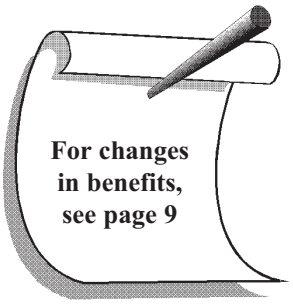
Health Net

www.healthnet.com

2003

A Health Maintenance Organization



Serving: Most of California

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

This plan has commendable accreditation from the NCQA.
See the 2003 Guide for more information on accreditation.

Enrollment codes for this Plan:

LB1 Self Only
LB2 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

Federal Employees
Health Benefits Program

RI 73-159

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).

- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

Table of Contents

Introduction

This brochure describes the benefits of Health Net under our contract (CS 2003) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for Health Net administrative offices is:

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

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan you are entitled to the benefits described in this brochure. If you are enrolled in 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, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

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

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

Stop Health Care Fraud

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) Program premium.

OPM's office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you are retired.

Protect Yourself From Fraud – Here are some things you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider 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 800-522-0088 and explain the situation.
  - If we do not resolve the issue:

CALL THE HEALTH CARE FRAUD HOTLINE
202-418-3300

OR WRITE TO:
The United States
Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E. Street, NW, Room 6400
Washington D.C. 20415

  - Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless he/she is disabled and incapable of self-support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

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

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

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

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

Who provides my health care

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

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

Your Rights

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

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

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

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

Service Area

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

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

Partial counties: El Dorado, Fresno, Kern, Nevada, Placer, Riverside, and San Bernardino, counties, California. The following ZIP codes are those included in these partial counties:

EL DORADO

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

FRESNO

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

KERN

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

NEVADA

95712	95924	95945-46	95949	95959-60
95975				

PLACER

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

RIVERSIDE

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

SAN BERNARDINO

91701	91708-10	91729-30	91737	91739
91743	91758-59	91761-64	91784-86	91798
92252	92256	92268	92277-78	92284-86
92301	92305	92307-18	92314-18	92321-22
92324-27	92329	92333-37	92339-42	92345-47
92350	92352	92354	92356-59	92365
92368-69	92371-78	92382	92385-86	92391-94
92397-99	92400-27			

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

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

Section 2. How we change for 2003

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

Program-wide changes

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal premium will increase by 9.4% for Self Only or 9.4% for Self and Family.
- We have added a $100 per admission copayment for all hospital, skilled nursing facility, mental health and substance abuse facility admissions. (Section 5(c) See page 29)
- We have added a $100 copayment for outpatient hospital and ambulatory surgical facility services for outpatient surgery. (Section 5(c) See page 30)
- We have added a $10 copay per visit for well-child care (birth through 30 days of life). (Section 5(a) See page 17)
- We have added a $10 copay per visit for prenatal and postnatal care copay. (Section 5(a) See page 17)
- We have increased the emergency room copay from $35 to $100 per visit. (Section 5(d) See page 33)
- We have increased the generic and brand name Pharmacy copays to $10 for generic and $20 for brand name at a retail pharmacy and $20 for generic and $40 for brand name through mail order. (Section 5(f) See page 38)
- We now cover routine patient care costs for clinical cancer trials (Section 5 (a) See page 24)
- We will no longer be offered in the following counties: Amador, Colusa, Glenn, Lassen, Mariposa, Mendocino, Plumas, Sierra, Tehama.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-522-0088. You may also request replacement cards through our website at www.healthnet.com.

Where you get covered care

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

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do to get covered care

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

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

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

- **Primary care**

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

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

• **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see a participating chiropractor (as described on page 22) and a woman may see her participating gynecologist at anytime without a referral.

Here are other things you should know about specialty care:

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

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

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

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

  - terminate our contract with your specialist for other than cause; or
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
  - reduce our service area and you enroll in another FEHB Plan,

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

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

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

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

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

- **Hospital care**

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

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

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

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

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

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

Section 4. Your costs for covered services

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

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

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

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

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

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

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

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

- Prescription Drugs
- Chiropractic Care

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

Section 5. Benefits – OVERVIEW

(See page 9 for how our benefits changed this year and page 60 for a benefits summary.)

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

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

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.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

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

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations, and care (through age 22) Examinations, such as: - Eye exams to determine the need for vision correction. - Ear exams to determine the need for hearing correction - Examinations done on the day of immunizations	$10 per office visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Postnatal care	$10 per office visit
• Delivery Note: Here are some things to keep in mind: • You do not need to pre-certify your normal delivery; see page 12 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing

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

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

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

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

Durable Medical Equipment continued on next page

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

Alternative treatments	You pay
Acupuncture – if referred by your primary care physician	$10 per office visit
Not covered: • *naturopathic services* • *hypnotherapy* • *biofeedback*	*All charges*
Educational classes and programs	
Coverage is limited to: • Diabetes self-management • Wellness programs provided by your selected Participating Physician Group • Quitting Matters Smoking Cessation Program • Teen Health Website • Prenatal Program with Free Infant Car Seat • Women Matter Website Please visit out website at www.healthnet.com for more information.	Nothing
A comprehensive range of services, such as:	$10 per office visit

Clinical trials	You pay
Routine patient care costs for patients diagnosed with cancer who are accepted into phase I, II, III or IV clinical trials are covered when medically necessary, recommended by the Member's treating Physician and authorized by Health Net. • The Physician must determine that participation has a meaningful potential to benefit the Member and the trial has therapeutic intent. • Services rendered as part of a clinical trial that involves either a drug that is exempt from Federal regulation in relation to a new drug application, or is approved by one of the following: - The National Institutes of Health; - The FDA as an investigational new drug application; - The Department of Defense; or - The Veterans' Administration Note: "Routine patient care costs" include drugs, items, devices and services that would normally be covered under this plan if they were not provided in connection with a clinical trials program.	Your cost sharing responsibilities are no greater than for other covered services
Not covered: *Coverage for clinical trials does not include the following items:* *Drugs or devices that are not approved by the FDA* • *Services other than health care services, including but not limited to cost of travel, or costs of other non-clinical expenses* • *Services provided to satisfy data collection and analysis needs which are not used for clinical management* • *Items and services provided free of charge by the research sponsors to Members in the trial.*	*All charges*

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.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity • Insertion of internal prostethic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per office visit
Voluntary Sterilization (Female)	$150
Voluntary Sterilization (Male)	$50

Surgical procedures continued on next page

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

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

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

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

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.
- We have no calendar year deductible.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).

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 • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
Operating, Recovery and other treatment rooms used in connection with outpatient surgery	$100 per admission
• Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Conditions for which hospitalization would be covered include hemophilia and heart disease: the need for anesthesia by itself is not such a condition.	Nothing
Not covered: blood and blood derivatives replaced by the member	*All charges*

Extended care benefits/Skilled nursing care facility benefits	You pay
Extended care/Skilled nursing facility (SNF): Up to 100 days per calendar year for services such as: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor	$100 per admission
Not covered: custodial care and personal comfort items such as telephone and television.	*All charges*
Hospice care Hospice care: Up to 210 days for services such as: • Inpatient and outpatient care • Family counseling Note: Hospice care services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Hospice care	
Hospice care: Up to 210 days for services such as: • Inpatient and outpatient care • Family counseling Note: Hospice care services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less	Nothing
Not covered: Independent nursingm homemaker services	*All charges*
Ambulance	
• Local professional ground and air ambulance service when medically appropriate	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 and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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. An emergency will also include screening, examination and evaluation by a physician (or other health care professional acting within the scope of his or her license) to determine if a psychiatric medical emergency condition exists and the treatment necessary to relieve or eliminate such condition, within the capability of the facility. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

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

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

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

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

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

Benefit Description	You pay
Emergency within our service area	
• Emergency care at your primary care physician's office • Emergency care at your participating physician group's urgent care center	$10 per office visit
• Emergency care at an emergency room • Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: If the emergency results in admission to a hospital, the copay is waived	$100 per visit
• Emergency care at an urgent care center	$35 per visit
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center	$35 per visit
• Emergency care at an emergency room • Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: If the emergency results in admission to a hospital, the copay is waived	$100 per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Follow-up care not authorized by your participating physician group.*	*All charges*
Ambulance	
Professional ground and air ambulance service when medically appropriate. See 5(c) for non-emergency service.	Nothing

Section 5 (e) Mental health and substance abuse benefits

IMPORTANT

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

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

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

IMPORTANT

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

Mental health and substance abuse - Continued on next page

Mental health and substance abuse benefits *(continued)*	You pay
• Diagnostic tests	Nothing if you receive these services during your office visit; otherwise $10 per visit
• Inpatient services provided by a hospital or other facility	$100 per admission
• Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Preauthorization

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

Limitation

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

Section 5 (f) Prescription drug benefits

IMPORTANT

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

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

IMPORTANT

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

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

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

  You can get a copy of the formulary by calling us at 1-800-522-0088 or visit our web site at www.healthnet.com
- **These are the dispensing limitations.**

  - When the prescription drug is filled at a Plan pharmacy: The pharmacy may dispense up to a 30-day supply for each drug or for each refill at the appropriate time interval
  - When the prescription drug is filled through the mail order program, the mail order pharmacy may dispense up to a 90-day supply for each maintenance drug or refill allowed by the prescription order at the appropriate time interval.

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

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

    - Drugs requiring immediate use that the delay in obtaining such drugs would interfere with the physician's treatment plan
    - Drugs requiring detailed instruction which cannot be provided by the mail order pharmacy compared to a retail pharmacist at the time the prescription is filled.
    - A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

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

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

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

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.
- **When you have to file a claim.** In most cases you do not have to file a claim when purchasing drugs at the Plan pharmacy. However, you must pay for the drug when it is dispensed, and file a claim for reimbursement when the following occurs:

  - Your Plan ID card is not available.

  - Eligibility cannot be determined.

  - The prescription drug is dispensed outside of California for a medical emergency.

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

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered*. • Insulin • Diabetic supplies, such as blood glucose monitoring strips, Ketone test strips and lancet. • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see limits below) • Contraceptive drugs and devices such as diaphragms and cervicalcaps	For drugs filled at a Plan pharmacy: • $10 for generic drugs • $20 for brand name drugs • $35 for non-formulary drugs For drugs filled through the mail order program: • $20 for generic drugs • $40 for brand name drugs • $70 for non-formulary drugs Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Limited benefits: • Drugs for sexual dysfunction are limited to 2 doses per week or 8 tablets per month. • Fertility drugs associated with covered services under the diagnosis and treatment of infertility are covered under the Medical Services and Supplies Benefits (see page 18).	50% of charges
Not covered: • *Drugs and supplies for cosmetic purposes* • *Medical supplies such as dressings and antiseptics* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Drugs available without a prescription or for which there is a nonprescription equivalent* • *Drugs to enhance athletic performance* • *Injectable Fertility Drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Anorectics (appetite suppressants), except for treatment of morbid obesity.* • *Non-prescription medications*	*All charges*

Section 5 (g) Special features

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

Section 5 (h) Dental benefits

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.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	You pay
We cover the restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury and treatment must be given within 24 hours of the injury.	Nothing at the dentist's office and a $100 copayment at the emergency room
Not covered: • *Damage to teeth while chewing food* • *Restorative services of the damaged tooth for cosmetic purposes* • *Follow-up treatment of an accidental injury to sound natural teeth*	*All charges*

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

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

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

Optional Dental and Vision Coverage

The Vis-A-Dent product from Health Net Dental and Vision bundles dental and vision coverage together into a plan that provides access to affordable, quality services. The plan offers a choice from two dental plans and combines it with a vision plan tailored to meet the needs of individuals and families. Two coverages, one bill.

Please note: The areas where Vis-A-Dent is offered may not be the same as the Health Net service area. Please call Health Net Dental and Vision at 1-800-999-2848 for information about their service area information.

Optional Indemnity Dental Coverage

Standalone dental insurance is available through Health Net Dental and Vision. This indemnity dental plan covers a broad range of services and allows you **complete freedom of choice in selecting your dentist**. This plan gives members an attractive combination of coverage, choice, and low cost.

Medicare Prepaid Plan Enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan (Health Net Seniority Plus program) through Medicare. Annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join Health Net Seniority Plus but will have to pay for Medicare Part A in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 1-800-596-6565 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 1-800-596-6565 for information on the benefits available under the Medicare HMO.

Section 6. General exclusions – Things we don't cover

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

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

When you must file a claim — such as for services you receive outside of the Plan's service area — submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

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

Prescription drugs

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

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

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

Step	Description
	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 more than one claim, 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. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

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

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

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may 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 or a covered family member have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

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

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

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

• What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

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

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

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

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

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

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 1-800-522-0088.

We do not waive any costs if the Original Medicare Plan is your primary payer.

(Primary payer chart begins on next page.)

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

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

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

• 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 cost-sharing for your FEHB coverage.

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

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

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

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

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable premiums.) 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 under the program.

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB 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 under the State program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 13.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 13.

Covered services

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

Custodial care

Custodial care is care provided to assist in meeting the activities of daily living such as help in walking, getting in and out of bed, bathing, feeding, and supervision of medications which are ordinarily self-administered. Custodial care that lasts 90 days or more is sometimes known as Long term care.

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 13.

Experimental or investigational services

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

Group health coverage

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

Medical necessity

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

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

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

Us/We

Us and we refer to Health Net

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

- 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.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for self and family coverage in the Federal Employees Health Benefits (FEHB) Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for self and family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for self and family coverage in the option of the Blue Cross and Blue Shield Benefit Plan that provides the lower level of coverage;
- If you have self only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to self and family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to self only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot make any changes after retirement. Contact your employing office for further information.

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.

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. This is the case even when the court has ordered your former spouse to supply health coverage for you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). 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. You can also download the guide from OPM's website, www.opm.gov/insure.

• Temporary Continuation of coverage (TCC)

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

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

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

- **Converting to individual coverage**

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Long Term Care Insurance Is Still Available

Open Season

The Federal Long Term Care Insurance Program's open season for enrollment ends on December 31, 2002. If you're a Federal employee, this is the chance for you and your spouse to apply by answering only a few questions about your health.

You Can Also Apply Later

You and your qualified relatives can still apply for coverage after open season ends. The difference for employees and their spouses is that they won't have the advantage of open season's abbreviated underwriting, so they'll have to answer more health-related questions. For annuitants and other qualified relatives, there's no difference in the underwriting requirements during and after the open season.

FEHB Doesn't Cover

It's important to keep in mind that neither your FEHB plan nor Medicare covers the cost of long term care. Also called "custodial care," it's care you receive when you need help performing activities of daily living – such as bathing or dressing yourself. This need can strike any one at any age and the coast of care can be substantial.

It's Not Too Late!

It's not too late to protect yourself against the high cost of long term care by applying for the Federal Long Term Care Insurance Program. Don't delay – if you apply during open season, your premiums will be based on your age as of July 1, 2002. After open season, your premiums are based on your age at the time your application for enrollment is received by LTC Partners.

Find Out More

Call 1-800-LTC-FEDS (1-800-582-3337) or visit www.ltcfeds.com to get more information and to request an application.

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

Notes

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Notes

Summary of benefits for Health Net HMO – 2003

- **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	16
Services provided by a hospital: • Inpatient • Outpatient	 $100 copay per admission $100 copay for surgical procedures, Nothing for all other services	 29 30
Emergency benefits: • In-and-Out-of-area Emergency Room • In-and-Out-of-area Urgent Care Facility	 $100 per visit (waived if admitted to hospital) $35 per visit	 32 32
Mental health and substance abuse treatment	Regular cost sharing	34
Prescription drugs	$10 copay for a 30 day supply of formulary generic drugs - $20 for a 90 day supply through mail order. $20 copay for a 30 day supply of formulary name brand drugs - $40 copay for a 90 day supply through mail order. $35 copay for a 30 day supply of non-formulary drugs - $70 for a 90 day supply through mail order	38
Dental Care	Accidental injury benefit; nothing at the dentist's office or a $100 copay at the emergency room.	40
Vision Care	$10 per visit; One refraction annually.	20
Special features: Early Bird Prenatal Program, Case Management Services, 24 hour nurse line to answer your health questions, Telecommunications Device for the Deaf, Centers of Excellence		39
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $1,500/Self Only or $4,500/Family enrollment per year Some costs do not count toward this protection	 13

2003 Rate Information for
Health Net

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 a special FEHB guide is published 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.

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Most of California							
Self Only	**LB1**	$94.43	$31.47	$204.59	$68.19	$111.74	$14.16
Self and Family	**LB2**	$223.52	$74.50	$484.28	$161.43	$264.49	$33.53

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