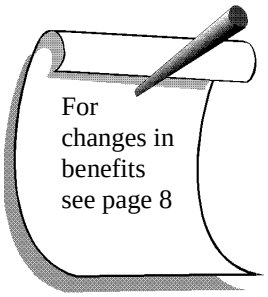
Health Net of Arizona, Inc.

Formerly Intergroup of Arizona
http://www.health.net

Health Net®

2002

A Health Maintenance Organization



Serving: Cochise, Coconino, Gila, Maricopa, Pima, Pinal and Santa Cruz counties

Enrollment in this Plan is limited; see page 7 for requirements.

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

Enrollment codes for this Plan:

A71 Self Only
A72 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

FEHB
Federal Employees
Health Benefits Program

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Introduction

Health Net of Arizona, Inc., 930 North Finance Center Drive, Tucson, Arizona 85710-1362

This brochure describes the benefits of Health Net of Arizona, Inc. HMO under our contract CS2121 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 are summarized on page 8. 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 of Arizona, Inc.
- 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 us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov.

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 1-800-289-2818 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

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

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 has been in existence since 1981
- Health Net is a for-profit organization

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you want more information about us, call 1-800-289-2818, or write to Health Net of Arizona, Inc., ATTN: Member Inquiry, 930 North Finance Center Drive, Tucson, Arizona 85710-1362. You may also contact us by fax at 1-520-258-5176 or visit our website at www.health.net.

Who provides my health care?

There are multiple locations throughout Maricopa County, Pima County, Cochise County, Coconino County, Gila County, Pinal County and Santa Cruz County serving Health Net members. When you enroll, you must select a primary care physician (PCP) for yourself and eligible family members. Each member may choose a different primary care physician. Health Net of Arizona sometimes contracts with Medical Groups to provide medical care. In these cases, the Medical Group determines the group of specialist(s) and hospital(s) that are available.

The first and most important decision each member must make is the selection of a primary care physician. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care physician to obtain any necessary authorizations from the plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when there has been a referral by the member's primary care physician with the following exceptions: a woman may see her plan obstetrician/gynecologist without a referral and a member who is diabetic may see a plan ophthalmologist for an annual eye examination to detect eye disease without a referral

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: Cochise, Coconino, Gila, Maricopa, Pima, Pinal and Santa Cruz counties.

You may also enroll with us if you live or work in the following places: the Tucson, Phoenix, Sierra Vista, Flagstaff, Casa Grande and Nogales City areas.

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. We will not pay for any other health care services unless the services have prior plan approval.

If you or a covered family member move 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

Program-wide changes

- We removed the requirement that services must be needed to restore functional speech from the speech therapy benefit

Changes to this Plan

- Your share of the non-Postal premium will increase by 21.1 % for Self Only or 39.5 % for Self and Family.
- The out of pocket maximums will change to $2,000 for self only or $4,000 for family enrollment per year. Previously, the out of pocket maximums were equal to 200% of your yearly premium.
- You will pay $100 per admission for inpatient hospital visits to Plan hospitals in 2002. Previously, you paid $0 for inpatient hospital admissions.
- You will pay $50 per visit for outpatient hospital services to Plan hospitals in 2002. Previously, you paid $0 for outpatient hospital services.
- You will pay $10 for generic, $20 for preferred brand name and $40 for non-preferred brand name medications in 2002. Previously, you paid $5 for generic and $10 for brand name medications.
- You will pay two times the preferred brand name ($40) for self-injectable drugs (excluding insulin) with prior approval from the Plan in 2002. Previously, you paid the brand name copay with prior approval from the Plan.
- We will cover up to 60 visits per year for speech therapy in 2002. Previously, we provided speech therapy as rehabilitative treatment up to two months per condition.
- We now cover certain intestinal transplants (section 5(b)).

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 obtain 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 1-800-289-2818.

Where you get covered care

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

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

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

- **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 website.

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. This decision is important since your primary care physician provides or arranges for most of your health care. You can find a primary care physician by looking in the provider directory, visiting our website, or calling us at 1-800-289-2818

- **Primary care**

Your primary care physician can be a Family Practice, General Practice, Internal Medicine, or Pediatrics physician. 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. However, you may see a plan obstetrician/gynecologist and diabetic members may see a plan opthamologist for an annual eye examination to detect eye disease 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 work with the specialist and/or the plan to 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 (the physician may have to get an authorization or approval beforehand).

- 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.

- **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 1-800-289-2818. 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.

We call this review and approval process prior authorization. Your physician must obtain prior authorization for services such as: hospital stays, some surgeries, home health care and organ transplants.

When your primary care physician feels that you may need such a service, he or she will submit a request for an authorization.

Authorization Made Easy Program

Because we want your healthcare to be easy and convenient, we have developed an Authorization Made Easy Program. Primary care physician's who are part of this program can give you a direct written referral or authorization. This allows you to see certain specialists or get certain tests, ***without any prior approval***. This could include an initial consultation or evaluation, diagnostic tests and same day treatment.

If the specialist you need to see or the test or procedure you need done is not eligible for an Authorization Made Easy referral or authorization, as described above, the following process will occur:

- Your primary care physician will submit the request to Health Net. Once we receive the request, our medical staff will review it. They review the treatment plan, covered benefits, medical history and national treatment standards.
- If a request is denied, it will automatically proceed to one of our doctors for review. He or she will either support the decision for denial or approve the care requested.
- If the case or treatment is complex, we may ask for an outside review from non-Health Net doctors who are experts in the field of care requested. If these doctors recommend the care, it will be approved.
- If a case involves new medical technology, our doctors may review current medical literature and/or consult with medical experts. Our doctors will use this information to decide if the care requested is appropriate.

Remember, your primary care physician must coordinate your medical care. If you need specialty care, your primary care physician will determine the most appropriate specialist, based on your medical condition. If you go to a specialist, or receive a service without prior authorization (except for emergencies, OB/GYN visits, and diabetic members may see a plan opthamologist for an annual eye exam), the services you receive will not be covered by your Health Net health plan.

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 when you receive services. Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay $100 per admission.
• **Deductible**	We do not have a deductible
• **Coinsurance**	We do not have coinsurance.

Your out-of-pocket maximum for deductibles, coinsurance, and copayments

After your copayments total $2,000.00 per person or $4,000.00 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
- infertility services

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

Section 5. Benefits – OVERVIEW

(See page 8 for how our benefits changed this year and page 56 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 1-800-289-2818 or at our website at www.health.net.

(a) Medical services and supplies provided by physicians and other health care professionals 14-23

- Diagnostic and treatment services
- Lab, X-ray, and other diagnostic tests
- Preventive care, adult
- Preventive care, children
- Maternity care
- Family planning
- Infertility services
- Allergy care
- Treatment therapies
- Physical and Occupational therapies
- Speech therapy
- Hearing services (testing, treatment, and supplies)
- Vision services (testing, treatment, and supplies)
- Foot care
- Orthopedic and prosthetic devices
- Durable medical equipment (DME)
- Home health services
- Chiropractic
- Alternative treatments
- Educational classes and programs

(b) Surgical and anesthesia services provided by physicians and other health care professionals 24-27

- Surgical procedures
- Reconstructive surgery
- Oral and maxillofacial surgery
- Organ/tissue transplants
- Anesthesia

(c) Services provided by a hospital or other facility, and ambulance services 28-30

- Inpatient hospital
- Outpatient hospital or ambulatory surgical center
- Extended care benefits/skilled nursing care facility benefits
- Hospice care
- Ambulance

(d) Emergency services/accidents 31-32

- Medical emergency
- Ambulance

(e) Mental health and substance abuse benefits 33-34

(f) Prescription drug benefits 35-37

(g) Special features 38

- Flexible benefits option
- Services for deaf and hearing impaired
- Disease Management Services

(h) Dental benefits 39

(i) Non-FEHB benefits available to Plan members 40

Summary of benefits 56

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

IMPORTANT

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.
- 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

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinions	$10 per visit
• In an urgent care center	$25 per visit
• During a hospital stay • In a skilled nursing facility	Nothing
At home	$10 per visit

Diagnostic and treatment services -- Continued on next page

Diagnostic and treatment services *(Continued)*	**You pay**
Not covered: hearing exams to determine extent of hearing loss, if you are over age 18	*All charges*
Lab, X-ray and other diagnostic tests	
Laboratory tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	If you receive these services during your office visit, only your $10 office visit copay will apply. If you receive these services at an outpatient hospital setting, a $50 copay per visit will apply.
Preventive care, adult	
Routine screenings, such as: • Total Blood Cholesterol – periodic depending on risk factors • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy, screening – every three to five years starting at age 50 Prostate Specific Antigen (PSA test) – testing as determined by physician Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment*, above.	$10 per visit

Preventive care, adult *(Continued)*	**You pay**
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 49, one every one or two years • At age 50 and older, one every year • Other screenings as requested by the Primary Care Physician	Nothing
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, ages 19 and over (except as provided for under Childhood immunizations)	$10 per visit
• Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing when performed by non-physician personnel or an affiliated flu shot clinic sponsored by your primary care physician or Health Net
Preventive care, children	**You pay**
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per visit
• Examinations, such as: - Eye exams through age 17 to determine the need for vision correction. - Ear exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (through age 22) • Well-child care charges for routine examinations, immunizations and care (up to age 22)	$10 per visit

Maternity care	You pay
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 10 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).	$10 per visit, nothing for prenatal and postnatal care after the initial diagnosis of pregnancy
Not covered: Sonograms, amniocenteses, ultrasound or any other procedure to determine fetal age, size or sex; non-medically necessary circumcision after the newborn period.	*All charges*
Family planning	
• Voluntary sterilization	$10 per visit in a physician's office; nothing in inpatient or outpatient hospital
• Surgically implanted contraceptives	50% of all services, limited to one implant in any 3 consecutive year period
• Elective removal of surgically implanted contraceptives	Nothing, limited to one non-medically necessary removal in any 3 consecutive year period
• Injectable contraceptive drugs • Intrauterine devices (IUDs) • Diaphragms	$10 per visit
• Elective removal of Intrauterine devices (IUDs)	$10 per visit, limited to one non-medically necessary removal in any 3 consecutive year period
Not covered: reversal of voluntary surgical sterilization, genetic counseling , diagnostic testing to establish paternity of a child, and genetic testing	*All charges*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: - *intravaginal insemination (IVI)* - *intracervical insemination (ICI)* - *intrauterine insemination (IUI)*	50% of all covered services
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm or sperm banking* • *Fertility drugs*	*All charges*
Allergy care	
Testing and treatment	$10 per visit
Allergy injection	$10 per visit; nothing if performed by non-physician personnel
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization, skin titration (Rinkel Method), cytotoxicity testing (Bryans Test), RAST testing, MAST testing, urine autoinjection	*All charges*
Treatment therapies	**You pay**
• 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 27. • Respiratory and inhalation therapy • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: – We will only cover GHT when we preauthorize the treatment. Call 1-800-863-7847 for preauthorization information. We will ask you or your doctor to submit information that establishes that the GHT is medically necessary. You or your doctor must ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you or your doctor does not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$10 per visit in provider office or $50 per visit if provided in outpatient hospital setting.

• Dialysis – Hemodialysis and peritoneal dialysis	$10 per visit
Not covered: Experimental, investigational or alternative therapies.	*All charges*
Physical and occupational therapies	
• Up to two consecutive months per condition, for the services of each of the following: — qualified physical therapists and — 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. • We provide cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, for two consecutive months per condition.	$10 per visit in provider's office or $50 per visit in outpatient hospital setting.
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Therapies provided for the purpose of maintaining physical condition*	*All charges*

Speech therapy	You pay
• 60 visits per year	$10 per visit in provider's office or $50 per visit in outpatient hospital setting.
Hearing services (testing, treatment, and supplies)	
• Hearing screening to determine hearing loss and/or to treat a suspected disease or injury to the ear • Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per visit
Not covered: • *All other hearing testing, including hearing exams to determine the extent of hearing loss if you are over age 18* • *Hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• The first pair of contact lenses or corrective lenses following cataract surgery, treatment of keratoconus, aphakia, or corneal transplantation, including a frame allowance of up to $75	$10 per visit
• Eye exam to determine the need for vision correction for children through age 17 (see preventive care) • Lenses and/or frames once every 24 months	$10 per visit
• Annual eye examination for refraction	Nothing
• Elective contact lenses once every 24 months Note: annual eye examination for refraction, lenses and/or frames and elective contact lenses benefits are administered by IVS. Call 800-443-4994 x410	You pay any amount over the $100 allowance we provide toward the cost of contact lenses, evaluation and fitting
Not covered: • *Eye exercises, orthoptics and any other vision training* • *Radial keratotomy, lasik and any other refractive surgery*	*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 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 charge*

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes, including the initial purchase and subsequent purchases due to physical growth. Coverage is limited to limbs that are necessary because of an illness, injury or surgery causing anatomical functional impairment, or from a congenital defect. • Prosthetic devices when determined to be medically necessary and result from an illness, injury or surgery causing anatomical functional impairment, or from a congenital defect. Coverage includes the fitting and purchase of a standard model. Replacement is covered only if determined to be medically necessary and results from a change in your physical condition. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy. • 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* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Repairs and/or replacement of parts or devices worn out due to misuse or abuse* • *Model upgrades, deluxe, or specialized equipment* • *Over-the-counter items*	*All charges*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Manual hospital beds • Standard size manual wheelchairs • Crutches, canes • Walkers • Plan approved standard blood glucose monitors • Insulin pumps • Plan approved peak flow meters • Medical supplies determined by Health Net to be medically necessary to operate and/or maintain a covered prosthesis or item of Durable Medical Equipment, subject to the following exclusions and limitations	Nothing
Not covered: • *Motorized, electric or specialized wheel chairs* • *Scooters or other power operated vehicles* • *More than one device to provide essentially the same functional assistance* • *Deluxe, specialized or customized equipment, model upgrades* • *Transcutaneous Electrical Nerve Stimulation (TENS) units* • *Repair or replacement of equipment or parts due to misuse and/or abuse* • *Over-the-counter braces and other DME devices, except as listed above* • *Prophylactic braces* • *Braces used primarily for sports activities* • *Foot orthotics which are not an integral part of a leg brace*	*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 who is part of a Health Net contracted Home Health Care Agency. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
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;* • *Housekeeping services;* • *Services of a person who resides in the patient's home* • *Custodial care, rest cures, respite care* • *Services performed by the patient's family member*	*All charges*

Chiropractic	You pay
• Up to 12 visits per year for manipulation of the spine and extremities Note: We cover adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application.	$10 per visit
Alternative treatments	
No benefit for services such as: • *Naturopathic services* • *Hypnotherapy* • *Acupuncture services* • *Acupressure services* • *Behavior training* • *Educational, recreational, art, dance, sex, sleep or music therapies* • *Other forms of holistic treatment or alternative therapies*	*All charges*
Educational classes and programs	
Coverage is limited to classes offered by or through Health Net's Health Education department. Recent classes and seminars include: • Smoking Cessation • Diabetes self-management • Stress management • Parenting • Health nutrition • Congestive heart failure counseling • Lamaze • Weight management	Nothing A nominal fee may be required for classroom materials

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

IMPORTANT

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.
- 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 charge (i.e. hospital, surgical center, etc.).

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information.	$10 per office visit, $50 per outpatient hospital visit, or $100 per hospital admission.

Surgical procedures continued on next page.

Surgical procedures *(Continued)*	**You pay**
• Voluntary sterilization • Treatment of burns	$10 per office visit, $50 per outpatient hospital visit, or $100 per hospital admission.
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.	$10 per office visit, $50 per outpatient hospital visit, or $100 per hospital admission.
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 or manipulation of fractures of the jaws or facial bones and supporting tissues; • 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.	$10 per office visit, $50 per outpatient hospital visit, or $100 per hospital admission.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Routine or general care of teeth or dental structures* • *Extraction of impacted or abscessed teeth* • *Dental splints, dental implants, dental prostheses or dentures* • *Accidental injury to the teeth or gums caused by chewing*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogenic (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. • Donor searches limited to $5,000 per organ per lifetime 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.	$10 per office visit, $50 per outpatient hospital visit, or $100 per hospital admission.
Not covered: • *Donor screening tests and donor search expenses which exceed the maximum lifetime benefit* • *Implants of artificial or non-human organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	Nothing
• Office	Nothing

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

IMPORTANT

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.
- 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 Section 5(a) or (b).

IMPORTANT

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.	$100 per admission

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	$100 per admission
Not covered: • *Custodial care* • *Non-covered facilities* • *Personal comfort or convenience items, such as telephone, television, barber services, guest meals and beds, travel expenses and take-home supplies* • *Private nursing care* • *Collection and/or storage of blood products for any unscheduled or non-covered medical procedure*	*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.	$50 per visit
Not covered: collection and/or storage of blood products for any unscheduled or non-covered medical procedure	*All charges*

Extended care benefits/skilled nursing care facility benefits	You pay
Skilled nursing facility (SNF): Coverage is provided when full-time skilled nursing care is medically necessary and confinement in a SNF is medically appropriate as determined by a plan doctor and approved by Health Net. Covered services include: • Bed, board and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the SNF when prescribed by a plan doctor.	Nothing
Not covered: custodial care, domiciliary care or convalescent care	*All charges*
Hospice care	
Members who are diagnosed as having an illness giving them a life expectancy of 6 months or less may request Hospice care. All Hospice care must be provided by a licensed participating Hospice and include inpatient and outpatient care related to the condition	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate • Air ambulance when prior authorized or if the member's condition is an emergency and the location of the accidental injury and/or illness is inaccessible by ground vehicles or transport by ground ambulance would be detrimental to the member's health	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

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.
- 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

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. 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:

If you are faced with a medical emergency, call 911 or go to the nearest emergency room.

Please notify your primary care physician within 48 hours following emergency services, or as soon as reasonably possible.

Emergency services do not include the use of a hospital emergency room or other emergency medical facility for routine medical care, or follow-up or continuing care unless prior authorization has been given by your primary care physician or Health Net.

Emergencies within our service area: : call 911 or go to the nearest emergency room

Emergencies outside our service area: : call 911 or go to the nearest emergency room

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$10 per visit
• Emergency care at an urgent care center	$25 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 per visit (waived if admitted; $100 inpatient hospital copayment will apply).
Not covered: Elective care or non-emergency care, continuing, routine or follow-up care without prior authorization	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office	$10 per visit
• Emergency care at an urgent care center	$25 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 per visit (waived if admitted; $100 inpatient hospital copayment will apply).
Not covered: • *Elective care or non-emergency care,* • *Continuing, routine or follow-up care without prior authorization* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
Professional ambulance service when medically appropriate and in an emergency situation. Air ambulance when prior authorized or if the member's condition is an emergency and the location of the accidental injury and/or illness is inaccessible by ground vehicles or transport by ground ambulance would be detrimental to the member's health 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 FOR INPATIENT 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 that we approve. 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 that we approve.	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 visit
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as a half-way house, residential treatment, or full-day hospitalization.	$100 per admission
• Services in approved alternative care settings such as partial hospitalization or facility based intensive outpatient treatment	$50 per admission

Mental health and substance abuse benefits	You pay
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 mental health and substance abuse benefits you must obtain a treatment plan and follow all of the following authorization processes. These include:

To access Mental Health and/or Substance Abuse benefits, you must contact Catalina Behavioral Health Services at 1-800-977-0281. Services are covered as necessary for the diagnosis and treatment of acute conditions and as outlined above.

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.
- 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 licensed physician must write the prescription
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, or by mail for a maintenance medication
- **We use a Formulary (Preferred Drug List).** Drugs are prescribed by Plan doctors in accordance with the Plan's Preferred Drug List. Generic drugs are available at the lowest copayment level. Preferred brand name drugs are available for a slightly higher copayment. Unless otherwise excluded, other FDA-approved brand name drugs are available at the highest copayment level.

  To order a Preferred Drug List call 1-800-289-2818 or visit our website at www.health.net.
- **These are the dispensing limitations.** Prescription drugs obtained at a plan pharmacy will be dispensed for up to a 31-day supply. Mail order prescriptions are limited to Health Net's mail order provider and will be dispensed for up to a 93-day supply. Some medications may be dispensed in quantities less than those stated due to prepackaging by the pharmaceutical manufacturer. Insulin, diabetic supplies and inhalers have quantity per copayment limitations, as stated below. Refills are only covered when authorized by a plan physician. You will be financially liable for the cost of medications obtained after you are no longer eligible for coverage under this plan.
- **Why use generic drugs.** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you – and us – less than a name brand prescription.
- **When you have to file a claim.** If you are required to pay for a prescription in an out-of-area emergency situation, you must submit an itemized statement to Health Net for the charges you paid, along with a completed claim form. Claims forms can be obtained by calling Health Net at 1-800-289-2818. Proof of payment must accompany the request for reimbursement.

  Claims should be addressed to:
  Health Net of Arizona, Inc.
  Attn: Pharmacy Department
  930 N. Finance Center Drive
  Tucson, Arizona 85710-1362

Prescription drug benefits begin on the next page.

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 for which a prescription is required by Federal law • Drugs for sexual dysfunction require prior authorization and have dispensing limitations. Contact plan for details. • Oral contraceptive drugs and contraceptive diaphragms • Insulin – limited to 2 vials per copayment • Disposable needles and syringes for the administration of covered medications – limited to 100 per copayment • Diabetic supplies, including lancets, glucose test strips, visual reading testing strips, and urine testing strips – limited to 100 per copayment • Insulin cartridges for the legally blind – limited to the equivalent of 2 vials of insulin per copayment • Automatic lancing devices – limited to one every six months per copayment • Insulin aids (insulin pen) – limited to one every six months per copayment • Glucogon (requires prior authorization) – limited to one per copayment • Spacers and holding chambers for inhaled medications – limited to one per six months per copayment • Inhalers – up to 2 (nasal or oral), or up to a 31-day supply, whichever is less, per copayment	$10 per generic prescription or refill obtained from a plan pharmacy $20 per preferred brand name prescription or refill obtained from a plan pharmacy $40 per non-preferred brand name prescription or refill obtained from a plan pharmacy $30 per generic prescription or refill obtained through our mail order program $60 per preferred brand name prescription or refill obtained through our mail order program $120 per non-preferred brand name prescription or refill obtained from a plan pharmacy

Covered medications and supplies *(continued)*	**You pay**
• Self-injectable drugs require prior authorization. (brand name copayment applies to insulin)	$40 per prescription or refill, up to a 31-day supply. Quantity limitations may apply to specific drugs.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Nonprescription medicine* • *Drugs obtained at a non-plan pharmacy, except for out-of-area emergencies* • *Anorexiants, appetite suppressants, diet aids, weight loss medication, and drugs used to treat obesity* • *Fertility drugs* • *Vitamins (except prenatal)* • *Drugs to enhance athletic performance* • *Any drug consumed at the place where it is dispensed or that is dispensed or administered by the physician* • *Drugs prescribed for non-covered services* • *Take home drugs; drugs prescribed for use after discharge from a hospital, nursing home, skilled nursing facility or other inpatient facility must be obtained from a plan pharmacy* • *Replacement prescriptions*	*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.
Services for deaf and hearing impaired	We provide a TTY line for the deaf and hearing impaired 1-800-977-6757.
Disease Management Services	We help our members and the community learn how to stay healthy and how to manage chronic conditions. Health Net offers AsthmaWise Education and Management, Senior Outreach Programs, Diabetes Management, Depression Management, Maternity Care, Congestive Heart Failure Management, Migraine Management, Secondary Prevention Following A Heart Attack, and Smoking Cessation Programs.

Section 5 (h). Dental benefits

IMPORTANT

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 dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a nondental 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.

IMPORTANT

Accidental injury benefit	You Pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth, the jawbone and supporting tissues (does not include injury caused by the act of chewing). The need for these services must result from an accidental injury.	Nothing

Dental benefits

We have no other dental benefits.

Section 5 (j). 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.

Health Net has added the WellRewards Program – a discount program offered to all Health Net members. Health Net has been able to negotiate reduced prices and excellent values on a number of products and services, including:

- Acupuncture
- Cosmetic surgery
- Health club discounts
- Home care management
- Lasik & PRK surgery
- Podiatry
- Safety
- Vitamins, herbs and supplements
- Chiropractic
- Eye exams/eyewear
- Hearing aids
- Home medical equipment/supplies
- Massage therapy
- Pregnancy & childbirth
- Sleep improvement (mattresses)
- Weight Watchers

If you would like more information regarding WellRewards, please contact our Customer Service department at 1-800-289-2818, or TTY 1-800-977-6757 for the hearing impaired, Monday through Friday from 7 a.m. to 6 p.m., excluding holidays.

Direct Information Automated Line (D.I.A.L.) is available 24 hours a day, 7 days a week for you to access information about your account. If you do not have a personal identification number (P.I.N.), please contact Customer Service.

Personal Health Advisor is available to members 24 hours a day, 7 days a week to speak directly with a registered nurse or obtain recorded health information whenever you have a question.

An Indemnity dental plan is now available to all eligible members. This insurance plan helps you cover the costs of dental care. Covered dental services include exams, cleanings, fillings and extractions as well as crowns, bridges, and dentures. This plan reimburses you for covered dental expenses based upon a percentage of the reasonable and customary (R & C) fee for those covered expenses. This plan allows you to select your own dentist and it is affordable for you and your family. Premiums may be paid monthly (automatic deduction from your checking account) or on either a quarterly or semi-annual basis.

Medicare Prepaid Plan Enrollment
This Plan offers Medicare recipients the opportunity to enroll in the plan through Medicare. As indicated on page 44, 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 re-enroll in the FEHB Program. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 1-800-289-2818 for information on the Medicare prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored in this Plan without dropping your enrollment in this Plan's FEHB plan, call the numbers above 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** and we agree, as discussed under *What Services Require Our Prior Approval* on page 11.

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, coinsurance, or deductible.

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 1-800-289-2818.

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 of Arizona, Inc.
Attn: Claims Department
930 N. Finance Center Drive
Tucson, Arizona 85710-1362

Prescription drugs

Follow the process as stated above, but send your request for reimbursement to the following address.

Submit your claims to:

Health Net of Arizona, Inc.
Attn: Pharmacy Department
930 N. Finance Center Drive
Tucson, Arizona 85710-1362

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 of Arizona, Inc. Attn: Member Inquiry Department 930 N. Finance Center Drive Tucson, Arizona 85710-1362; 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, DC 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 third 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 1-800-289-2818 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 202/606-0755 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-Stage 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 January 1, 1983, automatically qualifies) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for 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 The Original Medicare Plan 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 the Original Medicare Plan along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PRIMARY CARE PHYSICIAN and prior authorized as required.

We will not waive any of our copayments, coinsurance, or deductibles.
(Primary payer chart begins on next page.)

The following chart illustrates whether Original Medicare 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	✓	
b) Or, 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…		
a) Are eligible for Medicare based on disability, and are an annuitant	✓	
b) Are an active employee		✓
c) Are a former spouse of an annuitant	✓	
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 Medicare Plan.

- 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 1-800-289-2818.

When Medicare is the primary payer, we do not waive any out-of-pocket costs.

• Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from 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 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, coinsurance, or deductibles. 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+Choice service area.

• Enrollment in Medicare Part B

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

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 eligible 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.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.

Covered services

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

Custodial care

Room and board, nursing care (except for skilled nursing care), and personal care designed to assist a member who has reached the maximum level of recovery

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 12.

Experimental or investigational services

Our parent company, Health Net, Inc. (HNI), has a technology assessment policy committee whose sole function is to evaluate if a drug, device, medical treatment or procedure is experimental or investigational. HNI bases its determination on one or more of the following:

- Is it broadly accepted in the medical community as standard, safe and effective for the illness or injury being treated;
- Is it approved for use by the appropriate governmental regulatory bodies, including the FDA:
- It is attainable in the U.S. outside of a research institution, program or protocol;
- Does it clearly improve the net health outcome as evaluated against non-experimental or non-investigational health care services using credible and accepted medical evidence.

Group Health Coverage

Health care coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies.

Medical necessity

Services required to identify or treat an illness that is either diagnosed or reasonably suspected. Medically Necessary services must, in the judgement of Health Net:

1. be required to treat an illness or injury; and
2. be consistent and appropriate for the diagnosis and treatment of the Member's conditions; and
3. be in accordance with the standards of accepted principles of medical practice in the United States; and
4. be performed at the most appropriate level of care for the Member as determined by the Member's medical condition and not the Member's financial or family situations, or the distance the Member lives from the Hospital, or any other non-medical factor; and
5. not be for the convenience of the Member, nor the Member's family, support network, Physician or another Health Professional; and
6. not be Experimental, Unproved or Investigational or furnished in connection with medical or other research.

Us/We

Us and we refer to Health Net of Arizona, Inc.

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.

- **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.

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

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.

- **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 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 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 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. It 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. {RV: 7-26}*

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.

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Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

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Summary of Benefits – for Health Net of Arizona 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 primary care; $10 specialist	14
Services provided by a hospital: • Inpatient • Outpatient	$100 per admission $50 per visit	28 29
Emergency benefits: • In-area • Out-of-area	$50 per visit $50 per visit	31 32
• Mental health and substance abuse treatment	Regular cost sharing.	33
Prescription drugs	Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. You pay a $10 copay per generic prescription unit or refill; $20 copay per preferred brand name prescription unit or refill; $40 copay per non-preferred brand name prescription unit or refill; $40 copay per self-injectable (except for insulin) prescription unit or refill.	35
Dental Care	Accidental injury benefit. You pay nothing.	39

Vision Care	Comprehensive examination once every 12 months – you pay nothing Lenses and/or frames once every 24 months – you pay $10 copay for materials Elective contact lenses once every 24 months - $100 allowance provided toward cost of contacts, evaluation and fitting	20
Special features: Flexible benefits option, services for deaf and hearing impaired, Disease Management Services		38
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $2,000.00/Self Only or $4,000.00/Family enrollment per year Some costs do not count toward this protection	12

Notes

Notes

2002 Rate Information for
Health Net of Arizona, Inc.

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses, 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 who are not career postal employees. 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	USPS Share	Your Share
Self Only	A71	$87.21	$29.07	$188.96	$62.98	$103.20	$13.08
Self and Family	A72	$223.41	$90.35	$484.06	$195.75	$263.75	$50.01