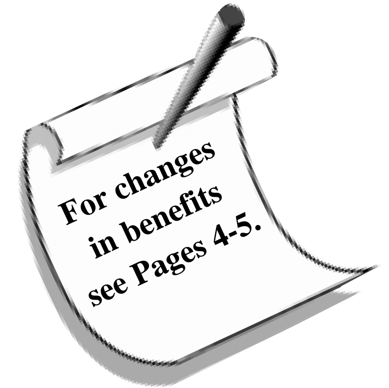
HEALTH NET® California's Health Plan

Health Net 2000

A Health Maintenance Organization



Serving: Most of California

Enrollment in this plan is limited; see page 5 for requirements.

Enrollment Code: **LB1 Self Only**
LB2 Self and Family

Visit the OPM web site at http://www.opm.gov/insure
and Health Net's web site at http://www.healthnet.com

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Table of Contents

	Page
Introduction	2
Plain language	2
How to use this brochure	3
Section 1. Health Maintenance Organizations	4
Section 2. How we change for 2000	4
Section 3. How to get benefits	5
Section 4. What to do if we deny your claim or request for service	10
Section 5. Benefits	13
Section 6. General exclusions – Things we don’t cover	24
Section 7. Limitations – Rules that affect your benefits	24
Section 8. FEHB facts	26
Department of Defense/FEHB Demonstration Project	30
Inspector General Advisory: Stop Healthcare Fraud!	31
Summary of benefits	32
Premiums	34

Introduction

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

This brochure describes the benefits you can receive from Health Net HMO under its contract (CS2002) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on pages 4–5. Premiums are listed at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to Health Net HMO as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How to use this brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. **Health Maintenance Organizations (HMO).** This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.

2. **How we change for 2000.** If you are a current member and want to see how we have changed, read this section.

3. **How to get benefits.** Make sure you read this section; it tells you how to get services and how we operate.

4. **What to do if we deny your claim or request for service.** This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.

5. **Benefits.** Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.

6. **General exclusions – Things we don't cover.** Look here to see benefits that we will not provide.

7. **Limitations – Rules that affect your benefits.** This section describes limits that can affect your benefits.

8. **FEHB facts.** Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventative care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure. When you receive emergency services 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. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How we change for 2000

Program-wide changes

To keep your premium as low as possible OPM has set a minimum copay of $10 for all primary care office visits.

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program. (See Section 3, How to get benefits, for more information).

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 are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

- Your share of the premium will increase by 1.7% for Self Only or for Self and Family.
- The office visit copay has increased from $5 per visit to $10 per visit.
- There will be no office visit copay required for routine immunizations and boosters and allergy testing and treatment, including allergy serum.
- Unlimited self-referrals are allowed for Obstetrician and Gynecological services. (See page 9)
- After the first 48 hours, the length of hospital stays related to mastectomies will be determined solely by the physician. (See page 14)
- The prescription drug copays have increased from $5 per prescription and $10 per mail order for a 90-day supply, to $5 per prescription for generic drugs listed on the Plan's formulary, $10 per name brand drugs listed on the Plan's formulary, $25 per non-formulary drugs, and $10 per generic and $20 per name brand mail order drugs for a 90-day supply. Non-formulary mail order drugs are covered with a $50 copay per 90 day supply. Some non-formulary drugs may require prior authorization from the Plan. (See page 20)
- Diabetic supplies have increased to include test strips and lancets under the prescription drug benefit. (See page 20)
- Benefits have been clarified for immunizations for occupational purposes to indicate that you pay 20% of charges. (See page 13)

Section 3. How to get benefits

What is this Plan's service area?

To enroll with us, you must live or work in our Health Net service area. This is where our providers practice. Our service area is:

Full counties: Alameda, Butte, Colusa, Contra Costa, Glenn, Humboldt, Kings, Lake, Los Angeles, Madera, Marin, Mariposa, Merced, Napa, Orange, Sacramento, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Sierra, Solano, Sutter, Ventura, Yolo, and Yuba counties.
Partial counties: El Dorado, Fresno, Imperial, Kern, Mendocino, Nevada, Placer, Plumas, Riverside, San Bernardino, San Joaquin, Sonoma, Stanislaus, Tehama, Trinity and Tulare counties. The following ZIP codes are those included in these partial counties:

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

FRESNO				
93210	93624-25	93660	93724-29	93771-80
93234	93627-28	93662	93740-41	93782
93242	93630	93664	93744-45	93784
93602	93634	93667-68	93747	93786
93605-09	93640-41	93675	93750	93790-94
93611-13	93648-52	93701-12	93755	
93616	93654	93714-18	93759-62	
93621-22	93656-57	93720-22	93764-65	

IMPERIAL

92274-75

KERN

93203	93238	93276	93311-13	93518-19
93205-06	93240-41	93280	93380-90	93523-24
93215-17	93249-52	93283	93399	93531
93220	93255	93285	93501-02	93560-61
93222	93263	93287	93504-05	93581-82
93224-26	93268	93301-09	93516	93596

MENDOCINO

95415	95445	95449	95463	95482

NEVADA

95712	95945-46	95959	95977
95924	93949	95975	

PLACER

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

PLUMAS

95981	96105-06	96129
96103	96122	96135

RIVERSIDE

91718-20	92240-41	92501-09	92561-64
91752	92253-55	92513-19	92567
91760	92258	92521-22	92570-72
92201-03	92260-64	92530-32	92581-87
92210-11	92270	92536	92589-93
92220	92276	92539	92595-96
92223	92282	92543-46	92860
92230	92292	92548-49	92880
92234-36	92320	92551-57	92882

SAN BERNARDINO

91701	91798	92321-22	92356-59	92410-16
91708-10	92252	92324-27	92365	92418
91729-30	92256	92329	92368-69	92420
91737	92268	92333-37	92371-78	92423-24
91739	92277-78	92339-42	92382	92427
91743	92284-86	92345-47	92385-86	
91758-59	92301	92350	92391-94	
91761-64	92305	92352	92397-99	
91784-86	92307-18	92354	92401-08	

SAN JOAQUIN

95201-13	95231	95253	95304	95366
95215	95234	95258	95320	95376
95219-20	95236-37	95267	95330	95378
95227	95240-42	95269	95336-37	95385-86

SONOMA

94922-23	95401-09	95433	95448	95476
94926-28	95416	95436	95450	95486-87
94931	95419	95439	95452	95492
94951-55	95421	95441-42	95462	
94975	95425	95444	95465	
94999	95430-31	95446	95471-73	

STANISLAUS

95230	95316	95326	95360-61	95380-82
95307	95319	95328	95363	95386-7
95313	95323	95350-58	95367-68	

TEHAMA

96021 and 96055

TRINITY

95526

TULARE

93201	93235	93265	93286	93646-47
93207-08	93237	93267	93291-92	93666
93218-19	93244	93270-72	93603	93670
93221	93247	93274-75	93615	93673
93223	93256-58	93277-79	93618	
93227	93260-61	93282	93631	

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.

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. When a dependent resides outside of the service area (including a child under a Medical Court Order) coverage will be limited to emergency services only. 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.

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services, except for medically necessary medical or surgical care received in a hospital or extended care facility, and rehabilitation therapy.

After you pay $1,500 in copayments or coinsurance for one family member, or $4,500 for two or more family members, you do not have to make any further payments for the rest of the year with Health Net. This is called a catastrophic limit. However, copayments or coinsurance for your prescription drugs do not count toward these limits and you must continue to make these payments.

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

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Who provides my health care?

Health Net is a Mixed Model (MMP) HMO and has an extensive network of over 600 contacting physician groups and 415 hospitals, conveniently located in the communities where you work and live. Over 36,000 primary care and referral specialist physicians are affiliated with Health Net through our contracting physician groups.

A Health Net member must select a contracting physician group within a 30-mile radius of his or her home or work-site. Although all members may choose their own primary care doctor and contracting physician group, we encourage family members to choose their primary care doctors within the same physician group. This helps Plan administration and will strengthen your family's doctor/patient relationships.

Members may transfer to another contracting physician group by notifying Health Net of their request to transfer. Call 1-800-522-0088. You may change physician groups during open season, upon change of address, when you exercise the once-a-month transfer option or upon approval of Health Net. All transfers will become effective on the first day of the month following Health Net's receipt of the transfer, provided such request is received by the 14th of the month. Such requests will not be honored if you are more than three months pregnant, confined to a hospital, in a surgery follow-up period (not yet released by the surgeon) or receiving treatment for an illness (if the treatment is not complete).

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care.

What do I do if I'm in the hospital when I join this Plan?

First, call our Member Services department at 1-800-522-0088. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching 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 became a member of this Plan, whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

Your primary care physician will arrange your referral to a specialist or other health care provider with the following exceptions: a woman may see her participating gynecologist at anytime and members may self-refer to a participating chiropractor as described on page 15.

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

What do I do if I am seeing a specialist when I enroll?

Prior to enrolling, call our Member Services Department at 1-800-522-0088 to see if your current specialist is affiliated with Health Net through one of our contracting physician groups. This may help you to choose a physician group more suitable for your specific needs. Your primary care physician will decide what treatment you need. If they decide 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.

What do I do if my 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.

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice. In addition, authorization by the Plan may be required for some formulary and non-formulary prescription drugs.

How do you decide if a service is experimental or investigational?

The Plan's Medical Policy Committee determines what procedures and services are experimental/investigational using published peer review medical and surgical literature. The procedure or service will be evaluated based on its health effects, safety, quality and cost effectiveness. In some cases, the Plan uses an independent medical review for expert evaluation and determination of coverage.

Section 4. What to do if we deny your claim or request for service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing,
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information.

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life threatening condition and you haven't responded to my request for service?

Call us at 1-800-522-0088 and we will expedite our review.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division IV at (202) 606-0737 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.

2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

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

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

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

- Anyone enrolled in the Plan;
- The estate of a person once enrolled in the Plan; and
- Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

What address should I send my disputed claim to?

Send your request for review to: Office of Personnel Management, Office of Insurance Programs Contracts Division IV, P.O. Box 436, Washington, D.C. 20044.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our 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 or supplies.

What laws apply if I file a lawsuit?

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Health Net Benefits

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** a $10 copay per visit. Within the Service Area, house calls will be provided if, in the judgment of the Plan doctor, such care is necessary and appropriate; **you pay** a $20 copay for a doctor's house call and a $20 a day copay after day 30 for home visits by nurses and health aides.

The following services are included:

- Preventive care, including well-baby care (office visit copay waived for infant through 30 days of life), routine physicals, periodic checkups and vision and hearing exams
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters (**you pay** nothing)
- Immunizations for occupational and foreign travel purposes (**you pay** 20% of charges)
- Consultations by specialists
- Diagnostic procedures, including laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor (office visit copays waived for maternity care). The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization (**you pay** a $150 copay for females and a $50 copay for males), and family planning services including contraceptive devices.
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including allergy serum (**you pay** nothing)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints

- Cornea, heart, heart/lung, kidney, liver, lung (single and double), and pancreas/kidney transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; testicular, mediastinal, retroperitoneal and ovarian germ cell tumors; selective congenital/genetic diseases; chronic myelogenous leukemia; aplastic anemia; breast cancer; epithelial ovarian cancer; and multiple myeloma when determined to be medically necessary and appropriate by Health Net. Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided as part of a peer-reviewed, non-random clinical trial approved under the guidelines of the National Institutes of Health, Food and Drug Administration, or Veterans Administration. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis. After the first 48 hours, the length of stay will be determined solely by the physician. Surgical reconstruction of a breast as the result of a mastectomy, including surgery to restore symmetry; also includes breast prosthesis and treatment of physical complications at all stages of mastectomies, including lymphodomas.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Orthopedic devices, such as braces
- Prosthetic devices, such as breast prostheses, surgical bras, and artificial limbs and lenses following cataract removal
- Durable medical equipment, such as wheelchairs and hospital beds
- Home health services of nurses and health aides, including intravenous fluids and medications when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness (you pay a $20 copay after the 30th visit)
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you
- Blood, blood plasma, blood factors, and blood derivatives

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Limited benefits

Oral and maxillofacial surgery is provided for nondental, surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. Orthognathic surgery will be provided to correct the malposition or improper development of the upper or lower jaw to correct a present functional disorder.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or injury that has produced a major effect on the member's appearance and the condition can reasonably be expected to be corrected by such surgery. A patient and her

attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

Rehabilitative therapy will be covered for physical, speech, occupational and respiratory; **you pay** nothing. Continued significant improvement must appear to be likely for services to be covered. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Diagnosis and treatment of infertility, including artificial insemination and fertility drugs (for covered services), are covered on an inpatient or outpatient basis; **you pay** 50% of charges. The following type(s) of artificial insemination are covered: intravaginal insemination (IVI), intracervical insemination (ICI) and intrauterine insemination (IUI); **you pay** 50% of the charges. Cost of donor sperm, ova, or their collection or storage is not covered. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization and embryo transfer, including any related service or supply (e.g., associated fertility drugs), are not covered.

Foot orthotics are covered only when they have been incorporated into a cast, splint, brace or strapping of the foot.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided at a Plan facility for up to 60 consecutive days; **you pay** nothing.

Chiropractic services are available to members (up to 20 visits per calendar year, **you pay** a $10 copay per visit) without referral from a Primary Care Physician. Chiropractic appliances are covered up to a maximum plan payment of $50. This benefit is available through the chiropractors who participate in Health Net's Chiro Net network.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically induced sterility
- Surgery primarily for cosmetic purposes
- Hearing aids
- Homemaker services
- Long-term rehabilitative therapy
- Transplants not listed as covered
- Hypnotherapy
- Experimental or Investigational services

Hospital Care / Extended Care Benefits

What is Covered

Hospital Care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay nothing. All necessary services are covered, including:**

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private-duty nursing care
- Specialized care units, such as intensive care or cardiac care units
- Blood, blood plasma, blood factors, and blood derivatives

Extended care

The Plan provides a comprehensive range of benefits up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. **You pay nothing. All necessary services are covered,** including:

- Bed, board and general nursing care
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home for up to 210 days. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor.

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 19 for nonmedical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care, rest cures, domiciliary or convalescent care

Emergency Benefits

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 the Plan may determine are medical emergencies — what they all have in common is the need for quick action.

Emergencies within the service area

If you are in an emergency situation, please call your contracting physician group. In extreme emergencies, if you are unable to contact your medical group, contact the local emergency system (i.e., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours, unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been notified in a timely manner.

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

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays...

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay...

A $35 copay per emergency room visit or urgent care center visit, if the urgent care center is not operated by the member’s selected contracting physician group (a **$10 office visit copay** applies at your physician group’s urgent care center); if the emergency results in admission to a hospital, the copay is waived.

Emergencies outside the service area

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

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays...

Reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers.

You pay...

A $35 copay per hospital emergency room visit or urgent care center visit; if the emergency results in admission to a hospital, the copay is waived.

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan

What is not covered

- Elective care or nonemergency care
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 10.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

To the extent shown below, this Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders.

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care

Up to 50 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; **you pay** a $30 copay per visit for each covered visit — all charges thereafter. There is a $30 charge for missed appointments, if the visit is not canceled for good cause at least 24 hours before the appointment. Group therapy sessions count as one-half of a private office visit; **you pay** a $15 copay for each covered visit.

Inpatient care

Up to 60 days of hospitalization each calendar year; **you pay** nothing for the first 60 days — all charges thereafter.

What is not covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition

Substance abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition. Services for the psychiatric aspects are provided in conjunction with the mental conditions benefit shown above. Outpatient visits to Plan providers for treatment are covered, as well as inpatient services necessary for diagnosis and treatment. The mental conditions benefit visit/day limitations apply to any covered substance abuse care.

What is not covered

- Treatment that is not authorized by a Plan doctor

Prescription Drug Benefits

What is covered

Prescription Drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. For each prescription unit or refill **you pay** a $5 copayment for generic drugs and $10 copayment for brand name drugs. When generic substitution is permissible (i.e., a generic drug is available and the prescription order does not state “do not substitute” or “dispense as written” in the prescribing doctor’s handwriting), but you request the brand name drug, you pay the difference between the generic and the brand name drug as well as the $10 copayment per prescription unit or refill.

Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan’s drug formulary. Non-formulary drugs are covered when prescribed by the Plan doctors. For each non-formulary prescription unit or refill you pay $25 for a 30-day supply.

Maintenance drugs may be obtained through a mail-order prescription drug program for up to a 90-day supply per order. You pay a $10 copayment for Generic Drugs and a $20 copayment for brand name drugs that are listed in the Plan’s formulary. For non-formulary drugs you pay $50. The prescribed supply may not always be an appropriate drug treatment plan, according to FDA or the Plan’s usage recommendations. If this is the case, the amount of medication dispensed may be reduced.

Some Formulary and Non-formulary drugs may require prior authorization from the Plan. For a copy of the Plan’s drug formulary, contact the Plan at 1-800-522-0088 or visit the Plan’s web site at www.healthnet.com.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Oral contraceptive drugs
- Insulin, with a copay charge applied to each vial
- Diabetic supplies, such as blood glucose monitoring strips and lancets
- Disposable hypodermic needles and syringes needed for injecting covered prescribed medication, including insulin
- Contraceptive devices such as diaphragms and IUDs

Intravenous fluids and medication for home use, implantable drugs, such as Norplant, and some injectable drugs, such as Depo Provera, are covered under Medical and Surgical Benefits.

Limited benefits

Fertility drugs associated with covered services under the diagnosis and treatment of infertility, including artificial insemination, are covered under Medical and Surgical Benefits; you pay 50% of charges. Fertility drugs associated with procedures not covered under the infertility treatment benefit, such as in vitro fertilization and embryo transfer, are not covered.

Drugs to treat sexual dysfunction are limited. Contact the Plan for dosage limits at 1-800-522-0088. **You pay** 50% of charges up to the dosage limits and all charges above that.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Anorectics (appetite suppressants), except for treatment of morbid obesity
- Smoking cessation products

Other Benefits

Dental care

Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered. The need for these services must result from an accidental injury, not biting or chewing. **You pay** nothing at the dentist's office and a $35 copayment at the emergency room.

What is not covered

- Other dental services not shown as covered

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (to provide a written lens prescription) may be obtained from Plan providers; **you pay** a $10 copay per visit.

What is not covered

- Eye exercises
- Eyeglasses, contact lenses or the fitting of contact lenses

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium; any charges for these services do not count toward any FEHB deductibles or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Optional Eyewear Coverage

The Vision One Discount Program is being extended to you by Health Net. No extra premiums or deductibles are required. The plan offers you savings of up to 20% on eyewear at stores you already know, including Sears, Montgomery Ward, JC Penney stores, and selected Pearle Vision locations. For more information on this program, contact Health Net's Member Services department at 1-800-522-0088.

Optional Dental Benefits

For a small monthly premium as a supplement to your Federal Employees Health Benefits program, Health Net Members have the option to join the Denticare Dental Plan. Please note, new Members must complete a Denticare application form and agree to pay its monthly premiums in order to be enrolled in a dental plan.

Denticare's Managed Dental Care Plan Option (DHMO):

The Denticare plan offers Members a broad spectrum of dental coverage at a lower out-of-pocket cost to the Member. You are able to individually choose a general dentist from a network of credentialed dentists and may change this selection monthly. Once you are enrolled, your selected dentist will provide diagnostic and preventive services at no charge to the Member and other dental services at a significantly reduced fee.

To receive more information about enrolling in the Denticare Dental Plan, simply complete and return the postage-paid card included in your Health Net information kit or call 1-800-999-2848.

Medicare Prepaid Plan Enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan (Health Net Seniority Plus program) through Medicare. As indicated on page 24, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those **without** Medicare Part A may join Health Net Seniority Plus but will have to pay for Medicare Part A in addition to the Part B premium. **Before** you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 1-800-935-6565 for information on the Health Net Seniority Plus Medicare prepaid plan and the cost of that enrollment. If you are eligible for Medicare and are interested in enrolling in a Medicare HMO sponsored by Health Net without dropping your enrollment in Health Net's FEHB plan, call 1-800-935-6565 for information on the benefits available under the Medicare HMO.

Benefits on this page are not part of the FEHB contract.

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 or condition.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits) or eligible self-referred services;
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, services, drugs and 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;
- Procedures, services, drugs and supplies related to sex transformations;
- Services or supplies you receive from a provider or facility barred from the FEHB Program; and
- Expenses you incurred while you were not covered under this Plan.

Section 7. Limitations – Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, 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.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800-638-6833. For information on the Medicare+Choice plan offered by this Plan, call us at 1-800-596-6565 or see page 23.

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. 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.

TRICARE

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. 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 disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;

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 the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

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

If you have a malpractice claim

If you have a malpractice claim because of services you did or did not receive from a plan provider, such claim shall not include this Plan, only the provider subject to the allegation.

Section 8. FEHB FACTS

You have a right to information about your HMO

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's web site (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 1-800-522-0088, or write to Health Net, P.O. Box 10348, Van Nuys, CA, 91410-0348. You may visit our web site at www.healthnet.com

Where do I get information about enrolling in the FEHB Program?

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
- The next Open Season for enrollment.

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.

When are my benefits and premiums effective?

The benefits in this brochure are effective on January 1. If you are new to this plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin January 1.

What happens when I 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, which is described later in this section.

What types of coverage are available for me and my 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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get 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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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.

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

Are my medical and claims records 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.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan 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 former spouse coverage or Temporary Continuation of Coverage.

What is former spouse 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 more information about your coverage choices.

What is TCC?

Temporary Continuation of Coverage (TCC). If you leave Federal service or if you lose coverage because you no longer qualify as a family member, you may be eligible for 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.

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an 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 if individual coverage is available. 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.

How can I get a Certificate of Group Health Plan Coverage?

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

Department of Defense/FEHB Demonstration Project

What is the Department of Defense (DoD) and FEHB Program Demonstration Project?

1) The National Defense Authorization Act for 1999, Public Law 105-261, established the DoD/FEHBP Demonstration Project. It allows some active and retired military members and their dependents to enroll in the FEHB Program. The demonstration will last for three years beginning with the 1999 Open Season for the year 2000. Open Season enrollments will be effective January 1, 2000. DoD and OPM have set-up some special procedures to successfully implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is Eligible?

DoD determines who is eligible to enroll in FEHB. You may enroll if:

- You are an active or retired military member and are eligible for Medicare,
- You are a dependent of an active or retired military member and are eligible for Medicare,
- You are a former spouses of an active or retired military member who has not remarried, or
- You are a survivor dependent of a deceased active or retired military member, and
- You live in one of the eight geographic demonstration areas.

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

Where Are The Demonstration Areas?

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

When Can I Join?

Your first opportunity to enroll will be during the 1999 Open Season, November 8, 1999, through December 13, 1999. Your coverage will begin January 1, 2000. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877-DOD-FEHB (1-877-363-3342).

You may select coverage for yourself (self-only) or for you and your family (self and family) during the 1999, 2000, and 2001 Open Seasons. Your coverage will begin January 1 of the year following the Open Season that you enrolled.

If you become eligible for the DoD/FEHBP Demonstration Project outside of Open Season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2000 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHBP Demonstration Project," on the OPM web site at www.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 1-800-522-0088 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 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 they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for Health Net – 2000

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions we set forth in this brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE AND CHIROPRACTIC CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing	**16**
	Extended Care	All necessary services for up to 100 days per calendar year. **You pay** nothing	**16**
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions for up to 60 days of inpatient care per year. **You pay** nothing	**19**
	Substance Abuse	Covered under Mental Conditions	**19**
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic checkups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** a $10 copay for office visits; a $20 copay per house call by a doctor; copays are waived for maternity care	**13**
	Home health care	All necessary visits by nurses and health aides. **You pay** nothing for the first 30 days and you pay a $20 a day copay starting on day 31	**16**
	Mental Conditions	Up to 50 outpatient visits per year. **You pay** a $30 copay per visit. There is a $30 charge for missed appointments if the visit is not cancelled for good cause at least 24 hours before the appointment. Group therapy sessions count as one-half of a private office visit; **you pay** $15 for each covered visit	**19**
	Substance Abuse	Covered under Mental Conditions	**19**

Emergency care	Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $35 copay per emergency room visit or non-Plan urgent care center visit, and any charges for services that are not covered by this Plan **17**
Prescription drugs	Drugs prescribed by a Plan doctor and obtained at a participating pharmacy. **You pay** a $5 copay for generic drugs and $10 copayment for name brand drugs per prescription or refill. For Non-formulary drugs **you pay** $25. For mail-order drugs up to a 90-day supply, **you pay** a $10 copay for generic drug and $20 for name brand drugs. For non-formulary mail order drugs **you pay** a $50 copay.. . . . . **20**
Dental care	Accidental injury benefit; **you pay** nothing at a dentist's office or a $35 copay at the emergency room **22**
Vision care	One refraction annually; **you pay** a $10 copay per visit **22**
Out-of-pocket limit	Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $1,500 per Self Only, or $4,500 per Self and Family enrollment per calendar year, covered benefits will be provided at 100 percent. This copay maximum does not include prescription drugs **8**

2000 Rate Information for Health Net

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

Postal rates apply to most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain employees. If you are a career postal employee, but not a member of a special postal employment class, refer to the category definitions in, “The Guide to Federal Employees Health Benefit Plans for United States Postal Service Employees,” RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable “Guide to Federal Employees Health Benefits Plans.”

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov’t Share	Your Share	Gov’t Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Most of California									
Self Only	**LB1**	**$61.28**	**$20.42**	**$132.77**	**$44.25**	**$72.51**	**$9.19**	**$72.51**	**$9.19**
Self and Family	**LB2**	**$145.04**	**$48.35**	**$314.26**	**$104.75**	**$171.63**	**$21.76**	**$171.63**	**$21.76**

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