

Health Net of Arizona, Inc.

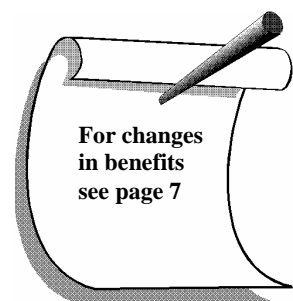
<http://www.healthnet.com>



2005

A Health Maintenance Organization

Serving: Cochise, Gila, Maricopa, Pima, Pinal and Santa Cruz counties
Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 6 for requirements.



Enrollment code for this Plan:

A71 Self Only

A72 Self and Family



Authorized for distribution by the:



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

RI 73-283



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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options, strengthening the Federal Employees Health Benefits (FEHB) Program and highlighting once again its unique and distinctive market-oriented features. I remain firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. Plan brochures provide information to help subscribers make these fully informed decisions. Please take the time to review the plan's benefits, particularly Section 2, which explains plan changes.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money. If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier life style brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventative screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at www.healthierfeds.opm.gov for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services website on Wellness and Safety, www.hhs.gov/safety/index.html, which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost-effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this brochure, in the 2005 Guide to FEHB Plans, and on the OPM Website at www.opm.gov/insure. I hope you find these resources useful, and thank you once again for your service to the nation.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay C. James".

Kay Coles James

Director



Notice of the United States 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 United States 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 health care 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 202-606-0745 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
United States 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 United States 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 are effective April 14, 2003.

Table of Contents

Introduction.....	3
Plain Language.....	3
Stop Health Care Fraud!.....	3
Preventing medical mistakes.....	4
Section 1. Facts about this HMO plan.....	6
How we pay providers.....	6
Your Rights.....	6
Service Area.....	6
Section 2. How we change for 2005.....	7
Program-wide changes.....	7
Changes to this Plan.....	7
Section 3. How you get care.....	8
Identification cards.....	8
Where you get covered care.....	8
• Plan providers.....	8
• Plan facilities.....	8
What you must do to get covered care.....	8
• Primary care.....	8
• Specialty care.....	9
• Hospital care.....	9
Circumstances beyond our control.....	10
Services requiring our prior approval.....	10
Section 4. Your costs for covered services.....	11
Copayments.....	11
Deductible.....	11
Coinsurance.....	11
Your catastrophic protection out-of-pocket maximum.....	11
Section 5. Benefits OVERVIEW (<i>See page 7 for how our benefits changed this year and page 60 for a benefit summary.</i>)12	
Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....	14
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	24
Section 5(c) Services provided by a hospital or other facility, and ambulance services.....	29
Section 5(d) Emergency services/accidents.....	32
Section 5(e) Mental health and substance abuse benefits.....	34
Section 5(f) Prescription drug benefits.....	37
Section 5(g) Special features.....	39
• Flexible benefits option.....	39
• 24 hour nurse line.....	39
• Services for deaf and hearing impaired.....	39
• High risk pregnancies.....	39
• Centers of excellence.....	39
• Travel benefit/services overseas.....	39
Section 5(h) Dental benefits.....	40
Section 5(j) Non-FEHB benefits available to Plan members.....	41

Section 6. General exclusions – things we don’t cover	42
Section 7. Filing a claim for covered services.....	43
Section 8. The disputed claims process.....	44
Section 9. Coordinating benefits with other coverage.....	46
When you have other health coverage.....	46
What is Medicare?.....	46
• Should I enroll in Medicare?	46
• The Original Medicare Plan (Part A or Part B)	46
• Medicare Advantage.....	49
TRICARE and CHAMPVA	49
Workers’ Compensation.....	49
Medicaid.....	50
When other Government agencies are responsible for your care	50
When others are responsible for injuries	50
Section 10. Definitions of terms we use in this brochure	51
Section 11. FEHB Facts	52
Coverage information.....	52
• No pre-existing condition limitation.....	52
• Where you can get information about enrolling in the FEHB Program.....	52
• Types of coverage available for you and your family	52
• Children’s Equity Act.....	53
• When benefits and premiums start	53
• When you retire	53
When you lose benefits	53
• When FEHB coverage ends.....	53
• Spouse equity coverage	54
• Temporary Continuation of Coverage (TCC).....	54
• Converting to individual coverage.....	54
• Getting a Certificate of Group Health Plan Coverage	54
Section 12. Two Federal Programs complement FEHB benefits	55
The Federal Flexible Spending Account Program – <i>FSAFEDS</i>	55
The Federal Long Term Care Insurance Program	58
Index.....	59
Summary of benefits for the <i>Health Net of Arizona- 2005</i>	60
2005 Rate Information for Health Net of Arizona.....	Back Cover

Introduction

This brochure describes the benefits of Health Net of Arizona, Inc. under our contract (CS 2121) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Health Net of Arizona, Inc. administrative offices is:

Health Net of Arizona, Inc.

1230 W. Washington Street, Suite 401

Tempe, Arizona 85281

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, 2005, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2005, and changes are summarized on page 8. 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 of Arizona, Inc..
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States 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 fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 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 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 retired.

Protect Yourself From Fraud – Here are some things that 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 800-289-2818 and explain the situation.

If we do not resolve the issue:

**CALL — THE HEALTH CARE FRAUD HOTLINE
202-418-3300**

OR WRITE TO:
**United States Office of Personnel Management
 Office of the Inspector General Fraud Hotline
 1900 E Street NW Room 6400
 Washington, DC 20415-1100**

- Do not maintain as a family member on your policy:
 Your former spouse after a divorce decree or annulment is final (even if your 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, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- 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.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. **Ask questions if you have doubts or concerns.**
 - Ask questions and make sure you understand the answers.
 - Choose a doctor with whom you feel comfortable talking.
 - Take a relative or friend with you to help you ask questions and understand answers.

2. **Keep and bring a list of all the medicines you take.**

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

3. **Get the results of any test or procedure.**

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. **Talk to your doctor about which hospital is best for your health needs.**

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. **Make sure you understand what will happen if you need surgery.**

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after surgery?
 - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.html. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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 pay only the copayments, and coinsurance, described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

How we pay providers

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

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site (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 of Arizona, Inc. complies with the State of Arizona statutes and is licensed to operate an HMO in Arizona
- Health Net of Arizona, Inc has been in existence since 1981 (we were formerly Intergroup of Arizona, Inc.)
- Health Net of Arizona, Inc. is a for profit organization.

If you want more information about us, call 800-289-2818, or write to Health Net of Arizona, P.O. Box 867, Shelton, CT 06484. You may also contact us by fax at 800-977-6762 or visit our Web site at www.healthnet.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is: Cochise, Gila, Maricopa, Pima, Pinal and Santa Cruz counties.

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

Section 2. How we change for 2005

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

- In Section 9, we revised the **Medicare Primary Payor Chart** and updated the language regarding Medicare Advantage plans (formerly called Medicare + Choice plans).
- In Section 12, we revised the language regarding the Flexible Spending Account Program – *FSAFEDS* and the Federal Long Term Care Insurance Program.

Changes to this Plan

- Your share of the non-Postal premium will increase by 7% for Self Only or 7% for Self and Family.
- The specialist office visit copayment will increase from \$15 per office visit to \$30 per office visit.
- The office visit copayment for the removal of Intrauterine devices (IUDs) will increase from \$15 per office visit to 50% coinsurance per visit.
- The outpatient setting copayment for the removal of Intrauterine devices (IUDs) will increase from \$50 per visit to 50% coinsurance per visit.
- The Hemodialysis and Peritoneal dialysis copayment will increase from \$15 per visit to \$30 per visit in either the provider's office or outpatient hospital setting.
- The inpatient hospital copay will increase from \$100 per day up to 5 days per admission to \$200 per day up to 3 days per admission.
- The copayment for surgical services at an outpatient hospital or ambulatory surgical center will increase from \$50 per visit to \$100 per visit.
- The copayments for prescription drugs will increase from \$10 per generic, \$30 per preferred brand name or \$45 per non-preferred brand name with 2.5 copayments for mail order to \$15 per generic, \$30 per preferred brand name or \$50 per non-preferred brand name with 2.5 copayments for mail order.
- The self-injectable drug copayment (except insulin) will increase from \$40 per prescription to \$60 per prescription.

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 800-289-2818 or write to us at Health Net of Arizona, Inc. P.O. Box 867, Shelton, CT 06484. You may also request replacement cards through our Web site at www.healthnet.com.

Where you get covered care

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

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our 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. This decision is important since your primary care physician provides or arranges for most of your health care. You can find a primary care physician by looking in the provider directory, visiting our Web site or calling us at 800-289-2818.

- **Primary care**

Your primary care physician can be a Family Practice, General Practice, Internal Medicine 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 Plan Provider for obstetrician/gynecologist, Plan chiropractor, Plan vision provider for routine eye exam, Plan provider for mental health and substance abuse services and diabetic members may see an ophthalmologist for an annual eye examination without a referral.

Here are some 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 (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and 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 program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan,

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-289-2818. If you are new to the FEHB Program, we will arrange for you to receive care.

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

- You are discharged, not merely moved to an alternative care center; or

- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process...Prior Authorization. Your physician must obtain prior authorization for the following services: hospital stays, certain surgeries, outpatient imaging and testing services, durable medical equipment, home health care, certain medications and organ transplants.

When your primary care physician feels that you may need such a service, he or she will submit a request for an authorization to Health Net. Once we receive the request, our medical staff will review it. They review the treatment plan, covered benefits, medical history and national treatment standards.

If a request is denied, it will automatically proceed to one of our doctors for review. He or she will either support the decision for denial or approve the care requested. If a case involves new medical technology, our doctors may review current medical literature and/or consult with medical experts. Our doctors will use this information to decide if the care requested is appropriate.

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

Section 4. Your costs for covered services

You must share the costs 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 \$15 per office visit and when you are admitted to the hospital, you pay \$200 per day up to three days per admission.

Deductible

We do not have a deductible.

Coinsurance

Coinsurance is the percentage of our allowance 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

After your copayments total \$2,000.00 per person or \$4,000.00 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments and/or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and/or coinsurance for these services

- Prescription drugs
- Infertility services

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

Section 5. Benefits – OVERVIEW

(See page 7 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 claim forms, claims filing advice, or more information about our benefits, contact us at 800/289-2818 or at our Web site at www.healthnet.com.

Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....	14
Diagnostic and treatment services.....	14
Lab, X-ray and other diagnostic tests.....	15
Preventive care, adult.....	15
Preventive care, children.....	16
Maternity care.....	17
Family planning.....	17
Infertility services.....	18
Allergy care.....	18
Treatment therapies.....	19
Physical and occupational therapies.....	19
Speech therapy.....	20
Hearing services (testing, treatment, and supplies).....	20
Vision services (testing, treatment, and supplies).....	20
Foot care.....	20
Orthopedic and prosthetic devices.....	21
Durable medical equipment (DME).....	22
Home health services.....	23
Chiropractic.....	23
Alternative treatments.....	23
Educational classes and programs.....	23
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	24
Surgical procedures.....	24
Reconstructive surgery.....	25
Oral and maxillofacial surgery.....	26
Organ/tissue transplants.....	27
Anesthesia.....	28
Section 5(c) Services provided by a hospital or other facility, and ambulance services.....	29
Inpatient hospital.....	29
Outpatient hospital or ambulatory surgical center.....	30
Extended care benefits/Skilled nursing care facility benefits.....	31
Hospice care.....	31
Ambulance.....	31
Section 5(d) Emergency services/accidents.....	32
Emergency within our service area.....	33
Emergency outside our service area.....	33
Ambulance.....	33
Section 5(e) Mental health and substance abuse benefits.....	34
Mental health and substance abuse benefits.....	34
Section 5(f) Prescription drug benefits.....	36
Covered medications and supplies.....	37

Section 5(g) Special features 39

- Flexible benefits option..... 39
- 24 hour nurse line 39
- Services for deaf and hearing impaired..... 39
- High risk pregnancies 39
- Centers of excellence 39
- Travel benefit/services overseas 39

Section 5(h) Dental Benefits 40

- Accidental injury benefit..... 40
- Dental benefits 40

Section 5(j) Non-FEHB benefits available to Plan members..... 41

Summary of benefits for the Health Net of Arizona, Inc. - 2005 60

2005 Rate Information for Health Net of Arizona Back Cover

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

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

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- 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.

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Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> ▪ In physician's office ▪ Office medical consultations ▪ Second surgical opinion 	\$15 per visit to your primary care physician \$30 per visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> ▪ In an urgent care center ▪ During a hospital stay ▪ In a skilled nursing facility 	Included in the facility copayment
At home	\$15 per visit by your primary care physician \$30 per visit by your specialist

Diagnostic and treatment services – continued on next page

Diagnostic and treatment services (continued)	You pay
<i>Not covered: hearing exams to determine extent of hearing loss, if you are over age 18</i>	<i>All charges.</i>
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Ultrasound • Electrocardiogram and EEG 	No charge for laboratory, X-ray and other diagnostic tests at the physician's office or freestanding facility. If you receive these services at an outpatient hospital setting a \$10 copay per visit will apply.
Outpatient imaging and testing, such as: <ul style="list-style-type: none"> • CAT/Scans/MRI • MRAs • Stress tests • PET/SPECT scans 	\$100 per visit at the physician's office, freestanding facility or at an outpatient hospital setting.
Preventive care, adult	
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including • Fecal occult blood test • Sigmoidoscopy, screening – every five years starting at age 50 • Double contrast barium enema – every five years starting at age 50 <ul style="list-style-type: none"> • Colonoscopy screening – every ten years starting at age 50 	\$15 per visit to your primary care physician \$30 per visit to a specialist
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$15 per visit to your primary care physician \$30 per visit to a specialist

Preventive care, adult – continued on next page

Preventive care, adult (continued)	You pay
Routine pap test Note: The office visit is covered if pap test is received on the same day; see <i>Diagnosis and Treatment</i> , above.	\$15 per visit to your primary care physician \$30 per visit to a specialist
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	No charge for laboratory, X-ray and other diagnostic tests at a physician's office or freestanding facility. If you receive these services at an outpatient hospital setting a \$10 copay per visit will apply.
Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and over or for high risk members under age 65 	Nothing when performed by a non-physician personnel or an affiliated flu shot clinic sponsored by your primary care physician or Health Net of Arizona, Inc.
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>
Preventive care, children	
Childhood immunizations recommended by the American Academy of Pediatrics	\$15 per visit to your primary care physician \$30 per visit to a specialist
Well-child care charges for routine examinations, immunizations and care (up to age 22) Examinations, such as: <ul style="list-style-type: none"> • Eye exams through age 17 to determine the need for vision correction • Ear exams through age 17 to determine the need for hearing correction • Examinations done on the day of immunizations (up to age 22) 	\$15 per visit to your primary care physician \$30 per visit to a specialist

Maternity care	You pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. <i>Circumcisions will be covered if performed prior to being discharged from the hospital.</i> • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	<p>\$15 per visit, nothing for prenatal and postnatal care after the initial diagnosis of pregnancy.</p> <p>\$100 copay per visit will apply for services in an outpatient hospital setting.</p> <p>Inpatient copayment will apply for Delivery.</p>
<p><i>Not covered: Routine sonograms, amniocenteses, ultrasound or any procedure to determine fetal age, size or sex; non-medically necessary circumcision after the newborn period (after discharge from the hospital).</i></p>	<p><i>All charges.</i></p>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Injectable contraceptive drugs (such as Depo provera) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$15 per visit to your primary care physician</p> <p>\$30 per visit to a specialist or</p> <p>\$100 copay per visit will apply for services in an outpatient hospital setting..</p>
<ul style="list-style-type: none"> • Surgically implanted contraceptives (such as Norplant) • Intrauterine devices (IUDs) (Limited to one-medically necessary removal in any 3 consecutive year period) 	<p>50% of all covered services.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> • <i>Diagnostic testing to establish paternity of a child</i> • <i>Genetic testing</i> 	<p><i>All charges.</i></p>

Infertility services	You pay
Diagnosis and treatment of infertility such as: <ul style="list-style-type: none"> • Artificial insemination: • <i>Intravaginal insemination (IVI)</i> • <i>Intracervical insemination (ICI)</i> • <i>Intrauterine insemination (IUI)</i> 	50% of all covered services
<i>Not covered:</i> <ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • Services and supplies related to ART procedures • Cost of donor sperm • Cost of donor egg • Fertility drugs 	<i>All charges.</i>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	\$15 per visit to your primary care physician \$30 per visit to a specialist Nothing for allergy injections performed by non-physician personnel
Allergy serum	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization, skin titration (Rinkel Method), cytotoxicity testing (Bryans Test), RAST testing, MAST testing, urine autoinjection</i>	<i>All charges.</i>

Treatment therapies	You pay
<ul style="list-style-type: none"> Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 27.</p> <ul style="list-style-type: none"> Respiratory and inhalation therapy Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy Growth hormone therapy (GHT) for children or adolescents who have documented growth hormone deficiency or a concomitant medical condition for which human growth hormone is an FDA approved indication. <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We only cover GHT when we preauthorize the treatment. Call 800-863-7847 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>\$15 per visit to your primary care physician</p> <p>\$30 per visit to a specialist or</p> <p>\$100 per visit if provided in outpatient hospital setting</p>
<ul style="list-style-type: none"> Dialysis – Hemodialysis and peritoneal dialysis <p>Note A maximum of 6 out-of-area dialysis treatments per year are provided when Prior Authorization has been obtained from Health Net of Arizona, Inc</p>	<p>\$30 per visit in the provider office or outpatient hospital setting.</p>
<p><i>Not covered: Experimental investigational or alternative therapies</i></p>	<p><i>All charges.</i></p>
Physical and occupational therapies	
<p>60 visits per calendar year for the services of each of the following:</p> <ul style="list-style-type: none"> qualified physical therapists and occupational therapists <p>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.</p> <ul style="list-style-type: none"> Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 60 sessions per calendar year. 	<p>\$20 per visit or outpatient hospital setting.</p> <p>Nothing per visit during covered inpatient admission.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Long-term rehabilitative therapy</i> <i>Exercise programs</i> <i>Therapies provided for the purposes of maintaining physical condition</i> 	<p><i>All charges.</i></p>

Speech therapy	You pay
60 visits per plan year	\$20 per visit or outpatient hospital setting. Nothing per visit during covered inpatient admission
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	\$15 per visit to your primary care physician \$30 per visit to a specialist
<p><i>Not covered:</i></p> <p><i>All other hearing testing including hearing exams to determine the extent of hearing loss if you are over age 18</i></p> <p><i>Hearing aids, testing and examinations for them</i></p>	<i>All charges.</i>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • One eye exam for refraction every 24 months <p>Note: Eye examination for refraction is administered by Health Net Vision. Call 866-392-6058.</p>	Nothing
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts surgery, treatment of keratoconus, aphakia or corneal transplants) – limited to a frame allowance of up to \$75. • Eye exam to determine the need for vision correction for children through age 17 (see <i>Preventive care, children</i>) 	\$15 per visit to your primary care physician \$30 per visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses and after age 17, examinations for them</i> • <i>Eye exercises, orthoptics and other vision training</i> • <i>Radial keratotom, lasik and any other refractive surgery</i> 	<i>All charges.</i>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	\$15 per visit to your primary care physician \$30 per visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (except the initial physician consult and if treatment is by open cutting surgery)</i> 	<i>All charges.</i>

Orthopedic and prosthetic devices	You pay
<ul style="list-style-type: none"> • Artificial limbs and eyes; including the initial purchase and subsequent purchases due to a physical growth. Coverage is limited to limbs that are necessary because of an illness, injury or surgery causing anatomical functional impairment, or from a congenital defect. • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 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. • Prosthetic devices when determined to be medically necessary and result from an illness, injury or surgery causing anatomical functional impairment, or from a congenital defect. Coverage includes the fitting and purchase of a standard model. Replacement is covered only if determined to be medically necessary and results from a change in your physical condition. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Repair and/or replacement of parts or devised worn out due to misuse or abuse</i> • <i>Model upgrades, deluxe, or specialized equipment</i> • <i>Over the counter items</i> 	<i>All charges.</i>

Durable medical equipment (DME)	You pay
<p>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:</p> <ul style="list-style-type: none"> ▪ Hospital beds; ▪ Standard size wheelchairs; one per lifetime; ▪ Crutches, canes; ▪ Walkers; ▪ Plan approved standard blood glucose monitors; ▪ Insulin pumps; ▪ Plan approved peak flow monitors; ▪ Medical supplies determined by Health Net to be medically necessary to operate and/or maintain a covered prosthesis or item of Durable Medical Equipment, subject to the following exclusions and limitations. <p>Note: Call us at 800-289-2818 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ▪ Motorized electric or specialized wheelchairs; ▪ ThAIRpy® vest, except when Health Net medical criteria is met, as determined by the Plan ▪ Scooters or other power operated vehicles ▪ More than one device to provide essentially the same functional assistance ▪ Deluxe, specialized or customized equipment, model upgrades ▪ Transcutaneous Electrical Nerve Stimulation (TEMS) units ▪ Repair or replacement of equipment or parts due to misuse and/or abuse ▪ Prophylactic braces ▪ Braces used primarily for sport activities ▪ Foot orthotics which are not an integral part of a leg brace 	<p><i>All charges.</i></p>

Home health services	You pay
<ul style="list-style-type: none"> 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. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> <i>Housekeeping services</i> <i>Services of a person who resides in the patient's home</i> <i>Custodial care, rest cures, respite cures</i> <i>Services performed by the patient's family member.</i> 	<i>All charges.</i>
Chiropractic	
<ul style="list-style-type: none"> Up to 12 visits per year for manipulation of the spine and extremities Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	\$15 per visit to your primary care physician \$30 per visit to a specialist
Alternative treatments	
No benefit	All charges
Educational classes and programs	
<p>Coverage is limited to classes offered by or through Health Net's Health Education department. To enroll contact us at 800-289-2818.</p> <p>Smoking Cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs.</p> <p>Diabetes self management through Plan Provider. Contact Customer Contact Center at 800-289-2818 for more information.</p> <p>Lamaze</p>	A nominal fee may be required for classroom material

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

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

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- 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
- 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.).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION OF SOME SURGICAL PROCEDURES.** Please refer to the prior authorization information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

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Benefit Description	You pay
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • 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) 	<p>\$15 per visit to your primary care physician \$30 per visit to a specialist or \$100 per outpatient hospital visit</p>

Surgical procedures - continued on next page

Surgical procedures (continued)	You pay
<ul style="list-style-type: none"> • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns <p>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.</p>	<p>\$15 per visit to your primary care physician \$30 per visit to a specialist or \$100 per outpatient hospital visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All charges.</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> • 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 of breasts; • treatment of any physical complications, such as lymphedemas; • breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$15 per visit to your primary care physician \$30 per visit to a specialist or \$100 per outpatient hospital visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges.</i></p>

Oral and maxillofacial surgery	You pay
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • 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. 	<p>\$15 per visit to your primary care physician \$30 per visit to a specialist or \$100 per outpatient hospital visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Routine or general care of teeth or dental structures</i> • <i>Extractions or impacted or abscessed teeth</i> • <i>Dental splints, dental implants, dental prostheses or dentures</i> • <i>Accidental injury to the teeth or gums created by chewing</i> 	<p><i>All charges.</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • 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 • Donor searches limited to \$5,000 per organ per lifetime • FDA approved Ventricular Assist Device only when bridges to transplant. <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-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.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient</p>	<p>Place of service copayment applies</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<p><i>All charges.</i></p>

Anesthesia	You pay
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing
Professional services provided in – <ul style="list-style-type: none"> • 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

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

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- 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 in Sections 5(a) or (b).

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Benefit Description	You pay
Inpatient hospital	
<p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	\$200 per day up to 3 days per admission
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • 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 • Medical supplies, appliances, medical equipment, including oxygen • Anesthetics, including nurse anesthetist services 	\$200 per day up to 3 days per admission

Inpatient hospital - continued on next page

Inpatient Hospital <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals, travel expenses, take-home supplies and beds • Collection and/or storage of blood products for any unscheduled or non-covered medical procedure • Private nursing care 	<p><i>All charges.</i></p>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • 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 <p>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.</p>	<p>\$100 per visit</p>
<p><i>Not covered: Blood and blood derivatives not replaced by the member</i></p>	<p><i>All charges.</i></p>
Extended care benefits/Skilled nursing care facility benefits	
<p>Skilled nursing facility (SNF): Coverage is provided when a full-time skilled nursing care is medically necessary and confinement in a SNF is medically appropriate as determined by Plan doctor and approved by Health Net</p>	<p>\$200 per day up to 3 days per admission</p>
<p><i>Not covered: Custodial care, domiciliary care or convalescent care</i></p>	<p><i>All charges.</i></p>
Hospice care	
<p>Members who are diagnosed as having an illness giving them a life expectancy of 6 months or less may request Hospice care. All Hospice care must be provided by a licensed participating Hospice and include inpatient and outpatient care related to the condition</p>	<p>Nothing</p>
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<p><i>All charges.</i></p>

Ambulance	You pay
<ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate • Air ambulance when prior authorized or if the member's condition is an emergency and the location of the accidental injury and/or illness is inaccessible by ground vehicles or transport by ground ambulance would be detrimental to the member's health. 	Nothing

Section 5(d) Emergency services/accidents

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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.

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What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

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

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

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

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

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

Benefit Description	You pay
Emergency within and outside our service area	
<ul style="list-style-type: none"> ▪ Emergency care at a doctor’s office 	\$15 per visit to your primary care physician \$30 per visit to a specialist
<ul style="list-style-type: none"> ▪ Emergency care at an urgent care center 	\$50 per visit
<ul style="list-style-type: none"> ▪ Emergency care as an outpatient or inpatient at a hospital, including doctors services 	\$100 per visit (waived if admitted; \$200 per day up to 3 days per admission inpatient hospital benefit applies)
<i>Not covered: Elective care or non-emergency care, continuing, routine or follow up care without prior authorization; 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; or medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.</i>	<i>All charges.</i>

Ambulance	You pay
<p>Professional ambulance service when medically appropriate and in an emergency situation. Air ambulance when prior authorized or if the member's condition is an emergency and the location of the accidental injury and/or illness is inaccessible by ground vehicles or transport by group ambulance would be detrimental to the member's health.</p> <p>Note: See 5(c) for non-emergency service.</p>	<p>Nothing</p>

Section 5(e) Mental health and substance abuse benefits

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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:

- 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.
- 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.

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Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$30 per visit to a specialist</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>No charge for laboratory, X-ray and other diagnostic tests at the physician's office or freestanding facility.</p> <p>If you receive these services at an outpatient hospital setting a \$10 copay per visit will apply.</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as a half-way house, residential treatment, full-day hospitalization, facility 	<p>\$200 per day up to 3 days per admission</p>
<ul style="list-style-type: none"> • Services in approved alternative care settings such as partial hospitalization or facility based intensive outpatient treatment 	<p>\$100 per visit</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>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.</i></p>	<p><i>All charges.</i></p>

Mental health and substance abuse benefits – continued on next page

Mental Health and substance abuse benefits
(continued)

You pay

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:

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

Limitation

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

Section 5(f) Prescription drug benefits

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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 have no calendar year
- 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.

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

- **Who can write your prescription.** A licensed physician must write the prescription
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy, or by mail for maintenance.
- **We use a formulary (Preferred Drug List).** Drugs covered by your prescription drug benefit are assigned to one of the following tiers: Tier 1 includes generic drugs. Tier 2 includes preferred brand drugs and preferred insulin vials. Tier 3 includes non-preferred drugs, and compounded prescriptions. There may be prior authorization requirements on select drugs in all three tiers. FDA-approved drugs may not be immediately covered. They may be available for coverage with prior authorization. The Tier 3 copayment will be assessed until the drug has been reviewed by the Health Net Pharmacy & Therapeutics Committee to determine tier placement on the Preferred Drug List. The Preferred Drugs List is update periodically throughout the year. To order a current Preferred Drug List call 800-289-2818 or visit our Web site at www.healthnet.com
- **These are the dispensing limitations.** Prescription drugs obtained at a plan pharmacy will be dispensed for up to a 31-day supply. Mail order prescriptions are limited to Health Net's mail order provider and will be dispensed for up to a 93-day supply. Some medications may be dispensed in quantities less than those stated due to the prepackaging by the pharmaceutical manufacturer. Insulin, diabetic supplies and inhalers have quantity per copayment limitations, as stated below. Refills are only covered when authorized by a plan physician and/or Health Net. Some medications required prior authorization by the Plan. You will be financially liable for the cost of medications obtained after you are no longer eligible for coverage under the plan.
- **Members called to Active Duty or during a National Emergency.** Members may contact our Customer Contact Center at 800-289-2818. Our Customer Contact Center will work with our Pharmacy Department to authorize the medications and/or supplies and which provider to obtain the services from.
- **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 higher brand copayment.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the brand name is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and brand name drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you - and us - less than a name brand prescription.
- **When you do have to file a claim.** If you are required to pay for a prescription in an out-of-area-emergency situation, you may request reimbursement from Health Net by submitting the actual prescription receipt(s) along with your Name, Member ID number and a brief explanation of the emergency circumstances to Health Net of Arizona, Attn: Pharmacy Department, 950 N. Finance Center Drive, Tucson, Arizona 85710-1362. The actual prescription receipt is provided by the pharmacy and includes patient name, medication name, price and date of service. If you do not have the original receipt(s) you may obtain a duplicate from the pharmacy. We are unable to process reimbursements with just cash register receipts.

Prescription drug benefits begin on the next page

Prescription drugs (continued)

Benefit Description	You pay
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> ▪ Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. ▪ Insulin – limited to 2 vials per copayment ▪ Disposable needles and syringes for the administration of covered medications – limited to 100 per copayment ▪ Diabetic supplies, including lancets, glucose test strips, visual reading strips, and urine testing strips – limited to 100 per copayment ▪ Insulin cartridges for the legally blind – limited to the equivalent to 2 vials of insulin per copayment ▪ Automatic lancing devices – limited to one every six months per copayment ▪ Insulin aids (insulin pen) – limited to one every six months per copayment ▪ Glucagon (requires prior authorization) – limited to one per copayment ▪ Spacers and holding chambers for inhaled medications – limited to one per six months per copayment ▪ Inhalers – up to 2 (nasal or oral), or up to a 31-day supply, whichever is less, per copayment ▪ Drugs for sexual dysfunction require Prior authorization and have dispensing limitations. Contact plan for details. ▪ Contraceptive drugs ▪ Growth hormones therapy (GHT) for children or adolescents who have documented growth hormone deficiency or a concomitant medical condition for which human growth hormone is an FDA approved indication. Growth hormone requires prior authorization. 	<p>\$15 per generic prescription or refill obtained from a plan pharmacy</p> <p>\$30 per preferred brand name prescription or refill obtained from a plan pharmacy</p> <p>\$50 per non-preferred brand name prescription or refill obtained from a plan pharmacy</p> <p>\$37 per generic prescription or refill obtained through our mail order program</p> <p>\$75 per preferred brand name prescription or refill obtained through our mail order program</p> <p>\$125 per non-preferred brand name prescription or refill obtained through our mail order program</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>

Covered medications and supplies – continued on next page

Covered medications and supplies <i>(continued)</i>	You pay
Self-injectable drugs require prior authorization (brand name copayment applies to insulin)	\$60 per prescription or refill, up to a 31-day supply or \$180 per prescription or refill up to a 93-day supply. Quantity limitations may apply to specific drugs.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> ▪ <i>Drugs and supplies for cosmetic purposes</i> ▪ <i>Drugs to enhance athletic performance</i> ▪ <i>Fertility drugs</i> ▪ <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> ▪ <i>Vitamins (except prenatal), nutrients and food supplements even if a physician prescribes or administers them</i> ▪ <i>Anorexiant, appetite suppressants, diet aids, weight loss medications, and drugs used to treat obesity.</i> ▪ <i>Any drug consumed at the place where it is dispensed or that is dispensed or administered by the physician.</i> ▪ <i>Drugs prescribed for non-covered services</i> ▪ <i>Take home drugs, drugs prescribed for use after discharge from a hospital, nursing home, skilled nursing facility or other inpatient facility must be obtained from a plan pharmacy.</i> ▪ <i>Replacement prescriptions</i> 	<i>All charges.</i>

Section 5(g) Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • 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	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 800-289-2818 and talk with a registered nurse who will discuss treatment options and answer your health questions. Health Net's Decision Power includes a suite of easy to use, evidence based decision-support tools designed to help people make informed decisions about their health care.</p>
Services for deaf and hearing impaired	<p>We provide a TTY line for the deaf and hearing impaired 800-977-6765.</p>
High risk pregnancies	<p>We contract with Matria Healthcare, Inc. This program is directed at high-risk pregnancies including pre-term labor, multiple gestations, tocolytic therapy, hypertension, diabetes and hydration therapy. The goal is to achieve optimal pregnancy prolongation by provided increased level of education and surveillance.</p>
Centers of excellence	<p>We contract with many respected institutions in our regions, such as, University Medical Centers, Barrows Neurological Institute, Maricopa County Burn Unit, St. Joseph's Hospital and Phoenix Children's Hospital.</p>
Travel benefit/services overseas	<p>We provide unforeseen urgent or emergency service. All emergency care must be authorized by your primary care physician and the Plan. (Refer to Section 5 (d) for more information).</p>

Section 5(h) Dental benefits

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan dentists must provide or arrange your care.
- We 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. See Section 5(c) for inpatient hospital benefits. 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.

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Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth, the jawbone and supporting tissues (does not include injury caused by the act of chewing). The need for these services must result from an accidental injury.	\$15 per visit to your primary care physician \$30 per visit to a specialist or \$100 per visit if provided in an outpatient hospital setting
Dental Benefits	
<i>We have no other dental benefits.</i>	<i>All charges.</i>

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 catastrophic protection out-of-pocket maximums.

It's Your Life Program – the goal is to help you take an individual path to a better balance and personal wellbeing.

- Includes wellness and safety programs
- Tools for managing emotional, legal or financial issues
- Childcare and elder care resources

Dental Program – Health Net of Arizona, Inc. is pleased to provide you and your enrolled family members with access to dental care through Employers Dental Services (EDS) at no additional premium. Health Net FEHB members are automatically enrolled in this program. Easy to Use -Select any provider from the Employer's Dental Services network and show your EDS identification card when you receive services. View the EDS Network and New Patient provider availability online at www.mydentalplan.net

Health Net's Rosetta Stone Program – A suite of easy-to-use, evidence-based decision support tools designed to help people make informed decisions about their health care. Just as the original Rosetta Stone unlocked the mysteries of an ancient language, the Health Net Rosetta Stone will unlock the mysteries of health care. Tools include:

- Decision Power, which gives people access to Health Coaches who can help them prepare for the most important decisions they will make about their health.
- EBM Solutions, an easy-to-use online reference library that gives members information on more than 100 medical conditions and the evidence-based, clinically tested treatments that are available for each.
- Hospital Comparison report powered by HealthShare, which provides a scorecard of hospitals nationwide, including procedural outcomes and patient satisfaction.

The new www.healthnet.com - Making health care decisions easier:

- See My Plan – provides you the information you need to get the most out of your benefit plan.
- Find Care – Directory search tool for providers, hospitals and pharmacies
- Make an Informed Decision – Access the Rosetta Stone tools
- Get Things Done – Change doctors, order a new ID card or update your information.

Medicare Advantage Enrollment

The Individual Plan offers Medicare beneficiaries the opportunity to enroll in a plan through Medicare or Health Net. As indicated on page 50, annuitants and former spouses with FEHB coverage and Medicare Parts A and B eligibility may elect to:

Contact your retirement system for information on your FEHB enrollment and changing to a **Medicare Advantage** plan or you may contact us at 800-977-7522, Monday through Friday 7:00 a.m. to 6:00 p.m. for more information. Hearing impaired assistance Monday through Friday 7:00 a.m. to 6:00 p.m. TTY 800-977-6567.

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 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;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- 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. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 800-289-2818.

When you must file a claim – such as for services you receive outside 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: ACS/Health Net, Inc. P.O. Box 14225, Lexington, KY 40512-4225

Prescription drugs

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

Submit your claims to: Health Net of Arizona, Inc. Attn: Pharmacy Department, 950 N. Finance Center Drive, Tucson, Arizona 85710-1362.

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: <i>P.O. Box 867 Shelton, CT 06484</i>Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial – go to step 4; orAsk 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	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">▪ 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. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p>

The disputed claims process (*continued*)

Send OPM the following information:

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

Note: If you want OPM to review 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.

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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 800-289-2818 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:

If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or

You may call OPM's Health Insurance Group 3 at 202-606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you 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 or older.
- Some people with disabilities under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since 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.

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or both Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don’t have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

• 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, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

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. Your care must continue to be authorized by your Plan PCP, or Us as required.

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

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

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 800-289-2818 or see our Web site at www.healthnet.com.

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

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

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above.	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and... You have FEHB coverage on your own or through your spouse who is also an active employee		✓
You have FEHB coverage through your spouse who is an annuitant	✓	
5) 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) and you are not covered under FEHB through your spouse under # 1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) 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	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and... • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and... • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation

- **Medicare Advantage**

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

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

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

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage 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 Advantage plan's service area.

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 plan 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.

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. You may also be responsible for additional amounts. See page 11.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Room and board, nursing care (except for skilled nursing care), and personal care designed to assist a member who has reached the maximum level of recovery. Custodial care that last 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 11.
Experimental or investigational services	<p>Our parent company Health Net, Inc. (HNI), has a technology assessment policy committee whose sole function is to evaluate if a drug, device, medical treatment or procedure is experimental or investigational. HNI bases its determination on one or more of the following:</p> <ul style="list-style-type: none">• It is broadly accepted in the medical community as standard, safe and effective for the illness or injury being related;• It is approved for use by the appropriate governmental regulatory bodies, including the FDA;• It is attainable in the U.S. outside of a research institution program or protocol;• Does it clearly improve the net health outcome as evaluated against non-experimental or non-investigational health care services using credible and accepted medical evidence
Group health coverage	Health care coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies.
Medical necessity	<p>Services required to identify or treat an illness that is either diagnosed or reasonably suspected. Medically Necessary service must, in the judgement of Health Net:</p> <ol style="list-style-type: none">1. be required to treat an illness or injury; and2. be consistent and appropriate for the diagnosis and treatment of the Member's condition; and3. be in accordance with the standards of accepted principles of medical practice in the United States; and4. be performed at the most appropriate level of care for the Member as determined by the Member's medical condition not the Member's financial or family situations or the distance the Member lives from the Hospital , or any other non-medical factor; and5. not be for the convenience of the Member, nor the Member's family, support network, Physician or another Health Professional; and6. not be Experimental, Unproved or Investigational if furnished in connection with medical or other research.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: <i>our contracted amount</i> .
Us/We	Us and We refer to <i>Health Net of Arizona, Inc.</i>
You	You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition 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 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 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 Blue Cross and Blue Shield Service Benefit Plan’s Basic Option;
- If you have a 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 cancel your coverage, change to Self Only, or change to a plan that doesn’t serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective 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. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2005 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan’s 2004 benefits until the effective date of your coverage with your new plan. 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 (TCC), or a conversion policy (a non-FEHB individual policy.)

- **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 provide health coverage to 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 Web site, 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 Federal 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 at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12. Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

The Federal Flexible Spending Account Program – *FSAFEDS*

• What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal income tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$4,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$4,000 each (\$8,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal income tax return (and who is mentally or physically incapable of self care).
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive.

• Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2005 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2005. Enrollment is easy!

- **Online:** visit www.FSAFEDS.com and click on **Enroll**.
- Telephone: call an FSAFEDS Benefits Counselor toll-free 1-877-FSAFEDS (372-3337) Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time. TTY: 1-800-952-0450.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and is responsible for enrollment, claims processing,

customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. *However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you are not eligible to participate in an HCFSA.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

• How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits of an FSA provides, the IRS places strict guidelines on how the money can be used. Under current IRS tax rules, you are required to forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. You will have until April 30, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through December 31. For example if you enroll in FSAFEDS for the 2005 Plan Year, you will have until April 30, 2006 to submit claims for eligible expenses.

The FSAFEDS Calculator at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

• What can my HCFSA pay for?

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 11 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under the Standard Option of this plan, typical out-of-pocket expenses include: *office visit copayments, inpatients hospital copayments, outpatient prescription drug copayments, eyewear, lasik surgery or routine chiropractic care.*

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

• Tax savings with an FSA

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 - a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal income tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

- **Health care expenses**

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

- **Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.FSAFEDS.com and download the [Dependent Care Tax Credit Worksheet](#) from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year, resulting in the forfeiture of funds remaining in your account (the IRS "use-it-or-lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at www.FSAFEDS.com, or contact SHPS directly via email or by phone. FSAFEDS Benefit Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. Eastern Time.

- E-mail: FSAFEDS@shps.net
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

- **It's important protection**

Why should you consider applying for coverage under the Federal Long Term Care Insurance Program (FLTCIP)?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To find out more and to request an application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Index

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

Accidental injury	20, 21, 26, 33, 40	Experimental or investigational....	19,42,51	Office visits.....	6, 11, 14
Allergy tests.....	18	Eyeglasses	21	Oral and maxillofacial surgical	26
Allogeneic (donor) bone marrow transplant.....	27	Family planning.....	17	Out-of-pocket expenses.....	11, 61
Alternative treatments.....	23	Fecal occult blood test.....	15	Oxygen.....	22
Ambulance.....	31, 33	Fraud	3, 4	Pap test.....	15
Anesthesia	28, 30	General Exclusions.....	42	Physician	14
Autologous bone marrow transplant.	19, 27	Hearing services	20	Prescription drugs	36, 37, 38, 61
Biopsy.....	24	Home health services.....	23	Preventive care, adult	15
Blood and blood plasma	30	Hospice care	31	Preventive care, children.....	16
Casts	30	Hospital 4, 5, 6, 8, 9, 11, 14, 21, 22, 24, 25, 26, 28, 29, 30, 31, 34, 36, 42, 44, 45, 48, 51, 54, 55, 66		Preventive services.....	6
Catastrophic protection out-of-pocket maximum	11, 41, 60	Immunizations	17	Prior approval.....	10
Changes for 2005.....	7	Infertility	11, 18	Prosthetic devices.....	22
Chemotherapy	19	Inpatient hospital benefits.....	31	Psychologist	35
Chiropractic.....	23	Insulin.....	37	Radiation therapy	19
Cholesterol tests.....	15	Magnetic Resonance Imagings (MRIs) ..	15	Room and board	29
Circumcision	17	Mammograms	15	Second surgical opinion	14
Claims.....	8, 12, 39, 43, 44, 45 55, 56, 60	Maternity benefits	17	Skilled nursing facility care	28, 30
Coinsurance.....	6 8, 11, 41, 43, 49, 51, 56	Medicaid.....	50	Smoking cessation.....	23
Colorectal cancer screening.....	15	Medically necessary 14, 17, 19, 22, 24, 30, 33, 35, 37, 42, 47		Social worker	34
Congenital anomalies	22	Medicare.....	46, 47, 48, 49	Speech therapy	20
Contraceptive drugs and devices	17, 37	Medicare Advantage	49	Splints	26
Covered charges	52	Original	46, 47, 48,	Subrogation	50
Crutches.....	23	Members		Substance abuse	34, 35
Deductible	8, 11, 14, 24, 29, 32, 40, 43, 49, 51,56	Associate.....	67	Surgery	
Definitions...14, 24, 30, 33, 35, 37, 42, 56, 66		Family	11, 57	Anesthesia.....	28
Dental care.....	40	Plan	8, 25, 46	Oral	26
Diagnostic services.....	15, 34, 60	Mental Health/Substance Abuse Benefits	35	Outpatient	30
Disputed claims review	41	Newborn care	17	Reconstructive	25
Donor expenses	27	Non-FEHB benefits.....	41	Syringes	37
Dressings	22	Nurse		Temporary Continuation of Coverage (TCC).....	54
Durable medical equipment.....	22	Licensed Practical Nurse (LPN).....	22	Transplants.....	27
Educational classes and programs	23	Nurse Anesthetist (NA).....	31	Treatment therapies.....	19
Effective date of enrollment	8,	Registered Nurse.....	41	Vision care	60
Emergency....	6, 31, 32, 33, 36, 39, 42, 43, 60	Occupational therapy.....	20	Vision services	21
		Ocular injury	21	Wheelchairs.....	22
				Workers Compensation.....	49
				X-rays.....	15, 16, 30

Summary of benefits for the *Health Net of Arizona- 2005*

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: \$15 primary care; \$30 specialist	14
Services provided by a hospital: • Inpatient	\$200 per day up to 3 days per admission	29
• Outpatient	\$100 per visit	30
Emergency within or outside our service area Emergency care as an outpatient or inpatient at a hospital, including doctors' services	\$100 per visit (waived if admitted; \$200 per day up to 3 days per admission inpatient hospital admission applies)	32
Mental health and substance abuse treatment	Regular cost sharing	34
Prescription drugs	\$15 per generic prescription or refill obtained from a plan pharmacy \$30 per preferred brand name prescription or refill obtained from a plan pharmacy \$50 per non-preferred brand name prescription or refill obtained from a plan pharmacy Mail Order available for 2.5 retail copayments for 93 day supply Note: If there is no generic equivalent available, you will still have to pay the brand name copay.	36
Dental care	No benefit.	40
Vision care One eye exam for refraction every 24 months <i>Note:</i> Eye examination for refraction is administered by Health Net Vision. Call 866-392-6058	Nothing.	20
Special features: <i>Flexible benefits option, Services for deaf and hearing impaired, Centers of excellence, High risk pregnancies, Case Management Programs</i>		39
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$2000/Self Only or \$4000/Family enrollment per year Some costs do not count toward this protection	11

2005 Rate Information for Health Net of Arizona, Inc.

Non-Postal rates apply to most non-Postal employees. 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.

		<i>Non-Postal Premium</i>				<i>Postal Premium</i>	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Location Information (include this text if the Plan has more than one enrollment code, then add a geographic location description.)							
Self Only	A71	\$113.57	\$37.85	\$246.06	\$82.02	\$134.39	\$17.03
Self & Family	A72	\$287.77	\$95.92	\$623.50	\$207.83	\$340.52	\$43.17