកប្រែភាសាដោយឥតអស់ថ្លៃ ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងឲ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន ។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខដែលមានកត់នៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក ឬអ្នកជាក់ពាក្យសុំជាក្រុមនៃក្រុមហ៊ុនការងារ សូមទូរស័ព្ទទៅ មណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្មរបស់ Health Net តាមលេខ 1-800-522-0088 ។ គំរោងបុគ្គលម្នាក់ៗ និងជាគ្រួសារ (IFP) ឬអ្នកជាក់ពាក្យសុំ Farm Bureau សូមទូរស័ព្ទទៅលេខ 1-800-909-3447 ចុចជំរើសទី 2 ។ សំរាប់ជំនួយថែមទៀត សូមទូរស័ព្ទទៅ ក្រសួងធានារ៉ាប់រងកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357 បើសិនជាអ្នកកំពុងតែចុះឈ្មោះក្នុងគំរោង PPO ។ បើសិនជាអ្នកកំពុងតែចុះឈ្មោះក្នុងគំរោង HMO សូមទូរស័ព្ទទៅ ខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219 ។

Khmer

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi. Koj thov tau kom muaj ib tug neeg txhais lus thiab nyeem cov ntawv ua koj hom lus rau koj. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis cov neeg thov kev pab tom hauj lwm thov hu rau Health Net's Commercial Contact Center ntawm 1-800-522-0088. Cov neeg thov kev pab hauv pawg Tus Kheej thiab Tsev Neeg (Individual and Family Plan [IFP]) los sis Farm Bureau thov hu rau 1-800-909-3447, xaiv nqe 2. Yog xav tau kev pab ntxiv hu rau CA Qhov Chaw Saib Xyuas Txog Kev Tuav Pov Hwm (Dept. of Insurance) ntawm 1-800-927-4357 yog hais tias koj koom rau hauv ib qho kev pab los ntawm PPO. Yog hais tias koj koom rau hauv ib qho kev pab los ntawm HMO, hu rau DMHC Tus Xov Tooj Muab Kev Pab ntawm 1-888-HMO-2219.

Hmong

T'áá Hó Hasaad Bee 'Áka'e'eyeed Doo Bą́ą́h 'Ílíní Da. Haíshíį́ shá 'ata' hodoolnih nínízinígíí łá' ná choídoot'eeł. Ła' naaltsoos t'áá ni nizaad bee nich'į' yídóolta dóó naaltsoos bee hadadilyaago nich'į' 'ádadoolníił. Shiká'e'doowoł nínízingo, ninaaltsoos nitł'izí bine'dę́ę́' béésh bee hane'í biká'ígíí bich'į' holne' dooleeł, doodago nidaalnishí hada'diilaaígíí 'éí Na'iiłniihí 'Atsíís Bik'ih 'Adeest'įį́' 'Iłnáhane' Bił Haz'áníjį' kojį' béésh bee holne' dooleeł 1-800-522-0088. T'áá Ła' Jizį́ dóó Hooghan Haz'ánígi Bił Nahat'a' (IFP) doodago Dá'ák'eh Yá Dah Háaztánígíí bił náha'dit'éego kojį' béésh bee holne' dooleeł 1-800-909-3447, naaki góne'ígíí bił yaa 'adidíílchił. PPO bił náhadilnéédhą́ą́' 'éí CA Béeso 'Ách'ą́ą́h Naa'nil Bił Haz'ánígííjį' shiká'e'doowoł diníigo béésh bee holne dooleeł 1-800-927-4357. HMO bił náhadilnéédhą́ą́', DMHC 'Áka'aná'áwo'go Bił Haz'áníjį' béésh bee holne' dooleeł 1-888-HMO-2219.

Navajo

خدمات لغوية بدون تكلفة. يمكنك الاستعانة بمترجم وطلب قراءة الوثائق لك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك (ID). وبالنسبة لمجموعات المصالح التجارية رجاء الاتصال بمركز خدمات القطاع التجاري لمؤسسة Health Net على الرقم 1-800-522-0088. المتقدمين بطلبات الحصول على تأمين لشخص واحد أو لعائلة (IFP) أو Farm Bureau رجاء الاتصال بالرقم 1-800-909-3447. خيار 2. للحصول على المزيد من المساعدة، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 إذا كنت مشتركاً في برنامج PPO. إذا كنت مشتركاً في برنامج HMO اتصل بالخط الساخن لـ DMHC على الرقم 1-888-HMO-2219.

Arabic

Health Net *of California, Inc.*

Guaranteed Issue Conversion Plan Rates effective January 1, 2013

Region 1

Los Angeles County

Tier/Age		HMO 40
Subscriber	<1	1,992
	1–4	535
	5–18	518
	19–24	640
	25–29	749
	30–34	940
	35–39	1,038
	40–44	1,089
	45–49	1,149
	50–54	1,360
	55–59	1,587
	60–64	1,587
	65+	1,905
Subscriber and spouse	19–24	1,283
	25–29	1,499
	30–34	1,883
	35–39	2,077
	40–44	2,181
	45–49	2,300
	50–54	2,720
	55–59	3,177
	60–64	3,177
	65+	3,811
Subscriber and child	19–24	1,246
	25–29	1,351
	30–34	1,541
	35–39	1,635
	40–44	1,688
	45–49	1,745
	50–54	1,878
	55–59	2,108
	60–64	2,108
	65+	2,415
Subscriber and children	19–24	1,776
	25–29	1,880
	30–34	2,068
	35–39	2,162
	40–44	2,213
	45–49	2,267
	50–54	2,398
	55–59	2,626
	60–64	2,626
	65+	2,980
Family	19–24	2,420
	25–29	2,631
	30–34	3,012
	35–39	3,201
	40–44	3,304
	45–49	3,418
	50–54	3,758
	55–59	4,216
	60–64	4,216
	65+	4,885

Region 2

Merced, Sacramento, San Joaquin, Sonoma, Stanislaus, Tulare, western El Dorado,[15] and western Placer[15] counties

Tier/Age		HMO 40
Subscriber	<1	2,147
	1–4	576
	5–18	559
	19–24	686
	25–29	802
	30–34	1,021
	35–39	1,115
	40–44	1,176
	45–49	1,239
	50–54	1,456
	55–59	1,701
	60–64	1,701
	65+	2,043
Subscriber and spouse	19–24	1,377
	25–29	1,606
	30–34	2,045
	35–39	2,230
	40–44	2,354
	45–49	2,480
	50–54	2,917
	55–59	3,405
	60–64	3,405
	65+	4,090
Subscriber and child	19–24	1,339
	25–29	1,451
	30–34	1,672
	35–39	1,762
	40–44	1,820
	45–49	1,883
	50–54	2,019
	55–59	2,264
	60–64	2,264
	65+	2,602
Subscriber and children	19–24	1,910
	25–29	2,023
	30–34	2,240
	35–39	2,330
	40–44	2,386
	45–49	2,446
	50–54	2,580
	55–59	2,825
	60–64	2,825
	65+	3,218
Family	19–24	2,601
	25–29	2,827
	30–34	3,262
	35–39	3,445
	40–44	3,563
	45–49	3,689
	50–54	4,040
	55–59	4,528
	60–64	4,528
	65+	5,264

Region 3

Riverside, San Bernardino and Ventura counties

Tier/Age		HMO 40
Subscriber	<1	2,181
	1–4	564
	5–18	547
	19–24	693
	25–29	804
	30–34	1,033
	35–39	1,128
	40–44	1,196
	45–49	1,261
	50–54	1,482
	55–59	1,732
	60–64	1,732
	65+	2,080
Subscriber and spouse	19–24	1,388
	25–29	1,609
	30–34	2,070
	35–39	2,257
	40–44	2,393
	45–49	2,524
	50–54	2,966
	55–59	3,468
	60–64	3,468
	65+	4,163
Subscriber and child	19–24	1,334
	25–29	1,445
	30–34	1,674
	35–39	1,764
	40–44	1,830
	45–49	1,892
	50–54	2,029
	55–59	2,281
	60–64	2,281
	65+	2,641
Subscriber and children	19–24	1,897
	25–29	2,000
	30–34	2,227
	35–39	2,318
	40–44	2,381
	45–49	2,446
	50–54	2,578
	55–59	2,828
	60–64	2,828
	65+	3,240
Family	19–24	2,590
	25–29	2,808
	30–34	3,265
	35–39	3,447
	40–44	3,580
	45–49	3,711
	50–54	4,061
	55–59	4,564
	60–64	4,564
	65+	5,322

[15]ZIP codes for western El Dorado County include: 95623, 95630 and 95762 only. See Region 7 for additional El Dorado County ZIP codes. ZIP codes for western Placer County include: 95602–04, 95648, 95650, 95658, 95661, 95663, 95677–78, 95746–47, and 95765 only. See Region 7 for additional Placer County ZIP codes.

Health Net *of California, Inc.*

Guaranteed Issue Conversion Plan Rates effective January 1, 2013

Region 4

Alameda, Contra Costa, San Francisco, San Mateo, Santa Clara, Santa Cruz and Solano counties

Tier/Age		HMO 40
Subscriber	<1	2,454
	1–4	644
	5–18	627
	19–24	782
	25–29	919
	30–34	1,162
	35–39	1,275
	40–44	1,337
	45–49	1,419
	50–54	1,647
	55–59	1,948
	60–64	1,948
	65+	2,337
Subscriber and spouse	19–24	1,565
	25–29	1,842
	30–34	2,327
	35–39	2,553
	40–44	2,675
	45–49	2,842
	50–54	3,296
	55–59	3,898
	60–64	3,898
	65+	4,678
Subscriber and child	19–24	1,516
	25–29	1,652
	30–34	1,890
	35–39	2,000
	40–44	2,063
	45–49	2,145
	50–54	2,276
	55–59	2,578
	60–64	2,578
	65+	2,971
Subscriber and children	19–24	2,155
	25–29	2,289
	30–34	2,531
	35–39	2,636
	40–44	2,697
	45–49	2,777
	50–54	2,905
	55–59	3,209
	60–64	3,209
	65+	3,668
Family	19–24	2,939
	25–29	3,213
	30–34	3,694
	35–39	3,915
	40–44	4,035
	45–49	4,199
	50–54	4,554
	55–59	5,157
	60–64	5,157
	65+	5,819

Region 5

Orange and San Diego counties

Tier/Age		HMO 40
Subscriber	<1	2,191
	1–4	564
	5–18	547
	19–24	693
	25–29	804
	30–34	1,021
	35–39	1,115
	40–44	1,176
	45–49	1,242
	50–54	1,463
	55–59	1,720
	60–64	1,720
	65+	2,063
Subscriber and spouse	19–24	1,388
	25–29	1,609
	30–34	2,045
	35–39	2,230
	40–44	2,354
	45–49	2,487
	50–54	2,929
	55–59	3,440
	60–64	3,440
	65+	4,127
Subscriber and child	19–24	1,337
	25–29	1,445
	30–34	1,660
	35–39	1,751
	40–44	1,810
	45–49	1,876
	50–54	2,012
	55–59	2,267
	60–64	2,267
	65+	2,628
Subscriber and children	19–24	1,897
	25–29	2,000
	30–34	2,218
	35–39	2,306
	40–44	2,363
	45–49	2,425
	50–54	2,560
	55–59	2,815
	60–64	2,815
	65+	3,238
Family	19–24	2,590
	25–29	2,808
	30–34	3,240
	35–39	3,422
	40–44	3,539
	45–49	3,670
	50–54	4,027
	55–59	4,539
	60–64	4,539
	65+	5,302

Region 6

Fresno, Kern and Kings counties

Tier/Age		HMO 40
Subscriber	<1	2,186
	1–4	596
	5–18	579
	19–24	714
	25–29	841
	30–34	1,071
	35–39	1,178
	40–44	1,224
	45–49	1,303
	50–54	1,528
	55–59	1,776
	60–64	1,776
	65+	2,133
Subscriber and spouse	19–24	1,429
	25–29	1,684
	30–34	2,142
	35–39	2,357
	40–44	2,449
	45–49	2,609
	50–54	3,058
	55–59	3,556
	60–64	3,556
	65+	4,270
Subscriber and child	19–24	1,387
	25–29	1,513
	30–34	1,740
	35–39	1,844
	40–44	1,890
	45–49	1,968
	50–54	2,109
	55–59	2,357
	60–64	2,357
	65+	2,725
Subscriber and children	19–24	1,978
	25–29	2,102
	30–34	2,330
	35–39	2,432
	40–44	2,476
	45–49	2,553
	50–54	2,691
	55–59	2,939
	60–64	2,939
	65+	3,352
Family	19–24	2,694
	25–29	2,946
	30–34	3,401
	35–39	3,614
	40–44	3,704
	45–49	3,857
	50–54	4,221
	55–59	4,719
	60–64	4,719
	65+	5,489

Region 7

Eastern El Dorado,[16] eastern Placer,[16] Madera, Marin, Napa, Nevada, Santa Barbara and Yolo counties

Tier/Age		HMO 40
Subscriber	<1	2,225
	1–4	625
	5–18	608
	19–24	758
	25–29	904
	30–34	1,154
	35–39	1,252
	40–44	1,312
	45–49	1,368
	50–54	1,598
	55–59	1,876
	60–64	1,876
	65+	2,252
Subscriber and spouse	19–24	1,518
	25–29	1,808
	30–34	2,310
	35–39	2,509
	40–44	2,626
	45–49	2,742
	50–54	3,199
	55–59	3,753
	60–64	3,753
	65+	4,506
Subscriber and child	19–24	1,460
	25–29	1,604
	30–34	1,853
	35–39	1,951
	40–44	2,009
	45–49	2,063
	50–54	2,208
	55–59	2,487
	60–64	2,487
	65+	2,873
Subscriber and children	19–24	2,080
	25–29	2,223
	30–34	2,470
	35–39	2,565
	40–44	2,623
	45–49	2,675
	50–54	2,816
	55–59	3,095
	60–64	3,095
	65+	3,539
Family	19–24	2,839
	25–29	3,128
	30–34	3,626
	35–39	3,819
	40–44	3,937
	45–49	4,047
	50–54	4,418
	55–59	4,974
	60–64	4,974
	65+	5,795

[16]ZIP codes for eastern El Dorado County include: 95613–14, 95619, 95629, 95633–36, 95643, 95651, 95656, 95664, 95667, 95672, 95682, 95684, 95709, 95720–21, 95726, 95735, 96150-52, and 96154–58 only. See Region 2 for additional El Dorado County ZIP codes. ZIP codes for eastern Placer County include: 95631, 95681, 95701, 95703, 95713–15, 95717, 95722, 95724, 95736, 96140–43, 96145–46, 96148, and 96162 only. See region 2 for additional Placer County ZIP codes.

For more information please contact

Health Net Conversion Plan
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1-800-909-3447

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1-800-944-7287

Coverage for children in a low-income household
1-800-327-0502

Coverage for businesses with 50 and fewer employees
1-800-447-8812

Coverage for businesses with 50+ employees
1-800-448-4411, option 4

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