Summary *of* Benefits

PPO • Insurance Plan 4CR

DELIVERING CHOICES

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

If you have further questions, contact us:

By phone at 1-888-893-1572,

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

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

HNL believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at your group or to HNL's Customer Contact Center at the phone number on the back of your HNL ID Card. If you are enrolled in an employer plan that is subject to ERISA, 29 U.S.C. 1001 et seq, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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

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How the insurance plan works

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

SELECTION OF PHYSICIANS

This insurance plan allows you to:

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

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

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

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

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

HOW TO ENROLL

Your employer require you to use an electronic enrollment form or an interactive voice response enrollment system. Please contact your employer for more information

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

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

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

Schedule of benefits and coverage

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

Principal benefits and coverage matrix

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

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

Insurance Plan maximums	PPO	OON (out-of network)

Yearly Out-of-pocket maximum (OOPM) *(combined with Managed Health Network MHN)*

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

Chiropractic services copay/coinsurance do not apply toward out-of-pocket maximum. Once member meets out-of-pocket maximum, then benefits paid at 100% for the remaining of the calendar year PLUS the next calendar year

For each covered person	$1500	$1500
For a family	$3000	$3000

Type of services, benefit maximums & what you pay

Professional services	PPO	OON
Visit to physician	Covered in full	10%
Specialist consultations	Covered in full	10%
Visit to Christian Science practioner	Not Covered	10%
Prenatal and postnatal office visits	Covered in full	10%
Normal delivery, cesarean section, newborn inpatient professional care*	Covered in full	10%
Treatment of complications of pregnancy, including medically necessary abortions*	See note below**	See note below**
Physician visit to hospital or skilled nursing facility	Covered in full	10%
Surgeon or assistant surgeon services▲, *	Covered in full	10%
Administration of anesthetics	Covered in full	10%
Rehabilitative therapy (including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)*	Covered in full	10%
Organ and stem cell transplants (nonexperimental and noninvestigational)*	Covered in full	10%
Companion and donor travel**	Covered in full	10%
Chemotherapy	Covered in full	10%

Radiation therapy ..... Covered in full..... 10%

Vision and hearing examinations (for diagnosis or treatment, including refractive eye examinations) (birth through age 17) ..... Covered in full..... 10%

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

***** *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested.*

****** *Companion and donor travel. (Limited to the cost of 1 round trip coach airfare. Also, hotel or motel accommodation is limited to the number of days the member is confined in a hospital or medical facility.)*

▲ *Surgery includes surgical reconstruction of a breast incident to mastectomy, including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema.*

Allergy treatment and other injections (except for infertility injections)	**PPO**	**OON**
Allergy testing	Covered in full	10%
Allergy serum	Covered in full	10%
Allergy injection services	Covered in full	10%
Injections (except for infertility)		
Injectable drugs administered by a physician	Covered in full	10%
Self-injectable drugs*****	Covered in full	10%

***** *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested.*

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

Outpatient services	**PPO**	**OON**
Outpatient facility services (other than surgery, except for infertility services)*****	Covered in full	10%
Outpatient surgery (hospital or outpatient surgery center charges only, except for infertility services)*****	Covered in full	10%

***** *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested.*

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

Hospital services	PPO	OON
Semi-private hospital room or special care unit with ancillary services, including delivery and maternity care (unlimited days)*	Covered in full	10%
Hospitalization for infertility services	Covered in full	10%
Christian science sanatorium	Not Covered	10%
Skilled nursing facility stay*	Covered in full	10%

***** *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested.*

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

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

Radiological services	PPO	OON
Laboratory procedures and diagnostic imaging (including x-ray)	Covered in full	10%

These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested.

Preventive Care	PPO	OON
Adult preventive care		
Periodic health evaluations, including well-woman exam and annual preventive physical examinations (age 18 and older) ▣	Covered in full	10%
Immunization (age 18 and older)	Covered in full	10%
Child preventive care		
Periodic health evaluations, including newborn, well-baby care, annual preventive physical examinations and immunizations (birth through age 17) ⓘ	Covered in full	10%

▣ *Provided on the basis of age, medical need and health status. Adult preventive care includes: Mammography, cervical cancer screening test/pelvic and breast exams, preventive vision and hearing screening examinations and screening colonoscopy or sigmoidoscopy (refer to the Certificate for frequency and guidelines). However, if during the course of a screening colonoscopy or sigmoidoscopy, a therapeutic (surgical) procedure is performed, then the copayment or coinsurance applicable for outpatient surgery will also be required for the surgical procedure(s) performed. Refer to the "Outpatient Services" section above for the outpatient surgery copayment or coinsurance.*

ⓘ *Limited to evaluation and management of child's physical development for prevention of future medical problems, laboratory tests, x-rays, preventive vision and hearing screening examinations and standard immunizations.*

Emergency health coverage	PPO	OON
Emergency room (facility and professional services)	Covered in full	10%
Urgent care center (facility and professional services)	Covered in full	10%

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

Ambulance services	PPO	OON
Ground ambulance	Covered in full	Covered in full
Air ambulance*	Covered in full	Covered in full

These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested.

Medical supplies	PPO	OON
Durable medical equipment *	Covered in full	Covered in full
Diabetes education	Covered in full	Not Covered
Orthotics (such as bracing, supports and casts)*	Covered in full	10%
Corrective footwear*	Covered in full	10%
Diabetic equipment	Covered in full	10%
Prostheses*	Covered in full	10%
Diabetic footwear	Covered in full	10%
Hearing aids	Covered in full	Covered in full
Lifetime maximum ♁	*$1,500*	*$1,500*

♁ *Combined for PPO and Out-of-Network.*

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

Diabetic equipment and supplies are covered under the medical benefit (through "Diabetic equipment") and include blood glucose monitors (and monitors designed for the visually impaired) and testing strips, corrective footwear, insulin pumps and related supplies, specific brands of pen delivery systems for the administration of insulin (including pen needles), Ketone test strips, insulin syringes, and lancets and puncture devices when used in monitoring blood glucose levels.

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

Your physician must contact the HNL Pharmacy Department for prior authorization before you can obtain the following covered items upon presentation of your prescription at a contracting HNL Pharmacy: reusable pen delivery systems, specific brands of disposable insulin needles and syringes, and disposable pen needles.

***** *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested.*

Mental disorders and chemical dependency benefits	**PPO**	**OON**

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

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

Severe Mental Illness and Serious Emotional Disturbances of a Child

Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting) ◆..... Covered in full..... 10%

Inpatient services*..... Covered in full..... 10%

Other Mental Disorders

Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting) ◆..... Covered in full..... 10%

Inpatient* ..... Covered in full..... 10%

Chemical Dependency

Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting) ◆..... Covered in full..... 10%

Inpatient* ..... Covered in full..... 10%

Acute detoxification*..... Covered in full..... 10%

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

* *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested.*

Home Health Services	PPO	OON
Home health visits*	Covered in full.....	10%

* *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested.*

Other services	PPO	OON
Sterilization - Vasectomy	Covered in full	10%
Sterilization - Tubal ligation	Covered in full	10%
Blood, blood plasma, blood derivatives and blood factors	Covered in full	10%
Renal dialysis	Covered in full	10%
Hospice services*	Covered in full	10%
Infusion therapy (home or physician's office) *	Covered in full	10%
Number of days for each supply of injectable prescription drugs and other substances, for each delivery	*14*	*14*

***** *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested.*

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

Infertility services	PPO	OON
Infertility services and supplies (all covered services that diagnose, evaluate or treat infertility)	Covered in full	10%

Notes:

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

Chiropractic care	PPO	OON
Office visits*	10%	10%
Calendar year maximum[ϡ]	*$1500*	*$1500*

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

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

Acupuncture care	PPO	OON
Office visits*	10%	10%

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

Limits of coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- Air or ground ambulance and paramedic services that are not emergency care or which do not result in a patient's transportation will not be covered unless certification is obtained and services are medically necessary.
- Artificial insemination;
- Care for mental health care as a condition of parole or probation, or court-ordered treatment and testing for mental disorders, except when such services are medically necessary;
- Charges in excess of rate negotiated between any organization and the physician, hospital or other provider;
- Conception by medical procedures (IVF, GIFT and ZIFT);
- Conditions resulting from the release of nuclear energy when government funds are available;
- Corrective footwear is not covered unless medically necessary and custom made for the covered person;
- Cosmetic services or supplies;
- Custodial or live-in care;
- Dental services. However, medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures are covered. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate;
- Disposable supplies for home use;
- Experimental or investigational procedures, except as set out under the "Clinical trials" and "If you have a disagreement with our insurance plan" sections of this SB;
- Genetic testing is not covered except when determined by Health Net Life to be medically necessary. The prescribing physician must request prior authorization for coverage;
- Hearing aids;
- Hypnosis;
- Immunization (age 17 and older);
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder;
- Non-eligible institutions. This insurance plan only covers services or supplies provided by a legally operated hospital, Medicare-approved skilled nursing facility or other properly licensed facility as specified in the *Certificate*. Any institution, regardless of how it is designated, is not an eligible institution. Services or supplies provided by such institutions are not covered;
- Nontreatable disorders;
- Orthoptics (eye exercises);
- Orthotics (such as bracing, supports and casts) that are not custom made to fit the covered person's body. Refer to the "corrective footwear" bullet above for additional foot orthotic limitations;
- Outpatient prescriptions drugs or medications;
- Personal or comfort items;
- Physician self-treatment;
- Physician treating immediate family members;
- Pre-existing conditions that occur during the first six months of your coverage, except as stated elsewhere;
- Private rooms when hospitalized, unless medically necessary;

- Private-duty nursing;
- Refractive eye surgery unless medically necessary, recommended by the covered person's treating physician and authorized by Health Net Life;
- Reversal of surgical sterilization;
- Routine physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp or other nonpreventive purposes;
- Services and supplies determined not to be medically necessary as defined in the *Certificate*;
- Services and supplies not specifically listed in the plan's *Certificate* as covered expenses;
- Services and supplies that do not require payment in the absence of insurance;
- Services for an injury incurred in the commission (or attempted commission) of a crime unless the condition was an injury resulting from an act of domestic violence or and injury resulting from a medical condition;
- Services for conditions of pregnancy for a surrogate pregnancy are covered when the surrogate parent is the covered person under this HNL plan. However, when compensation is obtained for the surrogacy, Health Net Life shall have a lien on such compensation to recover its medical expense. A surrogate parent is a woman who agrees to become pregnant with the intent of surrendering custody of the child to another person;
- Services not related to a covered illness or injury, except as provided under preventive care and annual routine exams;
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the plan's *Certificate*;
- Services related to educational and professional purposes, except for behavioral health treatment for pervasive developmental disorder or autism;
- Sex change services;
- State hospital treatment, except as the result of an emergency or urgently needed care;
- Stress, except when rendered in connection with services provided for a treatable mental disorder;
- Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary;
- Treatment of obesity, weight reduction or weight management, except for treatment of morbid obesity;

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

Benefits and coverage

WHAT YOU PAY FOR SERVICES

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

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

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

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

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

NOTICE OF REQUIRED COVERAGE

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

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

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

SERVICES REQUIRING CERTIFICATION[1]

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

Services that require certification include:

All inpatient admissions, any facility:

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

Ambulance

- Non-emergency air or ground ambulance services
- Ambulance service not resulting in patient transport

Bariatric-related services:

- Non-surgical bariatric-related consultations and services
- All bariatric-related surgical services

Clinical trials

Custom orthotics

Durable medical equipment:

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

Experimental/investigational services and new technologies.

Home Health Care Services including home uterine monitoring, hospice, intravenous (IV) infusion, nursing, occupational therapy, physical therapy, speech therapy, and tocolytic services.

Hospice Care

Intensity modulated radiation therapy (IMRT)

Occupational and speech therapy.

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

Outpatient Diagnostic Imaging:

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

Outpatient pharmaceuticals

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

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

Outpatient surgical procedures including:

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

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

Stereotactic radiosurgery and stereotactic body radiotherapy (SBRT).

Tocolytic services (intravenous drugs used to decrease or stop uterine contraction in premature labor)

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

CREDITABLE COVERAGE

In accordance with state and federal law, you are entitled to credit for creditable coverage, which may reduce or offset the pre-existing condition exclusion applicable under this PPO insurance plan. Creditable coverage includes any individual, group or government plan medical insurance coverage that you had from another carrier immediately prior to enrolling in this PPO insurance plan. Health Net Life will give you credit for any creditable health coverage, and will assist you in obtaining this information if you are unable to do so.

Creditable coverage will not be granted if you were without health coverage for more than 63 days prior to enrolling in this PPO insurance plan, unless your previous health coverage was discontinued because you lost your job. In such an event, you are entitled to qualifying creditable coverage credit as long as you enroll within 180 days of the end of your previous coverage.

Coverage under the following types of policies does not qualify for creditable coverage: accident only, automobile or no-fault insurance, dental, disability income, long-term care vision and workers' compensation. For a more complete list of policies that do not qualify for creditable coverage please refer to the Certificate.

COVERAGE FOR NEWBORNS

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

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

EMERGENCIES

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

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

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

***Emergency care** means any otherwise covered service for an acute illness, a new injury or an unforeseen deterioration or complication of an existing illness, injury or condition already known*

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

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

MEDICALLY NECESSARY CARE

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

CLINICAL TRIALS

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

CONTINUITY OF CARE

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

EXTENSION OF BENEFITS

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

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

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

OUT OF STATE PROVIDERS

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

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

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

CONFIDENTIALITY AND RELEASE OF COVERED PERSON INFORMATION

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

PRIVACY PRACTICES

Once you become a Health Net Life covered person, Health Net Life uses and discloses a covered person's protected health information and nonpublic personal financial information* for purposes of treatment, payment, health care operations, and where permitted or required by law. Health Net Life provides covered persons with a Notice of Privacy Practices that describes how it uses and discloses protected health information; the individual's rights to access, to request amendments, restrictions, and an accounting of disclosures of protected health information; and the procedures for filing complaints. Health Net Life will provide you the opportunity to approve or refuse the release of your information for non-routine releases such as marketing. Health Net Life provides access to covered persons to inspect or obtain a copy of the covered person's protected health information in designated record sets maintained by Health Net Life. Health Net Life protects oral, written and electronic information across the organization by using reasonable and appropriate security safeguards. These safeguards include limiting access to an individual's protected health information to only those who have a need to know in order to perform payment, treatment, health care operations or where permitted or re-

quired by law. Health Net Life releases protected health information to insurance plan sponsors for administration of self-funded plans but does not release protected health information to plan sponsors/employers for insured products unless the plan sponsor is performing a payment or health care operation function for the plan. Health Net Life's entire Notice of Privacy Practices can be found in the plan's *Certificate*, at www.healthnet.com under "Privacy" or you may call the Customer Contact Center at the telephone number listed on the back cover to obtain a copy.

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

TECHNOLOGY ASSESSMENT

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

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

The expert medical reviewer also advises Health Net Life when patients require quick determinations of coverage, when there is no guiding principle for certain technologies, or when the complexity of a patient’s medical condition requires expert evaluation.

Utilization management

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

PRIOR CERTIFICATION

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

CONCURRENT REVIEW

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

DISCHARGE PLANNING

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

RETROSPECTIVE REVIEW

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

CARE OF CASE MANAGEMENT

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

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

Payment of premiums and charges

YOUR COINSURANCE, COPAYMENT AND DEDUCTIBLES

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

PREPAYMENT OF PREMIUMS

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

OTHER CHARGES

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

When the total amount of deductibles, copayments and coinsurance you pay equals the annual out-of-pocket maximum amount shown in the "Schedule of benefits and coverage" section, you will not have

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

- Charges in excess of covered expenses;
- Charges for services or supplies not covered by this insurance plan;
- Services for which certification was required but not obtained.

For further information please refer to the *Certificate*. Covered expenses for out-of-network providers are limited to the amount shown on the Resource Based Relative Value Schedule (RBRVS) established by the federal government for Medicare and then adjusted by 75%. For those services that do not have a RBRVS amount, Health Net Life has developed a limited fee schedule shown in the *Certificate.*

CONTRACTED RATE

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

LIABILITY OF ENROLLEE FOR PAYMENT

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

REIMBURSEMENT PROVISIONS

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

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

How to file a claim:

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

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

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

Renewing, continuing or ending coverage

RENEWAL PROVISIONS

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

INDIVIDUAL CONTINUATION OF BENEFITS

Please examine your options carefully before declining coverage. 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 your could be denied coverage entirely.

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

- **COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985).** For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside of California. Please check with your group to determine if you and your covered dependents are eligible.
- **Cal-COBRA Continuation Coverage.** If you have exhausted COBRA and you live in the United States, you may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if you began receiving federal COBRA coverage on or after January 1, 2003, have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage and you are not entitled to Medicare. If you are eligible, you have the opportunity to continue group coverage under the *Certificate* through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.
- **USERRA Coverage:** Under a federal law known as the Uniformed Services Employment and Reemployment Rights Act (USERRA), employers are required to provide employees who are absent from employment to serve in the uniformed services and their dependents who would lose

their group health coverage the opportunity to elect continuation coverage for a period of up to 24 months. Please check with your group to determine if you are eligible.

- **HIPAA:** The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people covered under existing group health insurance plans to maintain coverage regardless of pre-existing conditions when they change jobs or are unemployed for brief periods of time. California law provides similar and additional protections. Applicants who meet the following requirements are eligible to enroll in a guaranteed issue individual health insurance plan from any health insurance plan that offers individual coverage without medical underwriting. A health insurance plan cannot reject your application for guaranteed issue individual health coverage if you meet the following requirements, agree to pay the required premiums and live or work in the insurance plan's service area. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance. To be considered an eligible individual:

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

For more information regarding guarantee issue coverage through Health Net Life, please call our Individual Sales Department at 1-800-909-3447. If you believe your rights under HIPAA have been violated, please contact the Department of Insurance at 1-888-927-HELP.

Also, if you become ineligible for group coverage you may convert from group coverage to a type of individual coverage called conversion coverage. Application must be made within 63 days of the date group coverage ends. Please contact the Customer Contact Center for information about conversion insurance plan coverage. Furthermore, you may be eligible for continued coverage for a disabling condition (for up to 12 months) if your employer terminates its agreement with Health Net Life. Please refer to the "Extension of benefits" section of this SB for more information.

TERMINATION OF BENEFITS

Your coverage under this insurance plan ends when:

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

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

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

- You apply for conversion coverage within 63 days of that date; or

- You are totally disabled and apply for an extension of benefits for the disabling condition within 90 days.

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

If you have a disagreement with our insurance plan

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

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

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

GRIEVANCE AND APPEALS PROCESS

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

How to file a grievance or appeal:

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

You may also write to:

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

Please include all the information from your Health Net Life identification card as well as the details of your concern or problem. Health Net Life will acknowledge your grievance or appeal within five calendar days, review the information and tell you of our decision in writing within 15 days of receiving the grievance if the grievance pertains to a claims dispute or within 30 days of receiving the grievance for all other grievances. For conditions where there is an immediate and serious threat to your health, including severe pain or the potential loss of life, limb or major bodily function, Health Net Life will notify you of the status of your grievance no later than three days from receipt of all the required information.

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

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

ARBITRATION

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

Notice of language services

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

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o llame al 800-522-0088. Afiliados a PPO: para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Afiliados a HMO: llame a la Línea de Ayuda del Departamento de Atención Médica Administrada de California (DMHC, por sus siglas en inglés) al 1-888-HMO-2219. **Spanish**

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，部分文件可以翻譯成您的語言並寄送給您。如需協助，請撥您會員卡所列的電話號碼或撥 800-522-0088 與我們聯絡。PPO 會員：如需其他協助，請致電 CA 保險局，電話 1-800-927-4357。HMO 會員：請撥 DMHC 協助專線 1-888-HMO-2219。 **Chinese**

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

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

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

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

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

無料の言語サービス。通訳がご利用になれ、書類を日本語でお読みします。また、書類によっては日本語版をお届けできるものもあります。サービスをご希望の方は、IDカード記載の番号または 800-522-0088 までご連絡ください。PPO加入者: その他のお問い合わせはカリフォルニア州保険庁、1-800-927-4357 までご連絡ください。HMO加入者: DMHCヘルプライン、1-888-HMO-2219 までご連絡ください。 **Japanese**

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

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

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

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

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

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

Contact us

Health Net
Post Office Box 9103
Van Nuys, California 91409-9103

Customer Contact Center

Large Group (for companies with 51 or more employees):
1-888-893-1572 – HMO/Elect Open Access
1-888-893-1572 – PPO/Point-of-Service (SELECT/ELECT)

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

Telecommunications Device for the Hearing and Speech Impaired

1-800-995-0852