Health Net of Arizona, Inc.

http://www.healthnet.com

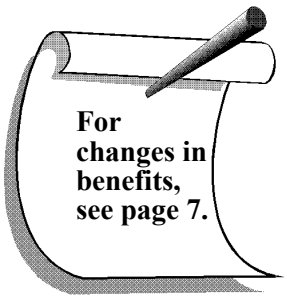
Health Net®

2009

A Health Maintenance Organization (high and standard option)

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 High Option – Self Only
A72 High Option – Self and Family
A74 Standard Option – Self Only
A75 Standard Option – 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

Important Notice from Health Net of Arizona, Inc. About

Our Prescription Drug Coverage and Medicare

OPM has determined that the Health Net of Arizona, Inc. prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and Health Net of Arizona, Inc. will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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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, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on page 7. 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 fehbwebcomments@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:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits 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) statements 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 1-800-289-2818 and explain the situation.

  If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

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 a court order stipulates otherwise); or
  - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, 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.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.

- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

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.

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.htm. 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. 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. We offer you a choice of enrollment in a High Option or a Standard Option HMO plan.

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

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

How we pay providers

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

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.
- Health Net of Arizona, Inc. is a for profit organization.

If you want more information about us, call 1-800-289-2818, or write to Health Net of Arizona, Inc. P.O. Box 867, Shelton, CT 06484. You may also contact us by fax at 1-800-977-6762 or visit our Web site at www.healthnet.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

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 2009

Do not rely only on these change descriptions; this Section 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.

Changes to this Plan

- Cover hearing aids, testing and examinations for children through age 17 years with a maximum benefit for hearing aid(s) not to exceed $4,000 every 36 months.
- The generic/preferred brand name/non-preferred brand name system has been changed to Level 1, Level 2 and Level 3:
  - **Level 1** generally includes generic drugs but may include some brand formulary or preferred brands and this level usually represents the lowest copay.
  - **Level 2** generally includes brand formulary and preferred brands, but may include some generics and brands not included in Level 1. Level 2 usually represents brand or middle-range copays.
  - **Level 3** may include all other covered drugs (including some generics) not on Levels 1 and 2 i.e. non-formulary, or non-preferred, and some specialty drugs.

Changes to High Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. See page 68.
- We will cover hearing aids, testing and examinations for individuals 18 years and older with a maximum benefit for hearing aid(s) not to exceed $4,000 every 36 months.

Changes to Standard Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. See page 68.
- The copayment for prescription drugs will decrease to $10 for Level 1 and $20 for Level 1 mail order.

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 letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-289-2818 or write to us at Health Net of Arizona, Inc. P.O. Box 867, Shelton, CT 06484. You may also request or print replacement cards through our Web site: www.healthnet.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance.

- **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 1-800-289-2818.

- **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 the following specialties without a referral: obstetrics/gynecology, chiropracic, vision services (for routine eye exams), mental health and substance abuse services, and diabetic members may see an ophthalmologist for an annual eye examination without 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 hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-289-2818. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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 cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

How to get approval for…

- **Maternity care**

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery, or 96 hours after a Cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

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, growth hormone therapy (GHT), 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 of Arizona, Inc. 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 cost for covered services

This is what you will pay out-of-pocket for covered care

Copayments

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

Example: If you have the High Option a specialist visit will require a $30 copayment per office visit, and when you are admitted to the hospital, you pay $200 per day up to three days per admission.

Example: If you have the Standard Option, a specialist visit will require a $40 copayment per office visit and when you are admitted to the hospital, you pay $250 per day up to three days per admission.

Copayments do not apply to services and supplies that are subject to a deductible and/or coinsurance amount.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward any deductible.

- Under the Standard Option the calendar year deductible is $1,000 per person. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $2,000.
- Under the High Option, there is no calendar year deductible.

Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for certain services you receive. Coinsurance doesn't begin until you meet your deductible.

Example: In our Standard Option Plan, you pay 15% of our allowance for durable medical equipment, after meeting your $1,000 calendar year deductible.

Your catastrophic protection out-of-pocket maximum

After your (copayments and coinsurance) total $2,000 per person or $4,000 per family enrollment (High Option plan) or $4,000 per person or $8,000 per family enrollment (Standard Option) in any calendar year, you do not have to pay any more for covered services. However, copayments and coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay 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.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

Section 5. High and Standard Option Benefits

See page 7 for how our benefits changed this year. Page 64 through page 67 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain more information about High and Standard Option benefits, contact us at 1-800-289-2818 or at our Web site at www.healthnet.com.

Both plans are designed to include preventive and acute care services provided by our Plan providers. Each plan offers its own unique features, including different levels of benefits and services for you to choose from. You select the plan that best fits your health care needs.

High Option

With the High Option your copayments may be lower than the Standard Option. Highlights of the FEHB High Option include:

- The High Option does not have a calendar year deductible.
- Most services are subject to copayments.
- $15 copayment for primary care providers and $30 copayment for specialist.
- $200 copayment per day up to three days per inpatient hospital admission.
- $100 copayment for outpatient hospital procedures.
- $200 copayment for outpatient imaging and testing.
- $10 copayment for Level 1 drugs, $30 copayment for Level 2 drugs and $50 for Level 3 drugs.

Standard Option

Our Standard Option features lower bi-weekly premium payments. Highlights of the FEHB Standard Option include:

- Calendar year deductible of $1,000 per person and $2,000 per family enrollment.
- $15 copayment for primary care providers and $40 copayment for specialist.
- $250 copayment per day up to three days per inpatient hospital admission (deductible does not apply).
- 15% coinsurance subject to deductible for outpatient hospital procedures.
- 15% coinsurance subject to deductible for outpatient imaging and testing.
- $10 copayment for Level 1 drugs, $40 copayment for Level 2 drugs and $70 for Level 3 drugs.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- *Under the High Option, there is* **no calendar year deductible**.
- Under the Standard Option the calendar year deductible is: $1,000 per person ($2,000 per family). We added "(No deductible)" to show when the calendar year deductible does not apply.
- Different copayments apply for primary care visits and specialty care visits.
- 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.

Benefit Description	You pay After the calendar year deductible…	
Note: The Standard Option plan's calendar year deductible applies to some benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In physician's office • Office medical consultations • Second Surgical Opinion	$15 per visit to your primary care physician $30 per visit to a specialist	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible)
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility	Included in the facility co-payment	Included in the facility co-payment
At home	$15 per visit to your primary care physician $30 per visit to a specialist	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible)
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound	No charge for laboratory, X-ray and other diagnostic tests	No charge for laboratory, X-ray and other diagnostic tests (No deductible)

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Lab, X-ray and other diagnostic tests (cont.)	**High Option**	**Standard Option**
• Electrocardiogram and EEG	No charge for laboratory, X-ray and other diagnostic tests	No charge for laboratory, X-ray and other diagnostic tests (No deductible)
Outpatient imaging and testing, such as: • CAT Scans/MRI • MRAs • Stress tests • PET/SPECT scans	$200 per visit at the physician's office, freestanding facility or at an outpatient hospital setting	You pay 15% of our allowance
Preventive care, adult	**High Option**	**Standard Option**
Routine physical every 24 months for individuals 18 years of age and older (additional exams will be covered if determined to be medically necessary) which includes: Routine screenings, such as: • 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 - Colonoscopy screening – every ten years starting at age 50	$15 per visit to your primary care physician $30 per visit to a specialist Facility charge applies see section 5(c) for outpatient hospital and ambulatory surgical facility charges	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible) Facility charge applies see section 5(c) for outpatient hospital and ambulatory surgical facility charges
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	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible)
Routine Pap test Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see *Diagnostic and treatment services*, on page 16.	$15 per visit to your primary care physician $30 per visit to a specialist	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible)
Routine mammogram – covered for women age 35 and older, or more frequently if recommended by a participating physician, as follows: • 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 calendar year	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	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.	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.
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	$15 per visit to your primary care physician $30 per visit to a specialist	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible)
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Hearing 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	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible)
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 9 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. Surgical benefits, not maternity benefits, apply to circumcision.	$15 per visit, nothing for prenatal and postnatal care after the initial diagnosis of pregnancy Inpatient copayment will apply for delivery	$15 per visit, nothing for prenatal and postnatal care after the initial diagnosis of pregnancy Inpatient copayment will apply for delivery

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Maternity care (cont.)	**High Option**	**Standard Option**
• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$15 per visit, nothing for prenatal and postnatal care after the initial diagnosis of pregnancy Inpatient copayment will apply for delivery	$15 per visit, nothing for prenatal and postnatal care after the initial diagnosis of pregnancy Inpatient copayment will apply for delivery
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).	*All charges*	*All charges*
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5(b)) • Injectable contraceptive drugs (such as Depo provera) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	$15 per visit to your primary care physician $30 per visit to a specialist See section 5(c) for facility charges	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible) See section 5(c) for facility charges
• Surgically implanted contraceptives (such as Norplant) • Intrauterine devices (IUDs) (Limited to one-medically necessary removal in any 3 consecutive year period)	50% of all covered services	50% of all covered services (No deductible)
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling.* • *Diagnostic testing to establish paternity of a child* • *Genetic testing*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI)	50% of all covered services	50% of all covered services (No deductible)
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization*	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Infertility services (cont.)	**High Option**	**Standard Option**
- *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• 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	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible) Nothing for allergy injections performed by non-physician personnel
Allergy serum	Nothing	Nothing
Not covered: • *Provocative food testing and sublingual allergy desensitization* • *Skin titration (Rinkel Method)* • *Cytotoxicity testing (Bryans Test)* • *RAST testing* • *MAST testing, and* • *Urine autoinjection*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants beginning on page 30. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • 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	$30 per office visit or hospital outpatient setting	$40 per office visit or hospital outpatient setting (No deductible)

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Treatment therapies (cont.)	**High Option**	**Standard Option**
Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. Call 1-800-863-7847 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 *Services requiring our prior approval* in Section 3.	$30 per office visit or hospital outpatient setting	$40 per office visit or hospital outpatient setting (No deductible)
Not covered: • *Experimental investigational therapies* • *Alternative therapies*	*All charges*	*All charges*
Physical and occupational therapies	**High Option**	**Standard Option**
60 visits for the services of each of the following: • qualified physical therapists and • occupational therapists Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 sessions.	$20 per visit or outpatient hospital setting Nothing per visit during covered inpatient admission	$40 per visit or outpatient hospital setting (No deductible) Nothing per visit during covered inpatient admission
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Therapies provided for the purposes of maintaining physical condition*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
60 visits per plan year	$20 per visit or outpatient hospital setting Nothing per visit during covered inpatient admission	$40 per visit or outpatient hospital setting (No deductible) Nothing per visit during covered inpatient admission

Benefit Description	You pay After the calendar year deductible…	
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17, which include; (see *Preventive care, children)* • *Hearing aids, testing and examinations (for children through age 17). A* maximum benefit for hearing aid(s) is not to exceed $4,000 every 36 months	$15 per visit to your primary care physician $30 per visit to a specialist	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible)
• *Hearing aids testing and examinations (for individuals 18 years and older).* A maximum benefit for hearing aid(s) is not to exceed $4,000 every 36 months	$15 per visit to your primary care physician $30 per visit to a specialist	*All charges*
• *All other hearing testing including hearing exams to determine the extent of hearing loss if you are over age 18*	$15 per visit to your primary care physician $30 per visit to a specialist	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• One eye exam for refraction every 24 months Note: Eye examinations for refraction is administered by Health Net Vision. Call 1-866-392-6058 .	Nothing	Nothing
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataract surgery, treatment of keratomconus, 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 Preventive care, children)	$15 per visit to your primary care physician $30 per visit to a specialist	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible)
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics and other vision training* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible…	
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	$15 per visit to your primary care physician $30 per visit to a specialist	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible)
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (except the initial physician consult and if treatment is by open cutting surgery)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs and eyes; including the initial purchase and subsequent purchases due to physical growth. Coverage is limited to limbs that are necessary because of an illness, injury or surgery causing anatomical functional impairment, or from a congenital defect. • 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) 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	15% of our allowance
Not covered: • *Orthopedic and corrective shoes* • *Arch supports*	*All charges*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Repair and/or replacement of parts or devised worn out due to misuse or abuse* • *Model upgrades, deluxe, or specialized equipment* • *Over the counter items*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment at our option, including repair and adjustment, prescribed by your Plan physician. Covered items include: • Oxygen; • Dialysis equipment; • Hospital beds; • Standard size wheelchairs; one per lifetime; • Crutches, canes; • Walkers; • Plan approved standard blood glucose monitors; • Insulin pumps; • Plan approved peak flow monitors; and • 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. Note: Call us at 1-800-289-2818 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.	Nothing	15% of our allowance
Not covered: • *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*	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
• *Transutaneious 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* • *Communications equipment, devices and aids (including computer equipment) such as "story boards" or other communications aids to assist communication-impaired individuals and /or training to use such devices*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• 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	15% of our allowance
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Housekeeping services* • *Services of a person who resides in the patient's home* • *Custodial care, rest cures, respite cures* • *Services performed by the patient's family member*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
• 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	$30 per visit to a specialist	$40 per visit to a specialist (No deductible)

Benefit Description	You pay After the calendar year deductible…	
Alternative treatments	**High Option**	**Standard Option**
No benefit	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Coverage is limited to classes offered by or through Health Net's Health Education department. To enroll contact us at 1-800-289-2818. • Smoking cessation - up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. • Diabetes self management through Plan Provider. Contact Customer Contact Center at 1-800-289-2818 for more information. • Lamaze	A nominal fee may be required for classroom material	A nominal fee may be required for classroom material

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- *Under the High Option, there is* ***no calendar year deductible.***
- Under the Standard Option the calendar year deductible is: $1,000 per person ($2,000 per family). We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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 PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible…	
Note: The Standard Option plan's calendar year deductiable applies to some benefits in this section. We say "(No deductible)" when the standard option deductible does not apply.		
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*)	$15 per visit to your primary care physician $30 per visit to a specialist Facility charge applies see section 5(c) for outpatient hospital and ambulatory surgical facility charges	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible) Facility charge applies see section 5(c) for outpatient hospital and ambulatory surgical facility charges
• Surgical treatment of morbid obesity – a condition where 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. For more information go to our website at www.healthnet.com or call 1-800-289-2818.	$15 per visit to your primary care physician $30 per visit to a specialist Facility charge applies see section 5(c) for outpatient hospital and ambulatory surgical facility charges	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible) Facility charge applies see section 5(c) for outpatient hospital and ambulatory surgical facility charges

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Surgical procedures (cont.)	**High Option**	**Standard Option**
- Bariatric surgery is reserved for people who are morbidly obese and have failed to lose weight, even after multiple, different medical interventions, including dieting, counseling, behavioral modification, and exercise. - Bariatric surgery is a major surgical procedure with short-term and long-term complications, some of which remain to be completely discovered or understood. - Before bariatric surgery is undertaken, the patient should undergo a thorough medical and psychological evaluation by a multidisciplinary team. - Bariatric surgery should only be performed by physicians with extensive experience with these procedures in facilities that are equipped and experienced to deal with this treatment. - Many patients who undergo bariatric surgery regain some or most of the weight they lost during the immediate post-operative period if other life-style changes are not also made. • 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 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.	$15 per visit to your primary care physician $30 per visit to a specialist Facility charge applies see section 5(c) for outpatient hospital and ambulatory surgical facility charges	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible) Facility charge applies see section 5(c) for outpatient hospital and ambulatory surgical facility charges
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• 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	$15 per visit to your primary care physician $30 per visit to a specialist See section 5(c) for facility charges	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible) See section 5(c) for facility charges

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
• 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; and webbed fingers and 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*). 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.	$15 per visit to your primary care physician $30 per visit to a specialist See section 5(c) for facility charges	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible) See section 5(c) for facility charges
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • Non-dental treatment on Treatment of temporomandibular joint (TMJ) disorders.	$15 per visit to your primary care physician $30 per visit to a specialist See section 5(c) for facility charges	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible) See section 5(c) for facility charges
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Routine or general care of teeth or dental structures*	*All charges*	*All charges*

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
• *Extractions or impacted or abscessed teeth* • *Dental splints, dental implants, dental prostheses or dentures* • *Accidental injury to the teeth or gums created by chewing*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to *Other services* in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description. Solid organ transplants limited to: • Cornea • Heart • Heart/lung • Lung: single/bilateral/lobar • Kidney • Liver • Pancreas • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas	$30 per visit to a specialist office visit $200 per day up to 3 days per admission See section 5(c) for facility charges	$40 per visit to a specialist office visit $250 per day up to 3 days per admission See section 5(c) for facility charges
Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity limitation is considered satisfied if the patient meets the staging description). • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myleogenous leukemia - Hemoglobinopathy (i.e. Fanconi's, Thalessemia major) - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency	$30 per visit to a specialist office visit $200 per day up to 3 days per admission See section 5(c) for facility charges	$40 per visit to a specialist office visit $250 per day up to 3 days per admission See section 5(c) for facility charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Severe or very severe aplastic anemia - Amyloidosis • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Neuroblastoma - Amyloidosis • Autologous tandem transplants for - Recurrent germ cell tumors (including testicular cancer) - Muliple myeloma - De-novo myeloma	$30 per visit to a specialist office visit $200 per day up to 3 days per admission See section 5(c) for facility charges	$40 per visit to a specialist office visit $250 per day up to 3 days per admission See section 5(c) for facility charges
Blood or marrow stem cell transplants for • Allogeneic transplants for - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced neuroblastoma - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer	$30 per visit to a specialist office visit $200 per day up to 3 days per admission See section 5(c) for facility charges	$40 per visit to a specialist office visit $250 per day up to 3 days per admission See section 5(c) for facility charges
Mini-transplants (non-myeloblative, reduced intensity conditioning) for covered transplants: Subject to medical necessity	$30 per visit to a specialist office visit $200 per day up to 3 days per admission	$40 per visit to a specialist office visit $250 per day up to 3 days per admission

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
	See section 5(c) for facility charges	See section 5(c) for facility charges
Tandem transplants for covered transplants: Subject to medical necessity	$30 per visit to a specialist office visit $200 per day up to 3 days per admission See section 5(c) for facility charges	$40 per visit to a specialist office visit $250 per day up to 3 days per admission See section 5(c) for facility charges
Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for • Allogeneic transplants for - Chronic lymphocytic leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Myelodysplasia/Myelodysplastic syndromes - Multiple myeloma • Nonmyeloablative allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Myelodysplasia/Myelodysplastic syndromes - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders - Non-small cell lung cancer - Prostate cancer - Sarcomas • National Transplant Program (NTP) -	$30 per visit to a specialist office visit $200 per day up to 3 days per admission See section 5(c) for facility charges	$40 per visit to a specialist office visit $250 per day up to 3 days per admission See section 5(c) for facility charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	$30 per visit to a specialist office visit $200 per day up to 3 days per admission See section 5(c) for facility charges	$40 per visit to a specialist office visit $250 per day up to 3 days per admission See section 5(c) for facility charges
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Skilled nursing facility • Office	Nothing	Nothing
Professional services provided in - • Hospital outpatient department • Ambulatory surgical center	Nothing	15% of our allowance

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- *Under the High Option, there is* ***no calendar year deductible.***
- Under the Standard Option the calendar year deductible is: $1,000 per person ($2,000 per family). We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
Note: The Standard Option plan's calendar year deductible applies to some benefits in this section. We say "(No deductible)" when the standard option deductible does not apply.		
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$200 per day up to 3 days per admission	$250 per day up to 3 days per admission (No deductible)
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen	$200 per day up to 3 days per admission	$250 per day up to 3 days per admission (No deductible)
• Anesthetics, including nurse anesthetist services	Nothing	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools*	*All charges*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Collection and/or storage of blood products for any unscheduled or non-covered medical procedure* • *Private nursing care, unless medically necessary*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma , if not donated or replaced • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$100 copay per visit will apply for outpatient hospital / ambulatory surgical facility	15% of our allowance per visit will apply for outpatient hospital /ambulatory surgical facility
Not covered: Blood and blood derivatives not replaced by the member	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
Skilled nursing facility (SNF): • Coverage is provided when full-time skilled nursing care is medically necessary and confinement in a SNF is medically appropriate as determined by Plan doctor and approved by Health Net.	$200 per day up to 3 days per admission. Limited to 100 days per calendar year	$250 per day up to 3 days per admission. Limited to 100 days per calendar year (No deductible)
Not covered: Custodial care, domiciliary care or convalescent care	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
Members who are diagnosed as having an illness giving them a life expectancy of 6 months or less may request Hospice care. All Hospice care must be provided by a licensed participating Hospice and include inpatient and outpatient care related to the condition.	Nothing	$250 copay per day up to 3 days (No deductible)
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*

Benefit Description	You pay	
Ambulance	**High Option**	**Standard Option**
• 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	Nothing

Section 5(d). Emergency services/accidents

Important things you should 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.
- *Under the High Option, there is* **no calendar year deductible**.
- Under the Standard Option the calendar year deductible is: $1,000 per person ($2,000 per family). We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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.

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	**High Option**	**Standard Option**
• Emergency care at a doctor's office	$15 per visit to your primary care physician $30 per visit to a specialist	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible)
• Emergency care at an urgent care center	$50 per visit	$75 per visit (No deductible)
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$100 per visit (waived if admitted; inpatient hospital benefit then applies - see section 5c)	$150 per visit (waived if admitted; inpatient hospital benefit then applies - see section 5c) (No deductible)
Not covered:	*All charges*	*All charges*

Emergency within and outside our service area - continued on next page

Benefit Description	You pay	
Emergency within and outside our service area (cont.)	**High Option**	**Standard Option**
• *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*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
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 ambulance would be detrimental to the member's health. Note: See 5(c) for non-emergency service.	Nothing	Nothing

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

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.

Important things you should 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.
- *Under the High Option, there is* **no calendar year deductible**.
- Under the Standard Option the calendar year deductible is: $1,000 per person ($2,000 per family). We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay	
Mental health and substance abuse benefits	**High Option**	**Standard Option**
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$30 per visit to a specialist	$40 per visit to a specialist (No deductible)
• Diagnostic tests	No charge for laboratory, X-ray and other diagnostic tests at the physician's office	No charge for laboratory, X-ray and other diagnostic tests at the physician's office
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$200 per day up to 3 days per admission	$250 per day up to 3 days per admission (No deductible)
• Services in approved alternative care settings such as partial hospitalization, or facility based intensive outpatient treatment	$30 per visit	$40 per visit (No deductible)
Not covered: Services we have not approved.	*All charges*	*All charges*

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay	
Mental health and substance abuse benefits (cont.)	**High Option**	**Standard Option**
Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.	*All charges*	*All charges*

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 1-800-977-0281. Services are covered as necessary for the diagnosis and treatment of acute conditions as outlined below.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.
- *Under the High Option, there is* **no calendar year deductible**.
- Under the Standard Option the calendar year deductible is: $1,000 per person ($2,000 per family). We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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.

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication**.**
- **We use a formulary**. (Preferred Drug List). Drugs covered by your prescription drug benefit are assigned to one of the following levels: **Level 1** generally includes generic drugs, but may include some brand formulary or preferred brands, and it usually represents the lowest copay. **Level 2** generally includes brand formulary and preferred brands, but may include some generics and brands not included in Level 1. Level 2 usually represents brand or middle-range copays. **Level 3** may include all other covered drugs (including some generics) not on Levels 1 and 2, i.e. non-formulary, or non-preferred, and some specialty drugs. There may be prior authorization requirements on select drugs in all three levels. FDA-approved drugs may not be immediately covered. They may be available for coverage with prior authorization. The Level 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 updated periodically throughout the year. To order a current Preferred Drug List call 1-800-289-2818 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 require 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 1-800-289-2818. 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 for the emergency circumstances to Health Net of Arizona, Inc. 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.

Benefit Description	You pay After the calendar year deductible…	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin – limited to 2 vials per copayment. • Disposable needles and syringes for the administration of covered medications – limited 100 per copayment. • Diabetic supplies, including lancets, glucose test strips, visual reading strips, and urine testing strips – limited 100 per copayment. • Insulin cartridges for the legally blind – limited to the equivalent of 2 vials of insulin per copayment. • Automatic lancing devices – limited to one every six months per copayment. • Insulin aids (insulin pen) – limited to one every six months per copayment. • Glucogon (requires prior authorization) – limited to one per copayment. • Spacers and holding chambers for inhaled medications – limited to one per six months per copayment. • Inhalers – up to 2 (nasal or oral), or up to a 31-day supply, whichever is less, per copayment. • Drugs for sexual dysfunction require prior authorization and have dispensing limitations. Contact plan for details. • Contraceptive drugs and devices. • 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.	$10 per Level 1 prescription or refill obtained from a plan pharmacy $30 per Level 2 prescription or refill obtained from a plan pharmacy $50 per Level 3 prescription or refill obtained from a plan pharmacy $20 per Level 1 prescription or refill obtained through our mail order program $60 per Level 2 prescription or refill obtained through our mail order program $100 per Level 3 prescription or refill obtained through our mail order program Note: If there is no generic equivalent available, you will still have to pay the brand name copay.	$10 per Level 1 prescription or refill obtained from a plan pharmacy $40 per Level 2 prescription or refill obtained from a plan pharmacy $70 per Level 3 prescription or refill obtained from a plan pharmacy $20 per Level 1 prescription or refill obtained through our mail order program $80 per Level 2 prescription or refill obtained through our mail order program $140 per Level 3 prescription or refill obtained through our mail order program Note: If there is no generic equivalent available, you will still have to pay the brand name copay. (No deductible)
• Amino acid-based formula for members diagnosed with eosinophilic gastrointestinal disorder (EOS). Limited to $20,000 benefit per calendar year.	25% coinsurance	25% coinsurance (No deductible)

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• Enteral nutrition and supplies in the home. Limited to $5,000 benefit per calendar year.	50% coinsurance	50% coinsurance (No deductible)
• Self-injectable drugs require prior authorization (Level 2 copayment applies to insulin).	$60 per prescription or refill, up to a 31-day supply	$80 per prescription or refill, up to a 31-day supply (No deductible)
Not covered: • *Drugs and supplies for cosmetic purposes.* • *Drugs to enhance athletic performance.* • *Fertility drugs.* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies.* • *Vitamins, nutrients and food supplements even if a physicianprescribes or administers them.* • *Anorexiants, appetite suppressants, diet aids, weight loss medications, and drugs used to treat obesity.* • *Any drug consumed at a place where it is dispensed or that is dispensed or administered by the physician.* • *Drug prescribed for non-covered services.* • *Take home drugs, drugs prescribed for use after discharge from a hospital, nursing home, skilled nursing facility or other impatient facility must be obtained from a plan pharmacy.* • *Replacement prescriptions.*	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should 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.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- *Under the High Option, there is* ***no calendar year deductible.***
- Under the Standard Option the calendar year deductible is: $1,000 per person ($2,000 per family). We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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.

Accidental injury benefit	You Pay	
Accidental injury benefit	**High Option**	**Standard Option**
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 Facility charge applies see section 5 (c) for outpatient hospital and ambulatory surgical facility charges	$15 per visit to your primary care physician $40 per visit to a specialist (No deductible) Facility charge applies see section 5 (c) for outpatient hospital and ambulatory surgical facility charges

Dental benefits
We have no other dental benefits.

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • 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 except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-800-289-2818 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.
Services for deaf and hearing impaired	We provide a TTY line for the deaf and hearing impaired 1-800-977-6757.
High risk pregnancies	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 providing increased level of education and surveillance.
Centers of excellence	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.
Travel benefit/services overseas	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). Qualified travel reimbursement coverage on a per diem basis of $150 with a calendar year maximum benefit of $3,000 (it does not accumulate toward the out of pocket maximum).

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. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact Health Net of Arizona at 1-800-289-2818 or visit their website at www.healthnet.com.

DECISION POWER: HEALTH IN BALANCE - *Information, resources and support for every person, every stage of health*
Decision Power brings together under one roof the information, resources and personal support that fit you, your health and your life. Whether you ...
• have a question
• want help with a specific health goal
• need treatment but want to understand all your options
• are living with illness

... you choose how and when to use the information, resources and support available. You can use Decision Power online. Or by calling a Health Coach. Try multiple resources at once, or one at a time. 24 hours-a-day, seven days-a-week, Decision Power is here for you.

Log on to www.healthnet.com**:**
* **Take the health risk questionnaire (HRQ)** - with its instant results and interactive features, the HRQ is your gateway to recommendations and resources based on your unique health profile. Among the highlights: you'll receive e-mail alerts on information and action steps to take based on your HRQ results.
* **Try a step-by-step plan** for losing weight, stopping smoking or boosting nutrition. You can start with our online coaching and self-help tools. Phone coaching support is included so making lasting, healthy changes is easier.
* **Track your health progress** and build a complete medical snapshot to have whenever you need it with a Personal Health Record (PHR).
* **Find support** for any kind of mental health concern such as depression, alcohol use, eating disorders, etc.
* **Be informed** - access information resources, such as Healthwise Knowledgebase, and online health encyclopedia; HEAR Audio Library, which contains information on 355 health topics; and Health Crossroads Web Modules, which explains the risks of various treatments.
* **Know your numbers** - with our health trackers (cholesterol, diet, fitness), treatment cost estimator and hospital comparison reports.

Talk to a Health Coach to get:
* **1:1 consultations** and a single point of contact for any and every health question, goal or situation. You can talk to the same Health Coach every time you call.
* **24-hour answers** to health questions or concerns. Always call 9-1-1 or go straight to the emergency room in a life-threatening situation.
* **Techniques** to help you feel comfortable talking with your doctor and expressing your preferences.
* **Pointers** for setting achievable health goals; guidance on evaluating treatment options.
* **Guidance** and support for living with an ongoing illness such as asthma, diabetes, heart disease, etc.
* **Specialized consultation** from nurse case managers to help both patients and family members deal with the complexity of end-stage illnesses.

Commercial HMO plan rated "Excellent" by the National Committee for Quality Assurance

Medicare Advantage Enrollment

The Individuals Plan offers Medicare beneficiaries the opportunity to enroll in a plan through Medicare or Health Net. As indicated on page 54, 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 1-800-977-7522, 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 1-800-977-6757

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **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 (see specifics regarding transplants).**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergencyservices/accidents*);
- 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 (see specifics regarding transplants);
- 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, coinsurance, or deductible.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1-800-289-2818.

When you must file a claim – such as for services you received 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 or call 1-800-289-2818.

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, AZ 85710-1362 or call 1-800-289-2818.

Other supplies or services

Submit your claims to: ACS/Health Net, Inc. P.O. Box 14225, Lexington, KY 40512-4225 or call 1-800-289-2818.

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 benefits for 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 required by Section 3.

1 Ask us in writing to reconsider our initial decision. You must:

a) Write to us within 6 months from the date of our decision; and

b) Send your request to us at: P.O. Box 867 Shelton, CT 06484; and

c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

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

a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or

b) Write to you and maintain our denial - go to step 4; or

c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

3 You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

4 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

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

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-289-2818 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 has coverage under any other health plan or has 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; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) 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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We at Health Net of Arizona, Inc. offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **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 more 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.

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.

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 will probably not need 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. To find out if you need to do something to file your claim, call us at 1-800-289-2818 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 Advantage (Part C)**

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 and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, 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 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, coinsurance, or deductibles. 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.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

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		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) 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 #3 above	✓	
5) 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	✓	
6) 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 #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
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	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
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.

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 TRICARE or CHAMPVA.

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.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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 11.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

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 service

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:

- 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 research institution program or protocol;
- Does it clearly improve the net health outcome as evaluated against non-experimental or non-investigational health care services using credible and accepted medical evidence.

Group health coverage

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

Medical necessity

Services required to identify or treat an illness that is either diagnosed or reasonably suspected.

Medically Necessary service must, in the judgment of Health Net:

1. be required to treat an illness or injury; and

2. be consistent and appropriate for the diagnosis and treatment of the Member's condition; and

3. be in accordance with the standards of accepted principles of medical practice in the United States; and

4. be performed at the most appropriate level of care for the Member as determined by the Member's medical condition no the Member's financial or family situations or the distance the Member lives from the Hospital, or any other non-medical factor; and

	5. not be for the convenience of the Member, nor the Member's family, support network, Physician or another Health Professional; and 6. not be Experimental, Unproved or Investigational 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: Our contracted amount.
Us/We	Us and We refer to *Health Net of Arizona, Inc.*
You	You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

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/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* 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;
- What happens 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 family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorcé, or when your child under age 22 marries.

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 2009 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 2008 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.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce**

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 for you. However, you may be eligible for your own FEHB coverage under either 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 Benefits 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 Benefits 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. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

The Federal Empolyees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877- 889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. 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. 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. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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Summary of benefits for the High Option of the Health Net of Arizona, Inc. - 2009

- **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.
- Under the High Option, there is no calendar year deductible.

High Option 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	16
Services provided by a hospital:		
• Inpatient	$200 per day up to 3 days per admission	34
• Outpatient	$100 per hospital surgical visit	35
Emergency benefits 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 benefit applies)	37
Mental health and substance abuse treatment:	Regular cost sharing	39
Prescription drugs:		41
• Retail pharmacy	$10 per Level 1 prescription or refill obtained from a plan pharmacy $30 per Level 2 prescription or refill obtained from a plan pharmacy $50 per Level 3 prescription or refill obtained from a plan pharmacy	
• Mail order	Mail Order Available for two times retail copayments for 93 day supply	
	Note: If there is no Level 1 equivalent available, you will still have to pay the Level 2 or Level 3 copay.	
Dental care:	No benefit.	44
Vision care: One eye exam for refraction every 24 months *Note:* Eye examination for refraction is administered by Health Net Vision. Call 1-866-392-6058	Nothing	22
Special features: *Flexible benefits option, Services for deaf and hearing impaired, Centers of excellence, High risk pregnancies, Case Management Programs*		45

High Option Benefits	You pay	Page
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $2000/Self Only or $4000/ Family enrollment per year Some costs do not count toward this protection	12

Summary of benefits for the Standard Option of the Health Net of Arizona, Inc. - 2009

- 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.
- Below, an asterisk (*) means the item is subject to the $1,000 per person ($2,000 per family) calendar year deductible.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $15 primary care; $40 specialist	16
Services provided by a hospital:		
• Inpatient	$250 per day up to 3 days per admission	34
• Outpatient	15% of our allowance*	35
Emergency benefits within or outside our service area:		
Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$150 per visit (waived if admitted; $250 per day up to 3 days per admission inpatient hospital benefit applies)	37
Mental health and substance abuse treatment:	Regular cost sharing	39
Prescription drugs:		41
• Retail pharmacy	$10 per Level 1 prescription or refill obtained from a plan pharmacy $40 per Level 2 prescription or refill obtained from a plan pharmacy $70 per Level 3 prescription or refill obtained from a plan pharmacy	
• Mail order	Mail Order Available for two times retail copayments for 93 day supply	
	Note: If there is no Level 1 equivalent available, you will still have to pay the Level 2 or Level 3 copay.	
Dental care:	No benefit.	44
Vision care: One eye exam for refraction every 24 months *Note:* Eye examination for refraction is administered by Health Net Vision. Call 1-866-392-6058	Nothing.	22
Special features: *Flexible benefits option, Services for deaf and hearing impaired, Centers of excellence, High risk pregnancies, Case Management Programs*		45

Standard Option Benefits	You Pay	Page
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $4000/Self Only or $8000/ Family enrollment per year Some costs do not count toward this protection	12

2009 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 Guide to Federal Benefits 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 *Guide to Benefits for Career United States Postal Service Employees,* RI 70-2, and to the rates shown below.

The rates shown below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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 Guide to Federal Benefits.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	A71	$146.09	$48.69	$316.52	$105.50	$168.48	$26.30
High Option Self and Family	A72	$352.56	$140.43	$763.88	$304.27	$406.42	$86.57
Standard Option Self Only	A74	$132.22	$44.07	$286.47	$95.49	$152.49	$23.80
Standard Option Self and Family	A75	$334.97	$111.66	$725.78	$241.92	$386.33	$60.30