Health Net of California

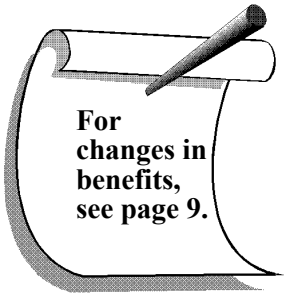
www.healthnet.com

2008

A Health Maintenance Organization

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 7 for requirements.



This plan has been granted Excellent Accreditation for its HMO plan from the NCQA. See the 2008 Guide for more information on accreditation.

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**

Special Notice: Health Net of California will split the Northern and Southern Region and offer a High and Standard Option for each region in 2008. Any current federal members under the enrollment LB that resides in the counties assigned to the Southern Region must change during Open Season. Federal subscribers will not automatically be transferred to the Southern Region. Members in the Southern Region who do not make a positive election during Open Season will receive emergency benefits only.

Authorized for distribution by the:

United States
Office of Personnel Management

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

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

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. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for 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 (TYY 1-800-325-0778).

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

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

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Introduction

This brochure describes the benefits of Health Net of California under our contract (CS 2002) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. 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, 2008, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2008, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

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

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

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

Stop Health Care Fraud!

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

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

Protect Yourself From Fraud

– Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.

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

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

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

If we do not resolve the issue:

CALL --THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:

Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

Your child over age 22 (unless he/she is disabled and incapable of self support).

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

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

1. **Ask questions if you have doubts or concerns.**

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

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

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

- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask 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 you are taking.

Visit these websites for more information about patient safety.

- www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this HMO plan

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

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.

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.

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, Kings, 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:

Los Angeles, Orange, San Diego, Santa Barbara 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, 93215-17, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93249-52, 93255, 93263, 93268, 93276, 93280, 93283, 93285, 93287-88, 93300-91, 93399, 93501-05, 93516, 93518-19, 93523-24, 93531, 93560-61, 93581-82, 93596

RIVERSIDE:

91718-20, 91752, 91760, 92201-03, 92210-11, 92220, 92223, 92230, 92234-36, 92240-41, 92247, 92253-55, 92258, 92260-64, 92270, 92274, 92276, 92282, 92292, 92302-03, 92306, 92313, 92320, 92330-31, 92343-44, 92348-49, 92353, 92355, 92360-62, 92367, 92370, 92380-81, 92383, 92387-88, 92390, 92395-96, 92500-23, 92530-32, 92536, 92539, 92543-46, 92548-57, 92561-64, 92567, 92570-72, 92581-93, 92595-96, 92860, 92877-83

SAN BERNARDINO:

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

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

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

Section 2. How we change for 2008

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

Changes to this Plan

Your share of the non-Postal premium will increase for Self Only and for Self and Family. See page 66.

We have added hearing aid coverage for children with hearing loss caused by congenital birth defects. See page 23.

We have changed our service area for this plan to be limited to Northern California counties. Please see page 7 for a description of the Northern and Southern California counties.

We are offering a Northern California Standard Option for the first time during the 2007 Open Season. Your share of the non-Postal premium will increase under this plan. See page 66 for plan codes and rates.

We are offering a Southern California High Option for the first time during the 2007 Open Season. Your share of the non-Postal premium will decrease under this plan. See page 66 for plan codes and rates.

We are offering a Southern California Standard Option for the first time during the 2007 Open Season. Your share of the non-Postal premium will decrease under this plan. See page 66 for plan codes and rates.

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 Web site at www.healthnet.com.

Where you get covered care

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

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. 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 25) 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 use our criteria when creating your treatment plan.
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:

  - Terminate our contract with your specialist for other than cause; or

  - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or

  - Reduce our service area and you enroll in another FEHB Plan,

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

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

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

To request an authorization for a second opinion, contact your Primary Care Physician or Health Net 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 you 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; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

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

Circumstances beyond our control

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

Services requiring our prior approval

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

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

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

Section 4. Your costs for covered services

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

Copayments

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

Example: When you see your primary care physician you pay a copayment of $15 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 $250 per admission on the High Option and $500 per admission on the Standard Option.

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.

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.

Your catastrophic protection out-of-pocket maximum

After your copayments and/or coinsurance total $1500 per person or $4500 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription Drugs (Note: Injectables coinsurance will count towards the maximum)
- Chiropractic Care

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

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.

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.

High and Standard Option Benefits

See page 9 for how our benefits changed this year. Pages 64 and 65 are benefits summaries for the High and Standard Options.

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Section 5. High and Standard Option Benefits Overview

This Plan offers a High and Standard Option. Our benefit packages are described in Section 5. Make sure that you review the benefits carefully.

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 filling advice, or more information about High or Standard Option benefits, contact us at 800-522-0088 or at our Web site at www.healthnet.com.

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:

- Office visit copay - $15
- Inpatient Hospitalization - $250
- Prescriptions Drug Copays - $10 generic, $35 brand, $50 non-formulary
- Chiropractic - $10 copay, 20 visits

Our Standard Option benefits include:

- Office visit copay - $30
- Inpatient Hospitalization - $500
- Prescriptions Drug Copays - $10 generic, $35 brand, $50 non-formulary
- 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	$15 per visit	$30 per visit
Professional services of physicians • In an urgent care center	$15 per visit	$15 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 • Electrocardiogram and EEG	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**
MRI/CAT/PET AND SPECT Scans	Nothing	$100 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 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50	$15 per office visit	$30 per office visit
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing	Nothing
Routine Pap test Note: You do not pay a separate copay for a Pap test performed during your periodic health evaluation; see *Diagnostic and treatment services.*	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 if you receive these services during your office visit; otherwise, $15 per office visit	Nothing if you receive these services during your office visit; otherwise, $30 per office visit
Immunizations for occupational and foreign travel	20% of charges	20% of charges
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	$15 per office visit	$30 per office visit
• Well-chld care charges for routine examinations, immunizations and care (up to age 22)	$15 per office visit	$30 per office visit
Examinations, such as:	$15 per office visit	$30 per office visit

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**High Option**	**Standard Option**
- 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	$15 per office visit	$30 per office visit
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 • Postnatal care	$15 per office visit	$30 per office visit
Delivery Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; • 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 (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing	Nothing
Family planning	**High Option**	**Standard Option**
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

Family planning - continued on next page

Benefit Description	You pay	
Family planning (cont.)	**High Option**	**Standard Option**
• Voluntary sterilization (females)(e.g., Tubal ligation)	$150	$150
• 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 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*

Benefit Description	You pay	
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 32. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	Nothing	Nothing
• Growth hormone therapy (GHT) Note: – We only cover GHT when we preauthorize the treatment. Physicians must follow the prior authorization guidelines. Call 800-522-0088 for information on preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	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 and • occupational therapists Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided 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*

Benefit Description	You pay	
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 • Self Administered • Injectable contraceptive drugs (such as Depo provera) • Growth Hormone Therapy (GHT) Note: Does not apply to: Allergy serum injections (see page 21); Injectable fertility drugs (see page 21); Routine immunizations (see page 19) and Immunizations for occupational and foreign travel (see page 19).	20% to a maximum of $200 per day	20% to a maximum of $200 per day
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17, which include; (see *Preventive care, children)*	$15 per office visit	$30 per office visit
Hearing aids for children (under 18 years of age) with hearing loss caused by congenital birth defects - $1000 maximum benefit every 36 months	Nothing	Nothing
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them*	*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	$15 per office visit	$30 per office visit
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Eyeglasses or contact lenses after Interocular lens implant*	*All charges*	*All charges*

Benefit Description	You pay	
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	$15 per office visit	$30 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*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 • Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(a) for payment information. Note: Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	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* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*	*All charges*

Benefit Description	You pay	
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; • Blood glucose monitors; and • Insulin pumps.	Nothing	You pay all charges above $2000 per calendar year
Not covered: • *Exercise equipment;* • *Hygienic equipment and supplies (to achieve cleanliness even when related to other covered medical services;* • *Stockings;* • *Surgical dressings, except primary dressings that are applied by a Plan physician or a Hospital to lesions of the skin or surgical incisions;* • *Jacuzzis and whirlpools;* • *Orthotics which are not custom made to fit your body (Orthotics are supports or braces for weak or ineffective joints or muscles);* • *Foot orthotic, except when they have been incorporated into a cast, splint, brace or strapping of the foot*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 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*

Benefit Description	You pay	
Chiropractic	**High Option**	**Standard Option**
• Chiropractic services – by the chiropractors that participate in the American Specialty Health Plan (ASHP) network20 visit 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 (when medically necessary and authorized by PPG)	$15 per office visit	$30 per office visit
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Coverage is limited to: • Diabetes self management • Wellness programs provided by your selected Participating Physician Group • Quitting Matters Smoking Cessation Program Prenatal Program with gift certificate upon completion	Nothing	Nothing
Clinical Trials	**High Option**	**Standard Option**
Routine patient care costs for patients diagnosed with cancer who are accepted into phase I, II, III or IV clinical trials are covered when medically necessary, recommended by the Member's treating Physician and authorized by Health Net of California. • The Physician must determine that participation has a meaningful potential to benefit the Member and the trial has therapeutic intent. • Services rendered as part of a clinical trial that involves either a drug that is exempt from Federal regulation in relation to a new drug application, or is approved by one of the following: The National Institutes of Health; The FDA as an investigational new drug application; The Department of Defense; or The Veterans' Administration	Your cost sharing responsibilities are no greater than for other covered services	Your cost sharing responsibilities are no greater than for other covered services

Clinical Trials - continued on next page

Benefit Description	You pay	
Clinical Trials (cont.)	**High Option**	**Standard Option**
Note: "Routine patient care costs" include drugs, items, devices and services that would normally be covered under this plan if they were not provided in connection with a clinical trials program.	Your cost sharing responsibilities are no greater than for other covered services	Your cost sharing responsibilities are no greater than for other covered services
Not covered: *Coverage for clinical trials does not include the following items:* • *Drugs or devices that are not approved by the FDA* • *Services other than health care services, including but not limited to cost of travel, or costs of other non-clinical expenses* • *Services provided to satisfy data collection and analysis needs which are not used for clinical management* • *Items and services provided free of charge by the research sponsors to Members in the trial.*	*All charges*	*All charges*

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 amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**

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;	$15 per office visit	$30 per office visit

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. • 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.	$15 per office visit	$30 per office visit
• Voluntary sterilization (e.g., Tubal ligation)	$150 copay	$150 copay
• 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*

Benefit Description	You pay	
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	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing	Nothing

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
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**
Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to Other services in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description and can safely tolerate the procedure. • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Kidney/Pancreas • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas	Nothing	Nothing
Blood or marrow stem cell transplants limited to the stages of the following diagnoses: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkins lymphoma - Advanced non-Hodgkins lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Severe or very severe aplastic anemia	Nothing	Nothing
• Autologous transplants for		
- Acute lymphocytic or non-lymphocytic (i.e., myelogenous leukemia)		
- Advanced Hodgkin's lymphoma		
- Advanced non-Hodgkin's lymphoma		
- Advanced neuroblastoma		
• Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer)		
Blood or marrow stem cell transplants for		
• Allogeneic transplants for		
- Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)		
- Advanced forms of myelodysplastic syndromes		
- Advanced neuroblastoma		
- Infantile malignant osteoporosis		
- Kostmann's syndrome		
- Leukocyte adhesion deficiencies		
- Mucolipidosis (e.g., Gaucher's disease, metachromatic		
- Mucoplysaccharidosis (e.g. Hurler's syndrome, Maroteaux-Lamy syndrome variants)		
- Myeloproliferative disorders		
- Sickle cell anemia		
- Thalassemia major (homozygous beta-thalassemia)		
• Autologous transplants for		
- Multiple myeloma		
- Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors		
- Breast cancer		
- Epithelial ovarian cancer		
- Amyloidosis		
- Ependymoblastoma		

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Ewing's sarcoma - Medulloblastoma - Pineoblastoma Blood or marrow stem cell transplants covered only in a National Cancer Institute – or National Institutes of Health-approved clinical trial or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for: • Allogeneic transplants for - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma • Nonmyeloablative allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced forms of myelodysplastic syndromes - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple meloma - Myeloproliferative disorders - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas • Autologous transplants for	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • National Transplant Program (NTP)- • Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	Nothing

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;	$250 per admission	$500 per admission
General nursing care; and 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.	$250 per admission at Hospital $100 per admission at Ambulatory Surgical Center	$500 per admission at Hospital $100 per admission at Ambulatory Surgical Center
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	$15 per visit	$15 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	$100 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	$15 per visit	$15 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	$100 per visit
Not covered: • Elective care or non-emergency care • Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area • *Follow-up care not authorized by your participating physician group*	*All charges*	*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	Nothing

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

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

Important things 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 sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay	
Mental health and substance abuse benefits	**High Option**	**Standard Option**
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management • Diagnostic tests	$15 per visit	$30 per visit
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$250 per admission	$500 per admission
Not covered: Services we have not approved	*All charges*	*All charges*
Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.		

Preauthorization	To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes. Contact MHN toll-free at 1-888-779-2236 twenty-four hours a day, seven days a week and MHN will direct you to the appropriate provider of care.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 43.
- 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.
- 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 Plan physician or referral physician must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail if a maintenance medication
- **We use a formulary.** A formulary is the approved list of drugs that are covered. It identifies whether a generic version of a brand name drug exists, and if prior authorization is required. Drugs that are not excluded or limited from coverage are also covered and are considered non-formulary drugs. Non-formulary drugs require a higher copayment.

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

We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from 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) Contraceptive devices such as diaphragms and cervical caps	For drugs filled at a Plan pharmacy: $10 for generic drugs $35 for brand drugs $50 for non-formulary drugs For drugs filled through the mail order program: $20 for generic drugs $70 for brand drugs $100 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: $10 for generic drugs $35 for brand drugs $50 for non-formulary drugs For drugs filled through the mail order program: $20 for generic drugs $70 for brand drugs $100 for non-formulary drugs Note: If there is no generic equivalent available, you will still have to pay the brand name copay
• Office Based – Injectable Medications • Self Administered – Injectable Medications • Injectable contraceptive drugs (such as Depo provera) • Growth Hormone Therapy (GHT) Note: Does not apply to: Allergy serum injections; Injectable fertility drugs (see page 21); Routine immunizations (see page 19) and Immunizations for occupational and foreign travel (see page 19).	20% to a maximum of $200 per day	20% to a maximum of $200 per day

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
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 21)	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 • Drugs available without a prescription or for which there is a nonprescription equivalent • Drugs to enhance athletic performance • Injectable Fertility Drugs • Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies • Anorectics (appetite suppressants), except for treatment of morbid obesity • *Non-prescription medications*	*All charges*	*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.	$15 copay at the doctor's office and a $100 copayment at the emergency room.	$30 copay at the doctor's office and a $100 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.	$15 per office visit	$30 per office visit
Not covered:		
Other dental services not shown as covered	*All charges*	*All charges*

Section 5(h). Special features

Feature	Description
Services for deaf and hearing impaired	Please contact our Telecommunications Device for the Deaf at 1-800-995-0852.
Early Prenatal Program	We encourage our mothers-to-be to participate in our special prenatal health program. **Upon successful completion of the program, participants will receive a gift certificate.** Parents learn answers to their early pregnancy concerns, such as caffeine or alcohol use, tests during pregnancy and other general prenatal information. Please call 1-800-522-0088 for more information.
Centers of Excellence	For organ and tissue transplants, we contract with premier transplant centers of excellence in Northern, Southern and Central California that have established their superior ability to perform certain transplant procedures. Your participating physician group will work with you to find the best center for your condition.
Decision Power	Decision Power is a health-support program designed to directly involve individuals in their own health care. With Decision Power, after you enroll, you can: • Talk to a Health Coach *anytime* to discuss your health concerns. • Watch support videos that show why different people might choose different treatment courses for the same health condition. • Learn more about a broad array of health topics, from resources you can trust and understand. • Assess and monitor your health, using a variety of online tools.
It's Your Life	A wellness program designed to help individuals balance work, life and family issues. With It's Your Life, solutions can begin with a single step. After you enroll, you can: • Get answers to your financial, legal and emotional health concerns. • Get help finding childcare and elder care resources. • Access wellness programs and member discounts on vitamins, eye care and massage therapy.

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.

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.

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

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

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

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

Submit your claims to:

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.

When we need more information

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

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3:

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.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or b) Write to you and maintain our denial – go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

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

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

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

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage Plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

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

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

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

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

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan physician.

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

Claims process when you have the Original Medicare Plan

– You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan. When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. 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 Web site at www.healthnet.com.

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare 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 1-800-633-4227) or at www.medicare.gov.

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

This Plan and our Medicare Advantage plan:

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

This Plan and another Plan's Medicare Advantage plan:

You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments or 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 payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB Plan.

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

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payer for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and... • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓ *	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

TRICARE and CHAMPVA

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

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 13.

Copayment

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

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.

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.

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:

Us/We

Us and We refer to Health Net of California.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health for enrollment information as well as:

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

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

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

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

- **Children's Equity Act**

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 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 2006 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

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

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

- **Upon divorce**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

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

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

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

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

- **Converting to individual coverage**

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

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

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

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

- **Getting a Certificate of Group Health Plan Coverage**

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

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

Section 12. Three Federal Programs complement FEHB benefits

Important information

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

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

Second, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, 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 qualified dependents.

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living - such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. **Annuitants are not eligible to enroll.**

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

- **Health Care FSA (HCFSA)** –Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by FEHBP coverage or other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-333), Monday through Friday, 9 a.m. until 9 p.m. Eastern Time. TTY: 1-800-952-0450.

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This program has no pre-existing condition limitations. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Premiums are withheld from salary on a pre-tax basis.

Dental Insurance

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

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

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

Vision Insurance

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

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

Additional Information

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

How do I enroll?

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

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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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Notes

Notes

Summary of benefits for the High Option of Health Net of California - 2008

- **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	$15 primary care; $15 specialist	17
Services provided by a hospital:		
• Inpatient	$250 per admission copay	34
• Outpatient Surgery at a Hospital	$250 copay	35
• Outpatient Surgery at an Amublatory Surgical Center	$100 copay	35
Emergency benefits:		
• In-area	$100 per visit (waived if admitted to Hospital)	38
• Out-of-area	$100 per visit (waived if admitted to Hospital)	38
Mental health and substance abuse treatment:	Regular cost sharing	39
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. $50 copay for a 30 day supply of non-formulary drugs - $100 for a 90 day supply through mail order.	42
Dental care - Accidental Injury	$15 office visit, $100 Emergency Room	44
Vision care:	$15 office visit	18, 22
Special features:	Services for the deaf and hearing impaired, Early Prenatal Program, Centers of Excellence, Decision Power, It's Your Life	45
Protection against catastrophic costs (your catastrophic out-of-pocket maximum)**:**	Nothing after $1,500/Self Only or $4,500 / Family enrollment per year. Some costs do not count toward this protection.	13

Summary of benefits for the Standard Option of Health Net of California - 2008

- **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; $30 specialist	17
Services provided by a hospital:		
• Inpatient	$500 copay	34
• Outpatient surgery at a hospital	$500 copay	35
• Outpatient surgery at an ambulatory surgical center	$100 copay	35
Emergency benefits:		
• In-area	$100 per visit (waived if admitted to hospital)	38
• Out-of-area	$100 per visit (waived if admitted to hospital)	38
Mental health and substance abuse treatment:	Regular cost sharing	39
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. $50 copay for a 30 day supply of non-formulary drugs - $100 for a 90 day supply through mail order.	42
Dental care - accidental injury	$30 office visit; $100 emergency room	44
Vision care:	$30 office visit	18, 22
Special features:	Services for the deaf and hearing impaired, Early Prenatal Program, Centers of Excellence, Decision Power, It's Your Life	45
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. Some costs do not count toward this protection	13

2008 Rate Information for Health Net of California

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

Postal Category 1 rates apply to certain career non-loaw enforcement Postal Service employees. Postal Category 2 rates apply to other career non-law enforcement Postal Service employees. PostalEASE, the employee self-service system used for FEHB enrollment, automatically provides the applicable premium to individual employees. Career non-law enforcement employees may also refer to the *Guide to Federal Benefits for United States Postal Service Employees*, RI 70-2 to determine their rates.

Different rates apply and a special Guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

For further assistance, Postal Service employees should call Human Resources Shared Service Center 1-877-3273, Option 5 TTY: 1-866-260-7507.

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable *Guide to Federal Benefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Northern California							
High Option Self Only	LB1	145.04	105.82	314.25	229.28	81.64	79.63
High Option Self and Family	LB2	329.30	250.72	713.48	543.23	195.84	191.26
Standard Option Self Only	LB4	145.04	91.72	314.25	198.73	67.54	65.53
Standard Option Self and Family	LB5	329.30	218.10	713.48	472.55	163.22	158.64
Southern California							
High Option Self Only	LP1	139.48	46.49	302.21	100.73	23.25	20.92
High Option Self and Family	LP2	322.49	107.49	698.72	232.90	53.75	48.37
Standard Option Self Only	LP4	132.62	44.20	287.33	95.78	22.10	19.89
Standard Option Self and Family	LP5	306.62	102.21	664.35	221.45	51.10	45.99