Andre Hamil
Health Net

Health Net®

Health Net Life Insurance Company (Health Net)

Health Net Travel Tips

for Stanford Students and their enrolled dependents

Wherever you go, Health Net has you covered

Healthy travel packing list

- **Health Net ID card.** Your ID card tells doctors, medical facilities and pharmacies that you have Health Net coverage.
- **Medications.** Be sure to pack the medications you take. If you need refills, you have access to Health Net-contracted pharmacies anywhere in the United States. If you need extra medication for a trip outside of the United States, contact the Vaden Health Center pharmacy for assistance before you leave campus.
- **List of local providers.** Do some advance planning to find the in-network providers, urgent care centers and pharmacies nearest your travel destination.

How to find providers and pharmacies

Go to **www.healthnet.com/cardinalcare**, and click *ProviderSearch.*

- **To search for network doctors and facilities within California** but away from the Stanford campus, select *Stanford Student PPO* from the ProviderSearch drop-down menu.
- **To search for network doctors and facilities outside of California**, select *National PPO – First Health* from the drop-down menu. Follow the steps to search for local network providers.
- **To find a pharmacy anywhere in the United States, go to** www.healthnet.com/cardinalcare > *ProviderSearch* > *Find a pharmacy.*

How to access care away from school

Within the U.S.

Students may access covered services under tier 2 of the plan. Other than in the case of an emergency, while you are in California, you must access the Health Net PPO network; and when outside of California, you must access the First Health Network. If you don't have an emergency but need immediate care – say for a sprained ankle or high fever – you have the option to go to the closest Health Net or First Health-contracted urgent care center.

In an emergency, **call 911** or go to the nearest emergency facility. Be sure to have the hospital staff or a family member contact Health Net by calling the number on the back of your ID card within 48 hours to inform us of the situation.

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Call (215) 942-8226 to access services (collect calls accepted).

Care away from school

International

Students may access covered services under tier 2 of the plan from any licensed physician or hospital anywhere in the world. You'll need to file a claim for reimbursement if you received care from a provider or facility outside the United States. Be sure to:

1. Make a photocopy of the itemized statement from the doctor or facility for your records.
2. Include the original itemized statement and proof of payment (in U.S. dollars) with your claim form. "Proof of Payment" includes, but is not limited to, a copy of the credit card charge slip, a cruise ship statement or canceled checks. (Include the name of the country and currency used.)
3. Mail claim form to Health Net within 90 days of service date.

Travel note

Request documentation in English, if possible, or get forms translated to English before submitting your claim. Submit medical and pharmacy charges together only if both services are provided as part of an inpatient stay. Otherwise submit your medical and pharmacy claims separately.

International SOS (ISOS)

ISOS provides comprehensive emergency travel assistance to Cardinal Care enrollees when traveling internationally for both leisure and school-sponsored trips.[1]

As a Cardinal Care enrollee, you are automatically enrolled in this program. Simply download an ISOS ID card from the ISOS website, and contact the numbers on the back of the card in the event of an emergency.

Some services include:

- Emergency medical evacuation[2]
- Medically necessary repatriation[2]
- Medical/behavioral health/dental/pharmacy/hospital referral and deposit arrangements.
- Prescription drug replacement assistance.

To print an ISOS member card, go to www.internationalsos.com.

Important information

Phone numbers

Health Net Customer Contact Center: 1-800-250-5226

Health Net International Customer Contact Center: (818) 676-6767

ISOS: (215) 942-8226 (collect calls accepted)

Personalized identification card

Health Net offers several options for accessing an image, printing a copy or ordering a replacement of your ID card:

- via smartphone with Health Net Mobile;
- online at www.healthnet.com/cardinalcare;

or

- call 1-800-250-5226.

Forms

Necessary forms are located at the end of this PDF, or they can be downloaded from www.healthnet.com/cardinalcare by clicking *Travel Guide.*

[1]Travel period must not exceed one year.

[2]Medical evacuation and repatriation services must be pre-approved and arranged by International SOS (ISOS). This is only an outline of your plan's benefits. Please refer to internationalsos.com for conditions, limitations and exclusions. Call (215) 942-8226 (collect calls accepted) to access services.

Health Net® *Member Reimbursement* Claim *Form*

This form may be used for Health Net of California, Inc. and Health Net Life Insurance Company (Health Net) products.

Important: Complete a separate Member Reimbursement Claim Form for each member asking for reimbursement for covered services and for each doctor and/or facility.

To avoid processing delays, please include the following information with this form:

- Copy of itemized bill showing all services received. Must include name, address, phone number, tax ID number of doctor and/or facility, and all diagnosis and procedure codes.
- Proof of payment for reimbursement requests over $200.[1]

Mail all documents to: Health Net, Inc.
Commercial Claims
PO Box 9040
Farmington, MO 63640-9040

Section 1: Member information – Please complete a separate form for each person who received services.

Last name:	First name:	MI:
Member ID #:	Date of birth (Mo./Day/Yr.): _____ / _____ / _____	
Phone #:	Email address:	
Address:	City:	State: ZIP:

Section 2: Other insurance – Complete if it applies.

Is the member also covered by other medical insurance at this time? ☐ Yes *(Complete information below.)* ☐ No

Name of other insurance company:	Policy #:
Subscriber/Member ID #:	Does this member have Medicare coverage? ☐ Yes ☐ No

Section 3: Services received – If services were received outside the U.S., please complete Section 4 also.

Name of doctor and/or facility:	Phone number of doctor and/or facility:
Address of doctor and/or facility:	
Medical description or nature of illness or injury:	Amount requested to be reimbursed:

Medical information authorization and release[2]

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medically related facility (as listed above) to furnish to Health Net, its agents, designees, or representatives any and all information pertaining to medical treatment for purposes of reviewing, investigating or evaluating applications or claims. I also authorize Health Net, its agents, designees, or representatives to disclose to a hospital or health care service plan, insurer or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a Group Benefit Agreement held by my employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them to the extent necessary for utilization review or financial audit purposes. This authorization shall become effective immediately and shall remain in effect as long as Health Net is asked to process claims under my coverage. A photostatic copy of this authorization shall be considered as effective and valid as the original. I hereby certify that the above statements are correct.

Name of person completing form (please print):	Signature:
Date:	Relationship – description of authority to act on behalf of the member, if applicable:

[1] "Proof of Payment" includes: a copy of the credit card charge slip or online statement, canceled checks, a bank account statement, cash withdrawal slips, or a cruise ship statement. **Note:** Invoices are not acceptable proof of payment.

[2] You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the plan, as referenced in the Notice of Privacy Practices.

(continued)

Section 4: Foreign claims questionnaire

If you received health care services while traveling outside of the United States, or on a cruise in foreign or domestic waters, you'll need to complete this section. Be sure to answer every question so your claim can be processed quickly. Please provide all available documents for services received.

What dates were you traveling out of the country?
What was the nature of your emergency resulting in medical treatment?
How long were you ill before you received medical attention?

Were you admitted into the hospital? ☐ Yes ☐ No	If treated as an outpatient, how many times did you see the doctor?
Name of the hospital, clinic or doctor's office where you received treatment:	Dates of admission:
Address:	
Country:	Phone number:
Name of treating physician:	Phone number:
Did you receive diagnostic tests? ☐ Yes ☐ No	If "Yes," what type?
Were surgical procedures performed? ☐ Yes ☐ No	If "Yes," what type?
Was your primary doctor in the U.S. notified? ☐ Yes ☐ No	If "Yes," when?

Note: Only covered benefits or those deemed medically necessary will be considered for reimbursement.

For your protection, California law requires the following statement to appear on this form.
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Prescription Drug *Claim Form*

This claim form is to be used for reimbursement on covered medications provided by pharmacies. The filing of this form does not guarantee reimbursement. Please consult your plan documents for additional coverage information. If you have any questions regarding this form, or require additional forms, please contact Health Net of California, Inc. or Health Net Life Insurance Company (Health Net) at the telephone number listed on your member ID card, or visit **www.healthnet.com.**

Instructions

1. Complete the subscriber/enrollee information section below. You'll find your subscriber ID and group numbers on your Health Net ID card or on the copy of your application that serves as your temporary ID.
2. Please have your pharmacist complete the section on the back, and submit an itemized pharmacy receipt that includes the same information.
3. You must complete a separate claim form for each family member. You also need a separate form for each pharmacy you use.
4. This form must be completed in full, or it will be returned for completion. Please allow four weeks for completed claim forms to be processed.
5. Return the completed form to:
   Health Net of California
   C/O Caremark
   PO Box 52136
   Phoenix, AZ 85072-2136

Subscriber/Enrollee

Subscriber/Enrollee ID #:	Group #:	Contact phone #:	
Subscriber/Enrollee last name:	First name:		MI:
Address:	City:	State:	ZIP:
Patient name:	Prescriptions were for (diagnosis):	Patient's gender:	Date of birth:

Is this medication for an on-the-job-injury? ☐ Yes ☐ No

Is this medication covered under any other group insurance plan? ☐ Yes ☐ No

If "Yes," give name of insurance company and other employer: _____

Health Net PPO, Flex Net and Medicare Supplement are fully underwritten by Health Net Life Insurance Company.

HealthNet HMO is offered by Health Net of California, Inc. Health Net of California, Inc. is a subsidiary of Health Net, Inc.

I certify that the above information is correct and that the above-written person is eligible for benefits. I have received the medication described herein and authorize release of all information contained on this voucher to Health Net or its agent.

I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment or attempting assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

Any person who knowingly presents a false or fraudulent claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

X _____ _____

Signature (insured person) Date

(continued)

Please ask your pharmacist to complete the remaining portion. We cannot process this form without this information.

Rx number: 1.	Date filled:	Check one: ☐ New ☐ Rx refill ☐ Compound	Quantity:	Rx directions:	Days supply:	Rx price incl tax:
Medication name and strength:				MD DEA number:	NDC number required:	
Rx number: 2.	Date filled:	Check one: ☐ New ☐ Rx refill ☐ Compound	Quantity:	Rx directions:	Days supply:	Rx price incl tax:
Medication name and strength:				MD DEA number:	NDC number required:	
Rx number: 3.	Date filled:	Check one: ☐ New ☐ Rx refill ☐ Compound	Quantity:	Rx directions:	Days supply:	Rx price incl tax:
Medication name and strength:				MD DEA number:	NDC number required:	

If compound – please fill out the information below.

Place pharmacy label here.

Pharmacy name_____

Street address_____

City_____ State_____ ZIP_____

7-digit NABP number required _____

(Please obtain this number from your pharmacy.)

Are you a Health Net participating pharmacy? ☐ Yes ☐ No

Pharmacist signature X _____

Note: Benefits are payable directly to the covered individual, and any assignment of these benefits is void.

Compound prescription information

☐ Include Rx number(s), drug name(s), strength(s), and date filled.

☐ Include all the NDC number(s) for the drug(s) dispensed.

☐ Indicate the "metric quantity" expressed in number of tablets, grams or mls for liquids, creams, ointments, and injectables.

Compound prescriptions

Rx number	NDC number	Drug ingredient	Quantity	Cost

Nondiscrimination Notice

Health Net Life Insurance Company (Health Net) complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at 1-800-250-5226 (TTY: 711).

If you believe that Health Net has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Health Net's Customer Contact Center at the number above and telling them you need help filing a grievance. Health Net's Customer Contact Center is available to help you file a grievance. You can also file a grievance by mail, fax or email at:

Health Net Life Insurance Company Appeals & Grievances
PO Box 10348
Van Nuys, CA 91410-0348
Fax: 1-877-831-6019
Email: Member.Discrimination.Complaints@healthnet.com (Covered Persons) or
Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

You may submit a complaint by calling the California Department of Insurance at 1-800-927-4357 or online at https://www.insurance.ca.gov/01-consumers/101-help/index.cfm.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English
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 call 1-800-250-5226 (TTY: 711).

Arabic
خدمات اللغة مجانية. يمكنك الحصول على مترجم فوري. ويمكنك الحصول على وثائق مقروءة لك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية، أو اتصل على مركز الاتصال التجاري 1-800-250-5226 (TTY: 711)

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեզ համար: Օգնության համար զանգահարեք մեզ ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք 1-800-250-5226 (TTY: 711).

Chinese
免費語言服務。您可使用口譯員。您可請人使用您的語言將文件內容唸給您聽，並請我們將有您語言版本的部分文件寄給您。如需協助，請致電您會員卡上所列的電話號碼與我們聯絡，或致電 1-800-250-5226 (TTY: 711)。

Hindi
बिना लागत की भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं। आपको दस्तावेज पढ़ कर सुनाए जा सकते हैं। मदद के लिए, आपके आईडी कार्ड पर दिए गए सूचीबद्ध नंबर पर हमें कॉल करें, या 1-800-250-5226 (TTY: 711)।

Hmong
Kev Pab Txhais Lus Dawb. Koj xav tau neeg txhais lus los tau. Koj xav tau neeg nyeem cov ntaub ntawv kom yog koj hom lus los tau. Xav tau kev pab, hu peb tau rau tus xov tooj ntawm koj daim npav los yog hu 1-800-250-5226 (TTY: 711).

Japanese
無料の言語サービス。通訳をご利用いただけます。文書をお読みします。援助が必要な場合は、IDカードに記載されている番号までお電話いただくか、1-800-250-5226 、(TTY: 711)。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ អ្នកអាចស្តាប់គេអានឯកសារឱ្យអ្នក។ សម្រាប់ជំនួយ សូមទាក់ទងយើងខ្ញុំតាមរយៈលេខទូរសព្ទដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬ ទាក់ទងទៅមជ្ឈមណ្ឌលទំនាក់ទំនងពាណិជ្ជកម្ម នៃក្រុមហ៊ុន 1-800-250-5226 (TTY: 711).។

Korean
무료 언어 서비스. 통역 서비스를 받을 수 있습니다. 귀하가 구사하는 언어로 문서의 낭독 서비스를 받으실 수 있습니다. 도움이 필요하시면 보험 ID 카드에 수록된 번호로 전화하시거나 1-800-250-5226 (TTY: 711).

Navajo
Saad Bee Áká E'eyeed T'áá Jíík'e. Ata' halne'ígíí hóló. T'áá hó hazaad k'ehjí naaltsoos hach'į' wóltah. Shíká a'doowoł nínízingo naaltsoos bee néího'dólzinígíí bikáa'gi béésh bee hane'í bikáá' áajį' hodíílnih éí doodaii' 1-800-250-5226 (TTY: 711).

Persian (Farsi)
خدمات زبان به طور رایگان. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید که اسناد برای شما قرائت شوند. برای دریافت راهنمایی، با ما به شماره ای که روی کارت شناسایی شما درج شده تماس بگیرید یا با مرکز تماس بازرگانی 1-800-250-5226 (TTY: 711).

Panjabi (Punjabi)
ਬਨਿਾਂ ਕਸਿੇ ਲਾਗਤ ਤੋ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ਿਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਚਿ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦੱਤਿੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਕਰਿਪਾ ਕਰਕੇ 1-800-250-5226 (TTY: 711).

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Кроме того, вы можете позвонить в 1-800-250-5226 (TTY: 711).

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete. Puede obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o comuníquese con el 1-800-250-5226 (TTY: 711).

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng isang interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo. Para sa tulong, tawagan kami sa nakalistang numero sa inyong ID card o tawagan ang 1-800-250-5226 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังได้ สำหรับความช่วยเหลือ โทรหาเราตามหมายเลขที่ให้ไว้บนบัตรประจำตัวของคุณ หรือ โทรหาศูนย์ติดต่อเชิงพาณิชย์ของ 1-800-250-5226 (TTY: 711)

Vietnamese
Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu cầu được đọc cho nghe tài liệu. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ ID của quý vị hoặc gọi 1-800-250-5226 (TTY: 711).