Summary of Benefits and Disclosure Form

SELECT • Plan E9H
DELIVERING CHOICES

When it comes to your health care, the best decisions are made with the best choices. Health Net of California, Inc. (Health Net) provides you with ways to help you receive the care you deserve. This Summary of benefits and disclosure form (SB/DF) answers basic questions about this versatile plan.

If you have further questions, contact us.

By phone at 1-800-522-0088,

Or write to: Health Net of California
P.O. Box 10348
Van Nuys, CA 91410-0348

Please examine your options carefully before declining this coverage.

This Summary of benefits/disclosure form (SB/DF) is only a summary of your health plan. The plan’s Evidence of Coverage (EOC), which you will receive after you enroll, contains the exact terms and conditions of your Health Net coverage. You should also consult the Group Hospital and Professional Service Agreement (issued to your employer) to determine governing contractual provisions. It is important for you to carefully read this SB/DF and the plan’s EOC thoroughly once received, especially those sections that apply to those with special health care needs. This SB/DF includes a matrix of benefits in the section titled "Schedule of benefits and coverage."
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How the 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 AND PHYSICIAN GROUPS

With Health Net SELECT Point-of-Service (POS), you have the option to:

- Choose a physician from a POS network of doctors and hospitals affiliated with Health Net that's broader than our HMO network; and

- Take advantage of cost savings and the highest level of benefits when you use doctors affiliated with Health Net.

When you enroll,

- You choose a contracting physician group for the HMO level of care. From your physician group, you select one doctor to provide basic health care; this is your Primary Care Physician (PCP).

- Health Net requires the designation of a Primary Care Physician. A primary care physician provides and coordinates your medical care. You have the right to designate any Primary Care Physician who participates in our 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 Primary Care Physician. Until you make this Primary Care Physician designation, Health Net designates one for you. For information on how to select a Primary Care Physician and for a list of the participating Primary Care Physicians in the Health Net Service Area, refer to your Health Net directory of participating physicians. The provider directory is also available on the Health Net website at www.healthnet.com. You can also call the Customer Contact Center at the number shown on your Health Net I.D. Card to request provider information.

- You do not have to choose the same physician group or PCP for all members of your family. The names of physicians are listed in the Health Net directory of participating providers.

- At any time, you may seek care from other doctors and specialists contracted with Health Net (our preferred providers), or you may go out of network to see providers not contracted with Health Net. Your coverage and benefits are different at the Preferred Provider Organization (PPO) and Out-of-Network (OON) levels of care.
HOW TO CHOOSE A PHYSICIAN (HMO BENEFIT LEVEL)

Choosing a PCP is important to the quality of care you receive. To be comfortable with your choice, we suggest the following:

- Discuss any important health issues with your chosen PCP;
- Ask your PCP or the physician group about the specialist referral policies and hospitals used by the physician group; and
- Be sure that you and your family members have adequate access to medical care, by choosing a doctor located within 30 miles of your home or work.

If you reside outside the Health Net Service Area, then you may enroll based on the subscriber’s work address that is within the Health Net Service Area. Family members who reside outside the Health Net Service Area may also enroll based on the subscriber’s work address that is within the Health Net Service Area. If you choose a physician group based on its proximity to the subscriber’s work address, you will need to travel to that physician group for any non-emergency or non-urgent care that you receive. Additionally, some physician groups may decline to accept assignment of a member whose home or work address is not close enough to the physician group to allow reasonable access to care.

SPECIALISTS AND REFERRAL CARE (HMO BENEFIT LEVEL)

If you need medical care that your PCP cannot provide, your PCP may refer you to a specialist or other health care provider for that care. Refer to the "Mental Disorders and Chemical Dependency Care" section below for information about receiving care for Mental Disorders and Chemical Dependency.

You do not need prior authorization from Health Net or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical, gynecological, reproductive or sexual health care from an in-network health care professional 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 directory of participating physicians. The provider directory is also available on the Health Net website at www.healthnet.com.

MENTAL DISORDERS AND CHEMICAL DEPENDENCY CARE

Health Net contracts with MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator), which administers behavioral health services for mental disorders and chemical dependency conditions. For more information about how to receive care and the Behavioral Health Administrator's prior authorization requirements, please refer to the "Behavioral Health Services" section of this SB/DF.

PPO OR OUT-OF-NETWORK SPECIALISTS

At any time, you may self-refer to specialists using your PPO or Out-of-Network (OON) benefits. Your coverage and benefits will be different, depending on whether you use the services of a PPO or OON specialist.

CVS MINUTE CLINIC SERVICES

The CVS MinuteClinic is a health care facility, generally inside CVS/pharmacy stores, which is designed to offer an alternative to a Physician’s office visit for the unscheduled treatment of non-emergency illnesses or injuries.
such as strep throat, pink eye or seasonal allergies. Visits to a CVS MinuteClinic are covered as shown in the "Schedule of Benefits and Coverage" section.

You do not need prior authorization or a referral from your primary care physician or contracting physician group in order to obtain access to CVS MinuteClinic services. However, a referral from the contracting Physician Group or Primary Care Physician is required for any Specialist consultations under the SELECT 1 level of benefits. For more detailed information about CVS MinuteClinics, please refer to the plan's EOC or contact Health Net at the telephone number shown on the back cover.

HOW TO ENROLL

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

Some hospitals and other providers do not provide one or more of the following services that may be covered under the plan’s 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 the Health Net Customer Contact Center at the phone number on the back cover to ensure that you can obtain the health care services that you need.
Schedule of benefits and coverage

Health Net SELECT℠, a product of Health Net, combines three types of coverage into one health plan. The services covered and amount you must pay will depend upon which option you choose each time you need health care. The following charts show what you pay for most types of service under this plan.

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PLAN CONTRACT AND EVIDENCE OF COVERAGE (EOC) SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Principal benefits and coverage matrix

<table>
<thead>
<tr>
<th>Benefit levels</th>
<th>HMO</th>
<th>PPO</th>
<th>OON</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Features</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Primary Care Physician)</td>
<td>Care provided or authorized by your PCP or physician group contracted with Health Net.</td>
<td>Care provided by a broader network of doctors and specialists contracted with Health Net.</td>
<td>Care provided by any licensed physician not contracted with Health Net.</td>
</tr>
<tr>
<td>Highest level of benefits available at lowest cost</td>
<td>• Higher out-of-pocket costs</td>
<td>• Most expensive out-of-pocket costs</td>
<td></td>
</tr>
<tr>
<td>Convenience of having all your health care services coordinated by your Health Net doctor</td>
<td>• Greater freedom of choice</td>
<td>• Greatest freedom of choice</td>
<td></td>
</tr>
<tr>
<td>Coverage for preventive care services available</td>
<td>• Certification from Health Net required for certain services</td>
<td>• Certification from Health Net required for certain services</td>
<td></td>
</tr>
<tr>
<td>No claim forms</td>
<td>• Claim forms usually not required for reimbursement</td>
<td>• Must meet annual deductible and coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Coverage for preventive care services available</td>
<td>• Claim forms required for reimbursement</td>
<td></td>
</tr>
</tbody>
</table>

For the HMO level of benefits, the change to all small 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.

For the PPO level of benefits, the percentages that appear in this chart are based on the contracted rate.

For Out-of-Network level of benefits, the percentages that appear in this chart are based on the Maximum Allowable Amount. The member is responsible for charges in excess of the Maximum Allowable Amount in addition to the coinsurance shown even after the Out-of-Pocket-Maximum has been reached.
### Deductibles

<table>
<thead>
<tr>
<th></th>
<th>HMO</th>
<th>PPO</th>
<th>OON</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar year deductible</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per member</td>
<td>None</td>
<td>None</td>
<td>$200</td>
</tr>
<tr>
<td>Per family</td>
<td>None</td>
<td>None</td>
<td>$600</td>
</tr>
</tbody>
</table>

### Calendar Year Out-of-Pocket Maximum (OOPM)

Once your payments for covered services and supplies for each benefit level equals the amount shown below in any one calendar year, no additional copayment or coinsurance for covered services and supplies are required for the remainder of that calendar year for that benefit level, except as specifically stated. Once an individual member in a family satisfies the individual out-of-pocket maximum, the remaining enrolled family members must continue to pay copayments for covered services and supplies until the total amount of copayments paid by the family reaches the family out-of-pocket maximum or each enrolled family member individually satisfies the individual out-of-pocket maximum.

*Payments for services not covered by this plan, or for certain services as specified in the “Payment of fees and charges” section of this SB/DF, will not be applied to the yearly out-of-pocket maximum, unless otherwise noted. Also, copayments and deductibles for prescription drugs do not apply to the out-of-pocket maximum, unless otherwise noted. You must continue to pay copayments for any services and supplies that do not apply to the out-of-pocket maximum.*

#### Out-of-Pocket maximum for medical plans

<table>
<thead>
<tr>
<th>Family size</th>
<th>HMO</th>
<th>PPO</th>
<th>OON</th>
</tr>
</thead>
<tbody>
<tr>
<td>One member</td>
<td>$1500</td>
<td>$2000</td>
<td>$3000</td>
</tr>
<tr>
<td>Two members</td>
<td>$3000</td>
<td>$4000</td>
<td>$6000</td>
</tr>
<tr>
<td>Family (three members or more)</td>
<td>$4500</td>
<td>$6000</td>
<td>$9000</td>
</tr>
</tbody>
</table>

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

#### Out-of-Pocket maximum for pharmacy plans

<table>
<thead>
<tr>
<th>Family size</th>
<th>HMO</th>
<th>PPO</th>
<th>OON</th>
</tr>
</thead>
<tbody>
<tr>
<td>One member</td>
<td>$2000</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Family (three members or more)</td>
<td>$4000</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

*Once your payments for prescription drugs equals the amount shown above in any one calendar year, no additional copayments for prescription drugs are required for the remainder of the calendar year. Once an individual member in a family meets the individual out-of-pocket maximum, the other enrolled family members must continue to pay copayments for covered services and supplies until the total amount of copayments paid by the family reaches the family out-of-pocket maximum or each enrolled family member individually meets the individual out-of-pocket maximum. Payments for any other services or supplies will not count toward this calendar year out-of-pocket maximum, unless otherwise noted.*

*Out-of-pocket costs for prescription drugs exceeding prescription drug benefit coverage and any cost differential between brand/generic medications when dispensing brand name drugs not based on medical necessity.*
The copayments and coinsurances below apply to professional services only. Services that are rendered in a hospital or an outpatient center are also subject to the hospital or outpatient center services copayment or coinsurance. See “Hospitalization services” and “Outpatient services” in this section to determine if any additional payments may apply.

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Professional services</th>
<th>HMO</th>
<th>PPO</th>
<th>OON</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit to physician</td>
<td></td>
<td>$15</td>
<td>$20</td>
<td>30%</td>
</tr>
<tr>
<td>Visit to CVS MinuteClinic (preventive services)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MinuteClinic Services (All other non-preventive services)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist or specialty care consultations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal and postnatal visits</td>
<td>Covered in full</td>
<td></td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Normal delivery, cesarean section, newborn inpatient professional care</td>
<td>Covered in full</td>
<td></td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Treatment of complications of pregnancy</td>
<td>See note below**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon or assistant surgeon services</td>
<td>Covered in full</td>
<td>10%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Administration of anesthetics</td>
<td>Covered in full</td>
<td>10%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Laboratory procedures and diagnostic imaging (including x-ray) services</td>
<td>Covered in full</td>
<td></td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Rehabilitative therapy (including physical, speech, occupational, cardiac treatment and pulmonary rehabilitation therapy)</td>
<td>Covered in full</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar year maximum</td>
<td>No maximum</td>
<td></td>
<td>60 visits</td>
<td>60 visits</td>
</tr>
<tr>
<td>Organ and stem cell transplants (nonexperimental and noninvestigational)</td>
<td>Covered in full</td>
<td></td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Covered in full</td>
<td></td>
<td></td>
<td>30%</td>
</tr>
<tr>
<td>Radiation therapy</td>
<td>Covered in full</td>
<td></td>
<td></td>
<td>30%</td>
</tr>
<tr>
<td>Vision and hearing examinations (for diagnosis or treatment) (birth through age 17)</td>
<td>$15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision and hearing examinations (for diagnosis or treatment) (age 18 and older)</td>
<td>$15</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* For the HMO level of benefits, self-referrals are allowed for obstetrician and gynecological services including preventive care, pregnancy and gynecological ailments. Copayment requirements may differ depending on the service provided. The office visit copayment applies to visits to a primary care physician at a contracting physician group. The specialist copayment for specialist consultations will apply for visits to a member physician who is not a primary care physician.

** Specialist referrals following care at the CVS MinuteClinic must be obtained through the contracting physician group under the SELECT 1 level of benefits. Preventive care services through the CVS MinuteClinic are subject to the copayment shown below under "Preventive care."

*Prenatal, postnatal and newborn care that are preventive care services are covered in full under SELECT 1 and 2. See copayment listings for preventive care services below. If other non-preventive care services are received during the same office visit, the above copayment or coinsurance will apply for the non-preventive care services.

** Applicable deductible, copayment or coinsurance requirements apply to any services and supplies required for the treatment of an illness or condition, including but not limited to, complications of pregnancy. For example, if the complication requires an office visit, then the office visit copayment or coinsurance will apply.
Surgery includes surgical reconstruction of a breast incident to mastectomy (including lumpectomy), including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema. While Health Net and your physician group will determine the most appropriate services, the length of hospital stay will be determined solely by your PCP.

Some services require certification for PPO and OON coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB/DF. Routine care for condition of pregnancy does not require prior certification. However, notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced under the PPO and OON levels of benefits to 50% of covered expenses and a $250 penalty will also be charged for each inpatient admission.

Combined for PPO and Out-of-Network.

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>HMO</th>
<th>PPO</th>
<th>OON</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care services (birth through age 17)</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>30%</td>
</tr>
<tr>
<td>Preventive care services (age 18 and older)</td>
<td>Covered in full</td>
<td>Covered in full</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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 (USPSTF) Grade A&B recommendations, the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention, the guidelines for infants, children, adolescents and women’s preventive health care as supported by the Health Resources and Services Administration (HRSA).

For the HMO level of benefits, self-referrals are allowed for obstetrician and gynecological services including preventive care, pregnancy and gynecological ailments. Copayment requirements may differ depending on the service provided.

Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures 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 (as prescribed by your Physician) 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.

<table>
<thead>
<tr>
<th>Allergy treatment and other injections (except for infertility injections)</th>
<th>HMO</th>
<th>PPO</th>
<th>OON</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy testing</td>
<td>Covered in full</td>
<td>$20</td>
<td>30%</td>
</tr>
<tr>
<td>Allergy serum</td>
<td>$15</td>
<td>$20</td>
<td>30%</td>
</tr>
<tr>
<td>Allergy injection services</td>
<td>Covered in full</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Immunizations -- To meet foreign travel or occupational requirements</td>
<td>20%</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Injections (except for infertility)
- Office-based injectable medications (per dose) | Covered in full | 10% | 30% |

- 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 are covered under the outpatient prescription drug benefit and require prior authorization. Please refer to the plan's EOC for additional information.

- Certain injectable drugs which are considered self-administered are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefits even if they are administered in a physician’s office. If you need to have the provider administer the Specialty Drug, you will need to obtain the Specialty Drug prior authorization.
Injections for the treatment of infertility are described below in the "Infertility services" section.

<table>
<thead>
<tr>
<th>Outpatient Facility services</th>
<th>HMO</th>
<th>PPO</th>
<th>OON</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient facility services (other than surgery) *</td>
<td>Covered in full</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Outpatient surgery (surgery performed in a hospital or outpatient surgery center only) *</td>
<td>Covered in full</td>
<td>10%</td>
<td>30%</td>
</tr>
</tbody>
</table>

*Some services require certification for PPO and OON coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB/DF. Routine care for condition of pregnancy does not require prior certification. However, notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced under the PPO and OON levels of benefits to 50% of covered expenses and a $250 penalty will also be charged for each inpatient admission.

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

<table>
<thead>
<tr>
<th>Hospital services</th>
<th>HMO</th>
<th>PPO</th>
<th>OON</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi-private hospital room or special care unit with ancillary services, including delivery and maternity care (unlimited days) *</td>
<td>Covered in full</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Skilled nursing facility stay (per admission) *</td>
<td>Covered in full</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Calendar year maximum</td>
<td>50 days</td>
<td>60 days</td>
<td>60 days</td>
</tr>
<tr>
<td>Physician visit to hospital or skilled nursing facility</td>
<td>Covered in full</td>
<td>10%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Combined for PPO and Out-of-Network.

*Some services require certification for PPO and OON coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB/DF. Routine care for condition of pregnancy does not require prior certification. However, notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced under the PPO and OON levels of benefits to 50% of covered expenses and a $250 penalty will also be charged for each inpatient admission.

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

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

<table>
<thead>
<tr>
<th>Emergency health coverage</th>
<th>HMO</th>
<th>PPO</th>
<th>OON</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional services</td>
<td>Covered in full</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Emergency room</td>
<td>$50</td>
<td>$75</td>
<td>30%</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$35</td>
<td>$50</td>
<td>30%</td>
</tr>
</tbody>
</table>
The copayment shown for HMO emergency health care coverage will be applied for all emergency care, regardless of whether or not the health care provider is an HMO, PPO, or noncontracting provider. The copayments shown for PPO and OON providers are applicable only if non-emergency care is provided at an emergency room or urgent care center. Copayments for emergency room or urgent care center visits will not apply if the member is admitted as an inpatient directly from the emergency room or urgent care center. A visit to one of the urgent care centers that is owned and operated by the member’s physician group will be considered an office visit and the office visit copayment, if any, will apply.

<table>
<thead>
<tr>
<th>Ambulance services</th>
<th>HMO</th>
<th>PPO</th>
<th>OON</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ground ambulance*</td>
<td>Covered in full</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Air ambulance*</td>
<td>Covered in full</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Maximum per incident*</td>
<td>Unlimited</td>
<td>$750</td>
<td>$750</td>
</tr>
</tbody>
</table>

Combined for PPO and Out-of-Network.

* Some services require certification for PPO and OON coverage. For a complete listing of services requiring certification please refer to the “Services requiring certification” section of this SB/DF. Routine care for condition of pregnancy does not require prior certification. However, notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced under the PPO and OON levels of benefits to 50% of covered expenses and a $250 penalty will also be charged for each inpatient admission.

Prescription drug coverage

Please refer to the “Prescription drug program” section of this SB/DF for applicable definitions, benefit descriptions and limitations.

Retail participating pharmacy (up to a 30-day supply)

Tier 1 drugs (primarily generic) ................................................................. $5
Tier 2 drugs (primarily preferred brand name drugs, peak
  flow meters, inhaler spacers and diabetic supplies,
  including insulin) * ................................................................. $15
Tier 3 drugs or non-preferred drugs not on the Commercial
  Formulary * ........................................................................... $30
Appetite Suppressants ................................................................. 50%
Lancets .................................................................................. Covered in full
Preventive drugs, including smoking cessation drugs and
  women’s contraceptives* .......................................................... Covered in full

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

Tier 1 drugs (primarily generic) ................................................................. $10
Tier 2 (primarily preferred brand name drug and diabetic
  supplies, including insulin) * ...................................................... $30
Tier 3 drugs or non-preferred drugs not on the Commercial
  Formulary * ........................................................................... $60
Lancets .................................................................................. Covered in full
Preventive drugs, including smoking cessation drugs and
  women’s contraceptives* .......................................................... Covered in full

Orally administered anti-cancer drugs will have a copayment maximum of $200 for an individual prescription of up to a 30-day supply.

For information about Health Net’s Commercial Formulary, please call the Customer Contact Center at the telephone number on the back cover.

* Generic drugs will be dispensed when a generic drug equivalent is available unless a brand name drug is specifically requested by the physician or the member. When a brand name drug is dispensed and a generic equivalent is commercially available, the member must pay the difference between the generic equivalent and the brand name drug plus the Tier 1 drug copayment.
However, if the prescription drug order states "dispense as written," "do not substitute" or words of similar meaning in the physician’s handwriting to indicate medical necessity, only the Tier 2 or Tier 3 drug copayment, as appropriate, will be applicable.

* Preventive drugs, including smoking cessation drugs and women’s contraceptives that are approved by the Food and Drug Administration are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations.

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

If the pharmacy’s or the mail order administrator’s retail price is less than the applicable copayment, then you will pay the pharmacy’s or the mail order administrator’s retail price. Prescription drug covered expenses are the lesser of Health Net’s contracted pharmacy rate or the pharmacy’s retail price for covered prescription drugs.

Percentage Copayments will be based on Health Net’s contracted pharmacy rate.

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This plan uses the Commercial Formulary. The Health Net Commercial Formulary 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. The Commercial Formulary also shows which drugs are Tier 1, Tier 2 or Tier 3, so you know which copayment applies to the covered drug. Drugs that are not on the Commercial Formulary (that are not excluded or limited from coverage) are also covered at the Tier 3 drug copayment.

Some drugs require prior authorization from Health Net. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 24 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 72 hours, as appropriate and medically necessary, for the nature of the member’s condition after Health Net’s receipt of the information reasonably necessary and requested by Health Net to make the determination. For a copy of the Commercial Formulary, call the Customer Contact Center at the number listed on the back cover of this booklet or visit our website at www.healthnet.com.

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### Medical supplies

<table>
<thead>
<tr>
<th>Category</th>
<th>HMO</th>
<th>PPO</th>
<th>OON</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable medical equipment (including nebulizers, face masks and tubing for the treatment of asthma)*</td>
<td>Covered in full</td>
<td>50%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Orthotics (such as bracing, supports and casts)</td>
<td>Covered in full</td>
<td>10%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Diabetic equipment See the &quot;Prescription Drug Program&quot; section of the SB/DF for diabetic supplies benefit information</td>
<td>Covered in full</td>
<td>50%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Diabetic footwear</td>
<td>Covered in full</td>
<td>10%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Prostheses*</td>
<td>Covered in full</td>
<td>10%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>Covered in full</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Maximum limited every 36 months*</td>
<td>$1000</td>
<td>$1000</td>
<td>$1000</td>
</tr>
</tbody>
</table>

* Combined for PPO and Out-of-Network.

* Some services require certification for PPO and OON coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB/DF. Routine care for condition of pregnancy does not require prior certification. However, notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced under the PPO and OON levels of benefits to 50% of covered expenses and a $250 penalty will also be charged for each inpatient admission.

Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under “Preventive care” in this section.
Durable medical equipment is covered when medically necessary and acquired or supplied by a Health Net designated contracted vendor for durable medical equipment. Preferred Providers through SELECT 2 that are not designated by Health Net as a contracted vendor for durable medical equipment are considered Out-of-Network Providers for purposes of determining coverage and benefits. Durable medical equipment is not covered if provided by an Out-of-Network Provider. For information about Health Net’s designated contracted vendors for durable medical equipment, please contact the Health Net Customer Contact Center at the phone number on the back cover.

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

Mental disorders and chemical dependency benefits

HMO benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services. For definitions of severe mental illness or serious emotional disturbances of a child, please refer to the behavioral health section of this SB/DF, or call the Customer Contact Center at the number listed on the back cover of this booklet.

MENTAL DISORDERS and CHEMICAL DEPENDENCY SERVICES THROUGH MHN SERVICES

Severe mental illness and serious emotional disturbances of a child

MHN SERVICES

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including medication management and drug therapy monitoring)

- Individual session* .................................................................................................................................................. $15
- Group therapy session.............................................................................................................................................. $7.50

Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing; other outpatient procedures; intensive outpatient care program; day treatment; partial hospitalization; and therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day ......................................................................................................................... Covered in full

Participating mental health professional visit to member’s home (at the discretions of the participating mental health professional in accordance with the rules and criteria established by Behavioral Health Administrator) ................................................................................................................................. $15

Inpatient services at a hospital, behavioral health facility or residential treatment center (per admission) ........................................................................................................................................ Covered in full
Other mental disorders

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including medication management and drug therapy monitoring)

- Individual session*: $15
- Group therapy session: $7.50

Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization) Covered in full

Participating mental health professional visit to member’s home (at the discretion of the participating mental health professional in accordance with the rules and criteria established by Behavioral Health Administrator) $15

Inpatient services at a hospital, behavioral health facility or residential treatment center (per admission) Covered in full

Chemical dependency

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, medication management and drug therapy monitoring)

- Individual session*: $15
- Group therapy session: $7.50

Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization) Covered in full

Participating mental health professional visit to member’s home (at the discretion of the participating mental health professional in accordance with the rules and criteria established by Behavioral Health Administrator) $15

Inpatient services at a hospital, behavioral health facility or residential treatment center (per admission)* Covered in full

Acute care detoxification at a hospital, behavioral health facility or residential treatment center (per admission) Covered in full

* If two or more members in the same family attend the same outpatient treatment session, only one copayment will be applied.
MENTAL DISORDERS and CHEMICAL DEPENDENCY SERVICES THROUGH HEALTH NET

<table>
<thead>
<tr>
<th>Mental disorders and chemical dependency benefits</th>
<th>PPO</th>
<th>OON</th>
</tr>
</thead>
</table>

**Severe mental illness and serious emotional disturbances of a child**

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including medication management and drug therapy monitoring)

- Individual session ........................................... $20 .................................................. 30%
- Group therapy session* ..................................... $10 .................................................. 30%

Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing; other outpatient procedures; intensive outpatient care program; day treatment; partial hospitalization; and therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day) ......................................... Covered in full ........................................ 30%

Participating Mental Health Professional visit to Member’s home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by Health Net) ................................................ $20 .................................................. 30%

Inpatient services at a hospital, behavioral health facility or residential treatment center* ........................................ 10% .................................................. 30%

**Other mental disorders**

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including medication management and drug therapy monitoring)

- Individual session ........................................... $20 .................................................. 30%
- Group therapy session* ..................................... $10 .................................................. 30%

Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization) ......................................... Covered in full ........................................ 30%

Participating Mental Health Professional visit to Member’s home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by Health Net) ................................................ $20 .................................................. 30%
Inpatient services at a hospital, behavioral health facility or residential treatment center .................. 10% ..................................................... 30%

**Chemical dependency**

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including medication management and drug therapy monitoring)
- Individual session ........................................... $20 ..................................................... 30%
- Group therapy session* .................................. $10 ..................................................... 30%

Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization) ..................... Covered in full ........................................... 30%

Participating Mental Health Professional visit to Member’s home (at the discretion of the Participating Mental Health Professional in accordance with the rules and criteria established by Health Net) ........................................... $20 ..................................................... 30%

Inpatient services at a hospital, behavioral health facility or residential treatment center* .................................. 10% ..................................................... 30%

Acute care detoxification at a hospital, behavioral health facility or residential treatment center* .................................. 10% ..................................................... 30%

* Some services require certification for PPO and OON coverage. For a complete listing of services requiring certification please refer to the “Services requiring certification” section of this SB/DF. Routine care for condition of pregnancy does not require prior certification. However, notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced under the PPO and OON levels of benefits to 50% of covered expenses and a $250 penalty will also be charged for each inpatient admission.

**Home health services**

Home health visits, part-time or intermittent care only (Through HMO and PPO, the copayment starts the 31st calendar day after the first visit. Through OON, the coinsurance is applicable as of the first visit.) .......................... $15 ..................................................... 20 ..................................................... 30%

Calendar year maximum§ .................. Unlimited .................. 100 visits .................. 100 visits

§ Combined for PPO and Out-of-Network.

**Other services**

Vasectomy ............................................................... $50 ..................................................... 100 ..................................................... Not covered

Tubal ligation (through age 17) ..................... Covered in full ..................... Covered in full ........................................... 30%

Tubal ligation (age 18 and older) .................... Covered in full ..................... Covered in full ........................................... Not covered

Blood or blood products except for drugs used to treat hemophilia, including blood factors** .................. Covered in full .......................... 10% ..................................................... 30%

Blood products used to treat hemophilia, including blood factors**
Renal dialysis .................................................. Covered in full .......... $20 ......................... 30%
Hospice services* ........................................... Covered in full ...... 10% ....................... 30%
Chiropractic care ............................................ $15 ......................... Not covered ............ Not covered
Acupuncture .................................................... $15 ......................... Not covered ............ Not covered

* Some services require certification for PPO and OON coverage. For a complete listing of services requiring certification
please refer to the "Services requiring certification" section of this SB/DF. Routine care for condition of pregnancy does
not require prior certification. However, notification of pregnancy is requested. If certification is required but not
obtained, your benefit reimbursement level will be reduced under the PPO and OON levels of benefits to 50% of covered
expenses and a $250 penalty will also be charged for each inpatient admission.

** Drugs for the treatment of hemophilia, including blood factors, are considered self-injectable drugs and covered as a
Specialty Drug under the Prescription Drug benefit.

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

Sterilization of females and women’s contraception methods and counseling, as supported by HRSA guidelines, are
covered under “Preventive care” in this section.

<table>
<thead>
<tr>
<th>Infertility services</th>
<th>HMO</th>
<th>PPO</th>
<th>OON</th>
</tr>
</thead>
</table>
| Infertility services and supplies (all covered services that diagnose, evaluate or treat infertility) .................. 50% ......................... Not covered .................. Not covered

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

Infertility services which include GIFT, and all covered services that prepare the member to receive this
procedure are covered only for the Health Net member.

Injections for infertility are covered only when provided in connection with services that are covered by this
plan.

<table>
<thead>
<tr>
<th>Chiropractic services</th>
<th>HMO</th>
<th>PPO</th>
<th>OON</th>
</tr>
</thead>
</table>
| Benefits are administered by American Specialty Health Plans of California, Inc. (ASH Plans).
Office visits (20-visit maximum per calendar year) ................................................. $5 ......................... Not covered ............ Not covered
Annual chiropractic appliance allowance ................................................................. $50 ......................... N/A ......................... N/A
Limits of coverage

WHAT’S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- 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.
- Artificial insemination for reasons not related to infertility;
- Biofeedback therapy is limited to medically necessary treatment of certain physical disorders such as incontinence and chronic pain.
- 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;
- Conception by medical procedures (IVF and ZIFT);
- Corrective footwear is not covered unless medically necessary and custom made for the member or is podiatric device to prevent or treat diabetes-related complications;
- Cosmetic services and supplies;
- Custodial or live-in care;
- Dental services. However, medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures are covered. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate;
- Disposable supplies for home use;
- Experimental or investigational procedures, except as set out under the "Clinical trials" and "If you have a disagreement with our plan" sections of this SB/DF;
- Genetic testing is not covered except when determined by Health Net to be medically necessary. The prescribing physician must request prior authorization for coverage;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder;
- Non-eligible institutions. This plan only covers medically necessary services or supplies provided by a licensed hospital, hospice, Medicare-approved skilled nursing facility, residential treatment center or other properly licensed medical facility as specified in the plan’s EOC. Any institution that is not licensed to provide medical services and supplies, regardless of how it is designated, is not an eligible institution;
- Orthoptics (eye exercises);
- Outpatient prescription drugs or medications (except as noted under "Prescription drug program");
- Personal or comfort items;
- Physician self-treatment;
- Physician treating immediate family members;
- Private rooms when hospitalized, unless medically necessary;
- Private-duty nursing;
- Refractive eye surgery unless medically necessary, recommended by the member's treating physician and authorized by Health Net;
- Reversal of surgical sterilization;
- Routine foot care for treatment of corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes;
- Routine physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp or other nonpreventive purposes;
- Services for a surrogate pregnancy are covered when the surrogate is a Health Net member. However, when compensation is obtained for the surrogacy, Health Net shall have a lien on such compensation to recover its medical expense;
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the plan’s EOC;
• Services related to education or training, including for employment or professional purposes, except for behavioral health treatment for pervasive developmental disorder or autism;
• State hospital treatment, except as the result of an emergency or urgently needed care;
• Stress, except when rendered in connection with services provided for a treatable mental disorder;
• Treatment of jaw joint disorders or surgical procedures to reduce or realign jaw, unless medically necessary; and
• Treatment of obesity, weight reduction or weight management, except for morbid obesity.

The above is a partial list of the principal exclusions and limitations applicable to the medical portion of your Health Net SELECT POS Plan. The EOC, which you will receive if you enroll in this plan will contain the full list. Notwithstanding any exclusions or limitations described in the EOC, all medically necessary services for treatment of Severe Mental Illness or Serious Emotional Disturbance of a Child mental health conditions shall be covered.
Benefits and coverage

WHAT YOU PAY FOR SERVICES

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

TIMELY ACCESS TO CARE

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

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

Please see the "Notice of Language Services" section for information regarding the availability of no cost interpreter services.

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

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, Access for Infants and Mothers Program (AIM) or a Medi-Cal plan.

NOTICE OF REQUIRED COVERAGE

Benefits of this plan provide coverage required by the 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

The following services require certification for both PPO and OON coverage. If you do not contact Health Net 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/DF. A penalty will also be charged for uncertified inpatient admissions. These penalties do not apply to your out-of-pocket maximum (OOPM). (Note: If certification is not obtained after the OOPM has been reached, benefits for that 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 facility, except in an emergency
- Hospice
- Hospital, except in an emergency
- Mental health facility, except in an emergency
- Skilled nursing facility

Abdominal paracentesis (when performed at a Hospital*)

Ambulance: Non-emergency, air or ground ambulance services

Applied behavioral analysis (ABA) and other forms of behavioral health treatment (BHT) for autism and pervasive developmental
- Requires notification, certification of diagnosis and treatment plan for the first 6 months; after 6 months prior Certification is required for determination of ongoing medical necessity

Capsule endoscopy

Chemical Dependency services, including intensive outpatient programs and drug abuse testing (not required for office visits)

Chondrocyte implants

Clinical trials

Cochlear implants

Custom orthotics

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.

Dermatology in a Physician’s office
- Skin injections and implants
- Dermabrasions and chemical peels
- Laser treatment
- Chemical exfoliation and electrolysis
Durable medical equipment
Enhanced external counterpulsation (EECP)
Elective caesarean section
Experimental/investigational services and new technologies
Gender reassignment service
Genetic testing
Injection, including epidural, nerve, nerve root, face joint, trigger point, and sacroiliac (SI) joint injections

Mental Disorders and Chemical Dependency services other than office visits including:
• Outpatient psychological testing
• Outpatient neuropsychological testing
• Behavioral health treatment for pervasive developmental disorder or autism beyond the initial 6 months of treatment
• Outpatient Electroconvulsive Therapy (ECT)
• Outpatient transcranial magnetic stimulation

Neuro or spinal cord stimulator
Occupational and speech therapy (including home setting)
Organ, tissue and stem cell transplant services, including pre-evaluation and pre-treatment services and the transplant procedure

Outpatient diagnostic Procedures:
• CT (Computerized Tomography)
• Echocardiography
• MRA (Magnetic Resonance Angiography)
• MRI (Magnetic Resonance Imaging)
• Nuclear cardiology procedures, including SPECT (Single Photon Emission Computed Tomography)
• PET (Positron Emission Tomography)
• Sleep studies

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

Outpatient surgical procedures:
• Back surgery
• Balloon sinusplasty
• Bariatric procedures
• Blepharoplasty (includes brow ptosis)
• Breast reductions and augmentations
• Excision, excessive skin and subcutaneous tissue (including lipectomy) of the abdomen, thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad, and other areas
• Liposuction
• Mastectomy for gynecomastia
• Orthognathic procedures (includes TMJ treatment)
• Otoplasty
• Panniculectomy
• Rhinoplasty
• Septoplasty
• Spinal surgery
• Total joint replacements (hip, knee, shoulder)
• Treatment of varicose veins
• Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
• Vermilionectomy with mucosal advancement
• Vestibuloplasty
• X-Stop

Penile implant

Physical therapy, (exceeding 12 visits, includes home setting), subject to any benefit maximums stated in the "Schedule of benefits and coverage" section.

Prosthesis and orthotics over $2,500 in billed charges

Radiation therapy

\(^1\text{Certification is not required for the length of a hospital stay for reconstructive surgery incident to a mastectomy (including lumpectomy) or for renal dialysis. Certification is also not required for the length of stay for the first 48 hours following a normal delivery or 96 hours following cesarean delivery or for behavioral health treatment for pervasive developmental disorder or autism.}\)

**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 your physician group for all medical care provided after the 30th day of your baby’s life.
EMERGENCIES

Health Net SELECT POS covers emergency and urgently needed care throughout the world at the HMO level of benefits.

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 primary care physician or physician group (medical) or the Behavioral Health Administrator (severe mental illness and chemical dependency). If you are unable to call and you need medical care right away, go to the nearest medical center or hospital.

All follow-up care (including severe mental illness and serious emotional disturbances of a child) after the urgency has passed and your condition is stable, must be provided or authorized by your physician group (medical) or the Behavioral Health Administrator (mental illness and chemical dependency); in order to receive the highest level of care benefits under this plan.

Emergency care includes medical 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 an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person’s license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. 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 capability 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).

Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient’s health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Active labor is considered an emergency medical condition. “Active labor” means labor at the time that either of the following could reasonably be expected to occur; (1) There is inadequate time to effect safe transfer to another hospital prior to delivery; or (2) a transfer poses a threat to the health and safety of the member or unborn child.

Emergency Psychiatric Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the Mental Disorder.

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.
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 plans exclusions and limitations.

**MEDICALLY NECESSARY CARE**

All services that are medically necessary will be covered by your Health Net SELECT POS Plan (unless specifically excluded under the plan). All covered services or supplies are listed in the plan’s EOC; any other services or supplies are not covered.

**SECOND OPINIONS**

You have the right to request a second opinion when:

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

When you request a second opinion, you will be responsible for any applicable copayments. To obtain a copy of Health Net’s second opinion policy, contact the Health Net Customer Contact Center at the phone number on the back cover.

**CLINICAL TRIALS**

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

**EXTENSION OF BENEFITS**

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

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

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

**CONFIDENTIALITY AND RELEASE OF MEMBER INFORMATION**

Health Net knows that personal information in your medical records is private. Therefore, we protect your personal health information in all 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 for things 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
is required to comply with aggregated measurement and data reporting requirements. In those cases, we protect your privacy by not releasing any information that identifies our members.

**PRIVACY PRACTICES**

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

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

**TECHNOLOGY ASSESSMENT**

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

Health Net determines whether new technologies should be considered medically appropriate, or investigational or experimental, following extensive review of medical research by appropriately specialized physicians. Health Net requests review of new technologies by an independent, expert medical reviewer in order to determine medical appropriateness or investigational or experimental status of a technology or procedure. The expert medical reviewer also advises Health Net when patients require quick determinations of coverage, when there is no guiding principle for certain technologies or when the complexity of a patient’s medical condition requires expert evaluation. If Health Net denies or delays coverage for your requested treatment on the basis that it is experimental or investigational, you may be able to 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” in the Evidence of Coverage for additional details.
Utilization management

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

PRE-AUTHORIZATION

Certain proposed services may require an assessment prior to approval. Evidence-based criteria are used to evaluate 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 member’s progress, such as during inpatient hospitalization or while receiving outpatient home care services.

DISCHARGE PLANNING

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

RETROSPECTIVE REVIEW

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

CARE OR CASE MANAGEMENT

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

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

Payment of fees and charges

YOUR COINSURANCE, COPAYMENT AND DEDUCTIBLES

The comprehensive benefits of your Health Net plan are described in the "Schedule of benefits and coverage" section. Please take a moment to look it over.

PREPAYMENT FEES

Your employer will pay Health Net your monthly subscription charges for you and all enrolled family members. Check with your employer regarding any share that you may be required to pay. If your share ever increases, your employer will inform you in advance.
OTHER CHARGES

You are responsible for payment of your share of the cost of services covered by this plan. Amounts paid by you are the copayments, coinsurance and deductibles, which are described in the "Schedule of benefits and coverage" section of this SB/DF. Beyond these charges, the remainder of the cost of covered services will be paid by Health Net SELECT POS except that the member remains responsible for charges above allowable expenses for OON benefit level. Additionally, the Out-of-Network Provider may request that you pay the billed charges when the service is rendered. In this case, you are responsible for paying the full cost and for submitting a claim to Health Net. Health Net will determine what portion of the billed charges is reimbursable to you.

Under the HMO level of benefits, when the total amount of copayments and coinsurance you pay equals the HMO out-of-pocket maximum (OOPM) shown under “Schedule of benefits and coverage,” you will not have to pay additional copayments or coinsurance for the rest of the year for most services provided or authorized by your physician group.

When the total amount of PPO and OON copayments and coinsurance paid equals the OOPM, you will not have to pay additional copayments or coinsurance for the rest of the year for most services provided and authorized under the PPO and OON levels of benefits.

Deductibles, copayments, and coinsurance for supplemental benefits such as prescription drugs (with the exception of copayments for inhaler spacers, peak flow meters used for the treatment of asthma, and diabetic supplies), eyewear, chiropractic services and acupuncture services will not be applied to the OOPM amount, as well as:

- Any additional deductibles;
- Charges applied to the deductible;
- Charges in excess of the Maximum Allowable Amount (Out-of-Network benefit level only);
- Services for which the member is required to pay a 50 percent coinsurance;
- Services for which certification was required but not obtained; and
- Payment for services not covered by this plan.

CONTRACTED RATE

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

MAXIMUM ALLOWABLE AMOUNT

The Maximum Allowable amount is the amount on which Health Net bases its reimbursement for covered services and supplies provided by a SELECT 3 (Out-of-Network Provider), which may be less than the amount billed for those services and supplies. Health Net calculates Maximum Allowable Amount as the lesser of the amount billed by the SELECT 3 Provider or the amount determined as set forth below. Maximum Allowable Amount is not the amount that Health Net pays for a covered service; the actual payment will be reduced by applicable coinsurance, copayments, deductibles and other applicable amounts. Please refer to the plan’s Evidence of Coverage for additional information.

- Maximum Allowable Amount for Covered Services and Supplies, excluding Emergency Care and outpatient pharmaceuticals, received from a SELECT 3 Provider is a percentage of what Medicare would pay, known as the Medicare Allowable Amount, as defined in this Evidence of Coverage.

For illustration purposes only, SELECT 3 Provider: 70% Health Net Payment / 30% Covered Person Coinsurance:
SELECT 3 Provider’s billed charge for extended office visit $128.00

MAA allowable for extended office visit (example only; does not mean
that MAA always equals this amount) $102.40

**Your Coinsurance is 30% of MAA:** 30% x $102.40 (assumes
Deductible has already been satisfied) $30.72

**You also are responsible for** the difference between the billed charge ($128.00)
and the MAA amount ($102.40) $25.60

**TOTAL AMOUNT OF $128.00 CHARGE THAT IS YOUR RESPONSIBILITY** $56.32

The Maximum Allowable Amount for facility services, including but not limited to Hospital, Skilled Nursing Facility, and Outpatient Surgery, is determined by applying 150% of the Medicare Allowable Amount.

Maximum Allowable Amount for Physician and all other types of services and supplies is the lesser of the billed charge or 100% of the Medicare Allowable Amount.

In the event there is no Medicare Allowable Amount for a billed service or supply code:

a. Maximum Allowable Amount for professional and ancillary services shall be 100% of FAIR Health’s Medicare gapfilling methodology. Services or supplies not priced by gapfilling methodology shall be the lesser of: (1) the average amount negotiated with SELECT 2 (Preferred Providers) within the geographic region for the same Covered Services or Supplies provided; (2) the 50th percentile of FAIR Health database of professional and ancillary services not included in FAIR Health Medicare gapfilling methodology; (3) 100% of the Medicare Allowable Amount for the same Covered Services or Supplies under alternative billing codes published by Medicare; or (4) 50% of the SELECT 3 Provider’s billed charges for Covered Services. A similar type of database or valuation service will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination.

b. Maximum Allowable Amount for facility services shall be the lesser of: (1) the average amount negotiated with SELECT 2 (Preferred) Providers within the geographic region for the same Covered Services or Supplies provided; (2) 100% of the derived amount using a method developed by Data iSight for facility services (a data service that applies a profit margin factor to the estimated costs of the services rendered), or a similar type of database or valuation service, which will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination; (3) 150% of the Medicare Allowable Amount for the same Covered Services or Supplies under alternative billing codes published by Medicare; or (4) 50% of the SELECT 3 Provider’s billed charges for Covered Services.

- **Maximum Allowable Amount for covered outpatient pharmaceuticals** (including but not limited to injectable medications) dispensed and administered to the patient, in an outpatient setting, including, but not limited to, Physician office, outpatient Hospital facilities, and services in the patient’s home, will be the lesser of billed charges or the Average Wholesale Price for the drug or medication.

The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses See the plan’s Evidence of Coverage under “Schedule of Benefits and Copayments – SELECT 1,” “Schedule of Benefits and Copayments – SELECT 2 and SELECT 3,” “Covered Services and Supplies” and “Exclusions and Limitations” sections for specific benefit limitations, maximums, pre-certification requirements and payment policies that limit the amount Health Net pays for certain covered services and supplies. Health Net uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement.
In addition to the above, from time to time, Health Net also contracts with vendors that have contracted fee arrangements with providers (“Third Party Networks”). In the event Health Net contracts with a Third Party Network that has a contract with the SELECT 3 Provider, Health Net may, at its option, use the rate agreed to by the Third Party Network as the Maximum Allowable Amount. Alternatively, we may, at our option, refer a claim for SELECT 3 Services to a fee negotiation service to negotiate the Maximum Allowable Amount for the service or supply provided directly with the SELECT 3 Provider. In either of these two circumstances, You will not be responsible for the difference between billed charges and the Maximum Allowable Amount. You will be responsible for any applicable deductible, copayment and/or coinsurance at the SELECT 3 level.

NOTE: When the Centers for Medicare and Medicaid Services (CMS) adjusts the Medicare Allowable Amount, Health Net will adjust, without notice, the Maximum Allowable Amount based on the CMS schedule currently in effect. Claims payment will be determined according to the schedule in effect at the time the charges are incurred.

Claims payment will also never exceed the amount the SELECT 3 Provider charges for the service or supply. You should contact the Customer Contact Center if You wish to confirm the Covered Expenses for any treatment or procedure You are considering.

For more information on the determination of Maximum Allowable Amount, or for information, services and tools to help you further understand your potential financial responsibilities for covered SELECT 3 services and supplies, please log on to www.healthnet.com or contact Health Net Customer Service at the number on Your member identification card.

LIABILITY OF SUBSCRIBER OR ENROLLEE FOR PAYMENT

If you receive health care services without the required referral or authorization from your PCP or physician group, covered services will be paid at the PPO benefit level (if the doctor is a Health Net provider) or at the OON benefit level (if the doctor is not a member of Health Net’s network). You are responsible for any copayments and coinsurance for these services. Remember, under Health Net SELECT POS, HMO services are covered only when provided or authorized by a Health Net contracting physician or physician group, except for emergency or out-of-area urgent care. Consult the Health Net directory of participating providers for a full listing of Health Net contracting physicians.

REIMBURSEMENT PROVISIONS

Under the HMO level of benefits, payments that are owed by Health Net for services provided by or through your physician group (medical) or the Behavioral Health Administrator (mental illness and chemical dependency) will never be your responsibility.

If you have out-of-pocket expenses for covered services, call the Health Net Customer Contact Center at the phone number on the back cover for a claim form and instructions. You will be reimbursed for these expenses less any required copayment, deductible or coinsurance. Remember, you do not need to submit claims for medical services provided by your PCP or physician group (medical) or the Behavioral Health Administrator (mental illness and chemical dependency).

If you receive emergency services not provided or directed by your physician group (medical) or the Behavioral Health Administrator (mental illness and chemical dependency), you may have to pay at the time you receive the services. To be reimbursed for these charges, you should obtain a complete statement of the services received and, if possible, a copy of the emergency room report.

Please contact the Health Net Customer Contact Center at 1-800-676-6976 the phone number on the back cover to obtain claim forms, and to find out whether you should send the completed form to your physician group.
(medical) or the Behavioral Health Administrator (mental illness and chemical dependency) or directly to Health Net.

❗️ How to file a claim:

**For medical services**, please send a completed claim form within one year of the date of service to:

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

Please call Health Net’s Customer Contact Center at the phone number on the back cover of this booklet or visit our website at www.healthnet.com to obtain the claim form.

**For mental disorders or chemical dependency emergency services or for services authorized by MHN Services**, you must use the CMS (HCFA) - 1500 form. Please send the claim to MHN Services within one year of the date of service at the address listed on the claim form or to MHN Services at:

MHN Services  
P.O. Box 14621  
Lexington, KY 40512-4621

Please call MHN Services at 1-800-444-4281 to obtain a claim form.

❗️ How to file a claim:

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

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

Please call Health Net’s Customer Contact Center at the phone number on the back cover of this booklet or visit our website at www.healthnet.com to obtain a prescription drug claim form.

❗️ How to file a claim:

**For emergency chiropractic service or for other approved services**, please send your completed claim form within one year of the date of service to:

American Specialty Health Plans of California, Inc.  
Attention: Member Services Department  
P.O. Box 509002  
San Diego, CA 92150-9002

❗️ Claims for covered expenses filed more than one year from the date of service will not be paid unless you can show that it was not reasonably possible to file your claim within that time limit and that you have filed as soon as was reasonably possible.
PROVIDER REFERRAL AND REIMBURSEMENT DISCLOSURE

If you are considering enrolling in our plan, you are entitled to ask if the plan has special financial arrangements with our physicians that can affect the use of referrals and other services you may need. Health Net uses financial incentives and various risk sharing arrangements when paying providers at the HMO level of benefits. To get this information call the Health Net Customer Contact Center at the phone number on the back cover and request information about our physician payment arrangements. You can also contact your physician group or your PCP to find out about our physician payment arrangements.

Facilities

For the HMO level of benefits, health care services for you and eligible members of your family will be provided at:

- The facilities of the physician group you chose at enrollment; or
- A nearby Health Net-contracting hospital, if hospitalization is required.

Many Health Net contracting physician groups have either a physician on call 24 hours a day or an urgent care center available to offer access to care at all times.

**HMO**: the physician group you choose will also have a contractual relationship with local hospitals (for acute, subacute and transitional care) and skilled nursing facilities. These are listed in your directory of participating providers.

**PPO**: health care will be provided at the facilities used by the doctor you choose at the time you seek care. These are also listed in the directory of participating providers.

**OON**: you may choose any hospital or facility, if hospitalization is required.

PHYSICIAN GROUP TRANSFERS

You may switch doctors within the same physician group at any time. You may also transfer to another physician group monthly. Simply contact Health Net SELECT POS to have your transfer effective by the 1st of the following month.

Transfer requests will generally be honored, unless you are confined to a hospital. (However, Health Net may approve transfers under this condition for certain unusual or serious circumstances. Please call the Health Net Customer Contact Center at the phone number on the back cover of this booklet for more information.)

CONTINUITY OF CARE

Transition of Care for New Enrollees

You may request continued care from a provider who does not contract with Health Net if at the time of your enrollment with Health Net you were receiving care for the conditions listed below. Health Net may provide coverage for completion of services from a non-participating provider, subject to applicable copayments and any exclusions and limitations of your plan. You must request the coverage within 60 days of your group's effective date unless you can show that it was not reasonably possible to make the request within 60 days of the group's effective date and you make the request as soon as reasonably possible. The non-participating provider must be willing to accept the same contract terms applicable to providers currently contracted with Health Net, who are
not capitated and who practice in the same or similar geographic region. If the provider does not accept such terms, Health Net is not obligated to provide coverage with that provider.

Continuity of Care Upon Termination of Provider Contract

If Health Net’s contract with a physician group or other provider is terminated, Health Net will transfer any affected members to another contracted physician group or provider to ensure that care continues. Health Net will provide a written notice to affected members at least 60-days prior to termination of a contract with a physician group or an acute care hospital to which members are assigned for services. For all other hospitals that terminate their contract with Health Net, a written notice will be provided to affected members within 5 days after the effective date of the contract termination.

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

You may request continued care from a provider whose contract is terminated if at the time of termination the member was receiving care from such a provider for the conditions listed below.

The following conditions are eligible for continuation of care:

• An acute condition;
• A serious chronic condition not to exceed twelve months;
• A pregnancy (including the duration of the pregnancy and immediate postpartum care);
• A newborn (up to 36 months of age, not to exceed twelve months);
• A terminal illness (through the duration of the terminal illness);
• A surgery or other procedure that has been authorized by Health Net (or by the member’s prior health plan for a new enrollee) as part of a documented course of treatment.

If you would like more information on how to request continued care or to request a copy of Health Net's continuity of care policy, please contact the Health Customer Contact Center at the phone number on the back cover.

Renewing, continuing or ending coverage

RENEWAL PROVISIONS

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

INDIVIDUAL CONTINUATION OF BENEFITS

♀ Please examine your options carefully before declining coverage.

If your employment with your current employer ends, you and your covered family members may qualify for continued group coverage under:
• **COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985).** For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside of California. Please check with your group to determine if you and your covered dependents are eligible.

• **Cal-COBRA Continuation Coverage.** If you have exhausted COBRA and you live in the Health Net Service Area, you may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if you have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage, and you are not entitled to Medicare. If you are eligible, you have the opportunity to continue group coverage under this plan through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.

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

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

**TERMINATION OF BENEFITS**

*The following information describes circumstances when your coverage in this plan may be terminated. For a more complete description of termination of benefits, please see the plan’s EOC.*

**Termination for Nonpayment of Subscription Charges**
Your coverage under this plan ends when the agreement between the employer and Health Net terminates due to nonpayment of the subscription charges by the employer. Health Net will provide your employer a 30-day grace period to submit the delinquent subscription charges. If your employer fails to pay the required subscription charges by the end of the 30-day grace period, the agreement between Health Net and your employer will be cancelled and Health Net will terminate your coverage at the end of the grace period.

**Termination for Loss of Eligibility**
Your coverage under this plan ends on the date you become ineligible. Some reasons that you may lose eligibility in this plan include, but are not limited to, the following situations:

- The agreement between the employer covered under this Health Net SELECT POS Plan and Health Net ends;
- You cease to either live or work within Health Net’s service area;
- You no longer work for the employer covered under this Health Net SELECT POS Plan; or

**Termination for Cause**
Coverage under this Health Net SELECT POS Plan may be terminated for good cause with a 30-day written notice for a member who commits any act or practice, which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the agreement, including:

- Misrepresenting eligibility information about yourself or a dependent;
- Presenting an invalid prescription or physician order;
- Misusing a Health Net Member I.D. Card (or letting someone else use it); or
- Failing to notify us of changes in family status that may affect your eligibility or benefits.

We may report criminal fraud and other illegal acts to the authorities for prosecution.
How to Appeal Your Termination
You have a right to appeal Health Net's decision to terminate your coverage for the reasons described above file a complaint if you believe that your coverage is improperly terminated or not renewed. A complaint is also called a grievance or an appeal. Refer to the "If You Have a Disagreement With Our Plan" section for information about how to appeal Health Net's decision to terminate your coverage.

If your coverage is terminated based on any reason other than for nonpayment of subscription charges and your coverage is still in effect when you submit your complaint, Health Net will continue your coverage until the review process is completed, subject to Health Net's receipt of the applicable subscription charges. You must also continue to pay the deductible and copayments for any services and supplies received while your coverage is continued during the review process.

If your coverage has already ended when you submit your request for review, Health Net is not required to continue coverage. However, you may still request a review of Health Net's decision to terminate your coverage by following the complaint process described in the "If You Have a Disagreement With Our Plan" section.

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

If you have a disagreement with our plan
The California Department of Managed Health Care is responsible for regulating health care service plans. (Health Net is a health care service plan).

If you have a grievance against Health Net, you should first telephone Health Net at the phone number on the back cover, 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 IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department’s Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

MEMBER GRIEVANCE AND APPEALS PROCESS
If you are dissatisfied with the quality of care that you have received or feel that you have been incorrectly denied a service or claim, you may file a grievance or appeal.
How to file a grievance or appeal:

You may call the Customer Contact Center at the phone number on the back cover or submit a member grievance form through www.healthnet.com.

You may also write to: Health Net of California
P.O. Box 9103
Van Nuys, CA 91409-9103

Please include all the information from your Health Net identification card as well as the details of your concern or problem.

Health Net will acknowledge your grievance or appeal within five calendar days, review the information and tell you of our decision in writing within 30 days of receiving the grievance. For conditions where there is an immediate and serious threat to your health, including severe pain or the potential loss of life, limb or major bodily function, Health Net will notify you of the status of your grievance no later than three days from receipt of all the required information. For urgent grievances, Health Net will immediately notify you of the right to contact the Department of Managed Health Care. There is no requirement that you participate in Health Net’s grievance process prior to applying to the Department of Managed Health Care for review of an urgent grievance.

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

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

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 uses binding arbitration to settle disputes, including medical malpractice. When you enroll in Health Net, you agree to submit any disputes to arbitration, in lieu of a jury or court trial.

Additional plan benefit information

The following plan benefits show supplemental benefits available with your medical plan. For a more complete description of copayments and exclusions and limitations of service, please see the plan’s EOC.
**Behavioral health services**

Health Net contracts with MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator) which administers behavioral health services through a personalized, confidential and affordable mental health and chemical dependency care program.

Contact the Behavioral Health Administrator by calling the Health Net Customer Contact Center at the phone number on the back cover. The Behavioral Health Administrator will help you identify a participating mental health professional, a participating independent physician or a sub-contracted 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 Behavioral Health Administrator in order to be covered. No prior authorization is required for outpatient office visits, but a voluntary registration with the Behavioral Health Administrator is encouraged.

Please refer to the plan's EOC for a more complete description of mental disorder and chemical dependency services and supplies, including those that require prior authorization by the Behavioral Health Administrator.

**TRANSITION OF CARE FOR NEW ENROLLEES**

If you are receiving ongoing care for an acute, serious, or chronic mental health condition from a provider not affiliated with the Behavioral Health Administrator when you enroll with Health Net, we may temporarily cover services provided by that provider, subject to applicable copayments and any other exclusions and limitations of this plan.

Your non-participating mental health professional must be willing to accept the Behavioral Health Administrator’s standard mental health provider contract terms and conditions and be located in the plan’s service area.

If you would like more information on how to request continued care, or to request a copy of our continuity of care policy, please call the Health Net Customer Contact Center at the phone number on the back cover.

**SERIOUS EMOTIONAL DISTURBANCES OF A CHILD**

Serious emotional disturbances of a child is when a child under the age of 18 has one or more mental disorders identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, as amended to date, other than a primary substance use disorder or a developmental disorder, that result in behavior inappropriate to the child’s age according to expected developmental norms. In addition, the child must meet one or more of the following:

- As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home or (ii) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year;
- The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; or
- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.
SEVERE MENTAL ILLNESS

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

OTHER MENTAL DISORDERS

Other mental disorders are all other mental disorders not listed as severe mental illness, serious emotional disturbances of a child or chemical dependency conditions.

CONTINUATION OF TREATMENT

If you are in treatment for a mental health or chemical dependency problem, call the telephone number shown on your Health Net ID card to receive assistance in transferring your care to a network provider.

WHAT'S COVERED

Please refer to the "Schedule of benefits and coverage" section of this SB/DF for the explanation of covered services and copayments.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

Services or supplies for the treatment of mental health and chemical dependency are subject to the plan’s general exclusions and limitations. Please refer to the “Limits of coverage” section of this SB/DF for a list of what’s not covered under this plan.

This is only a summary. Please consult the plan’s EOC for specific information regarding your plan.

Prescription drug program

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

PRESCRIPTIONS BY MAIL DRUG PROGRAM

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

Schedule II narcotic drugs (which are drugs that have a high abuse risk as classified by the Federal Drug Enforcement Administration) are not covered through mail order. For further information, please refer to the plan’s EOC.
The Health Net Commercial Formulary
This plan uses the Commercial Formulary. The Health Net Commercial Formulary 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 in the Commercial Formulary, it ensures that you are receiving a high quality prescription medication that is also of high value.

The Commercial Formulary is updated regularly, based on input from the Health Net Pharmacy and Therapeutics (P&T) Committee. The committee members are actively practicing physicians of various medical specialties and clinical pharmacists. Voting members are recruited from 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 Commercial Formulary and drug usage guidelines are made as new clinical information become available.

The drug usage guidelines are reviewed and updated as new clinical information becomes available. In order to keep the Commercial Formulary 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 Commercial Formulary, please visit our web site at www.healthnet.com, under the pharmacy information, or call the Health Net Customer Contact Center at the phone number on the back cover.

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

How to request prior authorization:

Requests for prior authorization may be submitted by telephone or facsimile. Upon receiving your physician’s request for prior authorization, 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 e-mail. We must receive the appeal within 60 days of the date of the denial notice. Please refer to the Health Net EOC for details regarding your right to appeal.
To submit an appeal:

- Call the Health Net Customer Contact Center at the phone number on the back cover;
- Visit www.healthnet.com for information on e-mailing the Health Net Customer Contact Center; or
- Write to: Health Net Customer Contact Center  
  P.O. Box 9103  
  Van Nuys, CA 91409-9103

What’s covered

Please refer to the “Schedule of benefits and coverage” section of this SB/DF for the explanation of covered services and copayments.

This plan covers the following:

- Tier 1 drugs listed on the Commercial Formulary (include most generic drugs and some low-cost preferred brand name drugs when listed in the Commercial Formulary);
- Tier 2 drugs listed on the Commercial Formulary (include non-preferred generic, preferred brand name drugs, insulin and diabetic supplies and certain brand name drugs with a generic equivalent when listed in the Commercial Formulary); and
- Tier 3 drugs listed on the Commercial Formulary as Tier 3 (include non-preferred brand name drugs, brand name drugs with a generic equivalent when medically necessary, drugs listed as Tier 3 Drugs, drugs indicated as “NF”, if approved, or drugs not listed in the Commercial Formulary).
- Preventive drugs and women’s contraceptives

MORE INFORMATION ABOUT DRUGS THAT WE COVER

- Prescription drug covered expenses for participating pharmacies are the lesser of Health Net’s contracted pharmacy rate or the pharmacy’s retail price for covered prescription drugs;
- Prescription drug covered expenses for nonparticipating pharmacies are the lesser of the maximum allowable cost, as determined by Health Net, or the average wholesale price. For further information, please refer to the plan’s EOC;
- Prescription drug refills are covered, up to a 30-consecutive-calendar-day supply per prescription at a Health Net contracting pharmacy for one copayment. A copayment is required for each prescription. In some cases, a 30-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan according to the Food and Drug Administration (FDA) or Health Net’s usage guidelines. If this is the case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply;
- Percentage copayments will be based on Health Net’s contracted pharmacy rate;
- Mail order drugs are covered up to a 90-consecutive-calendar-day supply. When the retail pharmacy copayment is a percentage, the mail order copayment is the same percentage of the cost to Health Net as the retail pharmacy copayment;
- Prescription drugs for the treatment of asthma are covered as stated in the Commercial Formulary. Inhaler spacers and peak flow meters under the pharmacy benefit are covered when medically necessary. Nebulizers (including face masks and tubing) are covered under “Durable medical equipment” and educational programs for the management of asthma are covered under “Patient education” through the medical benefit. For information about copayments required for these benefits, please see the “Schedule of benefits and coverage” section of this SB/DF;
- Preventive drugs, including smoking cessation drugs, are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over-the-counter or are only available with a prescription. Vaginal, oral, transdermal and
emergency contraceptives are covered under this pharmacy benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit. Refer to the plan’s EOC for more information.

- Diabetic supplies (blood glucose testing strips, lancets, needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be “broken” (that is opened in order to dispense the product in quantities other than those packaged). When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times your physician has prescribed for a 30-day period. For more information about diabetic equipment and supplies, please see “Endnotes” in the "Schedule of benefits and coverage" section of this SB/DF.

- Self-injectable drugs (other than insulin) are considered specialty drugs and must be obtained through a Specialty pharmacy vendor. Specialty Drugs require Prior Authorization and upon approval, the specialty pharmacy vendor will arrange for the dispensing of the drugs. Please refer to the plan's EOC for additional information.

What’s not covered (exclusions and limitations)

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

In addition to the exclusion and limitations listed below, prescription drug benefits are subject to the plan’s general exclusions and limitations. Consult the plan’s EOC for more information.

- Allergy serum (allergy serum is covered as a medical benefit. See "allergy serum" benefit in the "Schedule of benefits and coverage" for details);
- Coverage for devices is limited to vaginal contraceptive devices, peak flow meters, spacer inhalers and diabetic supplies. No other devices are covered even if prescribed by a physician;
- Drugs that are prescribed for the treatment of obesity are covered for the treatment of morbid obesity. In such cases, the drugs will be subject to prior authorization from Health Net;
- Drugs or medicines administered by a physician or physician’s staff member;
- Drugs prescribed for routine dental treatment;
- Drugs prescribed to shorten the duration of the common cold;
- Drugs prescribed for sexual dysfunction when not medically necessary, including drugs that establish, maintain, or enhance sexual function or satisfaction;
- Experimental drugs (those that are labeled "Caution - Limited by Federal Law to investigational use only"). If you are denied coverage of a drug because the drug is investigational or experimental you will have a right to independent medical review. See "If you have a disagreement with our plan" section of this SB/DF for additional information;
- Hypodermic needles or syringes, except for insulin needles, syringes and specific brands of pen devices;
- Immunizing agents, injections (except for insulin), agents for surgical implantation, biological sera, blood, blood derivatives or blood plasma obtained through a prescription;
- Individual doses of medication dispensed in plastic, unit dose or foil packages unless medically necessary or only available in that form;
- Limits on quantity, dosage and treatment duration may apply to some drugs. Medications taken on an "as-needed" basis may have a copayment based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If medically necessary, your physician may request a larger quantity from Health Net;
- Medical equipment and supplies (including insulin), that are available without a prescription are covered when prescribed by a physician for the management and treatment of diabetes or for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations or for female contraception as approved by the FDA. Any other nonprescription drug, medical equipment or supply that can be purchased without a prescription drug order is not covered even if a physician writes a prescription...
drug order for such drug, equipment or supply. However, if a higher dosage form of a prescription drug or over-the-counter (OTC) drug is only available by prescription, that higher dosage drug will be covered. If a drug that was previously available by prescription becomes available in an OTC form in the same prescription strength, then any prescription drugs that are similar agents and have comparable clinical effect(s) will only be covered when medically necessary and prior authorization is obtained from Health Net;

- Prescription drugs filled at pharmacies in California that are not in the Health Net pharmacy network except in emergency or urgent care situations;
- Once you have taken possession of medications, replacement of lost, stolen or damaged medications is not covered;
- Supply amounts for prescriptions that exceed the FDA’s or Health Net’s indicated usage recommendation are not covered unless medically necessary and prior authorization is obtained from Health Net Drugs that are not approved by the FDA are not covered, except as described in the plan’s EOC; and
- Drugs prescribed for a condition or treatment not covered by this plan are not covered. However, the plan does cover drugs for medical conditions that result from nonroutine complications of noncovered services.

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

Chiropractic care program

Health Net has partnered with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable chiropractic coverage. With this program, you’re free to obtain this care by selecting a contracted chiropractor from our ASH Plans Contracted Chiropractor Directory. Although you’re always welcome to consult your PCP, you won’t need a referral to see a contracted chiropractor.

What’s covered

Please refer to the "Schedule of benefits and coverage" section of this SB/DF for the explanation of covered services and copayments.

This plan covers:

- Office visits; and
- Chiropractic items such as supports, collars, pillows, heel lifts, ice packs, cushions, orthotics, rib belts, and home traction units prescribed by a ASH Plans contracted chiropractor and approved by ASH Plans; and
- All covered chiropractic services require pre-approval from ASH Plans except for a new patient examination by a contracted chiropractor and emergency chiropractic services.

What’s not covered (exclusions and limitations)

Services or supplies excluded under the chiropractic care program may be covered under the medical benefits portion of the plan. Consult your plan’s EOC for more information.

- Air conditioners, air purifiers, therapeutic mattresses, vitamins, minerals, nutritional supplements, durable medical equipment, appliances or comfort items;
- Conjunctive physical therapy not associated with spinal, muscle or joint adjustment;
- Diagnostic scanning, MRI, CAT scans or thermography;
- Exams or treatment of strictly non-neuromusculoskeletal disorders;
- Hypnotherapy, behavioral training, sleep therapy, weight programs, educational programs, non-medical self-help or self-care, or any self-help physical exercise training;
- Lab tests, x-rays, adjustments, physical therapy or other services not chiropractically necessary or classified as experimental;
- Pre-employment physicals or vocational rehabilitation arising from employment or covered under any public liability insurance;
- Treatment for temporomandibular joint syndrome (TMJ);
- Experimental or investigational chiropractic services. Only chiropractic services that are non-investigational, proven and meet professionally recognized standards of practice in the chiropractic provider community are covered. ASH Plans will determine what will be considered experimental or investigational;
- Charges for hospital confinement and related services;
- Charges for anesthesia; and
- Treatment or services not authorized by ASH Plans or delivered by an ASH Plans provider (except emergency chiropractic services or upon a referral to a non-contracted provider approved by ASH Plans).

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

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 employer group applicants please call 1-800-522-0088 (TTY: 711). Individual & Family Plan (IFP) applicants please call 1-877-609-8711 (TTY: 711). For more help, if you are enrolled in a PPO or EPO insurance policy from Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in an HMO or HSP plan from Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219.

Arabic

Armenian

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，並請我們將有您的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，雇員團隊申請人請致電 1-800-522-0088 (TTY: 711)，個人與家庭計劃 (IFP) 申請人請致電 1-877-609-8711 (TTY: 711)。如需進一步協助：如果您透過 Health Net Life Insurance Company 投保 PPO 或 EPO 保單，請致電 1-800-927-4357 與加州保險局聯絡。如果您透過 Health Net of California, Inc. 投保 HMO 或 HSP 計畫，請致電 DMHC 協助專線 1-888-HMO-2219。

Hindi
बिना लागत की भाषा सेवाएं। आप एक दुसरे भाषा में पढ़ कर सुनाए जा सकते हैं। आपको दस्तावेज अपनी भाषा में पढ़ कर सुनाए जा सकते हैं। मदद के लिए, आपको आईडी कार्ड पर दिया गए सूचीबद्ध नंबर पर होल करें, या लियों का समर्थन आयोजन करें 1-800-522-0088 (TTY: 711) संपर्क केंद्र पर कॉल करें। कृपया व्यक्तिगत और पारंगत्रिक लेख (IFP) के आदेश 1-877-609-8711 (TTY: 711) पर कॉल करें। अधिक मदद के लिए: यदि आप Health Net Life Insurance Company PPO 亦或 EPO बीमा पोलिसी में नामांकित हैं, तो केलिफोर्निया बीमा विभाग को 1-800-927-4357 पर कॉल करें। यदि आप Health Net of California, Inc., एचएमओ HMO या एचएसपी HSP लेख में नामांकित हैं, तो हेल्पलाइन के 1-888-HMO-2219 पर कॉल करें।
Hmong

Japanese
無料の言語サービス。通訳をご利用いただけます。日本語で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にお電話いただくか、雇用主を通じた団体保険の申込者の方は、1-800-522-0088 (TTY: 711) までお電話ください。個人および家族向けプラン (IFP) の申込者の方は、1-877-609-8711 (TTY: 711) までお電話ください。さらに援助が必要な場合：Health Net Life Insurance CompanyのPPOまたはEPO保険ポリシーに加入されている方は、カリフォルニア州保険局1-800-927-4357 まで電話でお問い合わせください。Health Net of California, IncのHMOまたはHSPに加入されている方は、DMHCヘルプライン 1-888-HMO-2219 まで電話でお問い合わせください。

Khmer
ប្រការကាជាបងប្អូនារីប្រការរបស់អ្នកក្នុងក្រុមហ៊ុនហ៊ុនប្រការរបស់អ្នក ឬប្រការរបស់អ្នករបស់អ្នកដែលប្រការរបស់អ្នកបានប្រការរបស់អ្នក ប្រការរបស់អ្នកអាចផ្តល់ជូនការចូលប្រការរបស់អ្នកបានប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នកបានប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នក ប្រការរបស់អ្នक

Korean

Navajo
Persian (Farsi)
خدمات زبان به طور رایگان. می‌توانید یک مترجم شفاهی بگیرید. می‌توانید در خواست کنید که اسناد به زبان شما برای انداز ارسال شود. برای دریافت راهنمایی، می‌توانید به شماره ای که روی کارت نامه شما درج شده باشند بگیرید. درخواست نکننده گروه کار فرستا (IFP) با مکان تاشی بارگاه (TTY 711، 800-522-0088) یا شماره بگیرید. درخواست نکننده برنامه افراطی با بخش یک کیلومتری از سوی PPO یا CA Dept. of Insurance می‌تواند با حضور ویژه HMO با HMO به شماره 1-800-927-4357 صوتیت دارد. می‌توانید به شماره Health Net Life Insurance Company در سایر HMO با HMO از سوی این PPO یا CA Dept. of Insurance به شماره 1-800-888-888-B219 بگیرید. آگاه با بگیرید.

Panjabi (Punjabi)
ਖਿਚਤ ਦਿਸਤੇ ਸੰਧਿਆਂ ਦੇ ਹਾਸਾ ਵੀਸੀਨਾ। ਤੁਹੀਂ ਦੀਆਂ ਪ੍ਰਭਾਵਾਂ ਭੁਸ਼ਣ ਕਰ ਸਕਦੇ ਹੈ। ਉਸ ਤੋਂ ਮੁਹਾਂਡਸ਼ ਦੁਆਰ ਦੀ ਪਲੀ ਪਹਿਚਾਣ ਦੀ ਸੁਨਾ ਬਣ ਸਕਦੇ ਹਨ। ਉਸ ਤੋਂ ਮੁਹਾਂਡਸ਼ ਦੀ ਪਹਿਚਾਣ ਦੀ ਸੁਨਾ ਬਣ ਸਕਦੇ ਹਨ। ਸੁਨਾ ਬਣ ਸਕਦੇ ਹਨ। ਸੁਨਾ ਬਣ ਸਕਦੇ ਹਨ। 

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь устного переводчика. Вам могут прочитать документы в переводе на ваш родной язык. За помощью обращайтесь к нам по телефону, приведенному на вашей идентификационной карточке участника плана. Если вы хотите стать участником группового плана, предоставляемого работодателем, звоните в коммерческий контактный центр компании 1-800-522-0088 (TTY 711). Если вы хотите стать участником плана для семей и частных лиц (IFP), звоните по телефону 1-877-609-8711 (TTY 711). Дополнительная помощь: Если вы включены в полис PPO и EPO от страховой компании Health Net Life Insurance Company, звоните в Департамент страхованияartin Kali窗口 CA Dept. of Insurance, по телефону 1-800-927-4357. Если вы включены в план HMO или HSP от страховой компании Health Net of California, Inc., по контактной линии Департамента управленческого медицинского обслуживания (DMHC), телефон 1-888-HMO-2219.

Spanish

Tagalog
Thai

ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ได้ คุณสามารถใช้ได้免费 และไม่จำเป็นต้องใช้เวลารับประทานช่วงของคุณได้ สำหรับความช่วยเหลือ
โทรศัพท์ฉุกเฉินฉุกเฉินที่ให้บริการประจําตัวของคุณ หรือ ผู้สูงอายุ บริการด้านภาษาของคุณได้ต่อเครื่องจักรยานของ
1-800-522-0088 (TTY: 711) หรือเว็บไซต์เว็บไซต์ Individual & Family Plan (IFP) ของ
1-877-609-8711 (TTY: 711) สำหรับความช่วยเหลือเพิ่มเติม หากคุณสมัครทําการประกันภัย PPO หรือ EPO กับ
Health Net Life Insurance Company โทรทัศน์การประกันภัยวินาศภัยฟิวชั่นได้ที่ 1-800-927-4357 หากคุณสมัครทําการประกัน
HMO หรือ HSP กับ Health Net of California, Inc. โทรทัศน์การประกันภัยฟิวชั่นของ DMHC ได้ที่ 1-888-HMO-2219.

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 bằng ngôn ngữ của quý vị. Để nhận trợ giúp, hãy gọi cho chúng tôi theo số được liệt kê trên thẻ
ID của quý vị, hoặc người nộp đơn vào chương trình theo nhóm của chủ sở dụng lao động vui lòng gọi
1-800-522-0088 (TTY: 711). Người nộp đơn thuộc Chương Trình Cá Nhân & Gia đình viết tắt trong tiếng
Anh là (IFP) vui lòng gọi số 1-800-609-8711 (TTY: 711). Để nhận thêm trợ giúp. Nếu quý vị đăng ký hợp
đồng bảo hiểm PPO hoặc EPO từ Health Net Life Insurance Company, vui lòng gọi Số Y Tế CA theo số
1-800-927-4357. Nếu quý vị đăng ký vào chương trình HMO hoặc HSP từ Health Net of California, Inc.,
vui lòng gọi Đường Dạy Trợ Giúp DMHC theo số 1-888-HMO-2219.

CA Commercial Applicant Notice of Language Assistance

FLY007791EH00 (06/16)
Notice of Nondiscrimination

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. (“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:

IFP On Exchange/Covered California 1-888-926-4988 (TTY: 711)
IFP Off Exchange 1-800-839-2172 (TTY: 711)
Group Plans through Health Net 1-800-522-0088 (TTY: 711)

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

Health Net of California, Inc.
P.O. Box 10348
Van Nuys, California, 91410-0348

Fax: 1-877-831-6019

Online: healthnet.com (Group) or myhealthnetca.com (IFP)

If you are not satisfied with Health Net’s decision or it has been more than 30 days since you filed the complaint, you may submit a complaint form to the Department of Managed Health Care (DMHC). The form is available at www.dmhc.ca.gov/FileaComplaint. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available 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) if there is a concern of discrimination based on race, color, national origin, age, disability or sex.

Contact us

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

Customer Contact Center
Large Group:
1-800-522-0088 – HMO/Elect Open Access
1-800-676-6976 – PPO/Point-of-Service (SELECT/ELECT)
(for companies with 51 or more employees)

Small Business Group:
1-800-361-3366
(for companies with 2–50 employees)

1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

Telecommunications Device for the Hearing and Speech Impaired
1-800-995-0852

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