Health Net

www.healthnet.com

2002

A Health Maintenance Organization

For changes in benefits, see page 10

Serving: Most of California

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.

This plan has commendable accreditation from the NCQA. See the 2002 Guide for more information on accreditation.

Enrollment codes for this Plan:

LB1 Self Only
LB2 Self and Family

Authorized for distribution by the:
United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

Federal Employees Health Benefits Program
RI 73-159

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Introduction

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

This brochure describes the benefits of Health Net under our contract (CS 2002) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; "we" means Health Net.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm .gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E S treet, NW Washington, DC 20415-3650.

Inspector General Advisory

Stop health care fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800-522-0088 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

Typically, we contract with Participating Physician Groups (PPGs), rather than directly with physicians, on a capitated basis for HMO plans. We will also contract directly with an individual physician in rural areas where PPGs do not exist.

In contractual agreements with PPGs that are capitated, we prepay PPGs a monthly fixed dollar amount based on a Per Member Per Month (PMPM) rate schedule. The amount and the method for utilizing the capitation payment vary among the PPGs. Influencing the capitation payment is the division of financial responsibility agreed to between Health Net and the PPG, as well as Member demographics and level of benefits.

In dual risk arrangements, the PPG will receive a capitation that covers some hospital or institutional services as well as professional services. In shared risk arrangements, the PPG will receive a capitation that covers only professional services.

While we contract with PPGs on a capitated basis, the PPGs contract with and reimburse both primary and specialty care physicians. These reimbursement methods include subcapitation, salary, and discounted fee schedules. In those instances where we contract directly with physicians, the physician reimbursement is based on RBRVS (Resource Based Relative Value System), an industry accepted fee schedule that the Health Care Financing Administration (HCFA) established.

Who provides my health care

We are a Mixed Model HMO with an extensive network of over 600 participating physician groups and 415 hospitals conveniently located in the communities where you work or live. Over 36,000 primary care and referral specialist physicians are affiliated with us through our participating physician groups.

You must select a participating physician group within a 30-mile radius of your home or work-site. Although each of your family members may select their own primary care physician, we encourage family members to choose their primary care physicians within the same participating physicians group. This helps strengthen your family's doctor/patient relationships.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

Health Net is a for profit, Mixed Model (MMP) HMO that received certification as a Federally Qualified HMO in 1979 and was licensed by the California Department of Corporations in 1991.

If you want more information about us, call 1-800-522-0088, visit our website, www.healthnet.com, or write to:

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

Service Area
To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is:

Full counties: Alameda, Colusa, Contra Costa, Glenn, Kings, Los Angeles, Madera, Marin, Mariposa, Merced, Napa, Orange, Sacramento, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Sierra, Solano, Ventura, and Yolo counties, California.

Partial counties: El Dorado, Fresno, Kern, Mendocino, Nevada, Placer, Plumas, Riverside, San Bernardino, San Joaquin, Sonoma, Stanislaus, Tehama, Trinity and Tulare counties, California. The following ZIP codes are those included in these partial counties:

EL DORADO

95613-14	95633-36	95664	95682	95726-27
95619	95643	95667	95684	95762
95623	95651	95672	95709	

FRESNO

93210	93611-13	93640-42	93660	93700-99
93234	93616	93646	93662	
93242	93621-22	93648-52	93664	
93602	93624-31	93654	93667-68	
93605-09	93634	93656-57	93675	

KERN

93203	93238	93268	93300-91	93531
93205-06	93240-41	93276	93399	93560-61
93215-17	93243	93280	93501-05	93581-82
93220	93249-52	93283	93516	93596
93222	93255	93285	93518-19	
93224-26	93263	93287-88	93523-24	

MENDOCINO

95415	95445	95449	95463	95482

NEVADA

95712	95945-46	95959-60
95924	95949	95975

PLACER

95602-04	95658	95681	95717	95765
95631	95661	95701	95722	
95648	95663	95703	95736	
95650	95677-78	95713-14	95746-47	

PLUMAS

96103	96105-06	96122	96129	96135

RIVERSIDE

91718-20	92240-41	92320	92383	92561-64
91752	92253-55	92330-31	92387-88	92567
91760	92258	92343-44	92390	92570-72
92201-03	92260-64	92348-49	92395-96	92581-93
92210-11	92270	92353	92500-23	92595-96
92220	92274-76	92355	92530-32	92860
92223	92282	92360-62	92536	92877-83
92230	92302	92367	92539	
92234-36	92306	92370	92543-46	
	92313	92380-81	92548-57	

SAN BERNARDINO

91701	91761-64	92305	92345-47	92382
91708-10	91784-86	92307-18	92350	92385-86
91729-30	92252	92314-18	92352	92391-94
91737	92256	92321-22	92354	92397-99
91739	92268	92324-27	92356-59	92400-27
91743	92277-78	92329	92365	
91758-59	92284-86	92333-37	92368-69	
	92301	92339-42	92371-78	

SAN JOAQUIN

95201-13	95234	95258	95320	95376-78
95215-20	95236-37	95267-69	95330-31	95385
95227	95240	95290	95336-37	95686
95230-31	95253	95304	95366	

SONOMA

94922-23	94980-99	95430-31	95448	95480
94926-28	95400-09	95433	95450	95486-87
94931	95412-13	95436	95452	95492
94951-55	95416	95439	95462	95497
94972	95419	95441-42	95465	
94975	95421	95444	95471-73	
	95425	95446	95476	

STANISLAUS

95307	95323	95350-58	95374
95313	95326	95360-61	95380-82
95316	95328-29	95363	95384
95319	95334	95367-68	95386-87

TULARE

93201	93235	93265	93286	93666
93207-08	93237	93267	93291-92	93670
93218-19	93244	93270-72	93603	93673-74
93221	93247	93274-75	93615	
93223	93256-58	93277-79	93618	
93227	93260-62	93282	93647	

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member moves outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2002

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- We changed the address for sending disputed claims to OPM (Section 8)

Changes to this Plan

- Your share of the non-Postal premium will increase by 23.7% for Self Only or 23.7% for Self and Family.
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))
- We changed the address for sending disputed claims to OPM (Section 8)
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- We increased the non-formulary prescription drug copay to $35 at a retail pharmacy and $70 through mail order.
- We now cover smoking cessation products that require a prescription
- We decreased the copayment for home health care from $20 to $10 per visit after the first 30 visits.
- We will no longer be offered in the following counties: Butte, Humboldt, Lake, Sutter, and Yuba

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-522-0088.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, or coinsurance, and you will not have to file claims.

- **Plan providers**

Plan providers are participating physician groups, physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We maintain stringent credentialing and recredentialing criteria for our Plan Providers.

We list Plan providers in the provider directory, which we update periodically. The list is also on our web site.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our web site.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician from our network of participating physician groups. This decision is important since your primary care physician provides or arranges for most of your health care.

You must select a Participating Physicians Group (PPG) within a 30 mile radius of your home or work-site. Each family member may choose their own PPG and primary care physician.

You may transfer to another PPG by calling us at 1-800-522-0088. You may change PPG's once a month or upon our approval. All transfers will become effective on the first day of the month following our receipt of the transfer, provided the request is received by the 14th of the month. The request will be denied if you are more than three months pregnant, confined to a hospital, in a surgery follow-up period (not yet released by the surgeon) or receiving treatment for an illness that is not yet complete.

- **Primary care**

Your primary care physician can be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

• Specialty care

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see a participating chiropractor (as described on page 23) and a woman may see her participating gynecologist at anytime without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  - terminate our contract with your specialist for other than cause; or

  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  - reduce our service area and you enroll in another FEHB Plan,

  you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

You also have the right to request a second opinion when:

- Your primary care physician or a referral physician gives a diagnosis or recommends a treatment plan that you are not satisfied with; or
- You are not satisfied with the result of treatment you have received; or
- You are diagnosed with, or a treatment plan is recommended for a condition that threatens loss of like, limb or bodily function, or a substantial impairment, including but not limited to a serious chronic condition; or
- Your primary care physician or a referral physician is unable to diagnose your condition, or test results are conflicting.

To request an authorization for a second opinion, contact your Primary Care Physician or Health Net Member Services at (800) 522-0088. Physicians at your Physician Group or Health Net will review your request in accordance with Health Net's second opinion policy. You may obtain a copy of this policy from Health Net's Member Service Department. All second opinions must be provided by a participating network physician who specializes in the illness, disease or condition associated with the request. If there is no appropriately qualified physician in the network, your primary care physician will arrange for an out-of–network second opinion.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-522-0088. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

Services that are not authorized by your primary care physician or Health Net will not be covered.

In addition, authorization by the Plan may be required for some formulary and non-formulary prescription drugs.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments** — A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

  Example: When you see your primary care physician you pay a copayment of $10 per office visit.

- **Deductible** — We do not have a deductible.

- **Coinsurance** — Coinsurance is the percentage of our negotiated fee that you must pay for your care.

  Example: In our Plan, you pay 50% of our allowance for infertility services.

Your catastrophic protection out-of-pocket maximum for coinsurance and copayments

After your copayments and coinsurance total $1,500 per person or $4,500 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your out-of-pocket maximum and you must continue to pay copayments for these services:

- Prescription Drugs
- Chiropractic Care

Be sure to keep accurate records of your copayments and/or coinsurance since you are responsible for informing us when you reach the maximum.

Section 5. Benefits – OVERVIEW

(See page 10 for how our benefits changed this year and page 58 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-522-0088 or at our website at www.healthnet.com.

Section 5 (a) Medical services and supplies provided by physicians and other health care professionals

I M P O R T A N T	**Here are some important things to keep in mind about these benefits:** • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • Plan physicians must provide or arrange your care. • We have no calendar year deductible. • Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.	I M P O R T A N T

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion	$10 per office visit
Professional services of physicians • During a hospital stay • In a skilled nursing facility • In a physicians office for a newborn through the first 30 days of life	Nothing
• In an urgent care center	$35 per visit
At home	$20 per visit
Not covered: • *Treatment that is not authorized by a plan physician* • *Treatment that is not medically necessary*	***All charges.***

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing if your receive these services during your office visit; otherwise, $10 per visit.
Preventive care, adult	
Routine screenings, such as: • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50	Nothing if you receive these services during your office visit; otherwise, $10 per visit.
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	Nothing if you receive these services during your office visit; otherwise, $10 per visit
Routine pap test Routine Mammogram covered for women age 35 and older, as follows: • From age 35 through 39, one during this 5 year period • From age 40 through 64, one every calendar year • At age 65, one every two consecutive calendar years	Nothing if you receive these services during your office visit; otherwise, $10 per visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	All charges.
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing
Immunizations for occupational and foreign travel:	20% of charges

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing if you receive these services during your office visit; otherwise, $10 per visit
• Well-child care charges for routine examinations, and care (from 30 days old up to age 22) • Examinations, such as: - Eye exams to determine the need for vision correction. - Ear exams to determine the need for hearing correction - Examinations done on the day of immunizations (from 30 days old up to age 22)	$10 per office visit
• Well-child care charges for routine examinations and care (birth through 30 days of life)	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing

Family planning	**You pay**
A broad range of voluntary family planning services, limited to: • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms NOTE: We cover oral contraceptives, cervical caps and diaphragms under the prescription drug benefit.	Nothing
• Voluntary sterilization (females)	$150
• Voluntary sterilization (males)	$50
Not covered: reversal of voluntary surgical sterilization, genetic counseling,	*All charges.*
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	50% of charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* *- in vitro fertilization* *- embryo transfer, gamete GIFT and zygote ZIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm, ova, or their collection or storage* • *Injectable medications for infertility treatments not covered by the plan*	*All charges.*

Allergy care	You pay
Testing and treatment Allergy injection	Nothing
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 28. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT)	Nothing
Physical and occupational therapies	
• Services of the following are covered as long as significant improvement is expected for each condition: - qualified physical therapists; - occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Note: Occupational Therapy is limited to services to achieve and maintain self-care and improved functioning in activities of daily living.	Nothing
Speech Therapy	
• Services for speech therapy are covered as long as significant improvement is expected for the condition.	Nothing

Hearing Services (testing, treatment, and supplies)	You pay
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see Preventive care, children)	
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	
One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	$10 per office visit
• Eye exam to determine the need for vision correction (see preventive care) • Annual eye refractions	$10 per office visit
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Eyeglasses or contact lenses after Interocular lens implant*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	Nothing
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics, except when they have been incorporated into a cast, splint, brace or strapping of the foot* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic replacements provided less than 3 years after the last one we covered*	*All charges.*
Durable medical equipment (DME)	
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds; • standard wheelchairs, electric wheelchairs if medically necessary; • crutches; • walkers; • blood glucose monitors; and • insulin pumps.	Nothing

Durable Medical Equipment continued on next page

Durable medical equipment (DME) *(continued)*	You pay
Not covered: • *Exercise equipment.* • *Hygienic equipment and supplies (to achieve cleanliness even when related to other covered medical services.* • *Stockings* • *Surgical dressings, except primary dressings that are applied by a Plan physician or a Hospital to lesions of the skin or surgical incisions* • *Jacuzzis and whirlpools* • *Orthotics which are not custom made to fit your body (Orthotics are supports or braces for weak or ineffective joints or muscles.)* • *Foot orthotic, except when they have been incorporated into a cast, splint, brace or strapping of the foot.*	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. Note: Your Plan physician will review the home health service program for continuing appropriateness.	Nothing for the first 30 visits, $10 per visit thereafter.
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges.*
Chiropractic treatments	
Chiropractic services – by the chiropractors that participate in our ChiroNet network. 20 visits per calendar year are covered for these services without a referral from the Plan physician.	$10 per office visit
Chiropractic appliances are covered up to $50 per calendar year.	All charges above $50 per calendar year

Alternative treatments	**You pay**
Acupuncture – by a doctor of medicine or osteopathy for: pain relief	$10 per office visit
Not covered: • *naturopathic services* • *hypnotherapy* • *biofeedback*	*All charges.*
Educational classes and programs	
Coverage is limited to: • Diabetes self-management • Wellness programs provided by your selected Participating Physician Group • Online Smoking Cessation Program • Smoking Cessation Programs provided by your selected Provider Physician Group • WellChild Pregnancy Online Prenatal Program • Health Quotient personalized health profiling program. Please visit out website at www.healthnet.com for more information.	Nothing

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

I M P O R T A N T

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)

I M P O R T A N T

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity • Insertion of internal prostethic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per office visit, nothing for hospital visit
• Voluntary Sterilization (Female)	$150
• Voluntary Sterilization (Male)	$50

Surgical procedures continued on next page.

Surgical procedures *(Continued)*	**You pay**
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are protruding ear deformities, cleft lip, cleft palate, birth marks, webbed fingers, and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance on the other breast; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) • Note: If you need a mastectomy, you may choose to have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*

Oral and maxillofacial surgery	You pay
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach and pancreas. Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient) Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

Section 5 (c). Services provided by a hospital or other facility, and ambulance services

I M P O R T A N T

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).

I M P O R T A N T

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing

Inpatient hospital continued on next page.

Inpatient hospital *(Continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Conditions for which hospitalization would be covered include hemophilia and heart disease: the need for anesthesia by itself is not such a condition.	Nothing
Not covered: blood and blood derivatives replaced by the member	*All charges*

Extended care benefits/Skilled nursing care facility benefits	**You pay**
Extended care/Skilled nursing facility (SNF): Up to 100 days per calendar year for services such as: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor	Nothing
Not covered: custodial care and personal comfort items such as telephone and television.	*All charges*
Hospice care	
Hospice care: Up to 210 days for services such as: • Inpatient and outpatient care • Family counseling Note: Hospice care services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Local professional ground and air ambulance service when medically appropriate	Nothing

Section 5 (d). Emergency services/accidents

I M P O R T A N T

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

I M P O R T A N T

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. An emergency will also include screening, examination and evaluation by a physician (or other health care professional acting within the scope of his or her license) to determine if a psychiatric medical emergency condition exists and the treatment necessary to relieve or eliminate such condition, within the capability of the facility. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, contact the local emergency system (i.e., the 911 telephone system) or go to the nearest hospital emergency room. Please call your Participating Physician Group. In extreme emergencies, if you are unable to contact your medical group be sure to tell the emergency room personnel that you are a Health Net member so they can notify us at 1-800-522-0088. You or a family member should notify us within 48 hours, unless it was not reasonably possible to do so. It is your responsibility to ensure that we have been notified in a timely manner.

If you need to be hospitalized, we must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify us within that time. If you are hospitalized in a non- Health Net facility and Health Net doctors believe care can be better provided in a participating hospital, you will be transferred when medically feasible with any ambulance charges covered in full. Benefits are available for care from non- Health Net providers in a medical emergency only if delay in reaching a participating provider would result in death, disability or significant jeopardy to your condition.

Any follow-up care recommended by non-Health Net providers must be approved by us or provided by our participating providers.

Emergencies outside our service area: Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness. If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the plan within that time. If a Health Net doctor believes care can be better provided by a participating hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Any follow-up care recommended by non-Health Net providers must be approved by us or provided by our participating providers.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$10 per office visit
• Emergency care at an urgent care center or an emergency room • Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: If the emergency results in admission to a hospital, the copay is waived	$35 per visit
• Emergency care at your participating physician group's urgent care center	$10 per visit
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$35 per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Follow-up care not authorized by your participating physician group.*	*All charges.*
Ambulance	
Professional ground and air ambulance service when medically appropriate. See 5(c) for non-emergency service.	Nothing

Section 5 (e). Mental health and substance abuse benefits

IMPORTANT

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan Provider and contained in a treatment plan approved by Managed Health Network (MHN). The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan approved by Managed Health Network.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per office visit

Mental health and substance abuse – Continued on next page

Mental health and substance abuse benefits *(Continued)*	**You pay**
• Diagnostic tests	Nothing if you receive these services during your office visit; otherwise $10 per visit.
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes. Contact MHN toll-free at 1-888-779-2236 twenty-four hours a day, seven days a week and MHN will direct you to the appropriate provider of care.

Limitation

We may limit your benefits if you do not obtain a treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a deductible.
- Some formulary and non-formulary drugs require prior authorization from us. Contact us at 1-800-522-0088 to find out if your medication requires it and for information on what your physician must do to obtain prior authorization.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

There are important features you should be aware of. These include:

- **Who can write your prescription.** A plan physician or referral physician must write the prescription
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail if a maintenance medication
- **We use a formulary.** A formulary is the approved list of drugs that are covered. It identifies whether a generic version of a brand name drug exists, and if prior authorization is required. Drugs that are not excluded or limited from coverage are also covered and are considered non-formulary drugs. Non-formulary drugs require a higher copayment.

  You can get a copy of the formulary by calling us at 1-800-522-0088 or visit our web site at www.healthnet.com
- **We have an open formulary.** If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from our formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost.

  You can get a copy of the formulary by calling us at 1-800-522-0088 or visit our web site at www.healthnet.com
- **These are the dispensing limitations.**
  - When the prescription drug is filled at a Plan pharmacy: The pharmacy may dispense up to a 30-day supply for each drug or for each refill at the appropriate time interval
  - When the prescription drug is filled through the mail order program, the mail order pharmacy may dispense up to a 90-day supply for each maintenance drug or refill allowed by the prescription order at the appropriate time interval.

    If you send in an order too soon after the last one was filled, you will get a notice from the pharmacy indicating that it is too early to fill the prescription and when the next fill is available.

    Mail order is for the dispensing of chronic medications that your physician has already approved for long term use. Not all drugs are available via mail order, such as

    - Drugs requiring immediate use that the delay in obtaining such drugs would interfere with the physician's treatment plan
    - Drugs requiring detailed instruction which cannot be provided by the mail order pharmacy compared to a retail pharmacist at the time the prescription is filled.

- A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

The prescribed supply may not always be an appropriate drug treatment plan, according to the FDA or our usage guidelines. If this is the case, the amount of medication dispensed may be reduced.

If there is no generic equivalent available, you will still have to pay the brand name copayment.

Some formulary and non-formulary drugs may require prior authorization from us to be covered.

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

- **When you have to file a claim.** In most cases you do not have to file a claim when purchasing drugs at the Plan pharmacy. However, you must pay for the drug when it is dispensed, and file a claim for reimbursement when the following occurs:

  - Your Plan ID card is not available.
  - Eligibility cannot be determined.
  - The prescription drug is dispensed outside of California for a medical emergency.

  For claims questions and assistance, or to request a prescription drug claim form or mail order request form, call us at 1-800-522-0088.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Diabetic supplies, such as blood glucose monitoring strips, Ketone test strips and lancet. • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see limits below) • Contraceptive drugs and devices such as diaphragms and cervical caps	For drugs filled at a Plan pharmacy: • $5 for generic drugs • $10 for brand name drugs • $35 for non-formulary drugs For drugs filled through the mail order program: • $10 for generic drugs • $20 for brand name drugs • $70 for non-formulary drugs Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Limited benefits: • Drugs for sexual dysfunction are limited to 2 doses per week or 8 tablets per month. • Fertility drugs associated with covered services under the diagnosis and treatment of infertility are covered under the Medical Services and Supplies Benefits (see page 19).	50% of charges
Not covered: • *Drugs and supplies for cosmetic purposes* • *Medical supplies such as dressings and antiseptics* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Drugs available without a prescription or for which there is a nonprescription equivalent* • *Drugs to enhance athletic performance* • *Injectable Fertility Drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Anorectics (appetite suppressants), except for treatment of morbid obesity.* • *Non-prescription medications*	*All Charges*

Section 5 (g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-800-474-6515 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired.	Please contact our Telecommunications Device for the Deaf at 1-800-995-0852.
Early Prenatal Program	We encourage our mothers-to-be to participate in our special prenatal health program. **Upon successful completion of the program, participants will receive an infant car seat**. Parents learn answers to their early pregnancy concerns, such as caffeine or alcohol use, tests during pregnancy and other general prenatal information. Please call 1-800-522-0088 for more information.
Centers of Excellence	For organ and tissue transplants, we contract with premier transplant centers of excellence in Northern, Southern and Central California that have established their superior ability to perform certain transplant procedures. Your participating physician group will work with you to find the best center for your condition.

Section 5 (h). Dental benefits

I M P O R T A N T	**Here are some important things to keep in mind about these benefits:** • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • We have no calendar year deductible. • We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below. • Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.	I M P O R T A N T

Accidental injury benefit	You pay
We cover the restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury and treatment must be given within 24 hours of the injury.	Nothing at the dentist's office and a $35 copayment at the emergency room.
Not covered: • *Damage to teeth while chewing food* • *Restorative services of the damaged tooth for cosmetic purposes* • *Follow-up treatment of an accidental injury to sound natural teeth*	*All charges*

Dental benefits
Dental examinations and treatment of the gingival tissues (gums) when performed for the diagnosis or treatment of a tumor.
Not covered: • *Other dental services not shown as covered*

Section 5 (i). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

Optional Dental and Vision Coverage	The Vis-A-Dent product from Health Net subsidiaries DentiCare of California and AVP Vision Plans (DentiCare/AVP) bundles dental and vision coverage together into a plan that provides access to affordable, quality services. The plan offers a choice from two dental plans and combines it with a vision plan tailored to meet the needs of individuals and families. Two coverages, one bill. **Please note: The areas where Vis-A-Dent is offered may not be the same as the Health Net service area. Please call DentiCare/AVP at 1-800-999-2848 for information about their service area information.**
Optional Indemnity Dental Coverage	Standalone dental insurance is available through Health Net subsidiary, Foundation Health Systems Life and Health Insurance Company (FHS L&H). This indemnity dental plan covers a broad range of services and allows you **complete freedom of choice in selecting your dentist**. This plan gives members an attractive combination of coverage, choice, and low cost.
Medicare Prepaid Plan Enrollment	This Plan offers Medicare recipients the opportunity to enroll in the Plan (Health Net Seniority Plus program) through Medicare. Annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join Health Net Seniority Plus but will have to pay for Medicare Part A in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 1-800-935-6565 for information on the Health Net Seniority Plus Medicare prepaid plan and the cost of that enrollment. If you are eligible for Medicare and are interested in enrolling in a Medicare HMO sponsored by Health Net without dropping your enrollment in Health Net's FEHB plan, call 1-800-935-6565 for information on the benefits available under the Medicare HMO.

Section 6. General exclusions -- things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800-522-0088.

When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer -- such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to: **Health Net, P.O. Box 9103**
Van Nuys, CA 91409-9103

Prescription drugs

When you purchase a prescription drug, and your Plan ID card is not available, eligibility cannot be determined, or the prescription is for a medical emergency outside of California, you must pay for the drug when it is dispensed, and file a claim for reimbursement. For claims questions and assistance, or to request a prescription drug claim form call us at 1-800-522-0088.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Health Net, P.O. Box 9103, Van Nuys, CA 91409-9103; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E. Street, NW, Washington, D.C. 20415-3630.

The Disputed Claims process *(Continued)*

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

6 If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-522-0088 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

•What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-State Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

•The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

We will not waive any of our copayments or coinsurance if we are the primary payer. If Medicare is the primary payer, we will waive some copayments or coinsurance when the Plan provider can expect to receive payment amounting to more than any required copayment. (Chart on next page.)

The following chart illustrates whether the **Original Medicare** Plan or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart

A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is… Original Medicare**	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		
2) Are an annuitant,		
3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB, or		
b) The position is not excluded from FEHB (Ask your employing office which of these applies to you.)		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),		
5) Are enrolled in Part B only, regardless of your employment status,	(for Part B services)	(for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	(except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,		
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,		
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or		
b) Are an active employee, or		
c) Are a former spouse of an annuitant, or		
d) Are a former spouse of an active employee		

Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

Claims process when you have the Original Medicare Plan – You probably will never have to file a claim form when you have both our Plan and the Original MedicarePlan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 1-800-522-0088.

We do not waive any costs when you have Medicare.

• Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan -- a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments, coinsurance or deductibles for your FEHB coverage.

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments or coinsurance. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium (OPM does not contribute to your Medicare managed care plan premium). For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care service area.

• If you do not enroll in Medicare Part A or Part B

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

Medicaid

When you have this Plan and Medicaid, we pay first.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 14.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 14.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Custodial care is care provided to assist in meeting the activities of daily living such as help in walking, getting in and out of bed, bathing, feeding, and supervision of medications which are ordinarily self-administered.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 14.

Experimental or investigational services

Experimental or investigational services are services that are not widely accepted or recognized within the organized medical community as standards of care. Our Medical Policy Committee determines what procedures and services are experimental/investigational using published peer review medical and surgical literature. The procedure or service will be evaluated based on its health effects, safety, quality and cost effectiveness. In some cases, we use an independent medical review for expert evaluation and determination of coverage.

Group health coverage

Health coverage provided through a group policy, such as the FEHB program.

Medical necessity

Medical necessity is the criteria used by us and the participating physician group to provide covered services in the prevention, diagnosis, and treatment of your illness or condition. Medically necessary services are determined to be:

- Not experimental or investigational
- Appropriate and necessary for the symptoms, diagnosis, or treatment of a condition, illness, or injury
- Provided for the diagnosis or care and treatment of the condition, illness, or injury
- Not primarily for the convenience of the member, member's physician, or anyone else
- The most appropriate supply or level of service that can safely be provided. For example, outpatient rather than inpatient surgery may be authorized when the setting is safe and adequate.

Determination of whether services or supplies are medically necessary will be made according to procedures we and the participating physician group have established.

Us/We

Us and we refer to Health Net

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you *a Guide to Federal Employees Health Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as temporary continuation of coverage (TCC).

When you lose benefits

•When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

• Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

•Temporary Continuation of coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc..

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

•Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996. (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. LTC insurance can supplement care provided by family members, reducing the burden you place on them.

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. Many people now consider long term care insurance to be vital to their financial and retirement planing.

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8- hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Department of Defense/FEHB Demonstration Project

What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 open season for the year 2000. Open season enrollments will be effective January 1, 2002. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

DoD determines who is eligible to enroll in the FEHB Program. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

The demonstration areas

- Dover AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA

When you can join

You may enroll under the FEHB/DoD Demonstration Project during the 2001 open season, November 12, 2001, through December 10, 2001. Your coverage will begin January 1, 2002. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877/DOD-FEHB (1-877/363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during open season. Your coverage will begin January 1, 2002. If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

Department of Defense/FEHB Demonstration Project continues on next page

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2002 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

Temporary Continuation of coverage (TCC)

See Section 11, FEHB Facts; it explains temporary continuation of coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

Other features

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of benefits for Health Net HMO - 2002

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: $10 (waived for maternity care)	16
Services provided by a hospital: • Inpatient .... • Outpatient........	Nothing Nothing	29 30
Emergency benefits: • In-area .... • Out-of-area........	$35 per visit (waived if admitted to hospital) $35 per visit (waived if admitted to hospital)	32 32
Mental health and substance abuse treatment	Regular cost sharing	34
Prescription drugs........	$5 copay for a 30 day supply of formulary generic drugs - $10 for a 90 day supply through mail order. $10 copay for a 30 day supply of formulary name brand drugs - $20 copay for a 90 day supply through mail order. $35 copay for a 30 day supply of non-formulary drugs - $70 for a 90 day supply through mail order	36
Dental Care........	Accidental injury benefit; nothing at the dentist's office or a $35 copay at the emergency room.	40
Vision Care........	$10 per visit; One refraction annually.	18
Special features: Early Bird Prenatal Program, Case Management Services, 24 hour nurse line to answer your health questions, Telecommunications Device for the Deaf, Centers of Excellence		39
Protection against catastrophic costs (your out-of-pocket maximum)........	Nothing after $1,500/Self Only or $4,500/Family enrollment per year Some costs do not count toward this protection	14

NOTES:

2002 Rate Information for
Health Net

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to an FEHB Guide or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career U.S. Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Diferent postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	Gov't Share	Your Share
Self Only	**LB1**	$86.28	$28.76	$186.94	$62.31	$102.10	$12.94
Self and Family	**LB2**	$204.25	$68.08	$442.54	$147.51	$241.69	$30.64