



# Disclosure Form

PPO

## 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](https://www.healthnet.com)

1/2023 Large PPO DF



# Delivering Choices

When it comes to your health care, it's nice to have options. That's why Health Net of California, Inc. (Health Net) offers a Preferred Provider Organization (PPO) plan (called "Health Net PPO") – a plan that offers you flexibility and choice. This *Disclosure Form* answers basic questions about Health Net PPO.

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

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

*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](http://www.healthnet.com)

**This *Disclosure Form* (including any applicable *Disclosure Form Rider*) and the Summary of Benefits and Coverage (*SBC*) document provide a summary of your health plan. The plan's *Evidence of Coverage (EOC)*, which you will receive after you enroll, contains the exact terms and conditions of your Health Net coverage. You should also consult the *Group Hospital and Professional Service Agreement* (issued to your employer) to determine governing contractual provisions. It is important for you to carefully read this *Disclosure Form*, the *SBC* and, once received, the plan's *EOC*, especially those sections that apply to those with special health care needs. This *Disclosure Form* includes a matrix of benefits in the section titled "Benefit Matrix." The *SBC*, which is issued in conjunction with this *Disclosure Form*, describes what your plan covers and what you pay for covered services and supplies.**

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# How the Plan Works

Please read the following information so you will know from whom health care may be obtained.

## CHOICE OF PROVIDERS

When you enroll in the Health Net PPO plan, you choose your own doctors and hospitals for all your health care needs. Health Net PPO offers two different ways to access care:

- **In-network** - You choose a contracted doctor (or hospital) within our PPO network. You can take advantage of significant cost savings when you receive care from a provider who is contracted with Health Net PPO.
- **Out-of-network** - You choose a doctor (or hospital) outside of our PPO network. These providers do not have a contract with Health Net PPO. You will incur higher out-of-pocket costs than when you see a provider within our PPO Network.



*Except for emergency care, when you choose to see an out-of-network provider, you will pay the cost-sharing for the out-of-network benefit level, which is typically higher than the in-network benefit level. **Plus**, you are responsible for the difference between the amount the out-of-network provider bills and the maximum allowable amount (MAA). See “Payment of Fees and Charges” later in this Disclosure Form for more details.*

Your choice of doctors and hospitals may determine which services will be covered, as well as how much you will pay. Providers who are contracted with Health Net PPO are called “preferred providers” and they are listed on our website at [www.healthnet.com](http://www.healthnet.com). You can also call the Customer Contact Center at the telephone number listed on the back cover to obtain a copy of the *Health Net PPO Preferred Provider Directory* at no cost.



*In some instances, **prior authorization** (also known as preauthorization or treatment review) is required for full benefits to be paid. Refer to the “Prior Authorization Requirements” section of this Disclosure Form to find out which services or supplies require prior authorization.*

## SPECIALISTS CARE

If you need specialty care, you are free to see any specialist without a referral. Simply call and schedule an appointment. To lower your share of costs, obtain care at the in-network benefit level by seeing a specialist within our PPO network. Refer to the *Health Net PPO Preferred Provider Directory* to locate specialists within our PPO network.

You also do not need approval from Health Net or from any other person 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 or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics, gynecology or reproductive and sexual health, refer to your *Health Net PPO Preferred Provider Directory* on the Health Net website at [www.healthnet.com](http://www.healthnet.com). A copy of the *Health Net PPO Preferred Provider Directory* may also be ordered online or by calling Health Net Customer Contact Center at **1-800 522-0088**.

## MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Health Net contracts with MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator), which administers behavioral health services for mental health and substance use disorders. For more information about how to receive care and the Behavioral Health Administrator's prior authorization requirements, please refer to the "Behavioral Health Services" and "Prior Authorization Requirements" sections 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 services and supplies.

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

Principal Benefits	What You Pay
Deductible.....	The <i>SBC</i> 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 <i>SBC</i> under “If you visit a health care provider’s office or clinic.”
Outpatient services.....	Refer to the <i>SBC</i> under “If you have outpatient surgery.”
Hospitalization services .....	Refer to the <i>SBC</i> under “If you have a hospital stay.”
Emergency health coverage.....	Refer to the <i>SBC</i> under “If you need immediate medical attention.”
Ambulance services .....	Refer to the <i>SBC</i> under “If you need immediate medical attention.”
Prescription drug coverage.....	Refer to the <i>SBC</i> under “If you need drugs to treat your illness or condition.”
Durable medical equipment .....	Refer to the <i>SBC</i> under “If you need help recovering or have other special health needs.”
Mental health services.....	Refer to the <i>SBC</i> under “If you need mental health, behavioral health, or substance abuse services.”
Substance use disorder services .....	Refer to the <i>SBC</i> under “If you need mental health, behavioral health, or substance abuse services.”
Home health services.....	Refer to the <i>SBC</i> under “If you need help recovering or have other special health needs.”
Other services .....	Refer to the <i>SBC</i> under “If you have a test” and “If you need help recovering or have other special health needs.”

# Prior Authorization Requirements

For certain covered services, you must obtain prior authorization before receiving the services or you will be required to pay the nonauthorization penalty as shown in the *SBC* and the *EOC*. Prior authorizations are performed by Health Net (medical), the Behavioral Health Administrator (mental health and substance use disorders) or an authorized designee.

We may revise the prior authorization list from time to time. Any such changes including additions and deletions from the list will be communicated to preferred providers and posted on the [www.healthnet.com](http://www.healthnet.com) website.

**Prior authorization is NOT a determination of benefits. Some of these services or supplies may not be covered under your plan. Even if a service or supply is prior authorized, eligibility rules and benefit limitations will still apply. However, Health Net will not rescind or modify prior authorization after a provider renders health care services in good faith and pursuant to the prior authorization, and will pay benefits under the *Evidence of Coverage* for the services prior authorized.**



*Services provided as the result of an emergency are covered at the in-network benefit level and do not require prior authorization.*

## Services Requiring Prior Authorization

### Inpatient admissions

Any type of facility, including but not limited to:

- Acute rehabilitation center
- Behavioral health facility
- Hospice
- Hospital
- Skilled nursing facility
- Substance abuse facility

### Outpatient procedures, services or equipment

- Ablative techniques for treating Barrett's esophagus and for treatment of primary & metastatic liver malignancies
- Acupuncture (after the initial consultation)
- Ambulance: non-emergency, air or ground ambulance services
- Bariatric procedures
- Bronchial thermoplasty
- Capsule endoscopy
- Cardiovascular procedures

- Chiropractic care (after the initial consultation)
- Clinical trials
- Diagnostic procedures including:
  1. Advanced imaging
    - o Computerized Tomography (CT)
    - o Computed Tomography Angiography (CTA)
    - o Magnetic Resonance Angiography (MRA)
    - o Magnetic Resonance Imaging (MRI)
    - o Positron Emission Tomography (PET)
  2. Cardiac imaging
    - o Coronary Computed Tomography Angiography (CCTA)
    - o Echocardiography
    - o Myocardial perfusion imaging (MPI)
    - o Multigated acquisition (MUGA) scan
  3. Sleep studies
- Durable Medical Equipment (DME)
- Ear, Nose and Throat (ENT) procedures
- Enhanced External Counterpulsation (EECP)
- Experimental or Investigational services and new technologies
- Gender affirming services
- Genetic testing (Prior authorization is not required for biomarker testing for members with advanced or metastatic stage 3 or 4 cancer)
- Implantable pain pumps including insertion or removal
- Injection, including trigger point, and sacroiliac (SI) joint injections
- Joint surgeries
- Mental health and substance use disorder services other than office visits including:
  1. Applied behavioral analysis (ABA) and other forms of behavioral health treatment (BHT) for autism and pervasive developmental disorders
  2. Detoxification
  3. Electroconvulsive Therapy (ECT)
  4. Half-Day Partial Hospitalization
  5. Intensive Outpatient Program (IOP)
  6. Neuropsychological testing
  7. Partial Hospital Program or Day Hospital (PHP)
  8. Psychological testing
  9. Transcranial Magnetic Stimulation (TMS)
- Neuro or spinal cord stimulator
- Neuropsychological testing

- Orthognathic procedures (includes TMJ treatment)
- Orthotics (custom made)
- Pharmaceuticals
  1. Certain physician-administered drugs, including newly approved drugs, whether administered in a physician office, free-standing infusion center, home infusion, outpatient surgical center, outpatient dialysis center or outpatient hospital. Refer to the Health Net website, [www.healthnet.com](http://www.healthnet.com), for a list of physician-administered drugs that require prior authorization. Biosimilars are required in lieu of branded drugs, unless medically necessary.
- Prosthesis
- Quantitative drug testing
- Radiation therapy
- Reconstructive and cosmetic surgery, services and supplies such as:
  1. Bone alteration or reshaping such as osteoplasty
  2. Breast reductions and augmentations except when following a mastectomy (includes gynecomastia and macromastia)
  3. Dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate
  4. Dermatology such as chemical exfoliation, electrolysis, dermabrasion, chemical peel, laser treatment, skin injection or implants
  5. Excision, excessive skin and subcutaneous tissue (including lipectomy and panniculectomy) of the abdomen, thighs, hips, legs, buttocks, forearms, arms, hands, submental fat pad, and other areas
  6. Eye or brow procedures such as blepharoplasty, brow ptosis or canthoplasty
  7. Gynecologic or urology procedures such as clitoroplasty, labioplasty, vaginal rejuvenation, scrotoplasty, testicular prosthesis, and vulvectomy
  8. Hair electrolysis, transplantation or laser removal
  9. Lift such as arm, body, face, neck, thigh
  10. Liposuction
  11. Nasal surgery such as rhinoplasty or septoplasty
  12. Otoplasty
  13. Penile implant
  14. Treatment of varicose veins
  15. Vermilionectomy with mucosal advancement
- Spinal surgery
- Testosterone therapy
- Therapy (includes home setting)
  - Occupational therapy

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

**Exceptions:** *Prior authorization is not required for the length of a hospital stay for reconstructive surgery incident to a mastectomy (including lumpectomy). Prior authorization is not needed for the first 48 hours of inpatient hospital services following a vaginal delivery, nor the first 96 hours following a cesarean section. However, please notify Health Net within 24 hours following birth or as soon as reasonably possible. Prior authorization must be obtained if the physician determines that a longer hospital stay is medically necessary either prior to or following the birth.*

## Limits of Coverage

### WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- Acupuncture services, unless shown as covered on your plan's *SBC*;
- Ambulance and paramedic services that do not result in transportation or that do not meet the criteria for emergency care, unless such services are medically necessary and prior authorization has been obtained;
- Biofeedback therapy is limited to medically necessary treatment of certain mental health or physical disorders such as incontinence and chronic pain;
- Care for mental health care as a condition of parole or probation, or court-ordered testing for mental health and substance use disorders, except when such services are medically necessary;
- Chiropractic services, unless shown as covered on your plan's *SBC*;
- Corrective footwear is limited to medically necessary footwear that is custom made for the member and permanently attached to a medically necessary orthotic device that is also a covered benefit under this plan, or is a podiatric device to prevent or treat diabetes-related complications. Other corrective footwear is not covered unless specifically described in your plan's *EOC*;
- Cosmetic services and supplies;
- Custodial or live-in care;
- Dental services. However, Medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures are covered. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate;
- Disposable supplies for home use, except certain disposable ostomy or urological supplies;
- Experimental or investigational procedures, except as set out under the "Clinical Trials" and "If You Have a Disagreement with Our Plan" sections of this *Disclosure Form*;

- Fertility preservation coverage does not include the following: follow-up assisted reproductive technologies (ART) to achieve future pregnancy such as artificial insemination, in vitro fertilization and/or embryo transfer; pre-implantation genetic diagnosis; donor eggs, sperm or embryos; or gestational carriers (surrogates);
- Genetic testing is not covered except when determined by Health Net to be medically necessary. The prescribing physician must request prior authorization for coverage. However, prior authorization is not required for biomarker testing for members with advanced or metastatic stage 3 or 4 cancer;
- Infertility services and supplies, unless shown as covered on your plan's *SBC*;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental health or substance use disorder;
- Noneligible institutions. This plan only covers medically necessary services or supplies provided by a licensed hospital, hospice, Medicare-approved skilled nursing facility, residential treatment center or other properly licensed medical facility as specified in the plan's *EOC*. Any institution that is not licensed to provide medical services and supplies, regardless of how it is designated, is not an eligible institution;
- Orthoptics (eye exercises);
- Orthotics (such as bracing, supports and casts) that are not custom made to fit the member's body. Refer to the "corrective footwear" bullet above for additional foot orthotic limitations;
- Outpatient prescription drugs
- Personal or comfort items;
- Physician self-treatment;
- Physician treating immediate family members;
- Private rooms when hospitalized, unless medically necessary;
- Private-duty nursing;
- Refractive eye surgery unless medically necessary, recommended by the member's treating physician and authorized by Health Net;
- Reversal of surgical sterilization;
- Routine foot care for treatment of corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes;
- Services and supplies not authorized by Health Net or the Behavioral Health Administrator according to Health Net's procedures;
- Services for a surrogate pregnancy are covered when the surrogate is a Health Net member. However, when compensation is obtained for the surrogacy, Health Net shall have a lien on such compensation to recover its medical expense;
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the plan's *EOC*;
- Services related to education or training, including for employment or professional purposes, except for behavioral health treatment for pervasive developmental disorder or autism;

- State hospital treatment, except as the result of an emergency or urgently needed care;
- Stress, except when rendered in connection with services provided for a treatable mental health or substance use disorder.
- Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary; and
- Treatment of obesity, weight reduction or weight management, except for treatment of morbid obesity. Certain services may be covered as preventive care services as described in the plan's *EOC*.

**The above is a partial list of the principal exclusions and limitations applicable to the medical portion of your Health Net plan. The *EOC*, which you will receive if you enroll in this plan, will contain the full list. Notwithstanding any exclusions or limitations described in the *EOC*, all medically necessary services for treatment of mental health and substance use disorders shall be covered.**

## 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 services or supplies 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 call your physician or the Behavioral Health Administrator (mental health and substance use disorders) or 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 and 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 and substance use disorders).

Emergency care is covered at the in-network benefit level and does not require prior authorization. All follow-up care (including mental health and substance use disorders) after the urgency has passed and your condition is stable will be covered at whichever benefit level (in-network or out-of-network) it qualifies for, subject to any applicable prior authorization requirements, and your plan's exclusions and limitations.



***Emergency care*** includes medical screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of his or her

license and privileges) to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. "Active labor" means labor at the time that either of the following could reasonably be expected to occur: (1) There is inadequate time to effect safe transfer to another hospital prior to delivery; or (2) a transfer poses a threat to the health and safety of the member or unborn child.

Emergency care will also include additional screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, either within the capability of the facility or by transferring the member to a psychiatric unit within a general acute hospital or to an acute psychiatric hospital as medically necessary.

All air and ground ambulance and ambulance transport services provided as a result of a 911 call will be covered, if the request is made for an emergency medical condition (including mental health and substance use disorders).

**Emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) Placing the patient's health in serious jeopardy, (2) Serious impairment to bodily functions, or (3) Serious dysfunction of any bodily organ or part.

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

**Urgently needed care** includes 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 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 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 Right Act of 1998.

The Newborns' and Mothers' Health Protection Act of 1996 sets requirements for a minimum Hospital length of stay following delivery. Specifically, group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the



mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

## TIMELY ACCESS TO CARE TO PREFERRED PROVIDERS

The California Department of Managed Health Care (DMHC) has issued regulations (California Code of Regulations, Title 28, Section 1300.67.2.2) with requirements for timely access to non-emergency health care services. Providers within the Health Net PPO network agree to provide timely access to care.

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

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

## CLINICAL TRIALS

Routine patient care costs for patients diagnosed with cancer or other life-threatening disease or condition who are accepted 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*.

## 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).

## 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.

## OUT-OF-STATE PROVIDERS

Health Net PPO allows you access to participating providers outside of California. If you are outside California, require medical care or treatment, and use a provider from the supplemental network, your services are covered at the in-network benefit level. If your principle residence is outside of California, all in-network services are through the supplemental network.

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

The supplemental network consists of providers who participate in a network as shown on Your Health Net ID card, that agree to provide health care services to Health Net Members.

## 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 non-routine releases such as marketing. Health Net provides access to members to inspect or obtain a copy of the member's protected health information in designated record sets maintained by Health Net. Health Net protects oral, written and electronic information across the organization by using reasonable and appropriate security safeguards. These safeguards include limiting access to an individual's protected health information to only those who have a need to know in order to perform payment, treatment, health care operations or where permitted or required by law. Health Net releases protected health information to plan sponsors for administration of self-funded plans but does not release protected health information to plan sponsors/employers for insured products unless the plan sponsor is performing a payment or health care operation function for the plan. Health Net's entire Notice of Privacy Practices can be found in the plan's EOC, at [www.healthnet.com](http://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 pre-authorization, concurrent and retrospective review and care management, we evaluate the services provided to our members to be sure they are medically necessary and appropriate for the setting and time. These processes help to maintain Health Net's high quality medical management standards.

## 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 pre-authorization was required but not obtained.

## CARE OR CASE MANAGEMENT

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

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

# Payment of Fees and Charges

## 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.

## COVERED EXPENSES

Covered expenses are expenses incurred by you for covered services and supplies while enrolled under this plan. You are responsible for payment of your share of the cost of services (i.e., deductibles, copayments or coinsurance). Your share of cost is based on covered expenses.

A covered expense is not necessarily the amount a doctor or provider bills for a service. The amount of covered expenses varies by whether you obtain services from a preferred provider or an out-of-network provider. For a preferred provider, a covered expense is the contracted rate. For an out-of-network provider, a covered expense is the maximum allowable amount. See "Maximum Allowable Amount (MAA) for Out-of-Network Providers" later in this section for more information.

## OTHER CHARGES

The *SBC* explains your coverage and payment for services. Please take a moment to look it over.

With Health Net PPO, you are responsible for paying a portion of the costs for your care. Amounts paid by you are called **deductible**, **copayment** and **coinsurance**, which are described in the *SBC*. The amount you pay can vary from a flat amount to a significant percentage of the costs. It all depends on the doctor (and hospital) you choose. In general:

- If your benefits are subject to a deductible, you must pay the deductible before we begin to pay for those benefits.
- You pay less when you receive care from doctors or hospitals that are contracted with our PPO, since they have agreed in advance to provide services for a specific fee (a contracted rate). You will only pay the applicable in-network deductible, copayment or coinsurance. Preferred providers have agreed to accept the contracted rate as payment in full and may not bill you for charges in excess of the contracted rate.
- If you receive care from out-of-network doctors or hospitals, you will be responsible for the applicable out-of-network deductible, copayment or coinsurance, **plus** any charges that exceed MAA.

**Exceptions:** In the following circumstances, the in-network benefit level applies and you will not be responsible for any amounts in excess of MAA:

- o If we authorize medically necessary services through an out-of-network provider because such services are not available through a preferred provider;
- o When non-emergent services are provided by an out-of-network provider at an in-network health facility, and you were not informed prior to receiving the services that the provider is an out-of-network provider; or
- o When emergency services are provided by an out-of-network provider.

For further details and requirements, see the *EOC*.

- For some services, prior authorization is necessary to receive full benefits. Please see the "Prior Authorization Requirements" section of this *Disclosure Form* for details.
- To protect you from unusually high medical expenses, there is a maximum amount (or **out-of-pocket maximum**) that you will be responsible for paying in any given year. Once your total payment of the deductibles, copayments and coinsurance equals the out-of-pocket maximum shown on your plan's *SBC*, we will pay 100% of covered expenses. (There are exceptions, see the *SBC* and the *EOC* for details.)



*Payment for services not covered by this plan will not count toward the calendar year 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*.*

## MAXIMUM ALLOWABLE AMOUNT (MAA) FOR OUT-OF-NETWORK PROVIDERS

When you receive care from an out-of-network provider, your share of cost is based on MAA. You are responsible for any applicable deductible, copayments or coinsurance payment, **and** any amounts billed in excess of MAA. You are completely financially responsible for care that this plan does not cover.

MAA may be less than the amount the provider bills for services and supplies. Health Net calculates MAA as the lesser of the amount billed by the out-of-network provider or the amount determined as set forth below. MAA is not the amount that Health Net pays for a covered service; the actual payment will be reduced by applicable deductibles, copayments or coinsurance and other applicable amounts set forth in the *EOC*.

- **MAA 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.

**For illustration purposes only, Out-of-Network Provider: 70% Health Net Payment / 30% Member 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
<b>Your Coinsurance is 30% of MAA:</b> 30% x \$102.40 (assumes deductible has already been satisfied) .....	\$30.72
<b>You also are responsible for</b> the difference between the billed charge (\$128.00) and the MAA amount (\$102.40) .....	\$25.60
<b>TOTAL AMOUNT OF \$128.00 CHARGE THAT IS YOUR RESPONSIBILITY .....</b>	<b>\$56.32</b>

MAA 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.

MAA 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:

- MAA 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) the 50th percentile of FAIR Health database of professional and ancillary services not included in FAIR Health Medicare gapfilling methodology (3) 100% of the Medicare allowable amount for the same covered services or supplies under alternative billing codes published by Medicare; or (4) 50% of the 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. MAA 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.
- **MAA for out-of-network emergency care** will be the greatest of: (1) the median of the amounts negotiated with preferred providers for the emergency service provided, excluding any in-network copayment or coinsurance; (2) the amount calculated using the same method Health Net generally uses to determine payments for out-of-network providers, excluding any in-network deductible, copayment or coinsurance; or (3) the amount paid under Medicare Part A or B, excluding any in-network copayment or coinsurance. Emergency care from an out-of-network provider is subject to the applicable deductible, copayment and/or coinsurance at the preferred provider benefit level. The cost-sharing will be determined from the MAA as defined herein. You are not responsible for any amount that exceeds MAA for emergency care.
  - **MAA for non-emergent services at an in-network health facility**, at which, or as a result of which, You receive non-emergent covered services by an out-of-network provider, the non-emergent services provided by an out-of-network provider will be payable at the greater of the average contracted rate or 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered unless otherwise agreed to by the noncontracting individual health professional and Health Net.
  - **MAA 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 MAA may also be subject to other limitations on covered expenses. See the plan's *EOC* for specific benefit limitations, maximums, pre-authorization requirements and payment policies that limit the amount Health Net pays for certain covered services and supplies. Health Net uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement.

In addition to the above, from time to time, Health Net also contracts with vendors that have contracted fee arrangements with providers ("Third Party Networks"). In the event Health Net contracts with a Third Party Network that has a contract with the out-of-network provider, Health Net may, at its option, use the rate agreed to by the Third Party Network as the MAA. Alternatively, we may, at our option, refer a claim for out-of-network services to a fee negotiation service to negotiate the MAA 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 billed charges and the MAA.

You will be responsible for any applicable deductible, copayment and/or coinsurance at the out-of-network benefit level.

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

Claims payment will also never exceed the amount the 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.

## LIABILITY OF SUBSCRIBER OR ENROLLEE FOR PAYMENT

If you receive covered services and supplies, you are responsible for your share of costs as described herein. If you receive services that are not covered by this plan, you are responsible for the entire cost of such services.



*Except in an emergency, when you choose to obtain covered services from an out-of-network provider, you are responsible for your share of cost at the out-of-network benefit level **plus** the amount the provider bills that exceeds MAA.*

## REIMBURSEMENT PROVISIONS

Payments that are owed by Health Net for covered expenses will never be your responsibility.

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

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 the Behavioral Health Administrator (mental health and substance use disorders) or directly to Health Net. Medical claims must be received by Health Net within one year of the date of service to be eligible for reimbursement.

### How to File a Claim

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

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

Please call Health Net's Customer Contact Center at the phone number on the back cover of this booklet or visit our website at [www.healthnet.com](http://www.healthnet.com) to obtain the claim form.



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

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

Please call Health Net's Customer Contact Center at the phone number on the back cover of this booklet or visit our website at [www.healthnet.com](http://www.healthnet.com) to obtain a prescription drug claim form.

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

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

Please call MHN Claims at 1-800-444-4281 to obtain a 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.*

## REIMBURSEMENT DISCLOSURE

Health Net pays preferred providers on a fee-for-service basis, according to an agreed contracted rate. You may request more information about our payment methods by contacting the Customer Contact Center at the phone number on the back cover.

## Facilities

Health care services will be provided at the facilities used by the doctor you choose at the time you seek care. Health Net PPO providers and contracted facilities are listed in the *Health Net PPO Preferred Provider Directory*.

## CONTINUITY OF CARE

### TRANSITION OF CARE FOR NEW ENROLLEES

You may request continued care from a provider who does not contract with Health Net if at the time of your enrollment with Health Net you were receiving care for the conditions listed in the "Continuity of Care upon Termination of Provider Contract" provision immediately below.

Health Net may provide coverage for completion of services from an out-of-network provider at the in-network benefit level, subject to applicable deductible, copayments or coinsurance 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 out-of-network 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 at the in-network benefit level.

## Continuity of Care upon Termination of Provider Contract

If Health Net's contract with a preferred provider ends, Health Net will make every effort to ensure that care continues. You may request continued care from an out-of-network provider at the in-network benefit level if, at the time of contract termination, you were receiving care from such a provider for the conditions listed below. For providers and hospitals that end their contract with Health Net, a written notice will be provided to members with open certifications within five days after the effective date of the contract termination.

Health Net may provide coverage for completion of services at the in-network benefit level from a provider whose contract has ended, subject to applicable deductible, copayments or coinsurance 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.

The following conditions are eligible for continuation of care:

- an acute condition;
- a serious chronic condition not to exceed twelve months;
- a pregnancy (including the duration of the pregnancy and immediate postpartum care);
- maternal mental health, not to exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later;
- a newborn (up to 36 months of age, not to exceed twelve months);
- a terminal illness (through the duration of the terminal illness);
- a surgery or other procedure that has been authorized by Health Net (or by the member's prior health plan for a new enrollee) as part of a documented course of treatment.

To request continued care, you will need to complete a Continuity of Care Request Form. If you would like more information on how to request continued care or to request a copy of the Continuity of Care Request Form or of Health Net's continuity of care policy, please 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 your contract is amended or terminated, your employer will notify you in writing.

## INDIVIDUAL CONTINUATION OF BENEFITS



*Please examine your options carefully before declining coverage.*

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

- **COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985):** For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside of California. Please check with your group to determine if you and your covered dependents are eligible.
- **Cal-COBRA Continuation Coverage:** If you have exhausted COBRA and you live in the Health Net Service Area, you may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if you have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage, and you are not entitled to Medicare. If you are eligible, you have the opportunity to continue group coverage under this plan through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.
- **USERRA Coverage:** Under a federal law known as the Uniformed Services Employment and Reemployment Rights Act (USERRA), employers are required to provide employees who are absent from employment to serve in the uniformed services and their dependents who would lose their group health coverage the opportunity to elect continuation coverage for a period of up to 24 months. Please check with your group to determine if you are eligible.

Also, you may be eligible for continued coverage for a disabling condition (for up to 12 months) if your employer terminates its agreement with Health Net. Please refer to the "Extension of Benefits" section of this *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 Health Net's 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 a 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 Health Net, you should first telephone Health Net at the phone number on the back cover and use the 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, or a grievance that has not been satisfactorily resolved by Health Net, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-466-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's internet website <http://www.dmhca.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](http://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

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

You may obtain mental health and substance use disorder services from any behavioral health provider. To obtain care at the in-network benefit level, contact the Behavioral Health Administrator by calling the Health Net Customer Contact Center at the phone number on the back cover. The

Behavioral Health Administrator will help you identify a nearby participating behavioral health professional with whom you can make an appointment.

Certain services and supplies for mental health and substance use disorders require prior authorization by the Behavioral Health Administrator in order to be covered. Refer to the “Prior Authorization Requirements” section of this *Disclosure Form* for more details.

Please refer to the plan's *EOC* for a more complete description of covered mental health and substance use disorder services and supplies.

## TRANSITION OF CARE FOR NEW ENROLLEES

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

Your out-of-network mental health professional must be willing to accept the Behavioral Health Administrator's standard mental health provider contract terms and conditions and be located in the plan's service area.

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

## MENTAL HEALTH AND SUBSTANCE USE DISORDERS

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

## CONTINUATION OF TREATMENT

If you are in treatment for a mental health or substance use disorder, call the telephone number shown on your Health Net ID card to receive assistance in transferring your care to a network provider for covered services to be payable at the in-network benefit level.

## WHAT'S COVERED

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

## WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

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

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



# Nondiscrimination Notice

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, gender affirming care, sexual orientation, age, disability, or sex.

## Health Net:

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

If need these services, contact Health Net's Customer Contact Center at:

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

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

**Individual & Family Plan (IFP) Applicants** 1-877-609-8711 (TTY: 711)

**Group Plans through Health Net** 1-800-522-0088 (TTY: 711)

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

Health Net of California, Inc./Health Net Life Insurance Company Appeals & Grievances  
PO Box 10348, Van Nuys, CA 91410-0348

Fax: 1-877-831-6019

Email: [Member.Discrimination.Complaints@healthnet.com](mailto:Member.Discrimination.Complaints@healthnet.com) (Members) or  
[Non-Member.Discrimination.Complaints@healthnet.com](mailto:Non-Member.Discrimination.Complaints@healthnet.com) (Applicants)

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

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and

Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

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

# Notice of Language Services

## English

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call the Customer Contact Center at the number on your ID card or call Individual & Family Plan (IFP) Off Exchange: 1-800-839-2172 (TTY: 711). For California marketplace, call IFP On Exchange 1-888-926-4988 (TTY: 711) or Small Business 1-888-926-5133 (TTY: 711). For Group Plans through Health Net, call 1-800-522-0088 (TTY: 711).

## Arabic

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

## Armenian

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ: Փաստաթղթերը կարող են կարդալ ձեր լեզվով: Օգնության համար զանգահարեք Հաճախորդների սպասարկման կենտրոն ձեր ID քարտի վրա նշված հեռախոսահամարով կամ զանգահարեք Individual & Family Plan (IFP) Off Exchange՝ 1-800-839-2172 հեռախոսահամարով (TTY՝ 711): 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 ntawv rau koj ua koj hom lus hais. Txhawm rau pab, hu xovtooj rau Neeg Qhua Lub Chaw Tiv Toj ntawm tus npawb nyob ntawm koj daim npav ID lossis hu rau Tus Neeg thiab Tsev Neeg Qhov Kev Npaj (IFP) Ntawm Kev Sib Hloov Pauv: 1-800-839-2172 (TTY: 711). Rau California qhov chaw kiab khw, hu rau IFP Ntawm Qhov Sib Hloov Pauv 1-888-926-4988 (TTY: 711) lossis Lag Luam Me 1-888-926-5133 (TTY: 711). Rau Cov Pab Pawg Chaw Npaj Kho Mob hla Health Net, hu rau 1-800-522-0088 (TTY: 711).



**Japanese**

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

**Khmer**

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

**Korean**

무료 언어 서비스입니다. 통역 서비스를 받으실 수 있습니다. 문서 낭독 서비스를 받으실 수 있으며 일부 서비스는 귀하가 구사하는 언어로 제공됩니다. 도움이 필요하시면 ID 카드에 수록된 번호로 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 la' ná hádídot'íí. Naaltsoos da t'áá shí shizaad k'ehjí shichí' yídooltah nínízingo t'áá ná ákódooníí. Ákót'éego shiká 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) 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 ਸਮੈਲ 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 (โทรมา TTY: 711) สำหรับเขตแคลิฟอร์เนีย โทรหาฝ่ายแผนบุคคลและครอบครัวของรัฐ (IFP On Exchange) ได้ที่ 1-888-926-4988 (โทรมา TTY: 711) หรือ ฝ่ายธุรกิจขนาดเล็ก (Small Business) ที่ 1-888-926-5133 (โทรมา TTY: 711) สำหรับแผนแบบกลุ่มผ่านทาง Health Net โทร 1-800-522-0088 (โทรมา 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)

Health Net

Post Office Box 9103

Van Nuys, California 91409-9103

[Healthnet.com](http://Healthnet.com)

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