Health Net of California

www.healthnet.com/fehb

Customer service 1-800-522-0088

2015

A Health Maintenance Organization (high and standard option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details.

Serving: Northern and Southern California Service Areas

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 12 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2015: Page 13
- Summary of benefits: Page 74

Enrollment codes for this Plan:

Northern California High Option
LB1 Self Only
LB2 Self and Family

Northern California Standard Option
LB4 Self Only
LB5 Self and Family

Southern California High Option
LP1 Self Only
LP2 Self and Family

Southern California Standard Option
LP4 Self Only
LP5 Self and Family

This plan has been granted Accreditation for its HMO plan from the NCQA. See the 2015 Guide for more information.

Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-159

Important Notice from Health Net of California About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Health Net of California 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. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug 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 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 Medicare Part D 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 will 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 (October 15 through December 7) 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: 1-877-486-2048).

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Introduction

This brochure describes the benefits of Health Net of California under our contract (CS 2002) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The Customer Contact Center may be reached at 1-800-522-0088 or through our website: www.healthnet.com/fehb. The address for Health Net of California's administrative offices is:

Health Net of California
P.O. Box 9103
Woodland Hills, CA 91409-9103

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2015, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2015, and changes are summarized on page 13. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS)website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means Health Net of California.
- 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 will tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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.
- Periodically review your claim history for accuracy to ensure we have not billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.

- If the provider does not resolve the matter, call us at 800-522-0088 and explain the situation.

- If we do not resolve the issue:

CALL --THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/oig

You can also 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)

- Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)

- 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.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

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 and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements .
- Tell your doctor and pharmacist about any drug, food and other allergies you have, such as to latex.
- 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 your pharmacist about the medication 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 or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/ 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.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur cost to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use Health Net preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

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.

- **Minimum essential coverage (MEC)**

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **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 that 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
- 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. For information on your premium deductions, you must also contact 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 dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 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 of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

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.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren (including qualified children of same-sex domestic partners in certain states) are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

- **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 2015 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 2014 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.

If your enrollment continues after you are no longer eligible for coverage, (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for all services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance 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. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal 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 Website, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc. You may not elect TCC if you are fired from your Federal or Tribal 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/healthcare-insurance/healthcare/plan-information/guides . It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **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 or Tribal 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.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit **www.HealthCare.gov**. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

General Features of our High and Standard Options

How we pay providers

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

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

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

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

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles, or annual limits when received from a network provider.

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

If you want more information about us, call 800-522-0088, or write to Health Net of California, P.O. Box 9103, Van Nuys, CA 91409-9103. You may also contact us by fax at 714-934-3370 or visit our Web site at www.healthnet.com/fehb.

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:

Northern California full counties:

Alameda, Contra Costa, Madera, Marin, Merced, Napa, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, and Yolo counties, California

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

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

FRESNO: 93210, 93234, 93242, 93602, 93605-09, 93611-13, 93616, 93619, 93621-22, 93624-31, 93634, 93640-42, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93664, 93667-68, 93675, 93700-99

NEVADA: 95712, 95924, 95945-46, 95949, 95959-60, 95975

PLACER: 95602-04, 95631, 95648, 95650, 95658, 95661, 95663, 95668, 95677-78, 95681, 95701, 95703-04, 95713-14, 95717, 95722, 95736, 95746-47, 95765

Southern California full counties:

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:

Southern California (Excel Network) full counties:

Los Angeles, Orange, San Diego, and Ventura counties

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

KERN: 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93249-52, 93255, 93263, 93268, 93276, 93280, 93283, 93285, 93287, 93301-93309, 93311-93314, 93380, 93383-90, 93501-02, 93504-05, 93516, 93518-19, 93523-24, 93531, 93560-61, 93581, 93596

RIVERSIDE: 91752, 92201-03, 92210-11, 92220, 92223, 92230, 92234-36, 92240-41, 92247, 92253-55, 92258, 92260-64, 92270, 92274, 92276, 92282, 92320, 92501-09, 92513-19, 92521-22, 92530-32, 92536, 92539, 92543-46, 92548-49, 92551-57, 92561-64, 92567, 92570-72, 92581-87, 92589-92593, 92595-96, 92860, 92877-83

SAN BERNARDINO: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758, 91761-64, 91784-86, 92252, 92256, 92268, 92277-78, 92284-86, 92301, 92305, 92307-08, 92311-18, 92321-22, 92324-27, 92329, 92331, 92333-37, 92339-42, 92345-47, 92350, 92352, 92354, 92356-59, 92365, 92368-69, 92371-78, 92382, 92385-86, 92391-95, 92397-99, 92401-08, 92410-92413, 92415, 92418, 92423, 92427

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. Changes for 2015

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 the High Option and Standard Option Plans - Plan Codes LB and LP

- Your share of the non-Postal premium will increase for Self Only and Self and Family. See the back cover.
- Applied Behavioral Analysis (ABA) therapy for autism spectrum disorder has been added as a covered benefit. See page 51.
- A 4th tier has been added for Specialty prescription drugs which will be covered at 20% coinsurance to a maximum of $200 per prescription. See page 53.
- A Prescription drug catastrophic out-of-pocket maximum has been added. Members pay nothing after $2,900 for Self only or $8,700 for Self and Family. See pages 75 and 76.
- The copay for CT, MRI, PET, SPECT and other specialized scans will increase from $200 to $250. See page 25.
- The Tobacco Cessation limits on quit attempts and counseling sessions have been changed to unlimited. See page 34.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your 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 1-800-522-0088 or write to us at Health Net of California, PO Box 9103, Woodland Hills, CA 91409-9103. You may also request replacement cards through our Website www.healthnet.com/fehb.

Where you get covered care

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

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do to get covered care

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

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

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

- **Primary care**

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

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see a participating chiropractor (as described on page 33) and a woman may see her participating gynecologist at anytime without a referral.

Here are some other things you should know about specialty care:

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

  Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our plan, talk to your primary care physician. 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;

- 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.

If you are a new Health Net of California member and are currently receiving treatment for a qualifying medical condition from a provider who is not in our network, you may be eligible to complete treatment of your condition with the provider. Or, if you are an existing member and are currently receiving treatment for a qualifying medical condition from a provider who is leaving our network, you may be eligible to complete treatment of your condition with the provider. In order to receive more information about continuity of care and qualifying medical conditions and situations, please contact us at 1-800-522-0088 and we will assist you.

You also have the right to a second opinion when:

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

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

- **Hospital Care**

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

- **If you are 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 1-800-522-0088. 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;
- 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.

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services.*

- **Inpatient hospital admission**

Precertification is the process by which - prior to your inpatient hospital admission - we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for some services such as but not limited to:

- Acute rehabilitation and behavioral health facility admissions
- Air ambulance and non-emergent ambulance transportation
- All bariatric-related consultations, services and surgical services
- Clinical trials
- Durable medical equipment
- Home health services, including but not limited to IV infusion, hospice
- Outpatient diagnostic procedures, including but not limited to CT, MRA, MRI, PET and SPECT
- Transplants

- Growth Hormone Treatment (GHT)
- Certain formulary and non-formulary prescription drugs

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

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 800-977-7282 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim, (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) to end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow-up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-800-522-0088. You may also call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-522-0088. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

Emergency services and the minimum Hospital stay requirements for maternity do not require Prior Authorization. All other Hospital Services, whether Inpatient or Outpatient, must be arranged through the Primary Care Physician. Any member who receives Emergency Services must contact his or her Primary Care Physician within 48 hours of treatment, or as soon thereafter as is medically possible.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Prior authorization may be obtained by you or your Provider. Coverage for those services will be provided only if Prior Authorization has been obtained from us. If a Member receives care from a nonparticipating Physician or other health care Provider withour a required Prior Authorization, the Member shall be responsible for the cost of these services. Failure of the nonparticipating Provider to obtain the Prior Authorization shall in no way relieve the Member of the financial responsibility for services received from that Provider.

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.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

  Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

  1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

  2. Ask you or your provider for more information.

  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 of the information was due. We will base our decision on the information we already have. We will write to you with our decision.

  3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

  In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

  After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your cost for covered services

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

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.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services. Example: When you see your primary care physician, you pay a copayment of $20 per office visit for the High Option and $30 per office visit for the Standard Option, and when you go in the hospital you pay $150 per day (5 day max copay) per admission on the High Option and $750 per admission on the Standard Option.
Coinsurance	Coinsurance is the percentage of our negotiated fee that you must pay for your care. Example: In our Plan, you pay 50% of our allowance for infertility services and 20% to a maximum of $200 per day for injectable medications.
Deductible	We do not have a deductible.
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. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.
Your catastrophic protection out-of-pocket maximum	After your copayments and/or coinsurance total $1500 for self only or $4500 for self and family enrollment in any calendar year, you do not have to pay any more for covered services. However, your prescription drug benefit has a separate out-of-pocket maximum of $2900 for self only and $8700 for self and family that must be met before prescription copayments or coinsurance are waived. Be sure to keep accurate records of your copayments and/or coinsurance since you are responsible for informing us when you reach the maximum.

High and Standard Option Benefits

See page 13 for how our benefits changed this year. Pages 75 and 76 are benefits summaries for the High and Standard Options. 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 claim forms, claims filing advice, or more information about High or Standard Option benefits, contact us at 800-522-0088 or on our Website at www.healthnet.com/fehb.

Health Net of California offers two benefit plans to Federal members, High and Standard Options. Both Options include preventive and acute care services, but offer different levels of benefits and services for you to choose between to best fit your health care needs.

Both plans offer comprehensive coverage but have varying copays. The High Option has lower copayments and the Standard Option offers lower premiums.

Our High Option benefits include:

- PCP Office visit copay - $20
- Inpatient Hospitalization - $150 copay per day up to 5 days
- Prescriptions Drug Copays - $10 generic, $35 brand, $60 non-formulary, 20% to a maximum $200 per prescription for specialty drugs
- Chiropractic - $10 copay, 20 visits

Our Standard Option benefits include:

- PCP Office visit copay - $30
- Inpatient Hospitalization - $750
- Prescriptions Drug Copays Retail- $15 generic, $35 brand, $65 non-formulary, 20% to a maximum $200 per prescription for specialty drugs
- Chiropractic - $10 copay, 20 visits

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 amubulatory surgical center or the outpatient department of a hospital.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion	$20 per PCP office visit, $30 per specialist visit	$30 per PCP office visit, $50 per specialist visit
Professional services of healthcare professionals at CVS Minute Clinics (Plan Code LP only)	$20 per visit	$30 per visit
Professional services of physicians • In an urgent care center	$20 per visit	$30 per visit
Professional services of physicians • During a hospital stay • In a skilled nursing facility	Nothing	Nothing
At home	$20 per visit	$20 per visit
Not covered: • *Treatment that is not authorized by a plan physician* • *Treatment that is not medically necessary*	*All charges*	*All charges*
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	Nothing	Nothing

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

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests (cont.)	**High Option**	**Standard Option**
• Electrocardiogram and EEG	Nothing	Nothing
CT, MRI, PET, SPECT and other specialized scans	$250 Copay	$250 Copay
Preventive care, adult	**High Option**	**Standard Option**
Periodic health evaluation 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 - Colonoscopy screening – every ten years starting at age 50	Nothing	Nothing
Preventive care services at CVS Minute Clinics (Plan Code LP only)	Nothing	Nothing
• Surgical procedure during Colonoscopy screening	$200 outpatient surgery copay	$350 outpatient surgery copay
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing	Nothing
Well woman care; including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and and counseling for interpersonal and domestic violence	Nothing	Nothing
Routine mammogram - covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing	Nothing
Immunizations for occupational and foreign travel	20% of charges	20% of charges

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.		
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	Nothing	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 22)	Nothing	Nothing
Examinations, such as: - Eye exams to determine the need for vision correction - Ear exams to determine the need for hearing correction - Examinations done on the day of immunizations	Nothing	Nothing
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.		
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or for travel.	*All charges*	*All charges*
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at high risk • Postnatal care	$20 per PCP office visit, $30 per specialist visit	$30 per PCP office visit, $50 per specialist visit
Breastfeeding support, supplies and counseling for each birth	Nothing	Nothing
Delivery Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery;	Nothing	Nothing

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**High Option**	**Standard Option**
• 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. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	Nothing	Nothing
Family planning	**High Option**	**Standard Option**
Contraceptive counseling on an annual basis	Nothing	Nothing
A broad range of voluntary family planning services, limited to: • Surgically implanted contraceptives • Intrauterine devices (IUDs) • Diaphragms	Nothing	Nothing
• Injectable contraceptive drugs (such as Depo provera) Note: We cover oral contraceptives under the prescription drug benefit.	20% to a maximum of $200 per day	20% to a maximum of $200 per day
• Voluntary sterilization (females)(e.g., Tubal ligation)	Nothing	Nothing
• Voluntary sterilization (males)(e.g., Vasectomy)	$50	$50
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*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) - Fertility drugs	50% of charges	50% of charges

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High Option**	**Standard Option**
Note: We cover injectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	50% of charges	50% of charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* • *In vitro fertilization* • *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm, ova or their collection or storage* • *Injectable medications for infertility treatments not covered by the plan* • *Artificial insemination cycles in excess of 6 cycles*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment • Allergy injections • Allergy serum	Nothing	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*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 on page 38. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV or antibiotic therapy administered at home by home health nurse	Nothing	Nothing
• Growth hormone therapy (GHT)	20% to a maximum of $200 per day	20% to a maximum of $200 per day

Treatment therapies - continued on next page

Benefit Description	You pay	
Treatment therapies (cont.)	**High Option**	**Standard Option**
Note: – We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other servicesunder You need prior Plan approval for certain services on page 16.	20% to a maximum of $200 per day	20% to a maximum of $200 per day
Physical and occupational therapies	**High Option**	**Standard Option**
Services of each of the following: • Qualified physical therapists • Occupational therapists Note: We only cover therapy when a provider: • orders the care Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided in accordance with the treatment plan	Nothing	$30 per office visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *When medical documentation does not support the medical necessity because of the member's inability to progress toward the treatment plan goals or when the member has already met the treatment plan goals.*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
Services for speech therapy are covered	Nothing	$30 per office visit
Injectable Medications	**High Option**	**Standard Option**
• Office Based - Therapeutic Injections • Self Administered - acquired through specialty pharmacy with prescription • Growth Hormone Therapy (GHT) Note: Does not apply to: Allergy serum injections (see page 28); Injectable fertility drugs (see page 28); Routine immunizations (see page 25) and Immunizations for occupational and foreign travel (see page 25).	20% to a maximum of $200 per day	20% to a maximum of $200 per day

Benefit Description	You pay	
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• For treatment related to illness or injury, including evaluation and disgnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	$20 per PCP office visit, $30 per specialist visit	$30 per PCP office visit, $50 per specialist visit
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, See Section 5(a) *Orthopedic and prosthetic devices.*	$20 per PCP office visit, $30 per specialist visit	$30 per PCP office visit, $50 per specialist visit
Not covered: • *Hearing services that are not shown as covered*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Eye exam to determine the need for vision correction (see preventive care) Annual eye refractions	$20 per PCP office visit, $30 per specialist visit	$30 per PCP office visit, $50 per specialist visit
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Eyeglasses or contact lenses after Interocular lens implant*	*All charges*	*All charges*
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.	$20 per PCP office visit, $30 per specialist visit	$30 per PCP office visit, $50 per specialist visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above*	*All charges*	*All charges*

Foot care - continued on next page

Benefit Description	You pay	
Foot care (cont.)	**High Option**	**Standard Option**
• *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • External hearing aids for children (under 18 years of age) with hearing loss caused by congenital birth defects - $1500 maximum benefit every 36 months • External hearing aids for adults - 2 hearing aids every 36 months with a maximum benefit of $1500 every 36 months • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	Nothing	Nothing
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, except when they have been incorporated into a cast, splint, brace or strapping of the foot,or except to treat diabetes-related complications when prescribed by your Plan physician, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• *Prosthetic replacements provided less than 3 years after the last one we covered*	*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. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Standard wheelchairs, electric wheelchairs if medically necessary • Crutches • Walkers • Speech generating devices • Blood glucose monitors • Insulin pumps	Nothing	Nothing
Not covered: • *Exercise equipment* • *Hygienic equipment and supplies (to achieve cleanliness even when related to other covered medical services)* • *Stockings* • *Surgical dressings, except primary dressings that are applied by a Plan physician or a Hospital to lesions of the skin or surgical incisions* • *Jacuzzis and whirlpools* • *Orthotics which are not custom made to fit your body (Orthotics are supports or braces for weak or ineffective joints or muscles)* • *Foot orthotic, except when they have been incorporated into a cast, splint, brace or strapping of the foot* • *Laptop computers, desktop computers or PDA's that are not dedicated speech generating devices are not covered*	*All charges*	*All charges*

Benefit Description	You pay	
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. *Note: Your Plan physician will review the home health service program for continuing appropriateness.*	Nothing for the first 30 visits, $10 per visit thereafter	Nothing for the first 30 visits, $10 per visit thereafter
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
• Chiropractic services – by the chiropractors that participate in the American Specialty Health Plan (ASHP) network. 20 visits per calendar year are covered for these services without a referral from the Plan physician	$10 per office visit	$10 per office visit
Chiropractic appliances are covered up to $50 per calendar year	All charges above $50 per calendar year	All charges above $50 per calendar year
Alternative treatments	**High Option**	**Standard Option**
Acupuncture - by a doctor of medicine or osteopathy (when medically necessary and authorized by PPG) for: • anesthesia • pain relief	$20 per PCP office visit, $30 per specialist visit	$30 per PCP office visit, $50 per specialist visit
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Massage therapy*	*All charges*	*All charges*

Benefit Description	You pay	
Educational classes and programs	**High Option**	**Standard Option**
Coverage is provided for Tobacco Cessation: • Tobacco cessation programs, including telephonic counseling sessions, online program, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence • The following Smoking/Tobacco Cessation prescribed medications: Zyban, Chantix, Nicotrol Inhaler, and Nicotrol NS, dosage limits and prior authorization requirements apply • FDA approved over-the-counter Nicotine replacement therapy medications. Written prescription required and dosage limits apply	Nothing Nothing for drugs filled at a Plan pharmacy Nothing for drugs filled through mail order program	Nothing Nothing for drugs filled at a Plan pharmacy Nothing for drugs filled through mail order program
Health Net's Decision Power and Wellness Programs • Weight management • Diabetes self-management • Emotional health • Exercise • Nutrition • Stress management • Prenatal education • Treatment support videos	Nothing	Nothing

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

Benefit Description	You pay	
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*) • Surgical treatment of morbid obesity (bariatric surgery) Health Net considers the following bariatric surgical procedures medically appropriate when all of the general criteria and all of the criteria specific to the procedures are met. Here is a list of the general criteria: • Patient is an adult greater than 18 and less than 65 years of age unless the patient is greater than 65 and is considered a low-risk candidate; • Morbid Obesity has persisted for at least 5 years, especially in the year prior to the scheduled surgery;	$20 per PCP visit, $30 per specialist visit Nothing for surgery - $150 copayment per day up to 5 days per inpatient admission or $200 copayment for outpatient surgery	$30 per PCP visit, $50 per specialist visit Nothing for surgery - $750 copayment per inpatient admission or $350 copayment for outpatient surgery

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• The patient has clinically severe obesity defined by either Body mass index greater than or equal to 40 kg/m2 or a weight of at least two times the ideal weight for frame, age, height, and gender, as specified in the 1983 Metropolitan Life Insurance tables; or BMI of between 35 kg/m2 and 40 kg/m2 with one or more of life-threatening, obesity-related co-morbidities which have not responded to optimal medical management. • In the two years prior to the planned date of surgery, the patient has failed to lose weight or has regained weight despite participation in a six month dietary program supervised by either a physician or professional. • All patients must undergo a psychological evaluation by a psychiatrist/psychologist familiar with the implications of weight reduction surgery to rule out the presence of major psychological pathology (active substance abuse, schizophrenia, borderline personality disorder, uncontrolled depression) and to determine whether the patient will comply with the strict postoperative diet and lifelong follow-up. • Treatable metabolic causes for obesity, especially hypothyroidism, should be excluded before surgery. Consult with your physician for all specific criteria related to the above procedures. Health Net has a designated network of bariatric surgical centers to perform weight loss surgery. Your Member Physician can provide you with information about these centers. You will be directed to a Health Net designated bariatric surgical center at the time authorizations is obtained. If you live 50 miles or more from the nearest Health Net designated bariatric surgical center, you are eligible to receive travel expense reimbursement. All requests for travel reimbursement must be prior approved by Health Net.	$20 per PCP visit, $30 per specialist visit Nothing for surgery - $150 copayment per day up to 5 days per inpatient admission or $200 copayment for outpatient surgery	$30 per PCP visit, $50 per specialist visit Nothing for surgery - $750 copayment per inpatient admission or $350 copayment for outpatient surgery
• Insertion of internal prosthetic devices . See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.		

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• Voluntary sterilization (e.g., Tubal ligation)	Nothing	Nothing
• Voluntary sterilization (e.g., Vasectomy)	$50 copay	$50 copay
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 • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers and 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. .	Nothing for surgery - $150 copayment per day up to 5 days per inpatient admission or $200 copay for outpatient surgery	Nothing for surgery - $750 copayment per inpatient admission or $350 copayment for outpatient surgery
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*

Benefit Description	You pay	
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.	Nothing for surgery - $150 copayment per day up to 5 days per inpatient admission or $200 copayment for outpatient surgery	Nothing for surgery - $750 copayment per inpatient admission or $350 copayment for outpatient surgery
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival, and alveolar bone)*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Cornea • Heart • Heart/lung • Intestinal Transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis These **tandem blood or marrow cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures.	Nothing for surgery - $150 copayment per day up to 5 days for inpatient admission	Nothing for surgery - $750 copayment for inpatient admission

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Nothing for surgery - $150 copayment per day up to 5 days for inpatient admission	Nothing for surgery - $750 copayment for inpatient admission
Blood or marrow stem cell transplants limited to the stages of the following diagnosis. For the diagnosis listed below 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 - Advanced Hodgkins lymphoma with recurrence (relapsed) - Advanced non-Hodgkins lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e. Fanconi's PNH, Pure Red Cell Aplasis) - Mucolipidosis (e.g. Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g. Hurler's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodyplastic syndromes	Nothing for surgery - $150 copayment per day up to 5 days for inpatient admission	Nothing for surgery - $750 copayment for inpatient admission

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g. Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast cancer - Ependymoblastoma - Epithelial ovarian cancer - Advanced Ewing's sarcoma (pediatric only) - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Refroperitoneal, and ovarian germ cell tumors **Mini-transplants performed in a clinical trial setting** (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	Nothing for surgery - $150 copayment per day up to 5 days for inpatient admission	Nothing for surgery - $750 copayment for inpatient admission

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia (when criteria is met) - Advanced Myeloproliferative Disorders (MPDs)(when criteria is met) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e. Fanconi's PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	Nothing for surgery - $150 copayment per day up to 5 days for inpatient admission	Nothing for surgery - $750 copayment for inpatient admission
These blood or marrow stem cell transplants are 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.	Nothing for surgery - $150 copayment per day up to 5 days for inpatient admission	Nothing for surgery - $750 copayment for inpatient admission

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Sickle Cell anemia • Mini-transplants (non-myeloblative allogeneic, reduced instensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e. myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders (MSDs) - Myelodysplasia/Myelodyplastic syndromes - Non-small cell lung cancer - Ovarian cancer	Nothing for surgery - $150 copayment per day up to 5 days for inpatient admission	Nothing for surgery - $750 copayment for inpatient admission

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Prostate cancer - Renal cell carcinomas - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma (pediatric only) - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphoma - Breast cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) (adults only) - Small cell lung cancer	Nothing for surgery - $150 copayment per day up to 5 days for inpatient admission	Nothing for surgery - $750 copayment for inpatient admission
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.		
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*

Benefit Description	You pay	
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing after $150 copayment per day up to 5 days for inpatient admission or after $200 copayment for outpatient surgery	Nothing after $750 copayment for inpatient admission or $350 copayment for outpatient surgery

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

Benefit Description	You pay	
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations	$150 copayment per day up to 5 days per inpatient admission	$750 per admission
General nursing care Meals and special diets	Nothing	Nothing
Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.		
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing	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* • *Private nursing care*	*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.	$200 per outpatient surgery	$350 per outpatient surgery
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**
Extended care/Skilled nursing facility (SNF): Up to 100 days per calendar year for services such as: • Bed, board and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan physician	Nothing	Nothing
Not covered: Custodial care and personal comfort items such as telephone and television	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
Hospice care: Up to 210 days for services such as: • Inpatient and outpatient care • Family counseling Note: Hospice care services are provided under the direction of a Plan physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less	Nothing	Nothing

Hospice care - continued on next page

Benefit Description	You pay	
Hospice care (cont.)	**High Option**	**Standard Option**
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Local professional ambulance service when medically appropriate	Nothing	$100 per trip

Section 5(d). Emergency services/accidents

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. An emergency will also include screening, examination and evaluation by a physician (or other health care professional acting within the scope of his or her license) to determine if a psychiatric medical emergency condition exists and the treatment necessary to relieve or eliminate such condition, is within the capability of the facility. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

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

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

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

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

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

Benefit Description	You pay	
Emergency within our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office	$20 per visit	$30 per visit
• Emergency care at an urgent care center • Emergency care at an emergency room • Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: If the emergency results in admission to a hospital, the copay is waived	$100 per visit	$150 per visit
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office	$20 per visit	$30 per visit
• Emergency care at an urgent care center • Emergency care at an emergency room • Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: If the emergency results in admission to a hospital, the copay is waived	$100 per visit	$150 per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Follow-up care not authorized by your participating physician group*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Professional ground and air ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	Nothing	$100 copay per trip

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

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost - haring works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** 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. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan. See the instructions after the benefits description below.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- 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.

Benefit Description	You pay	
Professional services	**High Option**	**Standard Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	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
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$20 per visit	$30 per visit

Professional services - continued on next page

Benefit Description	You pay	
Professional services (cont.)	**High Option**	**Standard Option**
Applied Behavioral Analysis (ABA) therapy for autism spectrum disorder	Nothing	Nothing
Diagnostics	**High Option**	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner	$20 per visit	$30 per visit
• Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	No charge for laboratory, X-ray and other diagnostic tests. See Section 5(c) for facility charges	No charge for laboratory, X-ray and other diagnostic tests. See Section 5(c) for facility charges
• Inpatient diagnostic tests provided and billed by a hospital or other covered facility	$150 per day up to 5 days per admission	$750 per admission
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$150 per day up to 5 days per admission	$750 per admission
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$150 per day up to 5 days per admission	$750 per admission
Not covered	**High Option**	**Standard Option**
• Services that are not part of a preauthorized approved treatment plan	All charges	All charges

Preauthorization	To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes: To access Mental Health and/or Substance Abuse benefits, or Applied Behavioral Analysis (ABA) therapy for autism spectrum disorder you must contact MHN Health Services toll free at 1-888-779-2236. Services are covered as necessary for the diagnosis and treatment of acute conditions as outlined below. We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required. 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.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 52.
- 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.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- We do not have a calendar year deductible.
- Some formulary and non-formulary drugs require prior authorization from us. Contact us at 1-800-522-0088 to find out if your medication requires it and for information on what your physician must do to obtain prior authorization.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

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

You can get a copy of the formulary by calling us at 1-800-522-0088 or visit our web site at www.healthnet.com/fehb.

We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost.

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

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

- If a member requires an interim supply of medication due to an active military duty assignment or if there is a national emergency, call us at 1-800-522-0088 for immediate assistance

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

- Drugs requiring immediate use that the delay in obtaining such drugs would interfere with the physician's treatment plan

Drugs requiring detailed instruction which cannot be provided by the mail order pharmacy compared to a retail pharmacist at the time the prescription is filled.

- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

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

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

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

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

When you do have to file a claim. In most cases you do not have to file a claim when purchasing drugs at the Plan pharmacy. However, you must pay for the drug when it is dispensed, and file a claim for reimbursement when the following occurs:

- Your Plan ID card is not available.
- Eligibility cannot be determined.
- The prescription drug is dispensed outside of California for a medical emergency.

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

Benefit Description	You pay	
Covered medications and supplies	**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 • Diabetic supplies, such as blood glucose monitoring strips, Ketone test strips and lancet • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see limits below)	For drugs filled at a Plan pharmacy: $10 for generic drugs $35 for brand drugs $60 for non-formulary drugs 20% to a maximum of $200 per prescription for specialty drugs For drugs filled through the mail order program: $20 for generic drugs $70 for brand drugs $120 for non-formulary drugs Note: If there is no generic equivalent available, you will still have to pay the brand name copay	For drugs filled at a Plan pharmacy: $15 for generic drugs $35 for brand drugs $65 for non-formulary drugs 20% to a maximum of $200 per prescription for specialty drugs For drugs filled through the mail order program: $30 for generic drugs $70 for brand drugs $130 for non-formulary drugs Note: If there is no generic equivalent available, you will still have to pay the brand name copay
Women's contraceptive drugs and devices	Nothing	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Note: The "morning after pill" is an over-the-counter emergency contraceptive drug. It is considered a preventive service under contraceptives, with no cost to the member if prescribed by a physician and purchased at a network pharmacy.	Nothing	Nothing
• Office Based – Injectable Medications and Therapeutic Injections • Self Administered – Injectable Medications acquired through specialty pharmacy with prescription • Injectable contraceptive drugs (such as Depo provera) • Growth Hormone Therapy (GHT) Note: Does not apply to: Allergy serum injections; Injectable fertility drugs (see page 28) Routine immunizations (see page 25) and Immunizations for occupational and foreign travel (see page 25).	20% to a maximum of $200 per day for office based 20% to a maximum of $200 per prescription for self-administered	20% to a maximum of $200 per day for office based 20% to a maximum of $200 per prescription for self-administered
Limited benefits: • Drugs for sexual dysfunction are limited to 2 doses per week or 8 tablets per month. Fertility drugs associated with covered services under the diagnosis and treatment of infertility are covered under the Medical Services and Supplies Benefits. (See page 28)	50% of charges	50% of charges
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs with no FDA approved indications* • *Medical supplies such as dressings and antiseptics* • *Vitamins, nutrients, and food supplements even if a physician prescribes or administers them. ACA requires that Vitamin D is covered for adults 65 and older with a physician's prescription.* • *Drugs available without a prescription or for which there is a nonprescription equivalent* • *Drugs to enhance athletic performance* • *Injectable Fertility Drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Anorectics (appetite suppressants), except for treatment of morbid obesity* • *Non-prescription medications* *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 35)*	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	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 need for these services must result from an accidental injury.	$20 copay at the PCP's office, $30 at the specialist's office and a $100 copayment at the emergency room.	$30 copay at the PCP's office, $50 at the specialist's office and a $150 copayment at the emergency room.
Dental benefits	**High Option**	**Standard Option**
Dental examinations and treatment of the gingival tissues (gums) when performed for the diagnosis or treatment of a tumor.	$20 per PCP office visit, $30 per specialist visit	$30 per PCP visit, $50 per specialist visit
Not covered: *Other dental services not shown as covered*	*All charges*	*All charges*

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 regular contract benefits as a less costly alternative. 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 in addition to other terms as necessary. 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 do not 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 contract 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. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (See Section 8).
Services for deaf and hearing impaired	Please contact our Telecommunications Device for the Deaf at 1-800-995-0852.
Centers of Excellence	For organ and tissue transplants, we contract with premier transplant centers of excellence in Northern, Southern and Central California that have established their superior ability to perform certain transplant procedures. Your participating physician group will work with you to find the best center for your condition.
Decision Power	Decision Power addresses the health needs of the whole person - from wellness health coaching to chronic condition management to chronic case management. The member chooses how and when to use the information, resources and support available. Members can take a Health Risk Questionnaire (HRQ) to identify potential health risks, create an action plan for improving health and measure how lifestyle changes will impact overall health. Experienced nurses are available 24/7 through the Nurse24 line to help you with your health related questions and guide you through next steps with your immediate care. Quality and cost tools such as Hospital and Medical Group Comparison Reports or Treatment Cost Estimators help ensure the care members receive is the right care for them. To get more information on The Decision Power Health and Wellness Programs, members can call the Customer Servicer number found on the back of the Health Net member ID card or go to www.healthnet.com/fehb and click on "Wellness Center" Decision Power.

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 the Plan at 800-522-0088 or visit the website at www.healthnet.com/fehb.

Medicare Prepaid Plan Enrollment	This Plan offers Medicare recipients the opportunity to enroll in the Plan (Health Net Seniority Plus program) through Medicare. Annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join Health Net Seniority Plus but will have to pay for Medicare Part A in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 1-800-596-6565 for information on the Health Net Seniority Plus Medicare prepaid plan and the cost of that enrollment. If you are eligible for Medicare and are interested in enrolling in a Medicare HMO sponsored by Health Net of California without dropping your enrollment in Health Net's FEHB plan, call 1-800-596-6565 for information on the benefits available under the Medicare HMO.
Individual Plans for Domestic Partners	Health Net has affordable health care plans members can depend on. We offer a wide range of competitively-priced plans with the benefits your dependents are looking for. Members can also take advantage of our Wellness Center® a free series of tools and services to help you manage and support your well-being. For more information on Health Net Individual and Family plans go to www.healthnet.com and click on Shoppers or call Health Net at 1-800-909-3447.
Optional Dental Coverage	The Health Net Non-FEHB Dental HMO plan covers over 345 procedures with a listed copayment, without any deductible or calendar year maximum. In addition to covering preventive and diagnostic services, including cleanings and adult fluoride, the plan covers periodontics, crowns, bridges, dentures and orthodontics for adults and children. Even better, the plan covers cosmetic services, such as teeth whitening. The dental HMO plan is available to all Federal Employees in California. You select a primary care dentist from our broad network of general dentists. Your primary care dentist will perform all preventive and diagnostic services and coordinate referrals to participating dental specialists if you need additional care. For more information on the dental HMO plan, finding a participating provider and an enrollment application, go to www.healthnet.com/fehb, or you can call 888-679-8925. 1 2014 Non-FEHB Benefits available to Plan members

Section 6. General exclusions - services, drugs and supplies we do not 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 it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Extra care costs associated with clinical trials.
- 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 you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 1-800-522-0088, or at our Website www.healthnet.com/fehb.

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

- Covered member's name, date of birth, address, phone number 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 payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

Health Net of California, Commercial Claims, P.O. Box 14702, Lexington, KY 40512.

Prescription drugs

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

Deadline for filing your claim

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

Post-service claim procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims processed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow the required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.healthnet.com/fehb.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Contact Center by writing to P.O. Box 10348, Van Nuys, CA 91410-0348 or calling 1-800-522-0088.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Health Net of California, P.O. Box 10348, Van Nuys, CA 91410-0348; 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. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in a sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or

b) Write to you and maintain our denial or

c) Ask you or your provider for more information

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.

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

3

You must write to OPM within:

- 90 days after the date of our letter upholding our inital 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, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 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.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

4

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 file a lawsuit, 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 proces to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit 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 you did not indicate that your claim was a claim for urgent care, then call us at 1-800-522-0088. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at 202-606-0737 between 8 am and 5 pm Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and 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 payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at www.NAIC.org.

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

When we are the secondary payor, 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.

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 (or a covered family member) 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.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has 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 (1-800-633-4227), (TTY 1-877-486-2048) 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 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. 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. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY: 1-800-325-0778).

- **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, (TTY 1-800-325-0778) 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 do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee, you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time you are covered by the group plan.

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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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 physician.

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 payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-800-522-0088 or see our Website at www.healthnet.com/fehb.

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

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefit 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), (TTY 1-877-486-2048) or at www.medicare.gov.

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

This Plan and our Medicare Advantage plan:

You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. In this case, we do not waive cost-sharing for your FEHB coverage.

This Plan and another Plan's Medicare Advantage plan:

You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments or coinsurance. 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 more 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 payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, 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 payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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 Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor 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 payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor 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.

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.

Clinical Trials Cost Categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs - costs related to taking part in a clinical trial such as addtional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

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 20.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 20.

Cost-sharing

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

Covered services

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

Custodial care

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

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services.

Experimental or investigational service

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

Group health coverage

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

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity

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

- Not experimental or investigational

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

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

PCP office visit Primary care physician office visit

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:

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Urgent care claims A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize you life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-800-522-0088. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We Us and We refer to Health Net of California.

You You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about 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. Participating employees save an average of about 30% on products and services they 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 $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26)

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **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 out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26)
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children 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.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

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 Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.** 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	All dental plans provide a comprehensive range of services, including: • 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 12-month waiting period **Most FEDVIP dental plans cover adult orthodontia. Review your plan's brochure for information on this benefit.**
Vision Insurance	All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for 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/dental and www.opm.gov/vision. These sites also provide 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 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 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 such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in an adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. 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. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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

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Summary of benefits for the High Option of Health Net of California - 2015

- **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.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	$20 primary care; $30 specialist; $20 CVS Minute Clinics	24
Services provided by a hospital:		
• Inpatient	$150 per day up to 5 days per admission copay	45
• Outpatient Surgery at a Hospital or Ambulatory Surgical Center	$200 copay	46
Emergency benefits:		
• In-area	$100 per visit (waived if admitted to Hospital)	49
• Out-of-area	$100 per visit (waived if admitted to Hospital)	49
Mental health and substance abuse treatment:	Regular cost-sharing	50
Prescription drugs:	$10 copay for a 30 day supply of formulary generic drugs - $20 for a 90 day supply through mail order. $35 copay for a 30 day supply of formulary brand name drugs - $70 for a 90 day supply through mail order. $60 copay for a 30 day supply of non-formulary drugs - $120 for a 90 day supply through mail order. 20% to a maximum of $200 per prescription for specialty drugs - not available through mail order.	53
Dental care - Accidental Injury	$20 PCP office visit; $30 specialist visit; $100 Emergency Room	56
Vision care:	$20 PCP office visit, $30 specialist visit	30
Special features:	Services for the deaf and hearing impaired, Centers of Excellence, Decision Power	57
Protection against catastrophic costs (your catastrophic out-of-pocket maximum)**:**	Nothing after $1,500/Self Only or $4,500 / Family enrollment per year.	20

	For prescriptions Nothing after $2,900/Self Only or $8,700/Family enrollment per year.	

Summary of benefits for the Standard Option of Health Net of California - 2015

- **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.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	$30 primary care; $50 specialist; $30 CVS Minute Clinics	24
Services provided by a hospital:		
• Inpatient	$750 copay	45
• Outpatient surgery at a hospital or ambulatory surgical center	$350 copay	46
Emergency benefits:		
• In-area	$150 per visit (waived if admitted to hospital)	49
• Out-of-area	$150 per visit (waived if admitted to hospital)	49
Mental health and substance abuse treatment:	Regular cost-sharing	50
Prescription drugs:	$15 copay for a 30 day supply of formulary generic drugs - $30 for a 90 day supply through mail order. $35 copay for a 30 day supply of formulary brand name drugs - $70 for a 90 day supply through mail order. $65 copay for a 30 day supply of non-formulary drugs - $130 for a 90 day supply through mail order. 20% to a maximum of $200 per prescription for specialty drugs - not available through mail order.	53
Dental care - accidental injury	$30 PCP office visit; $50 Specialist visit; $150 emergency room	56
Vision care:	$30 office visit	30
Special features:	Services for the deaf and hearing impaired, Centers of Excellence, Decision Power	57
Protection against catastrophic costs (your catastrophic out-of-pocket maximum):	Nothing after $1,500/Self Only or $4,500/Self and Family enrollment per year. For prescriptions Nothing after $2,900/Self Only or $8,700/Family enrollment per year.	20

2015 Rate Information

For 2015 health premium information, please see:
http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.