

Summary *of* Benefits

Flex Med • Insurance Plan JDG



DELIVERING CHOICES

When it comes to your health care, the best decisions are made with the best choices. Health Net Life* provides you with ways to help you receive the care you deserve. This SB answers basic questions about this versatile plan. If you have further questions, just contact the Customer Contact Center at the telephone number listed on the back cover. Our friendly, knowledgeable representatives will be glad to help.

If you have further questions, contact us:



By phone at 1-800-522-0088,



Or write to: Health Net Life Insurance Company

P.O. Box 9103

Van Nuys, CA 91409-9103

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

This Summary of benefits (SB) is only a summary of your health insurance plan. The plan's Certificate of Insurance (Certificate), which you will receive after you enroll, contains the exact terms and conditions of your HNL coverage. You should also consult the Flex Net Benefit Agreement (issued to your employer) to determine governing contractual provisions. It is important for you to carefully read this SB and the plan's Certificate thoroughly once received, especially those sections that apply to those with special health care needs. This SB includes a matrix of benefits in the section titled "Schedule of Benefits and Coverage."

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How the Insurance Plan Works

Flex Net, underwritten by Health Net Life Insurance, is a managed fee-for-service plan. This plan coordinates benefits with Medicare Part A and Part B. Medicare is the primary payor of benefits. HNL is considered the secondary payor.

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 *Certificate* and that you or your dependent might need:

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

You should obtain more information before you enroll. Call your prospective doctor or clinic, or call the Customer Contact Center at 1-800-522-0088 to ensure that you can obtain the health care services that you need.

Schedule of Benefits and Coverage

The following charts show the type of services that are covered under this insurance plan. The percentage amounts represent HNL's payment level.

Covered Services for medical conditions and mental health and substance use disorder conditions provided appropriately as telehealth services are covered on the same basis and to the same extent as covered services delivered in-person.

Principal benefits and coverage matrix


The following shows the type of services that are covered under this plan. The percentage amounts represent HNL's payment level. Benefits are payable based on the Maximum Allowable Amount (MAA). The covered person is responsible for charges in excess of MAA.

All benefits are coordinated with Medicare to cover your expenses up to the Medicare Allowable amount, including the Medicare Parts A and B deductibles.

Insurance Plan Maximums

Yearly Out-of-pocket maximum (OOPM)

For each covered person	\$6350
For a family (two members or more).....	\$12700

 *Once your payment of coinsurance for the medical benefits equals the amount shown above in any one calendar year, no additional coinsurance for covered services is required for the remainder of that year. Payments for services not covered by this insurance plan, or for certain services as specified in the "Payment of Premiums and Charges" section of this SB, will not be applied to this yearly out-of-pocket maximum. You will need to continue making payments for any additional benefits as described in the "Additional Insurance Plan Benefit Information" section of this SB.*

Professional Services

Office visit	100%
Physician visit to covered person's home	100%
Specialist consultations.....	100%
Physician visit to hospital or skilled nursing facility	100%
Surgeon or assistant surgeon service [▲]	100%
Administration of anesthetics	100%
Rehabilitation therapy.....	100%
Chemotherapy.....	100%
Radiation therapy.....	100%

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

Outpatient Services

Outpatient facility services (other than surgery, except for infertility services)	100%
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Outpatient surgery (hospital or outpatient surgery center charges only, except for infertility services) 100%



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

Hospital Services

Semi-private hospital room or special care unit with ancillary services, including delivery and maternity care (unlimited days)

Days 1-60 Medicare Part A Deductible

Days 61-90 100%

Beyond 90 days (to lifetime reserve days)..... 100%

Beyond lifetime reserve days (to a maximum of 365 days) 90% of Maximum Allowable Amount

Skilled nursing facility stay (limited to a calendar year maximum of 100 days)

Days 1-20 Not Covered

Days 21-100 100%

Days 101-365 80% of Maximum Allowable Amount

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

Radiological Services

Laboratory procedures and diagnostic imaging (including x-ray) 100%

Preventive Care

Preventive care services 100%



Preventive care services are covered for children and adults, as directed by your physician, based on the guidelines from the U.S. Preventive Services Task Force Grade A&B recommendations, the Advisory Committee on Immunization Practices that have been adopted by the Center for Disease Control and Prevention, the guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA).

Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, and preventive vision and hearing screening examinations, female sterilization, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA.

Prenatal, postnatal and newborn care that are preventive care are covered in full. If other non-preventive services are received during the same office visit, the office visit copayment will apply for the non-preventive services.

Provide breastfeeding support, supplies, including a breast pump, and counseling consistent with HRSA Guidelines for Women's Prevent Services.

Screening colonoscopy or sigmoidoscopy will be covered as preventive care services. However, if during the course of a screening colonoscopy or sigmoidoscopy, a therapeutic (surgical) procedure is performed, then the copayment or coinsurance applicable for outpatient surgery will also be required for the surgical procedure(s) performed. Refer to the "Outpatient Services" section above for the outpatient surgery copayment or coinsurance.

Emergency Health Coverage (for Medical Care other than Mental Health and Substance Use Disorders)

Emergency room and Urgent care (professional and facility charges, within the United States).....	100%
Emergency room and Urgent care (facility charges, outside the United States)	100%
Emergency room and Urgent care (professional charges, outside the United States).....	80% of Maximum Allowable Amount

Emergency Health Coverage (for Mental Health and Substance Use Disorders)

Emergency room and Urgent care (professional charges and facility charges, within the United States).....	100%
Emergency room and Urgent care (facility charges, outside the United States)	100%
Emergency room and Urgent care (professional charges, outside the United States).....	80% of Maximum Allowable Amount

Ambulance Services

Ground ambulance.....	100%
Air ambulance.....	100%

Prescription Drug Plan

†The percentage amounts below represent HNL's payment level. Please refer to the "Prescription Drug Program" section of this SB for the definitions, benefits and limitations.

Deductibles, per calendar year

Outpatient prescription drugs, per covered person.....	\$75
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Retail Pharmacy (up to a 30-day supply)

Generic drugs.....	80%
Brand name drugs♦	80%
Preventive drugs, including smoking cessation drugs and women's contraceptives*	Covered in full

Mail-Order Program (up to a 90-day supply of maintenance medication)

Generic drugs 80%

Brand name drugs♦ 80%

Preventive drugs, including smoking cessation drugs, and women’s contraceptives* Covered in full

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

Prescription Drugs will have a Copayment maximum of \$250 for an individual prescription of up to a 30-day supply.

♦*Generic drugs will be dispensed when a generic drug equivalent is commercially available. If you require a brand name drug when a generic equivalent is commercially available, you must pay the difference between the generic equivalent and the brand name drug in addition to the listed copayment or coinsurance.*

**Preventive drugs, including smoking cessation drugs and all women’s contraceptives that are approved by the Food and Drug Administration are covered at no cost to the Member and are not subject to the deductible. Preventive drugs are prescribed over-the-counter drugs or Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations.*

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

Up to a 12-consecutive -calendar-month supply of covered FDA-approved, self-administered hormonal contraceptives may be dispensed with a single prescription drug order.

Medical Supplies

Medical social services 100%

Diabetes education..... 100%


Durable medical equipment..... 100%


Orthotics (such as bracing, supports and casts) 100%

Diabetic equipment..... 100%

Diabetic footwear..... 100%

Prosthetic devices 100%

 *Durable medical equipment is covered when medically necessary and acquired or supplied by an HNL designated contracted vendor for durable medical equipment. For information about HNL's designated contracted vendors for durable medical equipment, please contact the Customer Contact Center at the telephone number on the back cover.*

 *See also the "Prescription Drug Program" section of this SB/DF for diabetic supplies benefit information. Diabetic equipment covered under the medical benefit (through "Diabetic equipment") includes blood glucose monitors designed for the visually impaired, insulin pumps and related supplies, and corrective footwear. Diabetic equipment and supplies covered under the prescription drug benefit include insulin, specific brands of blood glucose monitors and testing strips, Ketone urine testing strips, lancets and lancet puncture devices, specific brands of pen delivery systems for the administration of insulin (including pen needles) and insulin syringes.*

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

Mental Health and Substance Use Disorder Benefits

Outpatient office visits [■]	100%
Outpatient professional consultation services other than office visits [▲]	100%
Inpatient facility	
Days 1-60	Medicare Part A Deductible
Days 61-90	100%
Beyond 90 days (to lifetime reserve days).....	100%
Beyond lifetime reserve days (to a maximum of 365 days)	90% of Maximum Allowable Amount
Acute care detoxification	100%

[■]*Services include psychological evaluation or therapeutic session in an office setting, medication management and drug therapy monitoring.*

[▲]*Services include psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment, partial hospitalization and other outpatient services.*

Home Health Services

Home health visits, part-time or intermittent care only.....	100%
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Other Services

Blood, blood plasma, blood derivatives (except for drugs used to treat hemophilia, including blood factors)*	100%
Renal dialysis.....	100%
Hospice services	100%
Respite care services.....	100%
Immunosuppressive drugs (following a covered transplant in accordance with Medicare guidelines).....	80%
Epoetin (EPO).....	100%
Osteoporosis drugs.....	100%
Oral cancer drugs.....	100%

**Drugs used to treat hemophilia, including blood factors, are covered under the pharmacy benefit. Specialty drugs are not covered under the medical benefit even if they are administered in a physician's office. If you need to have the provider administer the specialty drug, you will need to obtain the specialty drug through the Specialty Pharmacy Vendor and bring it with you to the provider's office. Alternatively, you may be able to coordinate delivery of the specialty drug directly to the provider's office through the Specialty Pharmacy Vendor.*

Infertility Services

Infertility services and supplies (all covered services that diagnose, evaluate or treat infertility)..... Not covered

Chiropractic Care

Office visits..... 100%

Limits of Coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- Acupuncture
- Allergy desensitizing serum;
- Air or ground ambulance and paramedic services that are not emergency care or which do not result in a patient's transportation will not be covered unless certification is obtained and services are medically necessary;
- Care for mental health disorders as a condition of parole or probation, or court-ordered testing for mental health disorders, except when such services are medically necessary;
- Certain injectable drugs which are considered self-administered are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefits even if it is administered in a Physician's office. If you need to have a provider administer the Specialty Drug, you will need to obtain the Specialty Drug through the Specialty Pharmacy Vendor and bring it with you to the provider office. Alternatively, you can coordinate delivery of the Specialty Drug directly to the provider's office through the Specialty Pharmacy Vendor.
- Conception by medical procedures (IVF, GIFT and ZIFT);
- Except for podiatric devices to prevent or treat diabetes-related complications, corrective footwear is not covered unless medically necessary, custom made for the member and permanently attached to a medically necessary orthotic device that is also a covered benefit under this plan;
- Cosmetic services and supplies;
- Custodial or live-in care;
- Dental services. However, medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures are covered. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate;
- Dietary or nutritional supplements, except when prescribed for the treatment of Phenylketonuria (PKU);
- Disposable items for home use;
- Education or training;
- Exercise equipment;
- Experimental or investigational procedures as set out under the "Clinical Trials" and "If You Have a Disagreement with Our Insurance Plan" sections of this SB;
- Eyeglasses or contact lenses;
- Genetic testing is not covered except when determined by Health Net Life to be medically necessary. The prescribing physician must request prior authorization for coverage;
- Hearing aids;
- Immunizations and injections for foreign travel and occupational purposes;
- Infertility services and supplies;
- Noneligible institutions. This insurance plan only covers services or supplies provided by a legally operated hospital, Medicare-approved skilled nursing facility or other properly licensed facility as specified in the *Certificate*. Any institution that is primarily a place for the aged, a nursing home or similar institution, regardless of how it is designated, is not an eligible institution. Services or supplies provided by such institutions are not covered;
- Orthotics (such as bracing, supports and casts) that are not custom made to fit the covered person's body. Refer to the "corrective footwear" bullet above for additional foot orthotic limitations;
- Outpatient prescription drugs or medications (except as noted under "Prescription Drug Program");
- Personal or comfort items;
- Physical examinations for nonpreventive purposes;
- Private rooms when hospitalized, unless medically necessary;

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

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

Benefits and Coverage

WHAT YOU PAY FOR SERVICES

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

With Flex Net, you are responsible for paying a portion of the costs for your care.

- Benefits are payable based on the maximum allowable amount.
- HNL will coordinate all benefits of this plan with Medicare, with Medicare as the primary plan. HNL is considered the secondary plan. All benefits are coordinated with Medicare to cover your expenses up to the Medicare Allowable Amount, including the Medicare Part A and B deductibles.

SPECIAL ENROLLMENT RIGHTS IF YOU LOSE ELIGIBILITY FROM THE ACCESS FOR INFANTS OR MOTHERS PROGRAM (AIM) OR A MEDI-CAL PLAN

If you become ineligible and lose coverage under the Access for Infants or Mothers Program (AIM) or a Medi-Cal plan, you are eligible for a special enrollment period in which you and your dependent(s) are eligible to request enrollment in this plan within 60 days of becoming ineligible and losing coverage from the Access for Infants and Mothers Program (AIM) or a Medi-Cal plan.

NOTICE OF REQUIRED COVERAGE

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

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

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

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 for all medical care provided after 31 days (including the date of birth).

EMERGENCIES

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

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



Emergency care means any otherwise covered service for an acute illness, a new injury or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or, if a minor, to the minor's parent or guardian that a reasonable person with an average knowledge of health and medicine (a prudent layperson) would believe requires immediate treatment and without immediate treatment, any of the following would occur: (a) his or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger); (b) his or her bodily functions, organs or parts would become seriously damaged; or (c) his or her bodily organs or parts would seriously malfunction. Emergency care also includes treatment of severe pain or active labor. Active labor

means labor at the time that either of the following would occur: (a) there is inadequate time to affect safe transfer to another hospital prior to delivery; or (b) a transfer poses a threat to the health and safety of the covered person or her unborn child.

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

MEDICALLY NECESSARY CARE

Care that you receive must be medically necessary in order to be covered by your HNL insurance plan. All covered services or supplies are listed in the plan's *Certificate*; any other services or supplies are not covered. This insurance plan also does not cover any medical treatment you received before coverage begins under this plan or any services you may receive after your coverage under this plan ends.

EXTENSION OF BENEFITS

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

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

Your application for an extension of benefits for disability must be made to HNL 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 YOUR INFORMATION

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

PRIVACY PRACTICES

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

organization by using reasonable and appropriate security safeguards. These safeguards include limiting access to an individual's protected health information to only those who have a need to know in order to perform payment, treatment, health care operations or where permitted or required by law. Health Net Life 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 insurance plan sponsor is performing a payment or health care operation function for the plan. Health Net Life's entire Notice of Privacy Practices can be found in the plan's *Certificate*, at www.healthnet.com under "Privacy" or you may call the Customer Contact Center at the telephone number listed on the back cover to obtain a copy.

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

TECHNOLOGY ASSESSMENT

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

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

The expert medical reviewer also advises Health Net Life when patients require quick determinations of coverage, when there is no guiding principle for certain technologies, or when the complexity of a patient's medical condition requires expert evaluation. If Health Net Life denies, modifies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational, you may request an independent medical review (IMR) of Health Net Life's decision from the Department of Insurance. Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" in the *Certificate* for additional details.

CLINICAL TRIALS

Routine patient care costs for patients diagnosed with cancer or other life-threatening disease or condition who is accepted into phase I, II, III or IV clinical trials are covered when medically necessary, either recommended by your treating physician or the covered person provides medical and scientific information establishing eligibility for the trial and authorized by HNL. For further information, please refer to the plan's *Certificate*.

Coordination of Benefits

HNL will coordinate all benefits of this plan with Medicare, with Medicare as the primary plan. HNL is considered the secondary plan.

MEDICARE COORDINATION OF BENEFITS (COB)

For services and supplies covered under Medicare Part A and Part B, claims are first submitted to the Medicare intermediary for determination and payment of allowable amounts. The Medicare intermediary then sends your medical care provider a Medicare Summary Notice (MSN), (formerly an Explanation of Medicare Benefits (EOMB)). In most cases, the MSN will indicate that the Medicare intermediary has forwarded the claim to HNL for secondary coverage consideration. HNL will process secondary claims received from the Medicare intermediary. Secondary claims not received from the Medicare intermediary must be submitted to HNL by you or the provider of service, and must include a copy of the MSN. HNL and/or your medical provider is responsible for paying the difference between the Medicare paid amount and the Covered Services outlined in the *Certificate*.

Payment of Premiums and Charges

YOUR COINSURANCE AND DEDUCTIBLES

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

PREPAYMENT OF PREMIUMS

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

OTHER CHARGES

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

Additionally, the provider may request that you pay the billed charges when the service is rendered. In this case, you are responsible for paying the full cost and for submitting a claim to Health Net Life. HNL will then determine what portion of the billed charges is reimbursable to you.

For further information please refer to the *Certificate*. Covered expenses for out-of-network providers are based on the maximum allowable amount.

MAXIMUM ALLOWABLE AMOUNT

The maximum allowable amount (MAA) is the amount on which HNL bases its reimbursement for covered services and supplies provided by an out-of-network provider, which may be less than the amount billed for those services and supplies. HNL calculates maximum allowable amount as the lesser of the amount billed by the out-of-network provider or the amount determined as set forth below. Maximum allowable amount is not the amount that HNL pays for a covered service; the actual payment will be reduced by applicable coinsurance, copayments, deductibles and other applicable amounts set forth in the *Certificate*. Please refer to the insurance plan's *Certificate* for additional information.

- **Maximum Allowable Amount for Covered Services and Supplies, excluding Emergency Care and outpatient pharmaceuticals**, received from an Out-of-Network Provider is a percentage of what Medicare would pay, known as the Medicare Allowable Amount, as defined in this Certificate.

For illustration purposes only, Out-of-Network Provider: 70% HNL Payment / 30% Covered Person Coinsurance:

Out-of-Network Provider's billed charge for extended office visit	\$128.00
MAA allowable for extended office visit (example only; does not mean that MAA always equals this amount)	\$102.40
Your Coinsurance is 30% of MAA: 30% x \$102.40 (assumes Deductible has already been satisfied)	\$30.72
You also are responsible for the difference between the billed charge (\$128.00) and the MAA amount (\$102.40)	\$25.60
Total amount of \$128.00 charge that is your responsibility	\$56.32

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

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

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

- a. **Maximum Allowable Amount for professional and ancillary services** shall be 100% of FAIR Health's Medicare gapfilling methodology. Services or supplies not priced by gapfilling methodology shall be the lesser of: (1) the average amount negotiated with Preferred Providers within the geographic region for the same Covered Services or Supplies provided; (2) 50th percentile of FAIR Health database of professional and ancillary services not included in FAIR Health Medicare gapfilling methodology; (3) 100% of Medicare Allowable Amount for the same Covered Services or Supplies under alternative billing codes published by Medicare; or (4) 50% of the Out-of-Network Provider's billed charges for Covered Services. A similar type of database or valuation service will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination.
- b. **Maximum Allowable Amount for facility services** shall be the lesser of: (1) the average amount negotiated with Preferred Providers within the geographic region for the same Covered Services or Supplies provided; (2) 100% of the derived amount using a method developed by Data iSight for facility services (a data service that applies a profit margin factor to the estimated costs of the services rendered), or a similar type of database or valuation service, which will only be substituted if a named database or valuation services becomes unavailable due to discontinuation by the vendor or contract termination; (3) 150% of the Medicare Allowable Amount for the same Covered Services or Supplies under alternative billing codes published by Medicare; or (4) 50% of the Out-of-Network Provider's billed charges for Covered Services.
- c. **Maximum Allowable Amount for Out-of-Network Emergency Care** will be the greatest of: (1) the amount negotiated with Preferred Providers for the emergency service provided, excluding any in-network Copayment or Coinsurance; (2) the amount calculated using the same method HNL generally uses to determine payments for Out-of-Network providers,

- excluding any in-network Copayment or Coinsurance; or (3) the amount paid under Medicare Part A or B, excluding any in-network Copayment or Coinsurance.
- d. **Maximum Allowable Amount for covered outpatient pharmaceuticals** (including but not limited to injectable medications) dispensed and administered to the patient, in an outpatient setting, including, but not limited to, Physician office, outpatient Hospital facilities, and services in the patient's home, will be the lesser of billed charges or the Average Wholesale Price for the drug or medication

The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses. See "Schedule of Benefits," "Plan Benefits" and "General Limitations and Exclusions" sections for specific benefit limitations, maximums, pre-certification requirements and payment policies that limit the amount HNL pays for certain Covered Services and Supplies. HNL uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement.

In addition to the above, from time to time, HNL also contracts with vendors that have contracted fee arrangements with providers ("Third Party Networks"). In the event HNL contracts with a Third Party Network that has a contract with the Out-of-Network Provider, HNL may, at its option, refer a claim for Out-of-Network Services to a fee negotiation service to negotiate the Maximum Allowable Amount for the service or supply provided directly with the Out-of-Network Provider. In either of these two circumstances, You will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable Deductible, Copayment and/or Coinsurance at the Out-of-Network level.

NOTE: HNL has the right to adjust, without notice, the Maximum Allowable Amount. Claims payment will be determined according to the schedule in effect at the time the charges are incurred. Claims payment will also never exceed the amount the Out-of-Network Provider charges for the service or supply. You should contact the Customer Contact Center if You wish to confirm the Covered Expenses for any treatment or procedure You are considering.

For more information on the determination of Maximum Allowable Amount, or for information, services and tools to help You further understand Your potential financial responsibilities for Out-of-Network Services and Supplies please log on to www.healthnet.com or contact HNL Customer Service at the number on Your member identification card.

REIMBURSEMENT PROVISIONS

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

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

+ **How to file a claim:**

For emergency services or for services rendered by your physician, please send a completed claim form to:

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

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 the Customer Contact Center at the telephone number listed on the back cover or visit our website at www.healthnet.com to obtain a prescription drug claim form.



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

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

Renewing, Continuing or Ending Coverage

RENEWAL PROVISIONS

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



Please examine your options carefully before declining coverage.

INDIVIDUAL CONTINUATION OF BENEFITS

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

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

from employment to serve in the uniformed services and their dependents who would lose their group health coverage the opportunity to elect continuation coverage for a period of up to 24 months. Please check with your group to determine if you are eligible.

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 Life. Please refer to the "Extension of Benefits" section of this SB for more information.

TERMINATION OF BENEFITS

Your coverage under this insurance plan ends when:

- The agreement between the employer covered under this insurance plan and HNL ends;
- The employer covered under this insurance plan fails to pay premiums;
- You cease to either live or work within HNL's service area; or
- You no longer work for the employer covered under this insurance plan.



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

If the employer covered under this insurance plan does not pay appropriate premiums, benefits will end on the last day for which premiums have been made, unless you are totally disabled and apply for an extension of benefits for the disabling condition within 90 days.

If You Have a Disagreement with Our Insurance Plan

The California Department of Insurance (CDI) regulates disability insurance carriers (HNL is a disability insurance carrier). The CDI has a toll-free telephone number (**1-800-927-HELP**) to receive complaints about carriers.

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

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

GRIEVANCE AND APPEALS PROCESS

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

† How to file a grievance or appeal:

You may call the Customer Contact Center at **1-800-522-0088**, or submit the grievance form through the HNL website at www.healthnet.com.

You may also write to:

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

Please include all the information from your Health Net Life identification card as well as the details of your concern or problem. For a grievance or appeal of our benefit determination, we shall notify you of our decision in writing or electronically within the following time frames:

Urgent Care claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours from the time the initial request was received by HNL, until the close of the case with the covered person.

Non-Urgent Care services that have not been rendered (pre-service claims): Within a reasonable period of time appropriate to the medical circumstances, but not later than 45 days from the time the initial request was received by HNL, until the close of the case with the covered person.

Non-Urgent Care services that have already been rendered (post-service claims): Within a reasonable period of time, but not later than 45 days from the time the initial request was received by HNL, until the close of the case with the covered person.



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

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

ARBITRATION

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

Additional Insurance Plan Benefit Information

The following insurance plan benefits show the coinsurance payments required for optional benefits available with your insurance plan. For a more complete description of coinsurance payments and exclusions and limitations of service, please see the plan's *Certificate*.

Prescription Drug Program

Health Net Life 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 Customer Contact Center the telephone number listed on the back cover.

For those covered persons residing in California, you must fill your prescriptions at a participating pharmacy, except for emergency or urgent care situations or when you are traveling outside of California.

For those covered persons residing outside California you may fill your prescriptions at any pharmacy.

If you are a non-California resident and your prescription is filled by a non-participating pharmacy, you will need to pay full price for your medication and submit a Prescription Drug Claim form to:

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

Call the Customer Contact Center at the telephone number listed on the back cover to order Prescription Drug Claim forms.

PRESCRIPTIONS BY MAIL DRUG PROGRAM

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



Schedule II narcotic drugs (which are drugs that have a high abuse risk as classified by the Federal Drug Enforcement Administration) are not covered through mail order. For further information, please refer to the Certificate.

WHAT IS "PRIOR AUTHORIZATION?"

Some drugs require prior authorization. This means that your doctor must contact Health Net Life in advance to provide the medical reason for prescribing the medication.

†How to request prior authorization:

Requests for prior authorization, including step therapy exceptions, may be submitted electronically or by telephone (at the phone number shown on your HNL ID card) or facsimile. Urgent requests from physicians for authorization are processed, and prescribing providers notified of HNL's determination, as soon as possible, not to exceed 24 hours after Health Net Life's receipt of the request and any additional information requested by Health Net Life that is reasonably necessary to make the determination. Routine requests from physicians are processed, and prescribing providers notified of HNL's determination, in a timely fashion, not to exceed 2 business days, as appropriate and medically necessary, for the nature of the member's condition after Health Net Life's receipt of the information reasonably necessary and requested by Health Net Life to make the determination. Upon receiving your physician's request for prior authorization, Health Net Life 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 the input from the P&T Committee as well as physician specialist experts. Your physician may contact Health Net Life to obtain usage guidelines for specific medications.

If authorization is denied by Health Net Life, you will receive written communication including specific reason for denial. If you disagree with the decision, you may appeal the decision.

The appeal may be submitted in writing, by telephone or through e-mail. We must receive the appeal within 60 days of the date of denial notice. Please refer to the plan's *Certificate* for details regarding your right to appeal.

To submit an appeal:

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

WHAT'S COVERED

†*Please refer to the "Schedule of Benefits and Coverage" section of this SB/DF for the deductibles and copayments.*

- Preventive drugs and women's contraceptives

MORE INFORMATION ABOUT DRUGS THAT WE COVER

- Pharmacy prescription drug refills are covered up to a 30-consecutive-calendar-day supply per prescription.
- The mail order coinsurance is the applicable retail pharmacy coinsurance, for up to a 90-consecutive-calendar-day supply of maintenance drugs.
- Diabetic supplies (blood glucose testing strips, lancets, needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (that is, opened in order to dispense the product in quantities other than those packaged). When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times your physician has prescribed for a 30-day period. For more information about diabetic equipment and supplies, please see the endnotes in the "Schedule of Benefits and Coverage" section of this SB.
- If the pharmacy's retail price is less than the applicable copayment, the covered person will only pay the pharmacy's retail price and it will accrue to the deductible and out-of-pocket maximum.
- Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are all FDA-approved contraceptives for women that are either available over-the-counter or are only available with a prescription. Vaginal, oral, transdermal and emergency contraceptives are covered under this pharmacy benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit. Refer to the plan's *Certificate* for more information.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

†*Services or supplies excluded under pharmacy services may be covered under the medical benefits portion of your insurance plan. In addition to the exclusion and limitations listed below, prescription*

drug benefits are subject to the insurance plan's general exclusions and limitations. Consult your insurance plan's Certificate for more information.

- Allergy serum;
- Coverage for devices is limited to FDA approved vaginal contraceptive devices and diabetic supplies. No other devices are covered whether or not prescribed by a physician;
- Drugs prescribed to shorten the duration of the common cold;
- Drugs (including injectable medications) prescribed for the treatment of sexual dysfunction are not covered;
- Drugs prescribed by a dentist, including prescription drugs for routine dental treatment;
- Drugs used for diagnostic purposes;
- Experimental drugs (those that are labeled "Caution – Limited by Federal Law to investigational use only") If you are denied coverage of a drug because the drug is investigational or Experimental you will have a right to Independent Medical Review. See "If You Have a Disagreement with Our Insurance Plan" section of this SB for additional information;
- Hypodermic needles or syringes, except for specific brands of disposable insulin needles and syringes, and specific brands of pen devices;
- Immunizing agents, injectable drugs (except for insulin), or agents for surgical implantation obtained through a prescription;
- Irrigation solutions and saline solutions;
- Limits on quantity, dosage and treatment duration may apply to some drugs. Medications taken on an "as-needed" basis may have a copayment based on a standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If medically necessary, your physician may request a larger quantity from Health Net Life;
- Individual doses of medication dispensed in plastic or foil packages;
- Nutritional, dietary and food supplements (vitamins);
- Medical equipment and supplies (including insulin), that are available without a prescription are covered when prescribed by a physician for the management and treatment of diabetes, or for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations or for female contraception as approved by the FDA. Any other nonprescription drug, medical equipment or supply that can be purchased without a prescription drug order is not covered even if a physician writes a prescription drug order for such drug, equipment or supply. However, if a higher dosage form of a prescription drug or over-the-counter (OTC) drug is only available by prescription, that higher dosage drug will be covered.
- Prescription drugs filled at nonparticipating pharmacies for residents of California, except when traveling outside California;
- Prescription drugs prescribed by an unlicensed physician;
- Prescriptions you received before you joined HNL;
- Replacement of lost, stolen or damaged medications, once you have taken possession of the drugs;
- Supply amounts for prescriptions that exceed the FDA's or Health Net Life's indicated usage recommendation are not covered unless medically necessary and prior authorization is obtained from Health Net Life;
- Drugs prescribed for a condition or treatment not covered by this insurance plan are not covered. However, the insurance plan does cover drugs for medical conditions that result from non-routine complications of a non-covered service.

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

Nondiscrimination Notice

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

Health Net:

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

If you need these services, contact Health Net's Customer Contact Center at 1-800-522-0088 (TTY: 711)

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

Health Net Life Insurance Company Appeals & Grievances

P.O. Box 10348

Van Nuys, CA 91410-0348

Fax: 1-877-831-6019

Email: Member.Discrimination.Complaints@healthnet.com (Covered Persons) or
Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

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

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

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

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: (TTY: 711) 1-800-839-2172. للتواصل في كاليفورنيا، يرجى الاتصال بالرقم الفرعي لخطة الأفراد والعائلة عبر الرقم: (TTY: 711) 1-888-926-4988 أو المشروعات الصغيرة (TTY: 711) 1-888-926-5133. لخطط المجموعة عبر Health Net، يرجى الاتصال بالرقم (TTY: 711) 1-800-522-0088.

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): Կալիֆոռնիայի 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 ntauv 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

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

Korean

무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 고객센터 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 hádídot'ííł. Naaltsoos da t'áá shí shizaad k'éhjí shichí' yídooltah nínízingo t'áá ná ákódoolníít. Ákót'éego shíká a'doowoł nínízingo Customer Contact Center hoolyéhíjí' hodíílnih ninaaltsoos nanítingo bee néého'dolzinígíí hodoonihjí' bikáá' éí doodago kojí' hólne' Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). California marketplace báhígíí kojí' hólne' IFP On Exchange 1-888- 926-4988 (TTY: 711) éí doodago Small Business báhígíí kojí' hólne' 1-888-926-5133 (TTY: 711). Group Plans through Health Net báhígíí éí kojí' hólne' 1-800-522-0088 (TTY: 711).

Persian (Farsi)

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

Panjabi (Punjabi)

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਬਾਸੀਏ 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 ਸਮੱਲ ਬਿਜਨੇਸ 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 (โทรมด TTY: 711) สำหรับเขตแคลิฟอร์เนีย โทรหาฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โทรมด TTY: 711) หรือ ฝ่ายธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โทรมด TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โทรมด 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

For more information, please contact us at:

Health Net Flex Med

Post Office Box 9103
Van Nuys, California 91409-9103

Customer Contact Center

Large Group (for companies with 101 or more employees):

1-800-522-0088 Flex Med

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

Telecommunications Device for the Hearing and Speech Impaired

1-800-995-0852

Online: www.healthnet.com

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