Health Net of California, Inc. (Health Net)

Disclosure Form

HMO

Large Group Plans

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

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 Health Maintenance Organization (HMO) 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 "Benefits Matrix." The SBC, which is issued in conjunction with this *Disclosure Form*, describes what your plan covers and what you pay for Covered Benefits.

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How the Plan Works

Please read the following information so you will know from whom health care may be obtained, or what physician group to use. If any network rider has been issued with this document, refer to the rider for additional information.

SELECTION OF PHYSICIANS AND PHYSICIAN GROUPS

- When you enroll with Health Net, you choose a contracting physician group. 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 PCP in the Service Area, refer to your *Health Net Group HMO Directory* (*Health Net HMO Directory*). *The Health Net HMO 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.
- Whenever you or a covered family member needs health care, your PCP will provide the Medically Necessary care. Specialist care is also available, when referred by your PCP or physician group.
- You do not have to choose the same physician group or PCP for all members of your family. Physician groups, with names of physicians, are listed in the *Health Net HMO Directory*.

HOW TO CHOOSE A PHYSICIAN

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.

SPECIALISTS AND REFERRAL CARE

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 or Substance Use Disorders” section below for information about receiving care for Mental Health or Substance Use Disorders.

You do not need prior authorization from Health Net or from any other person (including a PCP) 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 Group HMO Directory* (*Health Net HMO Directory*) on the Health Net website at www.healthnet.com. A copy of the *Health Net HMO Directory* may also be ordered online or by calling Health Net Customer Contact Center at **1-800-522-0088.**

MENTAL HEALTH OR 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*.

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**
- **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 Benefits.*

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."

Exclusions and Limitations

The Plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in the *Evidence of Coverage (EOC).*

These exclusions and limitations do not apply to Medically Necessary basic health care services required to be covered under California or federal law, including but not limited to Medically Necessary Treatment of a Mental Health or Substance Use Disorder, as well as preventive services required to be covered under California or federal law.

These exclusions and limitations do not apply when covered by the Plan required by law.

- **Acupuncture Services:** This Plan does not cover acupuncture services, except as described in the *EOC* in "Covered Services and Supplies" or as required by law.
- **Chiropractic Services:** This Plan does not cover Chiropractic Services, except described in the Plan's *EOC* in the "Schedule of Benefits and Copayments" section and the "Covered Services and Supplies" section or as required by law.
- **Clinical Trials:** This Plan does not cover clinical trials, except Approved Clinical Trials as described in the Plan's *EOC* in the "Covered Services and Supplies" section or as required by law.

  Coverage of Approved Clinical Trials does not include the following:
  - The investigational drug, item, or service itself.
  - Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member.
  - Drugs, items, devices, and services specifically excluded from coverage in the Plan's *EOC*, except for drugs, items, devices, and services required to be covered pursuant to state and federal law.
  - Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.

  This exclusion does not limit, prohibit, or modify a Member's rights to the Experimental Services or Investigational Services independent review process as described in the Plan's *EOC* in the "General Provisions" section or to the Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in the Plan's *EOC* in the "General Provision" section.
- **Cosmetic Services, Supplies, or Surgeries:** This Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function except as described in the Plan's *EOC* in the "Covered Services and Supplies" section, or as required by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in the Plan's *EOC* in the "Covered Services and Supplies" section, or as required by law.

  This exclusion does not apply to the following:
  - Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.

- Reconstructive surgery as described in the Plan's *EOC* in the "Covered Services and Supplies" section.
- For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in the Plan's *EOC* in the "Covered Services and Supplies" section.

- **Custodial or Domiciliary Care:** This Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as described in the Plan's *EOC* in the "Covered Services and Supplies" section or as required by law.

  This exclusion does not apply to the following:
  - Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals.
  - Assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care.
  - Custodial care provided in a healthcare facility.
- **Dental Services:** This Plan does not cover dental services or supplies, except as described in the Plan's *EOC* in the "Covered Services and Supplies" section or as required by law.
- **Dietary or Nutritional Supplements:** This Plan does not cover dietary or nutritional supplements, except as described in the Plan's *EOC* in the "Covered Services and Supplies" section or as required by law.
- **Disposable Supplies for Home Use:** This Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in the Plan's *EOC* in the "Covered Services and Supplies" section under "Ostomy and Urological Supplies" or as required by law.
- **Experimental Services or Investigational Services:** This Plan does not cover Experimental Services or Investigational Services, except as described in the Plan's *EOC* in the "Covered Services and Supplies" section or as required by law.

  Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

  Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:
  1. Testing is not complete; and
  2. The efficacy and safety of such services in human subjects are not yet established; and
  3. The service is not in wide usage.

  The determination that a service is an Experimental Service or Investigational Service is based on:

1. Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);
2. Consultation with provider organizations, academic and professional specialists pertinent to the specific service;
3. Reference to current medical literature.

However, if the Plan denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, the Plan must provide an external, independent review.

Qualifications

1. You must have a Life-Threatening or Seriously Debilitating condition.
2. Your Health Care Provider must certify to the Plan that you have a Life-Threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the Plan.
3. Either (a) your Health Care Provider, who has a contract with or is employed by the Plan, has recommended a drug, device, procedure, or other therapy that the Health Care Provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Health Care Provider, who is a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.
4. You have been denied coverage by the Plan for the recommended or requested service.
5. If not for the Plan's determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered.

External, Independent Review Process: If the Plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the Plan will notify you within five business days of its decision and your opportunity to request external review of the Plan's decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the Plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.

DMHC's Independent Medical Review (IMR): This exclusion does not limit, prohibit, or modify a Member's rights to an IMR from the DMHC as described in the Plan's *EOC* in the "General Provisions" section. In certain circumstances, you do not have to participate in the Plan's grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial. See the "General Provisions" section.

- **Vision Care:** This Plan does not cover vision services, except as described in the Plan's *EOC* in the "Covered Services and Supplies" section or as required by law.
- **Hearing Aids:** This Plan does not cover hearing aids, except as described in the Plan's *EOC* in the "Covered Services and Supplies" section or as required by law.
- **Immunizations:** This Plan does not cover non-Medically Necessary or non-preventive immunizations solely for foreign travel or occupational purposes, except as described in the Plan's *EOC* in the "Covered Services and Supplies" section or as required by law.
- **Nonlicensed or Noncertified Providers:** This Plan does not cover treatments or services rendered by a nonlicensed or noncertified Health Care Provider, except as described in the Plan's *EOC* in the "Covered Services and Supplies" section or as required by law.

  This exclusion does not apply to Medically Necessary Treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable state law.
- **Prescription Drugs/Outpatient Prescription Drugs:** The Plan does not cover the following Prescription Drugs, except as described in the Plan's *EOC* in the "Covered Services and Supplies" section or as required by law:
  - When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.
  - When prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.
  - When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of severe obesity. Enrollment in a comprehensive weight loss program, if covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.
  - When prescribed solely for the purpose of shortening the duration of the common cold.
  - Prescription Drugs available over the counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This exclusion does not apply to:
    - Insulin,
    - Over-the-counter drugs as covered under preventive services (e.g., over-the-counter FDA-approved contraceptive drugs),
    - Over-the-counter drugs for reversal of an opioid overdose, or
    - An entire class of Prescription Drugs when one drug within that class becomes available over the counter.
  - Replacement of lost or stolen drugs.

  - Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.
- **Private Duty Nursing:** This Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except as described in the Plan's *EOC* in the "Covered Services and Supplies" section or as required by law.
- **Personal or Comfort Items:** This Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.
- **Reversal of Voluntary Sterilization:** This Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications, except as required by law.
- **Surrogate Pregnancy:** This Plan does not cover testing, services, or supplies for a person who is not covered under this Plan for a surrogate pregnancy, except as described in the Plan's *EOC* in the "General Provisions" section or as required by law.
- **Therapies:** This Plan does not cover the following physical and occupational therapies, except as described in the Plan's *EOC* in the "Covered Services and Supplies" section or as required by law:
  - Massage therapy, unless it is a component of a treatment plan;
  - Training or therapy for the treatment of learning disabilities or behavioral problems;
  - Social skills training or therapy; and
  - Vocational, educational, recreational, art, dance, music, or reading therapy.
- **Routine Physical Examination:** The Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non-preventive purpose, except as described under the Plan's *EOC* in the "Covered Services and Supplies" section or as required by law.
- **Travel and Lodging:** This Plan does not cover transportation, mileage, lodging, meals, and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in the Plan's *EOC* in the "Covered Services and Supplies" section, as otherwise described in the Plan's *EOC* in the "Covered Services and Supplies" section or as required by law.
- **Weight Control Programs and Exercise Programs:** This Plan does not cover weight control programs and exercise programs, except as described in the Plan's *EOC* in the "Covered Services and Supplies" section or as required by law.

Benefits and Coverage

MEDICALLY NECESSARY CARE

All services that are Medically Necessary will be covered by your Health Net plan (unless specifically excluded under the plan). All Covered Benefits are listed in the plan's *EOC*; any other services or supplies are not covered.

EMERGENCIES

Health Net covers emergency and urgently needed care throughout the world. If you need emergency or urgently needed care, seek care where it is immediately available. Depending on your circumstances, you may seek this care by going to your physician group (medical) or participating mental health professional (Mental Health or Substance Use Disorders) or urgent care center. For an emergency, go to the nearest emergency facility or call **911**.

You are encouraged to use appropriately the **911** emergency response system, in areas where the system is established and operating, when you have an Emergency Medical Condition (including Mental Health or Substance Use Disorders) that requires an emergency response. 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 or Substance Use Disorders). You can also call 988, the national suicide and mental health crisis hotline system.

All follow-up care (including Mental Health or Substance Use Disorders) after the urgency has passed and your condition is stable, must be provided or authorized by your physician group (medical) or participating mental health professional (Mental Health or Substance Use Disorders) and, if required, authorized by your physician group (medical) or Health Net (Mental Health or Substance Use Disorders); otherwise, it will not be covered by Health Net.

Emergency Services and 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 Services and 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 or Substance Use Disorders).*

Emergency Medical Condition *means 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 or 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 Services and Care, as defined in this section. This may include services for which a person should have known an emergency did not exist.*

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 Rights 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 Rights 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 nonemergency 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.

APPROVED CLINICAL TRIALS

Routine patient care costs for patients diagnosed with cancer or other Life-Threatening disease or condition who are accepted into phase I, II, III, or IV clinical trials are covered when Medically Necessary, recommended by the Member's treating physician and authorized by Health Net. The physician must determine that participation has a meaningful potential 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, call the 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 group services 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 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 nonroutine releases such as marketing. Health Net provides access to Members to inspect or obtain a copy of the Member's protected health information in designated record sets maintained by Health Net. Health Net protects oral, written and electronic information across the organization by using reasonable and appropriate security safeguards. These safeguards include limiting access to an individual's protected health information to only those who have a need to know in order to perform payment, treatment, health care operations or where permitted or required by law. Health Net releases protected health information to plan sponsors for administration of self-funded plans but does not release protected health information to plan sponsors/employers for insured products unless the plan sponsor is performing a payment or health care operation function for the plan. Health Net's entire "Notice of Privacy Practices" can be found in the plan's *EOC*, at www.healthnet.com under "Privacy" or you may

call 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 prior 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.

PRIOR 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 prior 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 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 called deductibles and copayments, which are described in the *SBC*. Beyond these charges the remainder of the cost of Covered Benefits will be paid by Health Net.

When the total amount of deductibles and copayments you pay equals the out-of-pocket maximum shown in the *SBC*, you will not have to pay additional deductibles or copayments for the rest of the year for most services provided or authorized by your physician group.

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.

LIABILITY OF SUBSCRIBER OR MEMBER FOR PAYMENT

If you receive health care services without the required referral or authorization from your PCP or physician group (medical), or participating mental health professional (Mental Health or Substance Use Disorders), or, if required, authorization from your physician group (medical) or Health Net (Mental Health or Substance Use Disorders), you are responsible for the cost of these services.

Remember, this plan only covers services that are provided or authorized by a PCP or physician group, or participating mental health professional or, if required, authorized by your physician group (medical) or Health Net (Mental Health or Substance Use Disorders), except for emergency or out-of-area urgent care. Consult the Health Net HMO Directory for a full listing of Health Net contracted physicians.

REIMBURSEMENT PROVISIONS

Payments that are owed by Health Net for services provided by or through your physician group (medical), or participating mental health professional (Mental Health or Substance Use Disorders) will never be your responsibility.

If you have out-of-pocket expenses for Covered Benefits, call the Health Net Customer Contact Center for a claim form and instructions. You will be reimbursed for these expenses less any required copayment or deductible. (Remember, you do not need to submit claims for medical services provided by your PCP or physician group.)

If you receive Emergency Services and Care not provided or directed by your physician group (medical) or directed by Health Net (Mental Health or Substance Use Disorders), you may have to pay at the time you receive service. To be reimbursed for these charges, you should get a complete statement of the services received and, if possible, a copy of the emergency room report.

Please call 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 Health Net. Medical and mental health 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 or Mental Health or 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 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 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. To get this information, call the Health Net Customer Contact Center at the phone number on the back cover. You can also contact your physician group or your PCP to find out about our physician payment arrangements.

Facilities

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 contracted 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.

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 *Health Net HMO Directory*.

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 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 Members

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 nonparticipating provider, subject to applicable deductibles and 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 nonparticipating 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 ends, 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 end their contract with Health Net, a written notice will be provided to affected Members within five days after the effective date of the contract termination.

Health Net may provide coverage for completion of services from a provider whose contract has ended, subject to applicable deductibles and 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); or
- 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.

In addition, you may request continued care from a provider, including a hospital, if you have been enrolled in another Health Net HMO plan that included a larger network than this plan, Health Net will offer the same scope of continuity of care for completion of services, regardless of whether you had the opportunity to retain your current provider by selecting:

- a Health Net product with an out of network benefit;
- a different Health Net HMO network product that included your current provider; or
- another health plan or carrier product.

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 call 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 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 plan and Health Net ends;
- You cease to either live or work within the Service Area; or
- You no longer work for the employer covered under this plan.

Termination for Cause

Coverage under this Health Net 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 report criminal fraud and other illegal acts to the authorities for prosecution.

How to Appeal Your Termination

You have the right to 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 provisions referenced under this title as described below are applicable to services and supplies covered under this *Disclosure Form*.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (**1-800-522-0088**) and use your health plan's 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 your health plan, 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 the Health Net website at 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 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 the 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 the 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 benefits available with your 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 or 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 covered Mental Health or Substance Use Disorder services and supplies, including those that require prior authorization by Health Net.

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Health Net fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: (1) call your health plan at the telephone number on the back of your health plan identification card; (2) call the California Department of Managed Health Care's Help Center at 1-888-466-2219; or (3) contact the California Department of Managed Health Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

TRANSITION OF CARE FOR NEW MEMBERS

If you are receiving ongoing care for an acute, serious, or chronic Mental Health or Substance Use Disorder 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 deductibles and copayments and any other exclusions and limitations of this plan.

Your nonparticipating 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 OR SUBSTANCE USE DISORDERS

Mental Health or 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 or 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, 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 Benefits and copayments.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

Please refer to the "Exclusions and Limitations" section of this *Disclosure Form* for a list of what's not covered under this plan.

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 Formulary 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 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 and new drugs become 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 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 P&T Committee as well as physician specialist experts. Your physician may contact Health Net to obtain the usage guidelines for specific medications.

Urgent requests from physicians for authorization are processed, and prescribing providers notified of Health Net's determination, as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. A prior authorization request is urgent when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function. Routine requests from physicians are processed, and prescribing providers notified of Health Net's determination, in a timely fashion, not to exceed 72 hours. For both urgent and routine requests, Health Net must also notify the Member or their designee of its decisions. If Health Net fails to respond within the required time limit, the prior authorization request is deemed granted.

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 plan's *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 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 up to 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 Benefits and copayments.

This plan covers the following:

- Tier 1 drugs - Drugs listed as Tier 1 on the Formulary that are not excluded from coverage (include most generic drugs and low-cost preferred brand name drugs).
- Tier 2 drugs - Drugs listed as Tier 2 on the Formulary that are not excluded from coverage (include nonpreferred generic, preferred brand name drugs, and any other drugs recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost).
- Tier 3 drugs - Drugs listed on the Formulary as Tier 3 (include nonpreferred brand name drugs, or drugs that are recommended by the 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 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 Member to have special training or clinical monitoring for self-administration, or drugs that cost the health plan more than six hundred dollars ($600) net of rebates for a one-month supply).

- Preventive drugs and contraceptives.

MORE INFORMATION ABOUT DRUGS THAT WE COVER

- Prescription Drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's cost of the prescription for covered Prescription Drugs.
- If a 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, preventive drugs and contraceptives are not subject to the deductible. After the deductible is met, the copayment amounts will apply.
- Prescription Drug refills are covered, up to a 30-consecutive-calendar-day supply per prescription at a Health Net contracted pharmacy for one copayment. A copayment is required for each prescription. In some cases, a 30-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan according to the Food and Drug Administration (FDA) or Health Net's usage guidelines. If this is the case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply.
- Percentage copayments will be based on Health Net's contracted pharmacy rate.
- Mail order drugs are covered up to a 90-consecutive-calendar-day supply. When the retail pharmacy copayment is a percentage, the mail order copayment is the same percentage of the cost to Health Net as the retail pharmacy copayment.
- Prescription Drugs for the treatment of asthma are covered. 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)

Please refer to the "Exclusions and Limitations" section of this *Disclosure Form* for a list of what's not covered under this Plan.

Members' Rights and Responsibilities

As a member, you have a right to:

- Receive information about your rights and responsibilities.
- Receive information about your Plan, the services your Plan offers you, and the Health Care Providers available to care for you.
- Make recommendations regarding the Plan's Member rights and responsibilities policy.
- Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.
- Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.
- Choose a Health Care Provider in your Plan's network, and change to another doctor in your Plan's network if you are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a Health Care Provider in your Plan's network, including one with a specialist.
- Have an appointment with a Health Care Provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network Health Care Provider.
- Certain accommodations for your disability, including:
  - Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
  - Full and equal access, as other members of the public, to medical facilities.
  - Extra time for visits if you need it.
  - Taking your service animal into exam rooms with you.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
  - Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.
  - To be addressed by your preferred name and pronoun.
- Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically

Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.

- Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
- A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Receive health care coverage even if you have a pre-existing condition.
- Receive Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
- Receive certain preventive health services, including many without a copay, coinsurance, or deductible.
- Have no annual or lifetime dollar limits on basic health care services.
- Keep eligible dependent(s) on your Plan.
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a Health Care Provider.
- Request from your Plan a second opinion by an Appropriately Qualified Health Care Provider.
- Expect your Plan to keep your personal health information private by following its privacy policies, and state and federal laws.
- Ask most Health Care Providers for information regarding who has received your personal health information.
- Ask your Plan or your doctor to contact you only in certain ways or at certain locations.
- Have your medical information related to sensitive services protected.
- Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive health care services.
- Have an interpreter provided at no cost to you.
- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.
- Request continuity of care if your Health Care Provider or medical group leaves your Plan or you are a new Plan Member.
- Have an Advanced Health Care Directive.
- Be fully informed about your Plan's grievances procedure and understand how to use it without fear of interruption to your health care.
- File a complaint, grievance, or appeal in your preferred language about:

  - Your Plan or Health Care Provider.
  - Any care you receive, or access to care you seek.
  - Any covered service or benefit decision that your Plan makes.
  - Any improper charges or bills for care.
  - Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
  - Not meeting your language needs.
- Know why your Plan denies a service or treatment.
- Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your Plan.
- To ask for an Independent Medical Review if your Plan denied, modified, or delayed a health care service.

As a Plan Member, you have the responsibility to:

- Treat all Health Care Providers, Health Care Provider staff, and Plan staff with respect and dignity.
- Share the information needed with your Plan and Health Care Providers, to the extent possible, to help you get appropriate care.
- Participate in developing mutually agreed-upon treatment goals with your Health Care Providers and follow the treatment plans and instructions to the degree possible.
- To the extent possible, keep all scheduled appointments, and call your Health Care Provider if you may be late or need to cancel.
- Refrain from submitting false, fraudulent, or misleading claims or information to your Plan or Health Care Providers.
- Notify your Plan if you have any changes to your name, address, or family members covered under your Plan.
- Timely pay any premiums, copayments, and charges for non-Covered Benefits.
- Notify your Plan as soon as reasonably possible if you are billed inappropriately.

Definitions

Advanced Health Care Directive means a legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the Plan or the California Attorney General's Office.

Appropriately Qualified Health Care Provider means a Health Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another Life-Threatening disease or condition that meets at least one of the following:

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
  - The National Institutes of Health.
  - The federal Centers for Disease Control and Prevention.
  - The Agency for Healthcare Research and Quality.
  - The federal Centers for Medicare and Medicaid Services.
  - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs.
  - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
    - The United States Department of Veterans Affairs.
    - The United States Department of Defense.
    - The United States Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

Covered Benefits means those Medically Necessary services and supplies that you are entitled to receive under a group agreement and which are described in the *Evidence of Coverage* or under California health plan law.

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

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

Emergency Services and Care means (1) medical screening, examination, and evaluation by a Physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and/or (2) an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical 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 within the capability of the facility.

Evidence of Coverage (EOC) means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is entitled.

Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

Health Care Provider means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

Independent Medical Review (IMR) means a review of your Plan's denial, modification, or delay of your request for health care services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your Plan related to 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. Your Plan must pay for the services if an IMR decides you need it.

Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

1. Testing is not complete; and
2. The efficacy and safety of such services in human subjects are not yet established; and
3. The service is not in wide usage.

Life-Threatening means either or both of the following**:**

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Medically Necessary means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of care, including generally accepted standards of Mental Health or Substance Use Disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and Members or for the convenience of the patient, treating physician, or other Health Care Provider.

Member means a subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the Plan and for whom coverage is active or live.

Mental Health or Substance Use Disorder 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*.

Outpatient Prescription Drug means a self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or mail order pharmacy, requires a prescription, and has not been provided for use on an inpatient basis.

Prescription Drug or "drug'' means a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term "drug'' or "prescription drug'' includes: (A) disposable devices that are medically necessary for the administration of a covered prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs; (B) syringes for self-injectable prescription drugs that are not dispensed in pre-filled syringes; (C) drugs, devices, and FDA-approved products covered under the prescription drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and (D) at the option of the health plan, any vaccines or other health care benefits covered under the Plan's prescription drug benefit.

Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Seriously Debilitating means diseases or conditions that cause major irreversible morbidity.

Service Area means the geographic area designated by the plan within which a plan shall provide health care services.

Standard Fertility Preservation Services means procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Trans-Inclusive Health Care means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual's personal bodily autonomy; does not make assumptions about an individual's gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect.

Nondiscrimination Notice

Health Net complies with applicable State and Federal civil rights laws and does not discriminate, exclude people or treat them differently because of race, color, national origin, age, mental disability, physical disability, sex (including pregnancy, sexual orientation, and gender identity), religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender.

Health Net:

- Provides free aids and services to people with disabilities to help them communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - 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)

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call one of the phone numbers above or write to:
Health Net
Post Office Box 9103, Van Nuys, California 91409-9103

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, or sex (including pregnancy, sexual orientation, and gender identity), mental disability, physical disability, religion, ancestry, ethnic group identification, medical condition, genetic information, marital status, or gender, you can file a grievance with the 1557 Coordinator.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our **1557 Coordinator** is available to help you.

- By phone: Call 855-577-8234 (TTY: 711)
- By fax: 1-866-388-1769
- In writing: Write a letter and send it to Health Net 1557 Coordinator, PO Box 31384, Tampa, FL 33631

Electronically: Send an email to SM_Section1557Coord@centene.com. This notice is available at Health Net website: https://www.healthnet.com/en_us/disclaimers/legal/non-discrimination-notice.html.

If your health problem is urgent, if you already filed a complaint with Health Net and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net, 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.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/complaints/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)។ សម្រាប់ទីផ្សាररដ្ឋ 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 bą́ą́h ílínígóó saad bee háká ada'iiyeed. Ata' halne'ígíí da ła' ná hádídóot'ı́ı́ł. Naaltsoos da t'áá shí shizaad k'ehjí shichı́' yídooltah nínízingo t'áá ná ákódoolnííł. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíjı́' hodíílnih ninaaltsoos nanitingo bee néého'dolzinígíí hodoonihjı́' bikáá' éí doodago kojı́' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojı́' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí kojı́' hólne' 1-888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí kojı́' 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 (Off Exchange IFP) 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 cầu 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).

CA Commercial On and Off-Exchange Member Notice of Language Assistance

FLY017549EH00 (12/17)

Contact Us

Health Net

1-800-522-0088 (English) TTY: 711
1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

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Healthnet.com

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