Health Net of California, Inc. (Health Net)

Disclosure Form

SELECT

Large Group

Refer to the Summary of Benefits and Coverage (SBC) document to determine your share of costs for services and supplies that are covered by this plan.

Healthnet.com

1/2024 Select DF

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. The *Disclosure Form* answers basic questions about this SELECT plan.

If you have further questions, contact us:

By phone at 1-800-522-0088

By mail at:

Health Net of California
P.O. Box 9103
Van Nuys, CA 91409-9103

Online at www.healthnet.com

This Disclosure Form (including any applicable Disclosure Form Rider) and the Summary of Benefits and Coverage (SBC) document provide 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 Disclosure Form, the SBC and, once received, the plan's EOC, especially those sections that apply to those with special health care needs. This Disclosure Form includes a matrix of benefits in the section titled "Benefit Matrix." The SBC, which is issued in conjunction with this Disclosure Form, describes what your plan covers and what you pay for covered services and supplies.

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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. If any network rider has been issued with this document, refer to the rider for additional information.

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 PCP. A PCP provides and coordinates your medical care. You have the right to designate any PCP 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 PCP. Until you make this PCP designation, Health Net designates one for you. For information on how to select a PCP and for a list of the participating PCPs 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 ID 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 Health and Substance Use Disorders" section below for information about receiving care for mental health and substance use disorders.

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, gynecology or reproductive and sexual health. 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, gynecology or reproductive and sexual health, refer to your Health Net directory of participating physicians on the Health Net website at www.healthnet.com. A copy of the Health Net provider directory may also be ordered online or by calling Health Net Customer Contact Center at **1-800-522-0088**.

MENTAL HEALTH AND SUBSTANCE USE DISORDERS

For more information about how to receive care and Health Net's prior authorization requirements, please refer to the "Behavioral Health Services" section of this *Disclosure Form*.

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.

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 *Evidence of Coverage* 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.

Benefits Matrix

The matrix below lists examples of services that are provided under this plan. Refer to the SBC, which is issued in conjunction with this Disclosure Form, for the amount you will pay for covered services and supplies.

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

Principal Benefits	**What You Pay**
Deductible	The *SBC* shows if your plan has a deductible that has to be met before we begin to pay the benefits.
Lifetime maximums	This plan does not have a lifetime maximum.
Professional services	Refer to the *SBC* under "If you visit a health care provider's office or clinic."
Outpatient services	Refer to the *SBC* under "If you have outpatient surgery."
Hospitalization services	Refer to the *SBC* under "If you have a hospital stay."
Emergency health coverage	Refer to the *SBC* under "If you need immediate medical attention."
Ambulance services	Refer to the *SBC* under "If you need immediate medical attention."
Prescription drug coverage	Refer to the *SBC* under "If you need drugs to treat your illness or condition."
Durable medical equipment	Refer to the *SBC* under "If you need help recovering or have other special health needs."
Mental health services	Refer to the *SBC* under "If you need mental health, behavioral health, or substance abuse services."
Substance use disorder services	Refer to the *SBC* under "If you need mental health, behavioral health, or substance abuse services."
Home health services	Refer to the *SBC* under "If you need help recovering or have other special health needs."
Other services	Refer to the *SBC* under "If you have a test" and "If you need help recovering or have other special health needs."

Limits of Coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- Acupuncture services, unless shown as covered on your plan's *SBC*;
- 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;
- Biofeedback therapy is limited to medically necessary treatment of certain physical disorders (such as incontinence and chronic pain) and mental health and substance use disorders;
- Care for mental health care as a condition of parole or probation, or court-ordered treatment and testing for mental health and substance use disorders, except when such services are medically necessary. Exception: The plan will cover the cost of developing an evaluation pursuant to Welfare and Institutions Code Section 5977.1 and the provision of all health care services for a member when required or recommended for the member pursuant to a Community Assistance, Recovery, and Empowerment (CARE) agreement or a CARE plan approved by a court, regardless of whether the service is provided by an in-network or out-of-network provider. Services are provided to the member with no cost-share;
- Chiropractic services, unless shown as covered on your plan's *SBC*;
- Corrective footwear is limited to medically necessary footwear that is custom made for the member and permanently attached to a medically necessary orthotic device that is also a covered benefit under this plan or is a podiatric device to prevent or treat diabetes-related complications. Other corrective footwear is not covered unless specifically described in your plan's *EOC*;
- 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, except certain disposable ostomy or urological supplies;
- Experimental or investigational procedures, except as set out under the "Clinical Trials" and "If You Have a Disagreement with Our Plan" sections of this *Disclosure Form*;
- Fertility preservation coverage does not include the following: follow-up assisted reproductive technologies (ART) to achieve future pregnancy such as artificial insemination, in vitro fertilization and/or embryo transfer; pre-implantation genetic diagnosis; donor eggs, sperm or embryos; or gestational carriers (surrogates);
- Genetic testing is not covered except when determined by Health Net to be medically necessary. The prescribing physician must request prior authorization for coverage. However, prior authorization is not required for biomarker testing for members with advanced or metastatic stage 3 or 4 cancer;
- Infertility services and supplies, unless shown as covered on your plan's *SBC*;

- Marriage counseling, except when rendered in connection with services provided for a treatable mental health or substance use disorder;
- Noneligible 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);
- Orthotics (such as bracing, supports and casts) that are not custom made to fit the member's body. Refer to the "corrective footwear" bullet above for additional foot orthotic limitations;
- 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;
- 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;
- Telehealth consultations through a select telehealth services provider do not cover specialist services; and prescriptions for substances controlled by the DEA, non-therapeutic drugs or certain other drugs which may be harmful because of potential for abuse;
- Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary; and
- Treatment of obesity, weight reduction or weight management, except for morbid obesity. Certain services may be covered as preventive care services as described in the plan's *EOC*.

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.

Benefits and Coverage

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.

SERVICES REQUIRING PRIOR AUTHORIZATION

The following services require prior authorization 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 *SBC*. A penalty will also be charged for nonauthorized inpatient admissions. These penalties do not apply to your out-of-pocket Maximum (OOPM). (Note: If prior authorization 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 prior authorization.

Services that require prior authorization include:

All inpatient admissions, any facility[1]:

- Acute rehabilitation center
- Behavioral health facility, except in an emergency
- Hospice
- Hospital, except in an emergency
- Skilled nursing facility
- Substance abuse facility, except in an emergency

Outpatient procedures, services or equipment

- Ablative techniques for treating Barrett's esophagus and for treatment of primary & metastatic liver malignancies
- Acupuncture
- Ambulance: non-emergency, air or ground ambulance services
- Bariatric procedures
- Bronchial thermoplasty
- Capsule endoscopy
- Cardiovascular procedures
- Chiropractic care
- Clinical trials
- Diagnostic procedures including:
  - Advanced imaging

    - Computerized Tomography (CT)
    - Computed Tomography Angiography (CTA)
    - Magnetic Resonance Angiography (MRA)
    - Magnetic Resonance Imaging (MRI)
    - Positron Emission Tomography (PET)
  - Cardiac imaging
    - Coronary Computed Tomography Angiography (CCTA)
    - Multigated Acquisition (MUGA) scan
    - Myocardial Perfusion Imaging (MPI)
  - Sleep studies
- Durable Medical Equipment (DME)
- Ear, Nose and Throat (ENT) procedures
- Enhanced External Counterpulsation (EECP)
- Experimental/investigational services and new technologies
- Gender affirming services
- Genetic testing (Prior authorization is not required for biomarker testing for members with advanced or metastatic stage 3 or 4 cancer)
- Implantable pain pumps including insertion or removal
- Injection, including epidural, nerve, nerve root, facet joint, trigger point, and sacroiliac (SI) joint injections
- Joint surgeries
- Mental health and substance use disorder services other than office visits including:
  - Applied Behavioral Analysis (ABA) and other forms of Behavioral Health Treatment (BHT) for autism and pervasive developmental disorders
  - Electroconvulsive Therapy (ECT)
  - Half-Day Partial Hospitalization
  - Intensive Outpatient Program (IOP)
  - Neuropsychological testing
  - Partial Hospital Program or Day Hospital (PHP)
  - Psychological testing
  - Transcranial Magnetic Stimulation (TMS)
- Neuro or spinal cord stimulator
- Orthognathic procedures (includes TMJ treatment)
- Pharmaceuticals
  - Outpatient prescription drugs

  - Most specialty drugs, including self-injectable drugs and hemophilia factors, must have prior authorization through the outpatient prescription drug benefit and may need to be dispensed through the specialty pharmacy vendor. Please refer to the Formulary to identify which drugs require prior authorization. Urgent or emergent drugs that are medically necessary to begin immediately may be obtained at a retail pharmacy.
  - Other prescription drugs, as indicated in the Formulary, may require prior authorization. Refer to the Formulary to identify which drugs require prior authorization.
- 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 website, www.healthnet.com, for a list of physician-administered drugs that require prior authorization. Biosimilars are required in lieu of branded drugs, unless medically necessary.

- Prosthesis
- Quantitative drug testing
- Radiation therapy
- Reconstructive and cosmetic surgery, services and supplies such as:
  - Bone alteration or reshaping such as osteoplasty
  - Breast reductions and augmentations (includes gynecomastia and macromastia)
  - 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 such as chemical exfoliation, electrolysis, dermabrasion, chemical peel, laser treatment, skin injection, or implants
  - Excision, excessive skin and subcutaneous tissue (including lipectomy and panniculectomy) of the abdomen, thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad, and other areas
  - Eye or brow procedures such as blepharoplasty, brow ptosis or canthoplasty
  - Gynecologic or urology procedures such as clitoroplasty, labioplasty, vaginal rejuvenation, scrotoplasty, testicular prosthesis, and vulvectomy
  - Hair electrolysis, transplantation or laser removal
  - Lift such as arm, body, face, neck, thigh
  - Liposuction
  - Nasal surgery such as rhinoplasty or septoplasty
  - Otoplasty
  - Penile implant
  - Treatment of varicose veins
  - Vermilionectomy with mucosal advancement
- Spinal surgery
- Testosterone therapy
- Therapy (includes home setting):
  - Occupational therapy

  - Physical therapy
  - Speech therapy
- Transplant and related services; transplants must be performed through Health Net's designated transplantation specialty network
- Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
- Vestibuloplasty
- Wound care

[1] *Prior authorization is not required for the length of a hospital stay for reconstructive surgery incident to a mastectomy (including lumpectomy) or for renal dialysis. Prior authorization is also not required for the length of stay for the first 48 hours following a normal delivery or 96 hours following cesarean delivery. However, please notify Health Net within 24 hours following birth or as soon as reasonably possible. Prior authorization must be obtained if the physician determines that a longer hospital stay is medically necessary either prior to or following the birth.*

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 participating mental health professional (mental health and substance use disorders). If you are unable to call and you need medical care right away, go to the nearest medical center or hospital. You can also call 988, the national suicide and mental health crisis hotline system.

All follow-up care (including mental health and substance use disorders) after the urgency has passed and your condition is stable, must be provided by your physician group (medical) or participating mental health professional (mental health and substance use disorders) and, if required, authorized by your physician group (medical) or Health Net (mental health and substance use disorders) 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 their 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. "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 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 their 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 mental health and substance use disorders).*

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: (1) Placing the patient's health in serious jeopardy, (2) Serious impairment to bodily functions, or (3) Serious dysfunction of any bodily organ or part.*

Psychiatric emergency medical condition *means a mental health or substance use disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: (1) An immediate danger to themself or to others, or (2) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental health and substance use disorder.*

Urgently needed care *includes an otherwise covered medical service a person would seek for treatment of an injury, unexpected illness or complication of an existing condition, including pregnancy, to prevent the serious deterioration of their health, but which does not qualify as emergency care, as defined in this section. This may include services for which a person should 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.

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.

TIMELY ACCESS TO CARE

The California Department of Managed Health Care (DMHC) has issued regulations (California Code of 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.

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*.

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.

COVERAGE FOR NEWBORNS

Children born after your date of enrollment are automatically covered for 31 days (including the date of birth). To continue coverage, the child must be enrolled through your employer before the 31st day of the child's life. If the child is not enrolled within 31 days (including the date of birth):

- Coverage will end after 31 days (including the date of birth); and
- You will have to pay your physician group for all medical care provided after 31 days (including the date of birth).

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 a Medi-Cal plan.

EXTENSION OF BENEFITS

If you or a covered family member is totally disabled when your employer ends its agreement with Health Net, we may 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 settings (including oral, written and electronic information). The only time we would release your confidential information without your authorization is for payment, treatment, health care operations (including but not limited to utilization management, quality improvement, disease or case management programs) or when permitted or required to do so by law, such as for a court order or subpoena. We will not release your confidential claims details to your employer or their agent. Often, Health Net 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 "Legal Notices" 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.*

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 *SBC* explains your coverage and payment for services. 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 *SBC*. 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 in the *SBC* 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.

Payment for services not covered by this plan will not count toward the out-of-pocket maximum. Additionally, certain deductibles and copayments will not count toward the out-of-pocket maximum as shown in the SBC. For further information please refer to the plan's EOC.

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 the *Evidence of Coverage*.

For illustration purposes only, SELECT 3 provider: 70% Health Net payment / 30% member coinsurance:

SELECT 3 provider's billed charge for extended office visit..... $128.00
Maximum Allowable Amount (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 providers (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 providers (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.
c. 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, prior authorization 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 Contact Center 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 from your PCP or physician group or participating mental health professional, or, if required, authorization from your physician group (medical) or Health Net (mental health and substance use disorders), 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 by a Health Net contracting physician or physician group or participating mental health professional or, if required, authorized by your physician group (medical) or Health Net (mental health and substance use disorders), 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 participating mental health professional (mental health and substance use disorder) 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 participating mental health professional (mental health and substance use disorder).

If you receive emergency services not provided or directed by your physician group (medical) or directed by Health Net (mental health and substance use disorder), 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 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 to Health Net. Medical claims must be received by Health Net within one year of the date of service to be eligible for reimbursement.

How to File a Claim

For medical and mental health and substance use disorder services, *please send a completed claim form within one year of the date of service to:*

Health Net Commercial Claims
P.O. Box 9040
Farmington, MO 63640-9040

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 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.

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 at www.healthnet.com or at the phone number on the back cover of this booklet 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 in the “Continuity of Care Upon Termination of Provider Contract” provision immediately 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);
- maternal mental health, not to exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later;
- 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.

To request continued care, you will need to complete a Continuity of Care Request Form. If you would like more information on how to request continued care or to request a copy of the Continuity of Care Request Form or of Health Net's continuity of care policy, please contact the Health Net 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 California, 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 *Disclosure Form* 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; or
- You no longer work for the employer covered under this Health Net SELECT POS Plan.

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 ID 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 also 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 any applicable 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 **(1-888-466-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's internet website www.dmhc.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 10348
Van Nuys, CA 91410-0348

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

Contact Health Net by calling the Health Net Customer Contact Center at the phone number on the back cover. Health Net will help you identify a participating mental health professional within the network, close to where you live or work, with whom you can make an appointment.

Certain services and supplies for mental health and substance use disorders may require prior authorization by Health Net in order to be covered.

Please refer to the plan's *EOC* for a more complete description of mental health and substance use disorder services and supplies, including those that require prior authorization by Health Net.

TRANSITION OF CARE FOR NEW ENROLLEES

If you are receiving ongoing care for an acute, serious, or chronic mental health or substance use disorder condition from a provider not affiliated with Health Net 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 Health Net's standard mental health provider contract terms and conditions and be located in the plan's service area.

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

MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Mental health and substance use disorders means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this definition as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

CONTINUATION OF TREATMENT

If you are in treatment for a mental health or substance use disorder 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 *SBC* 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 substance use disorders are subject to the plan's general exclusions and limitations. Please refer to the "Limits of Coverage" section of this Disclosure Form for a list of what's not covered under this plan.

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

Prescription Drug Program

Health Net contracts 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.

THE HEALTH NET FORMULARY

This plan uses the Formulary. The Health Net 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 Formulary, it ensures that you are receiving a high quality prescription medication that is also of high value.

The 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 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 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 Formulary, please visit our website at www.healthnet.com, under the pharmacy information, or call the Health Net Customer Contact Center at the phone number on the back cover. You can search the Formulary to determine whether or not a particular drug is covered.

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. Step therapy exceptions are also subject to the prior authorization process.

How to Request Prior Authorization or Step Therapy Exceptions

Requests for prior authorization, including step therapy exceptions, may be submitted electronically or 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 365 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 10348
  Van Nuys, CA 91410-0348

PRESCRIPTIONS BY MAIL ORDER

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period), you may fill it through our convenient prescriptions by mail order program. This program allows you to receive a 90-consecutive-calendar-day supply of maintenance drugs from our network mail-order pharmacy. For complete information, visit www.healthnet.com or 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.

WHAT'S COVERED

Please refer to the SBC for the explanation of covered services and copayments.

This plan covers the following:

- Tier 1 drugs listed on the Formulary (include most generic drugs and low-cost preferred brand name drugs);

- Tier 2 drugs listed on the Formulary (include non-preferred generic, preferred brand name drugs, and any other drugs recommended by the health care service plan's pharmacy and therapeutics committee based on safety, efficacy, and cost); and
- Tier 3 drugs listed on the Formulary as Tier 3 (include non-preferred brand name drugs, or drugs that are recommended by the Health Net Pharmacy and Therapeutics Committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier).
- Specialty drugs - Drugs listed on the Formulary as specialty drugs (include drugs that are biologics, drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the enrollee to have special training or clinical monitoring for self-administration, or drugs that cost the health plan more than six hundred dollars for a one-month supply).
- Preventive drugs and 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 cost of the prescription for covered prescription drugs;
- If a brand name prescription drug deductible (per member each calendar year) applies, you must pay this amount for prescription drug covered expenses before Health Net begins to pay. Diabetic supplies and preventive drugs and contraceptives are not subject to the deductible. After the deductible is met the copayment amounts will apply.
- 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;
- 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 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;

- 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. No annual limits will be imposed on the number of days for the course of treatment for all FDA-approved smoking and tobacco cessation medications. Covered contraceptives are FDA-approved contraceptives that are either available over-the-counter or are only available with a prescription. Vaginal, oral, transdermal and emergency contraceptives and condoms 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 up to a 30-day period;
- 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);
- Coverage for devices is limited to FDA-approved vaginal contraceptive devices, peak flow meters, inhaler spacers 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 or when you meet Health Net prior authorization coverage requirements. 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 *Disclosure Form* for additional information;
- Hypodermic needles or syringes, except for insulin needles, syringes and specific brands of pen devices and pen needles;

- 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 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;
- 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 terms and conditions of your coverage.

Nondiscrimination Notice

In addition to the state of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. 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, gender affirming care, 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:

Individual & Family Plan (IFP) Members On Exchange/Covered California 1-888-926-4988 (TTY: 711)

Individual & Family Plan (IFP) Members Off Exchange 1-800-839-2172 (TTY: 711)

Individual & Family Plan (IFP) Applicants 1-877-609-8711 (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 based on one of the characteristics listed above, you can file a grievance by calling Health Net's Customer Contact Center at the number above and telling them you need help filing a grievance. Health Net's Customer Contact Center is available to help you file a grievance. You can also file a grievance by mail, fax or email at:

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

If your health problem is urgent, if you have already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019 (TDD: 1-800-537-7697)**.

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

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 the Customer Contact Center at the number on your ID card or call Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). For California marketplace, call IFP On Exchange 1-888-926-4988 (TTY: 711) or Small Business 1-888-926-5133 (TTY: 711). For Group Plans through Health Net, call 1-800-522-0088 (TTY: 711).

Arabic
خدمات لغوية مجانية. يمكننا أن نوفر لك مترجم فوري. ويمكننا أن نقرأ لك الوثائق بلغتك. للحصول على المساعدة اللازمة، يرجى التواصل مع مركز خدمة العملاء عبر الرقم المبين على بطاقتك أو الاتصال بالرقم الفرعي لخطة الأفراد والعائلة: 1-800-839-2172 (TTY: 711). للتواصل في كاليفورنيا، يرجى الاتصال بالرقم الفرعي لخطة الأفراد والعائلة عبر الرقم: 1-888-926-4988 (TTY: 711) أو المشروعات الصغيرة 1-888-926-5133 (TTY: 711). لخطط المجموعة عبر Health Net، يرجى الاتصال بالرقم 1-800-522-0088 (TTY: 711).

Armenian
Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Օգնության համար զանգահարեք Հաճախորդների սպասարկման կենտրոն ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք Individual & Family Plan (IFP) Off Exchange՝ 1-800-839-2172 հեռախոսահամարով (TTY՝ 711): Կալիֆորնիայի համար զանգահարեք IFP On Exchange՝ 1-888-926-4988 հեռախոսահամարով (TTY՝ 711) կամ Փոքր բիզնեսի համար՝ 1-888-926-5133 հեռախոսահամարով (TTY՝ 711): Health Net-ի Խմբային ծրագրերի համար զանգահարեք 1-800-522-0088 հեռախոսահամարով (TTY՝ 711):

Chinese
免費語言服務。您可使用口譯員服務。您可請人將文件唸給您聽並請我們將某些文件翻譯成您的語言寄給您。如需協助，請撥打您會員卡上的電話號碼與客戶聯絡中心聯絡或者撥打健康保險交易市場外的 Individual & Family Plan (IFP) 專線：1-800-839-2172（聽障專線：711）。如為加州保險交易市場，請撥打健康保險交易市場的 IFP 專線 1-888-926-4988（聽障專線：711），小型企業則請撥打 1-888-926-5133（聽障專線：711）。如為透過 Health Net 取得的團保計畫，請撥打 1-800-522-0088（聽障專線：711）。

Hindi
बिना शुल्क भाषा सेवाएं। आप एक दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेजों को अपनी भाषा में पढ़वा सकते हैं। मदद के लिए, अपने आईडी कार्ड में दिए गए नंबर पर ग्राहक सेवा केंद्र को कॉल करें या व्यक्तिगत और फैमिली प्लान (आईएफपी) ऑफ एक्सचेंज: 1-800-839-2172 (TTY: 711) पर कॉल करें। कैलिफोर्निया बाजारों के लिए, आईएफपी ऑन एक्सचेंज 1-888-926-4988 (TTY: 711) या स्मॉल बिजनेस 1-888-926-5133 (TTY: 711) पर कॉल करें। हेल्थ नेट के माध्यम से ग्रुप प्लान के लिए 1-800-522-0088 (TTY: 711) पर कॉल करें।

Hmong
Tsis Muaj Tus Nqi Pab Txhais Lus. Koj tuaj yeem tau txais ib tus kws pab txhais lus. Koj tuaj yeem muaj ib tus neeg nyeem cov ntaub ntawv rau koj ua koj hom lus hais. Txhawm rau pab, hu xovtooj rau Neeg Qhua Lub Chaw Tiv Toj ntawm tus npawb nyob ntawm koj daim npav ID lossis hu rau Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) Ntawm Kev Sib Hloov Pauv: 1-800-839-2172 (TTY: 711). Rau California qhov chaw kiab khw, hu rau IFP Ntawm Qhov Sib Hloov Pauv 1-888-926-4988 (TTY: 711) lossis Lag Luam Me 1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hu rau 1-800-522-0088 (TTY: 711).

Japanese
無料の言語サービスを提供しております。通訳者もご利用いただけます。日本語で文書をお読みすることも可能です。ヘルプが必要な場合は、IDカードに記載されている番号で顧客連絡センターまでお問い合わせいただくか、Individual & Family Plan（IFP）（個人・家族向けプラン）Off Exchange：1-800-839-2172（TTY：711）までお電話ください。カリフォルニア州のマーケットプレイスについては、IFP On Exchange 1-888-926-4988（TTY：711）または Small Business 1-888-926-5133（TTY：711）までお電話ください。Health Netによるグループプランについては、1-800-522-0088（TTY：711）までお電話ください。

Khmer
សេវាភាសាដោយឥតគិតថ្លៃ។ លោកអ្នកអាចទទួលបានអ្នកបកប្រែផ្ទាល់មាត់។ លោកអ្នកអាចស្តាប់គេអានឯកសារឱ្យលោកអ្នកជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ សូមហៅទូរស័ព្ទទៅកាន់មជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជនតាមលេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក ឬហៅទូរស័ព្ទទៅកាន់កម្មវិធី Off Exchange របស់គម្រោងជាលក្ខណៈបុគ្គល និងក្រុមគ្រួសារ (IFP) តាមរយៈលេខ៖ 1-800-839-2172 (TTY: 711)។ សម្រាប់ទីផ្សាររដ្ឋ California សូមហៅទូរស័ព្ទទៅកាន់កម្មវិធី On Exchange របស់គម្រោង IFP តាមរយៈលេខ 1-888-926-4988 (TTY: 711) ឬក្រុមហ៊ុនអាជីវកម្មខ្នាតតូចតាមរយៈលេខ 1-888-926-5133 (TTY: 711)។ សម្រាប់គម្រោងជាក្រុមតាមរយៈ Health Net សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-522-0088 (TTY: 711)។

Korean
무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 고객서비스 센터에 연락하시거나 개인 및 가족 플랜(IFP)의 경우 Off Exchange: 1-800-839-2172(TTY: 711)번으로 전화해 주십시오. 캘리포니아 주 마켓플레이스의 경우 IFP On Exchange 1-888-926-4988(TTY: 711), 소규모 비즈니스의 경우 1-888-926-5133(TTY: 711)번으로 전화해 주십시오. Health Net을 통한 그룹 플랜의 경우 1-800-522-0088(TTY: 711)번으로 전화해 주십시오.

Navajo
Doo bą́ąh ílínígóó saad bee háká ada'iiyeed. Ata' halne'ígíí da ła' ná hádídóot'įįł. Naaltsoos da t'áá shí shizaad k'ehjí shichį' yídooltah nínízingo t'áá ná ákódoolníił. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíjį' hodíílnih ninaaltsoos nanitingo bee néého'dolzinígíí hodoonihjį' bikáá' éí doodago kojį' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojį' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí kojį' hólne' 1-888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí kojį' hólne' 1-800-522-0088 (TTY: 711).

Persian (Farsi)
خدمات زبان بدون هزینه. می توانید یک مترجم شفاهی بگیرید. می توانید درخواست کنید اسناد به زبان شما برایتان خوانده شوند. برای دریافت کمک، با مرکز تماس مشتریان به شماره روی کارت شناسایی یا طرح فردی و خانوادگی (IFP) Off Exchange به شماره: 1-800-839-2172 (TTY:711) تماس بگیرید. برای بازار کالیفرنیا، با IFP On Exchange شماره 1-888-926-4988 (TTY:711) یا کسب و کار کوچک 1-888-926-5133 (TTY:711) تماس بگیرید. برای طرح های گروهی از طریق Health Net، با 1-800-522-0088 (TTY:711) تماس بگیرید.

Panjabi (Punjabi)
ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਸੇਵਾ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਯੋਜਨਾ (IFP) ਔਫ਼ ਐਕਸਚੇਂਜ 'ਤੇ ਕਾਲ ਕਰੋ: 1-800-839-2172 (TTY: 711)। ਕੈਲੀਫੋਰਨੀਆ ਮਾਰਕਿਟਪਲੇਸ ਲਈ, IFP ਔਨ ਐਕਸਚੇਂਜ ਨੂੰ 1-888-926-4988 (TTY: 711) ਜਾਂ ਸਮੌਲ ਬਿਜ਼ਨੇਸ ਨੂੰ 1-888-926-5133 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਹੈਲਥ ਨੈੱਟ ਰਾਹੀਂ ਸਾਮੂਹਿਕ ਪਲੈਨਾਂ ਲਈ, 1-800-522-0088 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian
Бесплатная помощь переводчиков. Вы можете получить помощь переводчика. Вам могут прочитать документы на Вашем родном языке. Если Вам нужна помощь, звоните по телефону Центра помощи клиентам, указанному на вашей карте участника плана. Вы также можете позвонить в отдел помощи участникам не представленных на федеральном рынке планов для частных лиц и семей (IFP) Off Exchange 1-800-839-2172 (TTY: 711). Участники планов от California marketplace: звоните в отдел помощи участникам представленных на федеральном рынке планов IFP (On Exchange) по телефону 1-888-926-4988 (TTY: 711) или в отдел планов для малого бизнеса (Small Business) по телефону 1-888-926-5133 (TTY: 711). Участники коллективных планов, предоставляемых через Health Net: звоните по телефону 1-800-522-0088 (TTY: 711).

Spanish
Servicios de idiomas sin costo. Puede solicitar un intérprete, obtener el servicio de lectura de documentos y recibir algunos en su idioma. Para obtener ayuda, comuníquese con el Centro de Comunicación con el Cliente al número que figura en su tarjeta de identificación o llame al plan individual y familiar que no pertenece al Mercado de Seguros de Salud al 1-800-839-2172 (TTY: 711). Para planes del mercado de seguros de salud de California, llame al plan individual y familiar que pertenece al Mercado de Seguros de Salud al 1-888-926-4988 (TTY: 711); para los planes de pequeñas empresas, llame al 1-888-926-5133 (TTY: 711). Para planes grupales a través de Health Net, llame al 1-800-522-0088 (TTY: 711).

Tagalog
Walang Bayad na Mga Serbisyo sa Wika. Makakakuha kayo ng interpreter. Makakakuha kayo ng mga dokumento na babasahin sa inyo sa inyong wika. Para sa tulong, tumawag sa Customer Contact Center sa numerong nasa ID card ninyo o tumawag sa Off Exchange ng Planong Pang-indibidwal at Pampamilya (Individual & Family Plan, IFP): 1-800-839-2172 (TTY: 711). Para sa California marketplace, tumawag sa IFP On Exchange 1-888-926-4988 (TTY: 711) o Maliliit na Negosyo 1-888-926-5133 (TTY: 711). Para sa mga Planong Pang-grupo sa pamamagitan ng Health Net, tumawag sa 1-800-522-0088 (TTY: 711).

Thai
ไม่มีค่าบริการด้านภาษา คุณสามารถใช้ล่ามได้ คุณสามารถให้อ่านเอกสารให้ฟังเป็นภาษาของคุณได้ หากต้องการความช่วยเหลือ โทรหาศูนย์ลูกค้าสัมพันธ์ได้ที่หมายเลขบนบัตรประจำตัวของคุณ หรือโทรหาฝ่ายแผนบุคคลและครอบครัวของเอกชน (Individual & Family Plan (IFP) Off Exchange) ที่ 1-800-839-2172 (โหมด TTY: 711) สำหรับเขตแคลิฟอร์เนีย โทรหาฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โหมด TTY: 711) หรือ ฝ่ายธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โหมด TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โหมด TTY: 711)

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có một phiên dịch viên. Quý vị có thể yêu c`ầu được đọc cho nghe tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, vui lòng gọi Trung Tâm Liên Lạc Khách Hàng theo số điện thoại ghi trên thẻ ID của quý vị hoặc gọi Chương Trình Bảo Hiểm Cá Nhân & Gia Đình (IFP) Phi Tập Trung: 1-800-839-2172 (TTY: 711). Đối với thị trường California, vui lòng gọi IFP Tập Trung 1-888-926-4988 (TTY: 711) hoặc Doanh Nghiệp Nhỏ 1-888-926-5133 (TTY: 711). Đối với các Chương Trình Bảo Hiểm Nhóm qua Health Net, vui lòng gọi 1-800-522-0088 (TTY: 711).

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1-877-891-9053 (Mandarin)
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Health Net
Post Office Box 9103
Van Nuys, California 91409-9103

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