

THE ENROLLMENT PROCESS

You should always start your enrollment process by going to the Gallagher Benefits Services website first

1. Before you begin the enrollment process, it's important to review the detailed plan information on the Gallagher Benefits Services (GBS) PSBP website so you are aware of what benefits you wish to choose before starting the enrollment process. https://clients.garnett-powers.com/pd/uc/plans_benefits/
2. To start the enrollment process click on the Enrollment/Change Form https://clients.garnett-powers.com/pd/uc/pre_enrollment/
3. When you click on this link, you will be asked to answer a series of questions that will determine which of two methods you will use to enroll in the PSBP. You must enroll in your benefits plan within 31 days of your hire date.
4. If you answered 'No' to the questions that are asked, you can use the UC At Your Service Online (AYSO) website to enroll. <https://atyourserviceonline.ucop.edu/ayso/>. Please see below on how to log on to AYSO
5. If you answer 'Yes' to one of the questions, you will click on the link provided that will take you to the enrollment section of the GBS PSBP website where you will complete the enrollment form.
6. Complete enrollment form: <https://clients.garnett-powers.com/pd/uc/enrollment/normal/>
7. Once you have completed your enrollment form, please print, sign and date it. Please email a scanned copy to the CoSolutionCenter@ucsf.edu. You will get a confirmation that your email was received.
8. Please always make sure that you keep a copy of the enrollment form for your own records as well.
9. It may take 6 - 8 weeks for your information to reach the carriers due to the timing of your enrollment. You should get your enrollment card 1 -2 weeks after the carries process the enrollment file.
10. If you need to seek services during this time, please contact Sharon Mendonca in the benefits office at Sharon.Mendonca@ucsf.edu.
11. **You have 31 days from your hire date to enroll yourself and your eligible dependents enroll in your postdoctoral benefits plan.**

Establish an At Your Service Online (AYSO) username and password

- Go to <https://atyourserviceonline.ucop.edu/ayso/>
- To begin, click New to UC and have a Temporary Password

Enter your Social Security number as your temporary username (no dashes or spaces).

Enter your birthdate in the format mmddyyyy (no dashes or slashes) as your temporary password.

After you sign in, you can personalize your username and password. To designate a new password, you'll be asked security questions. Creating your own username and password lets you access personal information on AYSO.

PLAN DISCLAIMER

This Schedule of Benefits is a brief list of benefits, with applicable copayments, coinsurance and deductibles information for your health plan. It does not list the exclusions and limitations or other important terms applicable to your plan.

The Evidence of Coverage (EOC) for your plan contains the complete terms and conditions of your Health Net coverage. It is important for you to thoroughly review the EOC for your plan.

**Health Net California Large Group HMO Plan Chart
Restricted Plan FMC**

FMC

OUT-OF-POCKET MAXIMUM: All eligible copayments and coinsurance apply to OOPM.

For each member.	\$1,500
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For each family.	\$4,500
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PROFESSIONAL SERVICES

Visit to a physician, physician assistant or nurse practitioner at a PPG. ¹	\$10
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Performed at CVS MinuteClinic for preventive care services includes preventive physical examinations, other immunization and preventive laboratory tests. ¹	\$0
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Performed at a CVS MinuteClinic for all other non- preventive care services.	\$10
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Telemedicine services. ²	\$0
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Periodic health evaluations. Includes annual preventive physical examinations, preventive vision/hearing screenings, well-woman exam and other women's preventive services, preventive laboratory tests and x-rays. ¹	\$0
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Annual routine physical examinations. Provided for employment, school, camp or sports.	Not covered
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Vision and hearing examinations.	\$10
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Specialist consultations. Includes OB/GYN self-referral. For podiatry services, refer below. For preventive services, refer to periodic health evaluations above. ¹	\$10
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Podiatry services, includes routine foot care for diabetes.	\$10
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Routine foot care (cutting/removal of corns, calluses, trimming of nails).	Not covered
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Physician visit to member's home (at discretion of physician).	\$20
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Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).	\$0
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Other immunizations (except foreign travel/occupational - see below).	\$0
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Immunizations for foreign travel/occupational purposes.	20%
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Allergy testing.	\$0
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Allergy serum.	\$0
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Allergy injection services (serum not included).	\$0
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Injections related to infertility services.	50%
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All other injections	
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Office-based injectables. ¹	\$0
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Self-administered injectable medications (up to a 30-day supply for each prescription).	Refer to Pharmacy Benefits \$0 per prescription
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Surgeon/assistant surgeon.	\$0
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Administration of anesthetics.	\$0
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X-ray and laboratory procedures, including genetic testing. Preventive x-ray/lab, refer to periodic health evaluations above. ¹	\$0
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Rehabilitation therapy (outpatient physical, speech, occupational). Provided as long as significant improvement is expected. For applied behavioral analysis (ABA), refer to the mental health benefits.	\$0
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Respiratory therapy and cardiac rehabilitation.	\$0
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Habilitation therapy (physical, occupational, speech, respiratory and cardiac therapy). Applied behavioral analysis (ABA) is covered through the mental health benefit.	Not covered
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Dental services (when medically necessary to properly monitor, control or treat a severe medical condition when excluded dental services are being performed).	\$0
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CARE FOR CONDITIONS OF PREGNANCY (professional services only)

Prenatal and postnatal office visit.	\$10
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Normal delivery, complications of pregnancy and Cesarean section. Includes newborn inpatient care provided by a member physician.	\$0
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Abortions services	\$0
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Genetic testing of fetus.	\$0
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Circumcision of newborn.	\$0
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FAMILY PLANNING (professional services only)

Contraceptive methods. Includes intrauterine device (IUD), injectable or implantable contraceptives. ¹	\$0
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Infertility services. Includes professional services, outpatient care, treatment by injection, prescription drugs if applicable, artificial insemination (AI), IUI and GIFT. ZIFT and IVF are not covered.	50%
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Sterilization of females. ¹	\$0
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Sterilization of males.	\$50
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Reversal of sterilization.	Not covered
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ALCOHOL/DRUG REHABILITATION and CARE FOR MENTAL DISORDERS

Administered by Managed Health Network (MHN)

Refer members to the MHN telephone number on the back of their Health Net ID card

Health Net California Large Group HMO Plan Chart Restricted Plan FMC		FMC
OTHER SERVICES		
Medical social services.		\$0
Patient education. Includes smoking cessation/weight management.		\$0
Ambulance services (ground and air).		\$0
Durable medical equipment. For preventive DME, refer to preventive care. ¹		\$0
Orthotics (braces and supports).		\$0
Corrective footwear. Custom made shoes and shoe inserts (custom foot orthotics).		Not covered
Diabetic supplies.		\$0
Hearing aids.		Not covered
Medical supplies. ¹		\$0
Prosthesis (replacing body parts).		\$0
Wigs (cranial prosthesis).		Not covered
Blood and blood products, except for blood-clotting factors, refer below.		\$0
Blood-clotting factors (up to a 30-day supply for each prescription).	Refer to Pharmacy Benefits \$0 per prescription	
Nuclear medicine.		\$0
Organ, tissue and stem cell transplants (non-experimental and noninvestigative. Professional services only).		\$0
Gender reassignment travel and lodging.	\$0 / \$75,000 lifetime max ³	
Chemotherapy or radiation therapy.		\$0
Renal dialysis.		\$0
Home health visit. Includes home health rehab. The copayment starts the 31st calendar day after the first visit.		\$10
Hospice care.		\$0
HOSPITAL AND SKILLED NURSING FACILITY SERVICES		
Unlimited days of hospital care (medical, surgical & maternity, including routine normal nursery charges) provided in a medically necessary private room, semi-private room or special care unit with ancillary services. Excludes care for mental disorders.		\$0
Confinement in a skilled nursing facility (limited to 100 days a calendar year).		\$0
Outpatient services.		\$0
EMERGENCY CARE/URGENTLY NEEDED CARE - Within or outside the PPG service area -		
NOTE: Non-emergency care (including urgently needed care) received within the PPG service area must be performed or authorized by the member's PPG in order for services to be covered. When urgently needed care is provided outside the PPG service area, authorization is not mandatory in order for services to be covered. When services are provided that meet the criteria for emergency care, whether within or outside the PPG service area, the services are covered, even if the member never contacted the PPG.		
Emergency professional services.		\$0
Use of emergency room (facility services). ⁴		\$35
Use of urgent care center.		\$35

1 Women's preventive care services include the following: Screening for gestational diabetes; human papilloma virus (HPV) DNA testing for women 30 years and older; sexually-transmitted infection counseling; human immunodeficiency virus (HIV) screening and counseling; family planning; FDA-approved contraception methods and contraceptive counseling; breastfeeding support, supplies and counseling; domestic violence screening and counseling; and preventive sterilizations. The applicable cost sharing for preventive care will apply to these services.

2 Telemedicine services are covered only when provided through the Teladoc program, including mental health and chemical dependency treatment. No benefits are payable for telemedicine services billed by other providers.

3 Travel and lodging expenses are covered as part of the Transgender Surgery. Prior Authorization required. Health Net's Case Manager will determine and set guidelines for lodging/travel/meal expenses using Health Net's Corporate Travel guidelines. Travel/meal/lodging expenses are only available for the patient (companion not covered), which includes coverage for the following: Pre-op, surgical procedures, post-op visits to Northern California Transgender surgeon only. The maximum meal allowance is \$55 per day. Only coach airfare is covered (patient will pay the difference to upgrade) and airport parking limited to long term parking rates for all over night trips in excess of one night. The traveling distance must be more than 50 miles from the provider for Health Net to cover travel/lodging/meal expenses. Health Net will not prepay for travel/lodging/meals expenses. Reimbursement will be provided after submission of the claims reimbursement form along with receipts for pre-approved expenses. The authorization number must be indicated on all forms. For use of personal care, member must provide: Purpose of trip, date, location, receipts for tolls and parking (mileage will be reimbursed at federal mileage allowance rates).

4 The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room.

PLAN DISCLAIMER

This Schedule of Benefits is a brief list of benefits, with applicable copayments, coinsurance and deductibles information for your health insurance plan. It does not list the exclusions and limitations or other important terms applicable to your insurance plan.

The Certificate of Insurance (COI) for your insurance plan contains the complete terms and conditions of your Health Net Life Insurance Company coverage. It is important for you to thoroughly review the COI for your insurance plan.

**Health Net California Large Group PPO
Restricted Plan FMB - Effective 1/1/2020**

PPO**OON**

Member pays coinsurance and any charges exceeding maximum allowable amount

Deductible Disclaimer: Through PPO, there is no calendar year deductible. Through OON, all services are subject to the deductible, unless otherwise noted. The member must satisfy the calendar-year deductible before benefit payment begins.

Prior Authorization Disclaimer: Prior authorization is required for some services, refer to the appropriate prior authorization list for specific requirements or to the member's Certificate of Insurance (COI). If prior authorization is not acquired, benefits are reduced to 50%. In addition, for uncertified outpatient services, a \$50 copayment is required for each visit; for uncertified inpatient admissions, a \$500 copayment is required for each inpatient admission. **Penalties for uncertified services do not apply to OOPM.**

CALENDAR YEAR DEDUCTIBLE: Through OON, 4th quarter deductible carryover applies.

For each member.	None	\$200
For each family.	None	\$600

CALENDAR YEAR OUT-OF-POCKET MAXIMUM: All copayments, coinsurance and deductibles for medical, mental health and chemical dependency, including copayment/coinsurance for uncertified services apply to OOPM. The OON calendar year deductible is included in OOPM. PPO/OON cross-accumulate.

For each member.	\$1,500
For each family.	\$4,500

LIFETIME BENEFIT MAXIMUM

For each member.	Unlimited
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PROFESSIONAL SERVICES

Visit to a physician, physician assistant or nurse practitioner. ¹	\$20	40%
Telemedicine services. ²	\$0	Not covered
Preventive care. Includes annual preventive physical examinations, preventive vision/hearing screenings, well-woman exam and other women's preventive services, preventive laboratory tests and x-rays. ¹	\$0	40%
Annual routine physical examinations. Provided for employment, school, camp or sports. Through PPO/OON, limited to calendar year maximum payment of \$250.	\$20	40%
Vision examinations for refractive eye exams. Children through age 16.	\$20	40%
Adult (age 17 and older).	Not covered	Not covered
Hearing examinations for hearing loss. Children through age 16.	\$20	40%
Adult (age 17 and older).	Not covered	Not covered
Specialist consultations (includes second surgical opinions). For podiatry services, refer below. For preventive services, refer to preventive care above. ¹	\$20	40%
Podiatry services, includes routine foot care for diabetes.	\$20	40%
Routine foot care (cutting/removal of corns, calluses, trimming of nails).	Not covered	Not covered
Physician visit to member's home (at discretion of physician).	20%	40%
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).	20%	40%
Immunizations (excluding foreign travel/occupational, see below).	\$0	40%
Immunizations for foreign travel/occupational purposes.	Not covered	Not covered
Allergy testing.	\$20	40%
Allergy serum.	20%	40%
Allergy injection services (serum not included).	\$20	40%
Injections for treatment of infertility.	Not covered	Not covered
All other injections		
Office based injectable medications. ¹	\$20	40%
Self-administered injectable medications (up to a 30-day supply for each prescription).	Refer to Pharmacy Benefits \$20 per prescription	Not covered
Surgeon/ assistant surgeon.	20%	40%
Administration of anesthetics.	20%	40%
X-ray and laboratory procedures, including genetic testing. Preventive x-ray/lab, refer to preventive care above. ¹	20%	40%
Complex radiology (CT scan, PET, MRI, SPECT, MUGA).	20%	40%
Physical, speech, and occupational therapy. includes ABA. Visit maximum combined for all therapies.	20%	40%
Cardiac and respiratory therapy. Visit maximum combined for all therapies.	20%	40%
Habilitation therapy (physical, occupational, speech, respiratory and cardiac therapy). Applied behavioral analysis (ABA) is covered through the mental health benefit.	Not covered	Not covered
Dental services (when medically necessary to properly monitor, control or treat a severe medical condition when excluded dental services are being performed).	20%	40%

Health Net Large Group PPO - *Restricted Plan FMB*

PPO

OON

Member pays coinsurance and any charges exceeding maximum allowable amount

Deductible Disclaimer: Through PPO, there is no calendar year deductible. Through OON, all services are subject to the deductible, unless otherwise noted. The member must satisfy the calendar-year deductible before benefit payment begins.

Prior Authorization Disclaimer: Prior authorization is required for some services, refer to the appropriate prior authorization list for specific requirements or to the member's Certificate of Insurance (COI). If prior authorization is not acquired, benefits are reduced to 50%. In addition, for uncertified outpatient services, a \$50 copayment is required for each visit; for uncertified inpatient admissions, a \$500 copayment is required for each inpatient admission. **Penalties for uncertified services do not apply to OOPM.**

CARE FOR CONDITIONS OF PREGNANCY

Prenatal office visit.	\$0	40%
Postnatal office visit.	20%	40%
Normal delivery, complications of pregnancy and Cesarean section. Includes newborn inpatient professional care. ³	20%	40%
Abortion services.	20%	40%
Genetic testing of fetus.	20%	40%
Circumcision of newborn.	20%	40%

FAMILY PLANNING (professional services only)

Contraceptive methods. Includes intrauterine device (IUD), injectable or implantable contraceptives. ¹	\$0	40%
Infertility services (including professional services, outpatient care and treatment by injection).	Not covered	Not covered
Sterilization of females. ¹	\$0	40%
Sterilization of males.	20%	40%
Reversal of sterilization.	Not covered	Not covered

ALCOHOL/DRUG REHABILITATION and CARE FOR MENTAL DISORDERS

Administered by Managed Health Network (MHN)

Refer members to the MHN telephone number on the back of their Health Net ID card

- | | |
|---|--|
| 1 | Women's preventive care services include the following: Screening for gestational diabetes; human papilloma virus (HPV) DNA testing for women 30 years and older; sexually-transmitted infection counseling; human immunodeficiency virus (HIV) screening and counseling; family planning; FDA-approved contraception methods and contraceptive counseling; breastfeeding support, supplies and counseling; domestic violence screening and counseling; and preventive sterilizations. The applicable cost sharing for preventive care will apply to these services. |
| 2 | Telemedicine services are covered only when provided through the Teladoc program, including mental health and chemical dependency treatment. No benefits are payable for telemedicine services billed by other providers. |
| 3 | In accordance with the Affordable Care Act, prenatal obstetrical office visits are covered as a preventive care service without member cost share responsibility on all in-network benefit tiers. |
| 4 | Additional visits are payable if precertified as medically necessary following neurological and orthopedic surgery, cerebral cardiovascular accident, third degree burns, head trauma or spinal cord injuries. Medically necessary rehabilitation therapy or habilitative services for treatment of autism or pervasive developmental disorder are not subject to the 20-visit limitation. |

Health Net Large Group PPO - *Restricted Plan FMB*

PPO

OON

Member pays coinsurance
and any charges exceeding
maximum allowable amount

Deductible Disclaimer: Through PPO, there is no calendar year deductible. Through OON, all services are subject to the deductible, unless otherwise noted. The member must satisfy the calendar-year deductible before benefit payment begins.

Prior Authorization Disclaimer: Prior authorization is required for some services, refer to the appropriate prior authorization list for specific requirements or to the member's Certificate of Insurance (COI). If prior authorization is not acquired, benefits are reduced to 50%. In addition, for uncertified outpatient services, a \$50 copayment is required for each visit; for uncertified inpatient admissions, a \$500 copayment is required for each inpatient admission. **Penalties for uncertified services do not apply to OOPM.**

OTHER SERVICES

Medical social services.	20%	40%
Patient education.		
Patient education for diabetes only.	20%	40%
Smoking cessation/weight management.	\$0	Not covered
Ambulance services (air and ground)	20%	40%
Durable medical equipment. For preventive DME, refer to preventive care. ¹	20%	40%
Orthotics (braces and supports).	20%	40%
Corrective footwear. Custom made shoes and shoe inserts (custom foot orthotics).	20%	40%
Diabetic supplies.	20%	40%
Hearing aids.	Not covered	Not covered
Medical supplies. ¹	20%	40%
Prosthesis (replacing body parts).	20%	40%
Wigs (cranial prosthesis).	Not covered	Not covered
Acupuncture.	Not covered	Not covered
Chiropractic care. Through PPO, a separate \$200 deductible applies each calendar year in addition to the 20% coinsurance. Once the \$200 deductible is satisfied, only the 20% coinsurance applies.	20%	40%
Blood and blood products, except for blood clotting factors, refer below.	20%	40%
Blood clotting factors (up to a 30-day supply for each prescription).	Refer to Pharmacy Benefits \$20 per prescription	Not covered
Nuclear medicine.	20%	40%
Organ, tissue and stem cell transplants (non-experimental and noninvestigative. Professional services only.)	20%	Not covered
Gender reassignment travel, lodging and meals.	20%	40%
	Combined lifetime maximum of \$75,000 (PPO/OON) ⁵	
Chemotherapy.	20%	40%
Radiation therapy.	20%	40%
Renal dialysis.	20%	40%
Home health visit includes home health rehab.	20%	40%
Infusion therapy (home or physician's office or outpatient).	20%	40%
Hospice care (elected by member).	20%	40%

HOSPITAL AND SKILLED NURSING FACILITY

Unlimited days of hospital care (medical, surgical & maternity, including routine normal nursery charges) provided in a medically necessary private room, semi-private room or special care unit with ancillary services. Excludes care for mental disorders. For newborns, a separate copayment/coinsurance will apply to a newborn requiring admission to a special care unit.	\$250 + 20%	\$250 + 40%
Confinement in a skilled nursing facility.	\$250 + 20%	\$250 + 40%
Outpatient services.	\$0	40%

EMERGENCY ROOM / URGENT CARE CENTER

ER Professional services.	20%	20% ded waived
Use of emergency room (facility services).	20%	20% ded waived
Use of urgent care center.	20%	20% ded waived

⁵ Gender reassignment surgery must be performed by Health Net-qualified provider in conjunction with gender transformation treatment. Prior authorization is required from Health Net.
Reasonable travel, lodging and meal costs, as determined by Health Net Life, for a member to undergo an authorized gender reassignment surgery are subject to a \$75,000 lifetime maximum. Travel and lodging are only available for the patient (companion not covered). **Note:** Non-surgical services related to gender reassignment treatment, such as psychotherapy for gender identity disorders and pre & post-surgical hormone therapy are included within the other covered plan benefits, e.g. mental health.



UNIVERSITY OF CALIFORNIA

Postdoctoral Scholar Benefit Plan

Health Insurance Quick Reference Guide

Deductible

A specific dollar amount that your health insurance company may require that you pay out-of-pocket each year before your health insurance plan begins to make payments for claims. Not all health insurance plans require a deductible.

Out-of-Pocket Maximum

Out-of-pocket maximums apply to all medical plans. This is the maximum amount you will pay for health care costs in a calendar year. Once you have reached the out-of-pocket maximum, the plan will fully cover most eligible medical expenses for the rest of the plan year.

Coinsurance

The amount that you are required to pay for covered medical services after you've satisfied any copayment or deductible required by your health insurance plan. Coinsurance is typically a percentage of the charge for a service rendered by a healthcare provider. For example, if your insurance company covers 80% of the allowable charge for a specific service, you may be required to cover the remaining 20% as coinsurance.

Copayment

A flat charge that your health insurance plan may require you to pay for a specific medical service or supply, also referred to as a "copay." For example, your health insurance plan may require a \$20 copayment for an office visit or brand-name prescription drug, after which the insurance company pays the remainder of the charges.

In-Network Provider

A healthcare professional, hospital or pharmacy that has a contractual relationship with your health insurance company. This contractual relationship typically establishes allowable charges for specific services. In return for entering into this kind of relationship with an insurance company, a healthcare provider typically gains patients, and a primary care physician may receive a capitation fee for each patient assigned to his or her care. An **Out-of-Network** provider is a healthcare professional, hospital, or pharmacy that *is not* part of your health plan's network of preferred (In-Network) providers. You will generally pay more for services received from out-of-network providers, in part because you may be responsible for out-of-pocket costs that are considered above the "reasonable and customary" fees.

Primary Care Physician (PCP)

A primary care physician usually serves as a patient's main healthcare provider, especially under an HMO plan. The PCP serves as a first point of contact for healthcare and may refer a patient to specialists for additional services.

Claim

A request by a plan member, or a plan member's health care provider, for the insurance company to pay for medical services.

Lifetime Maximum

The maximum dollar amount that a health insurance company agrees to pay on behalf of a member for covered services during the course of his or her lifetime.

Medical Evacuation and Repatriation Insurance

This coverage, required of all J-Visa holders, is for arranging and paying for emergency evacuation to the nearest adequate medical facility, and the repatriation of mortal remains.

COBRA (Consolidated Omnibus Reconciliation Act)

Federal legislation allowing an employee or an employee's dependents to maintain group health insurance coverage through an employer's health insurance plan, at the individual's expense, for up to 18 months after the loss of employment.

Insurance Carrier

The company responsible for providing you with your health insurance plan by paying your claims, maintaining provider networks, coordinating billing, and offering member assistance services.

Broker

A broker matches their clients with a health insurance company or plan that best suits the client's needs. The broker is paid a commission by the insurance company, but represents the interests of their client rather than the insurance company. In some cases, as with Garnett-Powers & Associates, a broker can also act as a third-party administrator, handling enrollment and billing, benefit and claims questions, etc.

Where Do I Access Care?

Type of Provider	Scenario	Type of Illness or Injury
Primary Care Physician (PCP) (Common under HMO plan)	Annual wellness exams, or moderate pain you need diagnosed	General checkup, moderate pain of unknown origin, etc.
Specialist (Requires referral from PCP under HMO)	Experiencing pain specific to a particular region of the body (i.e. muscular, gastrointestinal, ocular, bone/joint, skin, ears/nose/throat, etc.)	Ulcers, rash, digestive problems, vision problems, elevated levels, etc.
Hospital	Having an inpatient or outpatient procedure performed, in a critical state	Delivering a baby, major/minor surgery, recovery, monitoring, etc.
Walk-in Clinic	Treatment of unscheduled, non-emergency illnesses/injuries and certain immunizations	Vaccination, mild cold/flu, minor cuts/abrasions, etc.
Urgent Care (Alternative to ER)	Treatment of most non-life threatening emergencies	Broken bones (not multiple fractures), minor wounds (not bleeding profusely), mild fever, flu, acute sinusitis, etc.
Emergency Room (ER)	Treatment of all life/limb-threatening emergencies	Severe head trauma, multiple/compound fractures, heavy bleeding, elevated fever, severe burns, seizures, poison, etc.

Teladoc® Member Frequently Asked Questions

What is Teladoc?

Teladoc is the first and largest provider of telehealth medical consults in the United States, giving you 24/7/365 access to quality medical care.

Who are the Teladoc doctors?

Teladoc doctors are U.S. board certified in Internal Medicine, Family Practice, or Pediatrics. They average 20 years experience, are licensed in your state, and incorporate Teladoc into their day-to-day practice as a way to provide people with convenient access to quality medical care.

Does Teladoc replace my doctor?

No. Teladoc does not replace your primary care physician. Teladoc should be used when you need immediate care for non-emergent medical issues. It is an affordable, convenient alternative to urgent care and ER visits.

What kind of medical care does Teladoc provide?

Teladoc provides adult and pediatric general medical care.

What consult methods are available?

You can talk with a Teladoc doctor by video or phone.*

How do I set up my Teladoc account?

Setting up your account is a quick and easy process online. Visit the Teladoc website and click "Set Up Account". Follow the online instructions.

How do I request a consult to talk to a doctor?

Visit the Teladoc website, log into your account and click "Request a Consult".

How quickly can I talk to the doctor?

The doctor will call you back in minutes. If you miss the doctor, you will be returned to the bottom of the waiting list. The consult request is cancelled if you miss three attempts.

Is there a time limit when talking with a doctor?

There is no time limit for consults.

Can Teladoc doctors write a prescription?

Yes, Teladoc doctors can prescribe short-term medication for a wide range of conditions when medically appropriate. Teladoc doctors do not prescribe substances controlled by the DEA, non-therapeutic and/or certain other drugs which may be harmful because of their potential abuse.

How do I pay for a prescription called in by Teladoc?

When you go to your pharmacy of choice to pick up the prescription, you may use your health/prescription insurance card to help pay for the medication. You will be responsible for the co-pay based on the type of medication and your plan benefits.

Is the consult fee the same price, regardless of the time?

Yes! Teladoc charges one flat rate per consult.

How do I pay for the consult?

You can pay with your HSA (health savings account) card, credit card, prepaid debit card or by PayPal.

If the Teladoc doctor recommends that I see my primary care physician or a specialist, do I still have to pay the Teladoc consult fee?

Yes. Just like any doctor appointment, you must pay for the consulting doctor's time.

Can I provide consult information to my doctor?

Yes. You have access to your electronic medical record at anytime. Download a copy online from your account or call Teladoc and ask to have your medical record mailed or faxed to you.

Talk to a doctor anytime for free!



[Teladoc.com/hn](https://teladoc.com/hn)



[Facebook.com/Teladoc](https://facebook.com/Teladoc)



1-800-Teladoc (835-2362)



[Teladoc.com/mobile](https://teladoc.com/mobile)

***In Arkansas and Delaware, your first visit must be by video and future visits can be by phone or video.**

Health Net contracts with Teladoc to provide telehealth services. Teladoc services are not intended to replace services from your physician, but are a supplemental service. See your health plan Policy (PPO) or Plan Contract and Evidence of Coverage (HMO) for coverage details. Health Net HMO plans are offered by Health Net of California, Inc. Health Net EnhancedCare PPO insurance plans, Policy Form #P35001, are underwritten by Health Net Life Insurance Company. Health Net of California, Inc. and Health Net Life Insurance Company are subsidiaries of Health Net, Inc. Health Net is a registered service mark of Health Net, Inc. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

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

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）。

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).