SUMMARY OF BENEFITS AND DISCLOSURE FORM

Small Business Group
Elect Open Access 40 Standard (Plan 873)

DELIVERING CHOICES

When it comes to your health care, the best decisions are made with the best choices. Health Net of California, Inc. (Health Net) provides you with ways to help you receive the care you deserve. This Summary of Benefits/Disclosure Form (SB/DF) answers basic questions about this versatile plan.

If you have further questions, contact us:

By phone at 1-800-361-3366,

Or write to: Health Net of California
P.O. Box 10348
Van Nuys, CA 91410-0348

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

This Summary of benefits/disclosure form (SB/DF) is only a summary of your health plan. Your Evidence of Coverage (EOC), which you will receive after you enroll, contains the exact terms and conditions of your Health Net coverage. You have the right to view the EOC prior to enrollment. To obtain a copy of the EOC contact Member Services at 1-800-361-3366. You should also consult the Group Hospital and Professional Service Agreement (issued to your employer) to determine governing contractual provisions. It is important for you to carefully read this SB/DF and your EOC thoroughly once received, especially those sections that apply to those with special health care needs. This SB/DF includes a matrix of benefits in the section titled "Schedule of benefits and coverage."

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How the plan works

Please read the following information so you will know from whom health care may be obtained or what physician group to use.

SELECTION OF PHYSICIANS AND PHYSICIAN GROUPS

- When you enroll with Health Net, you choose a contracting physician group. From your physician group, you select one doctor to provide basic health care; this is your Primary Care Physician (PCP). See your Health Net directory of participating providers for detailed information about physicians and physician groups in the Health Net network. The Health Net directory of participating providers is also available on Health Net's website at www.healthnet.com.
- Whenever you or a covered family member needs health care, your PCP will provide the medically necessary treatment. Specialist care is also available through your Health Net plan, when authorized in advance through your PCP or physician group.
- You do not have to choose the same physician group or PCP for all members of your family. Physician groups, with names of physicians, are listed in the Health Net directory of participating providers.

HOW TO CHOOSE A PHYSICIAN

Choosing a PCP is important to the quality of care you receive. To be comfortable with your choice, we suggest the following:

- Discuss any important health issues with your chosen PCP;
- Do the same with the Health Net Coordinator at the physician group and ask for referral specialist policies and hospitals used by the physician group; and
- Ensure that you and your family members have adequate access to medical care, by selecting a doctor located within 30 miles of your residence or work.

SPECIALISTS AND REFERRAL CARE

If you need medical care that your PCP cannot provide, your PCP may refer you to a specialist or other health care provider for that care. Your physician group must authorize all treatments recommended by such provider.

HMO SPECIALIST ACCESS

Health Net offers Rapid Access®, a service that makes it easy for you to quickly connect with a specialist in Health Net's network. Ask your group or check the Health Net directory of participating providers to see if your physician group allows "self-referrals" or "direct referrals" to specialists within the same group. Self-referral allows you to contact a specialist directly for consultation and evaluation. Direct referral allows your doctor to refer you directly to a specialist without the need for physician group authorization. Information about your physician group's referral policies is also available to you on our web site at, www.healthnet.com.

OPEN ACCESS SPECIALISTS

At any time, you may self-refer to a physician contracted with Health Net. Check your Health Net directory of participating providers. Your coverage and benefits are different when you visit Open Access providers.

HOW TO ENROLL

Complete the enrollment form found in the enrollment packet and return the form to your employer. If a form is not included, your employer may require you to use an electronic enrollment form or an interactive voice response enrollment system. Please contact your employer for more information.

Some hospitals and other providers do not provide one or more of the following services that may be covered under your *Evidence of Coverage* and that you or your family member might need:

Family planning;
Contraceptive services; including emergency contraception;
Sterilization, including tubal ligation at the time of labor;
Infertility treatments; or
Abortion.

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic, or call Health Net Member Services Department at 1-800-361-3366 to ensure that you can obtain the health care services that you need.

Schedule of benefits and coverage

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PLAN CONTRACT AND EVIDENCE OF COVERAGE (EOC) SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Principal benefits and coverage matrix

Deductibles ..... None
Lifetime maximums ..... None

Out-of-Pocket maximum

One member $4000
Family (two members or more) $8000

Once your payments for covered services equals the amount shown above in any one calendar year, no additional copayments for covered services are required for the remainder of the calendar year. Once an individual member in a family meets the individual out-of-pocket maximum, the other enrolled family members must continue to pay copayments for covered services until the total amount of copayments paid by the family reaches the family out-of-pocket maximum or each enrolled family member individually meets the individual out-of-pocket maximum. Payments for any supplemental benefits or services not covered by this plan will not count toward this calendar year out-of-pocket maximum, unless otherwise noted. You will need to continue making payments for any additional benefits.

Professional services

☞ *The copayments below apply to professional services only. Services that are rendered in a hospital or an outpatient center are also subject to the hospital or outpatient center services copayment. See "Hospitalization services" and "Outpatient services" in this section to determine if any additional copayments may apply.*

Visit to physician $40
Specialist consultations ■ $40
Prenatal and postnatal office visits $40
Normal delivery, cesarean section, newborn inpatient care ..... Covered in full
Treatment of complications of pregnancy, including medically necessary abortions ..... Covered in full
Surgeon or assistant surgeon services ▲ ..... Covered in full
Administration of anesthetics ..... Covered in full
Laboratory procedures and diagnostic imaging (including x-ray) services ..... Covered in full
CT, SPECT, MRI, MUGA and PET $100
Rehabilitative therapy (includes physical, speech, occupational, and respiratory therapy) $40
Organ and bone marrow transplants (non-experimental and non-investigational) ..... Covered in full
Chemotherapy ..... Covered in full
Radiation therapy ..... Covered in full

■ *Self-referrals are allowed for obstetrics and gynecological services including preventive care, pregnancy and gynecological ailments. Copayment requirements may differ depending on the services provided.*

▲ *Surgery includes surgical reconstruction of a breast incident to mastectomy, including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema. While Health Net and your physician group will determine the most appropriate services, the length of hospital stay will be determined solely by your PCP.*

Preventive care

Adult preventive care

Periodic health evaluations, including well-woman exam and annual preventive physical examinations (age 18 and older) $40

Vision and hearing examinations $40

Child preventive care

Periodic health evaluations, including newborn, well-baby care, annual preventive physical examinations and immunizations

birth through 30 days ..... Covered in full

31 days through 24 months ..... Covered in full

age 2 through age 17 ..... $40

Vision and hearing examinations (birth through age 17) $40

For preventive health purposes, a periodic health evaluation and diagnostic preventive procedures are covered, based on recommendations published in the U. S. Preventive Services Task Force. In addition, a covered annual cervical cancer screening test includes a Pap test, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA..

Allergy treatment and other injections (except for infertility injection)

Allergy testing $40

Allergy serum ..... Covered in full

Allergy injection services $40

Immunizations -- To meet foreign travel requirements $40

Immunizations -- To meet occupational requirements $40

All other injections (except for infertility injection)

Injectable drugs administered by a physician (per dose) ..... Covered in full

Self injectable drugs 30%

Outpatient services

Outpatient services (other than surgery) ..... Error

Outpatient surgery (surgery performed in a hospital or outpatient surgery center only) $1000

Hospitalization services

Semi-private hospital room or intensive care unit with ancillary services, including maternity care (unlimited days) ..... $1000 per day for a maximum of 3 days per admission

Hospitalization for infertility services 50%

Skilled nursing facility stay (limited to 100 days each calendar year)

Days 1-10 ..... Covered in full

Days 11-100 ..... $25 per day

Physician visit to hospital or skilled nursing facility (excluding care for substance abuse and mental disorders) $40

Emergency health coverage

Emergency room (professional and facility charges) $100

Urgent care center (professional and facility charges) $50

Copayments for emergency room or urgent care center visits will not apply if the member is admitted as an inpatient directly from the emergency room or urgent care center. A visit to one of the urgent care centers that is owned and operated by the member's physician group will be considered an office visit and the office visit copayment, if any, will apply.

Ambulance services

Ground ambulance $100

Air ambulance $100

Prescription drug coverage

Please refer to the "Prescription drug program" section of this SB/DF for applicable definitions, benefit descriptions and limitations. Copayments for prescription drugs do not apply to the out-of-pocket maximum, except copayments for peak flow meter and inhaler spacers used for the treatment of asthma, and diabetic supplies.

Retail participating pharmacy (up to a 30-day supply)

Level I drugs (primarily generic) $15

Level II drugs (primarily brand name drugs, peak flow meters, inhaler spacers and diabetic supplies, including insulin) ◆ $30

Level III drugs ◆ $50

Smoking cessation drugs (covered up to a 12-week course of therapy per calendar year if you are currently enrolled in a comprehensive smoking cessation program) 50%

Appetite Suppressants 50%

Lancets ..... Covered in full

Contraceptive devices (including diaphragms and cervical caps $30

Mail-order program (up to a 90-day supply of maintenance drugs)

Level I drugs (primarily generic) $30

Level II drugs (primarily brand name drugs, peak flow meters, inhaler spacers and diabetic supplies, including insulin) ◆ $60

Level III drugs ◆ $100

Lancets ..... Covered in full

◆ *Generic drugs will be dispensed when a generic drug equivalent is available. When a brand name drug is dispensed and a generic equivalent is commercially available, the member must pay the difference between the generic equivalent and the brand name drug plus the Level I drug copayment.*

However, if the prescription drug order states "dispense as written," "do not substitute" or words of similar meaning in the physician's handwriting, only the Level II or Level III copayment, as appropriate, will be applicable.

Copayments for prescription drugs do not apply to the out-of-pocket maximum, except copayments for peak flow meters, inhaler spacers used for the treatment of asthma and diabetic supplies.

Percentage Copayments will be based on Health Net's contracted pharmacy rate.

If the retail price is less than the applicable copayment, then you will pay the retail price. Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.

This plan uses the Recommended Drug List. The Health Net Recommended Drug List (the List) is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. The List also shows which drugs are Level I, Level II or Level III, so you know which copayment applies to the covered drug. Drugs that are not on the List (that are not excluded or limited from coverage) are also covered at the Level III drug copayment.

Some drugs require prior authorization from Health Net. Urgent requests from physicians are handled in a timely fashion, not to exceed 72 hours, as appropriate and medically necessary, for the nature of the Member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 5 days, as appropriate and medically necessary, for the nature of the Member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination. For a copy of the Recommended Drug List, call Member Services at the number listed on the back cover of this booklet or visit our website at www.healthnet.com.

Medical Supplies

Durable medical equipment (including nebulizers, face masks and tubing for the treatment of asthma) 50%

Calendar year maximum payment by Health Net ▣ *$2000*

Orthotics (such as bracing, supports and casts) ..... Covered in full

Diabetic Equipment 20%

Diabetic footwear ..... Covered in full

Prostheses ..... Covered in full

▣ *The calendar year maximum does not apply to orthotics or to nebulizers, face masks and tubing used for the treatment of asthma.*

Diabetic equipment covered under the medical benefit (through "Diabetic Equipment"), includes blood glucose monitors designed for the visually impaired, insulin pumps and related supplies. In addition, the following supplies are covered under the medical benefit as specified: diabetic footwear, visual aids (excluding eyewear) to assist the visually impaired with the proper dosing of insulin are provided through the prostheses benefit; Glucagon is provided through the self-injectable benefit. Self-management training, education and medical nutrition therapy will be covered only when provided by licensed health care professionals with expertise in the management or treatment of diabetes (provided through the patient education benefit). Diabetic equipment and supplies covered under the prescription drug benefit include insulin, specific brands of blood glucose monitors and testing strips, Ketone urine testing strips, lancets and lancet puncture devices, specific brands of pen delivery systems for the administration of insulin (including pen needles) and specific brands of insulin syringes.

Mental health services for severe mental illness and serious emotional disturbances of a child

☞ *Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services. For definitions of severe mental illness or serious emotional disturbances of a child, please refer to to the Behavioral health section of this SB/DF, or call Member Services at the number listed on the back cover of this booklet.*

Outpatient $40

Inpatient ..... $1000 per day for a maximum of 3 days per admission

Mental health services for non-severe mental illness

☞ *Benefits are administered by MHN Services, an affiliate behavioral health administrative services com*pany *which provides behavioral health services.*

Outpatient *(20 visit maximum each calendar year)*

Individual session..... $30

Group session $15

Inpatient *(30 day maximum each calendar year)* ..... $1000 per day for a maximum of 3 days per admission

Detoxification

☞ *Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.*

Acute care (detoxification)..... $1000 per day for a maximum of 3 days per admission

Home health services

Home health services (copayment required for each day home health visits occur) $40

Calendar year maximum ..... 100 visits

Other services

Infertility services and supplies (including injections related to covered infertility services)..... 50%

Sterilizations --Vasectomy ..... Covered in full

Sterilizations --Tubal ligation ..... Covered in full

Blood, blood plasma, blood derivatives and blood factors ..... Covered in full

Renal dialysis ..... Covered in full

Hospice services ..... Covered in full

Open Access Benefits

☞ *Payment for Open Access specialist benefits and services not covered by this plan will not be applied to the Out-of-pocket maximum. You will also need to continue making payment for any additional benefits as described in the "Additional plan benefits" section of this SB/DF. The percentages that appear in this chart are based on amounts agreed to in advance by our health plan and the member's physician group or other contracted health care professionals. All other benefits must be provided or coordinated by your PCP.*

Office visit (including specialist consultation and evaluations)	$55
Vision or hearing examination	$55
Immunizations -- To meet foreign travel requirements	$40
Immunizations -- To meet occupational requirements	$40
Allergy testing	$55
Allergy serum	Covered in full
Allergy injection services	$55
All other injections (excluding infertility services)	$55
Self injectable drugs	30%
Rehabilitative therapy (including outpatient physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy ✍	$55
Maximum visits per calendar year	*12*
Laboratory procedures and diagnostic imaging (including x-ray) services◈	Covered in full

✍ *Benefits are limited to therapy provided only in an office.*

◈ *Laboratory procedures and diagnostic imaging (including x-ray) services performed in a physician's office or PPO facility are covered. However, complex radiology (MRI, MUGA, PET, and SPECT) is not covered though Open Access Benefits.*

Limits of coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS) UNDER YOUR MEDICAL BENEFIT PLAN

- Artificial insemination for reasons not related to infertility;
- Chemical dependency except for detoxification;
- Conception by medical procedures (IVF, GIFT and ZIFT);
- Corrective or support appliances or supplies except as provided for diabetic supplies;
- Cosmetic services and supplies;
- Custodial or live-in care;
- Dental services;
- Disposable supplies for home use;
- Experimental or investigational procedures, except as set out under the "Clinical trials" and "If you have a disagreement with our plan" sections of this SB/DF;
- Genetic testing is not covered except when determined by Health Net to be medically necessary. The prescribing physician must request prior authorization for coverage;
- Hearing aids;
- Non-eligible institutions. This plan only covers services or supplies provided by a legally operated hospital, Medicare-approved skilled nursing facility or other properly licensed facility as specified in the EOC. Any institution that is primarily a place for the aged, a nursing home or similar institution, regardless of how it is designated, is not an eligible institution. Services or supplies provided by such institutions are not covered;
- Orthoptics (eye exercises);
- Orthotic items for the foot, except when incorporated into a cast, splint, brace or strapping of the foot or when medically necessary for the treatment of diabetes;
- Personal or comfort items;
- Physician self-treatment;
- Physician treating immediate family members;
- Physician's visit to a member's home;
- Private rooms when hospitalized, unless medically necessary;
- Private-duty nursing;
- Refractive eye surgery unless medically necessary, recommended by the member's treating physician and authorized by Health Net;
- Reversal of surgical sterilization;
- Routine physical examinations for insurance, licensing, employment, school, camp or other nonpreventive purposes;
- Services and supplies not authorized by Health Net and the physician group according to Health Net's procedures;
- Services for a surrogate pregnancy are covered when the surrogate is a Health Net Member. However, when compensation is obtained for the surrogacy, Health Net shall have a lien on such compensation to recover its medical expense;
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the member's EOC;
- Sex change services;
- Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary; and
- Treatment of obesity, weight reduction or weight management, except for treatment of morbid obesity.

The above is a partial list of the principal exclusions and limitations applicable to the medical portion of your Health Net plan. The EOC, which you will receive if you enroll in this plan, will contain the full list.

Benefits and coverage

WHAT YOU PAY FOR SERVICES

The "Schedule of benefits and coverage" section explains your coverage and payment for services. Please take a moment to look it over.

NOTICE OF REQUIRED COVERAGE

Benefits of this plan provide coverage required by the Newborns' and Mothers' Health Protection Act of 1996 and the Women's Health and Cancer Right Act of 1998. Specifically, the

The Newborns' and Mothers' Health Protection Act requires group health plans to provide a minimum hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after delivery by cesarean section unless the attending physician, in consultation with the mother, determines a shorter hospital length of stay is adequate. If you are discharged earlier, your physician may decide, at his or her discretion, that you should be seen at home or in the office, within 48 hours of the discharge, by a licensed health care provider whose scope of practice includes postpartum care and newborn care.

The Women's Health and Cancer Right Act of 1998 applies to medically necessary mastectomies and requires coverage for prosthetic devices and reconstructive surgery on either breast provided to restore and achieve symmetry.

COVERAGE FOR NEWBORNS

Children born after your date of enrollment are automatically covered at birth. To continue coverage, the child must be enrolled through your employer before the 30th day of the child's life. If the child is not enrolled within 30 days of the child's birth:

- Coverage will end the 31st day after birth; and
- You will have to pay your physician group for all medical care provided after the 30th day of your baby's life.

EMERGENCIES

Health Net covers emergency and urgently needed care throughout the world. If you need emergency or urgently needed care, seek care where it is immediately available. Depending on your circumstances, you may seek this care by going to your physician group (medical) or the Behavioral Health Administrator (mental illness and detoxification), or to the nearest emergency facility or by calling 911.

You are encouraged to use appropriately the 911 emergency response system, in areas where the system is established and operating, when you have an emergency medical condition (including severe mental illness and serious emotional disturbances of a child) that requires an emergency response. All ambulance and ambulance transport services provided as a result of a 911 call will be covered, if the request is made for an emergency medical condition (including severe mental illness and serious emotional disturbances of a child).

All follow-up care (including severe mental illness and serious emotional disturbances of a child) after the urgency has passed and your condition is stable, must be provided or authorized by your physician group (medical) or the Behavioral Health Administrator (mental illness and chemical dependency); otherwise, it will not be covered by Health Net.

Emergency care *means any otherwise covered service for an acute illness, a new injury or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or, if a minor, to the minor's parent or guardian that a reasonable person with an average knowledge of health and medicine (a prudent layperson) would believe requires immediate treatment (including severe mental illness and serious emotional disturbances of a child), and without immediate treatment, any of the following would occur: (a) his or her health would be put in serious danger (and*

in the case of a pregnant woman, would put the health of her unborn child in serious danger); (b) his or her bodily functions, organs or parts would become seriously damaged; or (c) his or her bodily organs or parts would seriously malfunction. Emergency Care also includes treatment of severe pain or active labor. Active labor means labor at the time that either of the following would occur: (a) there is inadequate time to effect safe transfer to another Hospital prior to delivery; or (b) a transfer poses a threat to the health and safety of the Member or her unborn child.

Urgently Needed Care *means any otherwise covered medical service that a reasonable person with an average knowledge of health and medicine would seek for treatment of an injury, unexpected illness or complication of an existing condition, including pregnancy, to prevent the serious deterioration of his or her health, but which does not qualify as Emergency Care, as defined in this section. This may include services for which a person should reasonably have known an emergency did not exist.*

-+MEDICALLY NECESSARY CARE

All services that are medically necessary will be covered by your Health Net plan (unless specifically excluded under the plan). All covered services or supplies are listed in your EOC; any other services or supplies are not covered.

SECOND OPINIONS

You have the right to request a second opinion when:

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

To obtain a copy of Health Net's second opinion policy, call the Member Services Department at the phone number on the back cover.

CLINICAL TRIALS

Routine patient care costs for patients diagnosed with cancer who are accepted into phase I, II, III, or IV clinical trials are covered when medically necessary, recommended by the member's treating physician and authorized by Health Net. The physician must determine that participation has a meaningful potential benefit to the member and the trial has therapeutic intent. For further information, please refer to the EOC.

EXTENSION OF BENEFITS

If you or a covered family member is totally disabled when your employer ends its group services agreement with Health Net, we will cover the treatment for the disability until one of the following occurs:

A maximum of 12 consecutive months elapses from the termination date;

- Available benefits are exhausted;
- The disability ends; or
- The member becomes enrolled in another plan that covers the disability.

If you are hospitalized on the date your coverage ends, you will be covered until the discharge date. If you are not hospitalized, your application for an extension of benefits for disability must be made to Health Net within 90 days after your employer ends its agreement with us. We will require medical proof of the total disability at specified intervals.

CONFIDENTIALITY AND RELEASE OF MEMBER INFORMATION

Health Net knows that personal information in your medical records is private. Therefore, we protect your personal health information in all setting (including oral, written and electronic information). The only time we would release your confidential information without your authorization is for payment, treatment, health care operations (including but not limited to utilization management, quality improvement, disease or case management programs) or when permitted or required to do so by law for things such as a court order or subpoena. We will not release your confidential claims details to your employer or their agent. Often, Health Net is required to comply with aggregated measurement and data reporting requirements. In those cases, we protect your privacy by not releasing any information that identifies our members.

PRIVACY PRACTICES

Once you become a Health Net member, Health Net uses and discloses a member's protected health information for purposes of treatment, payment, health care operations, and where permitted or required by law. Health Net provides members with a Notice of Privacy Practices that describes how it uses and discloses protected health information; the individual's rights to access, to request amendments, restrictions, and an accounting of disclosures of protected health information; and the procedures for filing complaints. Health Net will provide you the opportunity to approve or refuse the release of your information for non-routine releases such as marketing. Health Net provides access to members to inspect or obtain a copy of the member's protected health information in designated record sets maintained by Health Net. Health Net protects oral, written and electronic information across the organization by using reasonable and appropriate security safeguards. These safeguards include limiting access to an individual's protected health information to only those who have a need to know in order to perform payment, treatment, health care operations or where permitted or required by law. Health Net releases protected health information to plan sponsors for administration of self-funded plans but does not release protected health information to plan sponsors/employers for insured products unless the plan sponsor is performing a payment or health care operation function for the plan. Health Net's entire Notice of Privacy Practices can be found in your plan's EOC, at www.healthnet.com under "Privacy" or you may call the Member Services Department at the phone number on the back cover of this booklet to obtain a copy.

TECHNOLOGY ASSESSMENT

New technologies are those procedures, drugs or devices that have recently been developed for the treatment of specific diseases or conditions or are new applications of existing procedures, drugs or devices. New technologies are considered investigational or experimental during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to be considered investigational or experimental if clinical study has not shown safety or effectiveness or if they are not considered standard care by the appropriate medical specialty. Approved technologies are integrated into Health Net benefits.

Health Net determines whether new technologies should be considered medically appropriate, or investigational or experimental, following extensive review of medical research by appropriately specialized physicians. Health Net requests review of new technologies by an independent, expert medical reviewer in order to determine medical appropriateness or investigational or experimental status of a technology or procedure.

The expert medical reviewer also advises Health Net when patients require quick determinations of coverage, when there is no guiding principle for certain technologies or when the complexity of a patient's medical condition requires expert evaluation.

Utilization management processes

Utilization management is an important component of health care management. Through the processes of pre-authorization, concurrent and retrospective review and care management, we evaluate the services provided to our members to be sure they are medically necessary and appropriate for the setting and time. These processes help to maintain Health Net's high quality medical management standards.

PRE-AUTHORIZATION

Certain proposed services may require an assessment prior to approval. Evidence-based criteria are used to evaluate whether or not the procedure is medically necessary and planned for the appropriate setting (that is, inpatient, ambulatory surgery, etc.).

CONCURRENT REVIEW

This process continues to authorize inpatient and certain outpatient conditions on a concurrent basis while following a member's progress, such as during inpatient hospitalization or while receiving outpatient home care services.

DISCHARGE PLANNING

This component of the concurrent review process ensures that planning is done for a member's safe discharge in conjunction with the physician's discharge orders and to authorize post-hospital services when needed.

RETROSPECTIVE REVIEW

This medical management process assesses the appropriateness of medical services on a case-by-case basis after the services have been provided. It is usually performed on cases where pre-authorization was required but not obtained.

CARE OR CASE MANAGEMENT

Nurse care managers provide assistance, education and guidance to members (and their families) through major acute and/or chronic long-term health problems. The care managers work closely with members, their physicians and community resources.

If you would like additional information regarding Health Net's utilization management process, please call the Health Net Member Services Department at the phone number on the back cover.

Payment of fees and charges

YOUR COINSURANCE, COPAYMENT AND DEDUCTIBLES

The 'Schedule of benefits and coverage" section explains your coverage and payment for services. Please take a moment to look it over.

PREPAYMENT FEES

Your employer will pay Health Net your monthly premiums for you and all enrolled family members. Check with your employer regarding any share that you may be required to pay. If your share ever increases, your employer will inform you in advance.

OTHER CHARGES

You are responsible for payment of your share of the cost of services covered by this plan. Amounts paid by you are called copayments, which are described in the "Schedule of benefits and coverage" section of this SB/DF. Beyond these charges the remainder of the cost of covered services will be paid by Health Net.

When the total amount of copayments you pay equals the out-of-pocket maximum shown in the "Schedule of benefits and coverage" section, you will not have to pay additional copayments for the rest of the year for most services provided or authorized by your physician group.

Payment for services not covered by this plan will not count toward the calendar year out-of-pocket maximum. Additionally, certain deductibles and copayments will not count toward the out-of-pocket maximum as shown in the "Schedule of benefits and coverage" section. For further information please refer to the EOC.

Liability of subscriber or enrollee for payment

If you receive health care services without the required referral or authorization from your PCP or physician group (medical) or the Behavioral Health Administrator (mental illness and detoxification), you are responsible for the cost of these services.

Remember, services are only covered when provided or authorized by a PCP or physician group or the Behavioral Health Administrator, except for emergency or out-of-area urgent care. Consult the Health Net directory of participating providers for a full listing of Health Net-contracted physicians.

Reimbursement provisions

Payments that are owed by Health Net for services provided by or through your physician group (medical) or the Behavioral Health Administrator (mental illness and detoxification) will never be your responsibility.

If you have out-of-pocket expenses for covered services, call the Member Services Department at 1-800-361-3366 for a claim form and instructions. You will be reimbursed for these expenses less any required copayment or deductible. (Remember, you do not need to submit claims for medical services provided by your PCP or physician group.)

If you receive emergency services not provided or directed by your physician group (medical) or the Behavioral Health Administrator (mental illness and detoxification), you may have to pay at the time you receive service. To be reimbursed for these charges, you should get a complete statement of the services received and, if possible, a copy of the emergency room report.

Please call the Health Net Member Services Department at the phone number on the back cover to obtain claim forms, and to find out whether you should send the completed form to your physician group (medical) or the Behavioral Health Administrator (mental illness and detoxification) or directly Health Net. Medical claims must be received by Health Net within one year of the date of service to be eligible for reimbursement.

☞ ***How to file a claim:***

***For medical services**, please send a completed claim form within one year of the date of service to:*

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

Please call Health Net Member Services at the phone number on the back cover of this booklet or visit our website at www.healthnet.com to obtain the claim form.

***For Mental Disorders or detoxification** emergency services or for services authorized by MHN Services you must use the CMS (HCFA) - 1500 form. Please send the claim to MHN Services within one year of the date of service at the address listed on the claims form or to MHN Services at:*

MHN Services
P.O. Box 14621
Lexington, KY 40512-4621

*Please call MHN Services at **1-800-444-4281** to obtain a claim form.*

***For outpatient prescription drugs**, please send a completed prescription drug claim form to:*

Health Net
C/O Caremark
P.O. Box 52136
Phoenix, AZ 85072

Please call Health Net Member Services at the phone number on the back cover of this booklet or visit our website at www.healthnet.com to obtain a prescription drug claim form.

Claims for covered expenses filed more than one year from the date of service will not be paid unless you can show that it was not reasonably possible to file your claim within that time limit and that you have filed as soon as was reasonably possible.

PROVIDER REFERRAL AND REIMBURSEMENT DISCLOSURE

If you are considering enrolling in our plan, you are entitled to ask if the plan has special financial arrangements with our physicians that can affect the use of referrals and other services you may need. Health Net uses financial incentives and various risk sharing arrangements when paying providers. To get this information, call the Health Net Member Services Department at the phone number on the back cover. You can also contact your physician group or your PCP to find out about our physician payment arrangements.

Facilities

Health care services for you and eligible members of your family will be provided at:

- The facilities of the physician group you chose at enrollment; or
- A nearby Health Net-contracted hospital, if hospitalization is required.

Many Health Net contracting physician groups have either a physician on call 24 hours a day or an urgent care center available to offer access to care at all times.

The physician group you choose will also have a contractual relationship with local hospitals (for acute, subacute and transitional care) and skilled nursing facilities. These are listed in your Health Net directory of participating providers.

PHYSICIAN GROUP TRANSFERS

You may switch doctors within the same physician group at any time. You may also transfer to another physician group monthly. Simply contact Health Net by the 15th of the month to have your transfer effective by the 1st of the following month. If you call after the 15th, your transfer will be effective the 1st of the second following month.

Transfer requests will generally be honored unless you are confined to a hospital. (However, Health Net may approve transfers under this condition for certain unusual or serious circumstances. Please call the Health Net Member Services Department at the phone number on the back cover of this booklet for more information.)

CONTINUITY OF CARE

Transition of Care For New Enrollees

You may request continued care from a provider who does not contract with Health Net if at the time of your enrollment with Health Net you were receiving care for the conditions listed below. Health Net may provide coverage for completion of services from a non-participating provider, subject to applicable copayments and any exclusions and limitations of your plan. You must request the coverage within 60 days of your group's effective date unless you can show that it was not reasonably possible to make the request within 60 days of your Group's effective date and you make the request as soon as reasonably possible. The non-participating provider must be willing to accept the same contract terms applicable to providers currently contracted with Health Net, who are not capitated and who practice in the same or similar geographic region. If the provider does not accept such terms, Health Net is not obligated to provide coverage with that provider.

Continuity of Care Upon Termination of Provider Contract

If Health Net's contract with a physician group or other provider ends, Health Net will transfer any affected members to another contracted physician group or provider to ensure that care continues. Health Net will provided a written notice to affected members at least 60-days prior to termination of a contract with a physician group or an acute care hospital to which members are assigned for services. For all other hospitals that end their contract with Health Net, a written notice will be provided to affected members within five days after the effective date of the contract termination.

Health Net may provide coverage for completion of services from a provider whose contract has ended, subject to applicable copayments and any other exclusions and limitations of your plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider's contract termination. You must request continued care within 30 days of the provider's date of termination, unless you can show that it was not reasonably possible to make the request within 30 days of the provider's date of termination and you make the request as soon as it is reasonably possible.

You may request continued care from a provider whose contract is terminated if at the time of termination the member was receiving care from such a provider for the conditions listed below.

The following conditions are eligible for continuation of care:

- An acute condition;
- A serious chronic condition not to exceed twelve months;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- A newborn (up to 36 months of age, not to exceed twelve months);
- A terminal illness (through the duration of the terminal illness);
- A surgery or other procedure that has been authorized by Health Net (or by the Member's prior health plan for a new enrollee) as part of a documented course of treatment.

If you would like more information on how to request continued care or to request a copy of Health Net's continuity of care policy, please contact the Health Net Member Services Department at the phone number on the back cover.

Renewing, continuing or ending coverage

RENEWAL PROVISIONS

The contract between Health Net and your employer is usually renewed annually. If your contract is amended or terminated, your employer will notify you in writing.

SMALL EMPLOYER CAL-COBRA COVERAGE

When the group is a small employer (as defined in the EOC, state law provides that members who enroll in this plan and later lose eligibility may be entitled to continuation of group coverage. More information regarding eligibility for this coverage is provided in your EOC.

INDIVIDUAL CONTINUATION OF BENEFITS

Please examine your options carefully before declining coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or your could be denied coverage entirely.

If your employment with your current employer ends, you and your covered family members may qualify for continued group coverage under:

- **COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985).** For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside of California. Please check with your group to determine if you and your covered dependents are eligible.
- **Small Employer Cal-COBRA Continuation Coverage:** For employers with fewer than 20 employees who were eligible to enroll in the employer's health plan on 50% of the employer's business days in the preceding year, Health Net is required by state law to offer continuation coverage.
- **Cal-COBRA Continuation Coverage.** If you have exhausted COBRA and you live in the Health Net Service Area, you may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if you began receiving federal COBRA coverage on or after January 1, 2003, have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage, and you are not entitled to Medicare. If you are eligible, you have the opportunity to continue group coverage under this plan through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.

- **Additional COBRA-like Coverage ("Senior"-COBRA):** California law provides that an employee and his or her spouse who elected COBRA or Cal-COBRA coverage following termination of employment may be entitled to additional COBRA-like coverage if the employee and spouse are eligible for Cal-COBRA prior to January 1, 2005.

  If the Subscriber was 60 years of age or older on the date of his or her termination of employment and had worked for the employer for the previous five years, the Subscriber and his or her spouse may be eligible for additional coverage when federal COBRA or Cal-COBRA coverage expires. Additionally, a former spouse of an employee or former employee whose coverage under COBRA or Cal-COBRA expires may be entitled to additional COBRA-like coverage.

  You may request additional information from Health Net. If you wish to purchase this additional COBRA-like coverage, you must notify Health Net in writing of your wish to do so within 30 calendar days prior to the date continuation coverage under COBRA or Cal-COBRA is scheduled to end.

- **USERRA Coverage:** Under a federal law known as the Uniformed Services Employment and Reemployment Rights Act (USERRA), employers are required to provide employees who are absent from employment to serve in the uniformed services and their dependents who would lose their group health coverage the opportunity to elect continuation coverage for a period of up to 24 months. Please check with your group to determine if you are eligible.
- **HIPPA Guaranteed Issue Coverage:** The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people covered under existing group health plans to maintain coverage regardless of pre-existing conditions when they change jobs or are unemployed for brief periods of time. California law provides similar and additional protections. Applicants who meet the following requirements are eligible to enroll in a guaranteed issue individual health plan from any health plan that offers individual coverage, including Health Net's Guaranteed HMO Plans, without medical underwriting. A health plan cannot reject your application for guaranteed issue individual health coverage if you meet the following requirements, agree to pay the required premiums and live or work in the plan's service area. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance. To be considered an eligible individual:

  1. The applicant must have a total of 18 months of coverage (including COBRA, if applicable) without a significant break (excluding any employer-imposed waiting periods) in coverage of more than 63 days.
  2. The most recent coverage must have been under a group health plan. COBRA and Cal-COBRA coverage are considered group coverage.
  3. The applicant must not be eligible for coverage under any group health plan, Medicare or Medicaid, and must not have other health insurance coverage.
  4. The individual's most recent coverage could not have been terminated due to fraud or nonpayment of premiums.
  5. If COBRA or Cal-COBRA coverage was available, it must have been elected and such coverage must have been exhausted.

  For more information regarding guarantee issue coverage through Health Net please call the Individual Sales Department at 1-800-909-3447. If you believe your rights under HIPAA have been violated, please contact the Department of Managed Health Care at 1-888-HMO-2219 or visit the Department's website at **www.hmohelp.ca.gov**.

Also, if you lose group coverage, you may convert from group coverage to a type of individual coverage called conversion coverage. Application must be made within 63 days of the date group coverage ends. Please contact the Health Net Member Services Department for information about conversion plan coverage. Furthermore, you may be eligible for continued coverage for a disabling condition (for up to 12 months) if your employer

terminates its agreement with Health Net. Please refer to the "Extension of benefits" section of this SB/DF for more information.

TERMINATION OF BENEFITS

Your coverage under this plan ends when:

- The agreement between the employer covered under this plan and Health Net ends;
- The employer covered under this plan fails to pay subscription charges;
- You cease to either live or work within Health Net's service area; or
- You no longer work for the employer covered under this plan.

Also, coverage under this Health Net plan may be terminated who the date the notice of termination is mailed for a member who:

- Threatens the safety of the health care provider, his or her office staff, the contracting physician group or Health Net personnel if such behavior does not arise from a diagnosed illness or condition; or
- Knowingly omits or misrepresents a meaningful fact on your enrollment form or fraudulently or deceptively uses services or facilities of Health Net, its contracting physician group or other contracting providers (or knowingly allows another person to do so), including altering a prescription.

In addition, coverage under this Health Net plan end upon 15 days prior written notice if you repeatedly or materially disrupt the operations of the physician group or Health Net to the extent that your behavior substantially impairs Health Net's ability to furnish or arrange services for you or other Health Net members, or the physician's office or contracting physician group's ability to provide services to other patients.

If the person involved in any of the above activities is the enrolled employee, coverage under this plan will end as well for any covered dependents.

If you have a disagreement with our plan

The California Department of Managed Health Care is responsible for regulating health care service plans.

If you have a grievance against Health Net, you should first telephone Health Net at **1-800-361-3366** and use the plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, or a grievance that has not been satisfactorily resolved by Health Net, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

You may also be eligible for an independent medical review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department' s Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

MEMBER GRIEVANCE AND APPEALS PROCESS

If you are dissatisfied with the quality of care that you have received or feel that you have been incorrectly denied a service or claim, you may file a grievance or appeal.

☞ ***How to file a grievance or appeal:***

You may call the Member Services Department at the phone number on the back cover or submit a member grievance form through www.healthnet.com.

You may also write to:

Health Net of California
P.O. Box 10348
Van Nuys, CA 91410-0348

Please include all the information from your Health Net identification card as well as details of your concern or problem.

Health Net will acknowledge your grievance or appeal within five calendar days, review the information and tell you of our decision in writing within 30 days of receiving the grievance. For conditions where there is an immediate and serious threat to your health, including severe pain or the potential loss of life, limb or major bodily function, Health Net will notify you of the status of your grievance no later than three days from the receipt of all the required information. For urgent grievances, Health Net will immediately notify you of the right to contact the Department of Managed Health Care. There is no requirement that you participate in Health Net's grievance process prior to applying to the Department of Managed Health Care for review of an urgent grievance.

In addition, you can request an independent medical review of disputed health care services from the Department of Managed Health Care if you believe that health care services eligible for coverage and payment under the plan was improperly denied, modified or delayed by Health Net or one of its contracting providers.

Also, if Health Net denies your appeal of a denial for lack of medical necessity, or denies or delays coverage for requested treatment involving experimental or investigational drugs, devices, procedures or therapies, you can request an independent medical review of Health Net's decision from the Department of Managed Health Care if you meet the eligibility criteria set out in the EOC.

ARBITRATION

If you are not satisfied with the result of the grievance hearing and appeals process, you may submit the problem to binding arbitration. Health Net uses binding arbitration to settle disputes, including medical malpractice. When you enroll in Health Net, you agree to submit any disputes to arbitration, in lieu of a jury or court trial.

Additional plan benefit information

The following plan benefits show benefits available with your plan. For a more complete description of copayments, and exclusions and limitations of service, please see your plan's EOC.

Behavioral health services

Health Net contracts with MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services through a personalized, confidential and affordable mental health and detoxification care program. Just call the toll-free number shown on your Health Net ID Card before receiving care.

TRANSITION OF CARE FOR NEW ENROLLEES

If you are receiving ongoing care for an acute, serious, or chronic mental health condition from a provider not affiliated with the Behavioral Health Administrator when you enroll with Health Net, we may temporarily cover services provided by that provider, subject to applicable copayments and any other exclusions and limitations of this plan.

Your non-participating mental health professional must be willing to accept the Behavioral Health Administrator's standard mental health provider contract terms and conditions and be located in the plan's service area.

If you would like more information on how to request continued care, or to request a copy of our continuity of care policy, please call the Health Net Member Services Department at the phone number on the back cover.

SERIOUS EMOTIONAL DISTURBANCES OF A CHILD

Serious emotional disturbances of a child is when a child under the age of 18 has one or more mental disorders identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following:

- As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home or (ii) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year;
- The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; or
- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

SEVERE MENTAL ILLNESS

Severe mental illness includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition the Diagnostic and Statistical Manual for Mental Disorders), autism, anorexia nervosa, and bulimia nervosa.

CONTINUATION OF TREATMENT

If you are in treatment for a mental health problem or for detoxification, call the telephone number shown on your Health Net ID card to receive assistance in transferring your care to a network provider.

WHAT'S COVERED

Please refer to the "Schedule of benefits and coverage" section of this SB/DF for the explanation of covered services and copayments.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

☞ *Services or supplies excluded under behavioral health services may be covered under the medical benefits portion of your plan.*

In addition to the exclusions and limitations listed below, mental health and detoxification are subject to the plan's general exclusions and limitations. Consult your plan's EOC for more information.

- Congenital or organic disorders, including organic brain disease and mental retardation, except for some conditions when the level of severity meets the criteria of severe mental illness or serious emotional disturbances of a child as described in the EOC;
- Experimental or investigational therapies;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder;
- Nontreatable mental disorders;
- Private-duty nursing;
- Services related to educational and professional purposes;
- Smoking cessation, weight reduction, obesity, stammering, sleeping disorders or stuttering;
- State hospital treatment, except as the result of an emergency or urgently needed care;
- Stress, except when rendered in connection with services provided for a treatable mental disorder;
- Treatment of detoxification in newborns;
- Treatment, testing or screening of learning disabilities, except for some conditions when the level of severity meets the criteria of severe mental illness or serious emotional disturbances of a child as described in the EOC;
- Care for mental health care as a condition of parole or probation, or court-ordered testing for mental disorders, except when such services are medically necessary and subject to the plan's day or visit limits.

This is only a summary. Consult your plan's EOC to determine the exact terms and conditions of your coverage.

Prescription drug program

Health Net contracts with many major pharmacy chains, supermarket based pharmacies and privately owned neighborhood pharmacies in California. For a complete and up-to-date list of participating pharmacies, please visit our website at www.healthnet.com or call the Health Net Member Services Department at the phone number on the back cover.

PRESCRIPTIONS BY MAIL DRUG PROGRAM

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period), you have the option of filling it through our convenient Prescriptions By Mail Drug Program. This program allows you to receive a 90-consecutive-calendar-day supply of maintenance medications. For complete information, call the Health Net Member Services Department at the phone number on the back cover.

Schedule II narcotic drugs (which are drugs that have a high abuse risk as classified by the Federal Drug Enforcement Administration) are not covered through mail order.

THE HEALTH NET RECOMMENDED DRUG LIST

This plan uses the Recommended Drug List. The Health Net Recommended Drug List (Formulary or the List) is the approved list of medications covered for illnesses and conditions. It was developed to identify the safest and most effective medications for Health Net members while attempting to maintain affordable pharmacy benefits.

We specifically suggest to all Health Net contracting PCPs and specialists that they refer to this List when choosing drugs for patients who are Health Net members. When your physician prescribes medications listed in the Recommended Drug List, it ensures that you are receiving a high quality prescription medication that is also of high value.

The Recommended Drug List is updated regularly, based on input from the Health Net Pharmacy and Therapeutics (P&T) Committee. The Committee members are actively practicing physicians of various medical specialties and clinical pharmacists. Voting members are recruited from contracting physician groups throughout California based on their experience, knowledge and expertise. In addition, the P&T Committee frequently consults with other medical experts to provide additional input to the Committee. Updates to the Recommended Drug List and drug usage guidelines are made as new clinical information and new drugs become available. In order to keep the List current, the P&T Committee evaluates clinical effectiveness, safety and overall value through:

- Medical and scientific publications;
- Relevant utilization experience; and
- Physician recommendations.

To obtain a copy of Health Net's most current Recommended Drug List, please visit our web site at www.healthnet.com, under the pharmacy information, or call the Health Net Member Services Department at the phone number on the back cover.

WHAT IS "PRIOR AUTHORIZATION?"

Some drugs require prior authorization. This means that your doctor must contact Health Net in advance to provide the medical reason for prescribing the medication.

☞ ***How to request prior authorization:***

Urgent requests from physicians are handled in a timely fashion, not to exceed 72 hours, as appropriate and medically necessary, for the nature of the member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination.

Routine requests from physicians are processed in a timely fashion, not to exceed 5 days, as appropriate and medically necessary, for the nature of the member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination.

Upon receiving your physician's request for prior authorization, Health Net will evaluate the information submitted and make a determination based on established clinical criteria for the particular medication. The criteria used for prior authorization are developed and based on input from the Health Net P&T Committee as well as physician specialist experts. Your physician may contact Health Net to obtain the usage guidelines for specific medications.

If authorization is denied by Health Net, you will receive written communication including the specific reason for denial. If you disagree with the decision, you may appeal the decision.

The appeal may be submitted in writing, by telephone or through e-mail. We must receive the appeal within 60 days of the date of the denial notice. Please refer to your Health Net EOC for details regarding your right to appeal.

To submit an appeal:

- Call the Health Net Member Services Department at the phone number on the back cover;
- Visit www.healthnet.com for information on e-mailing the Member Services Department; or
- Write to:
  Health Net Member Services Department
  P.O. Box 10348
  Van Nuys, CA 91410-0348

WHAT'S COVERED

☞ *Please refer to the "Schedule of benefits and coverage" section of this SB/DF for the explanation of covered services and copayments.*

Outpatient prescription medication:

- Level I drugs listed on the Recommended Drug List (primarily generic);
- Level II drugs listed on the Recommended Drug List (primarily brand name) and diabetic supplies (including insulin); and
- Level III drugs listed on the Recommended Drug List (or drugs that are not listed on the Recommended Drug List).

MORE INFORMATION ABOUT DRUGS THAT WE COVER

- Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.
- Prescription drug refills are covered, up to a 30-consecutive-day supply per prescription at a Health Net contracted pharmacy for one copayment. A copayment is required for each prescription.
- If the pharmacy's retail price is less than the applicable copayment, the member will only pay the pharmacy's retail price.

- Percentage Copayments will be based on Health Net's contracted pharmacy rate.
- Mail order drugs are covered up to a 90-consecutive-calendar-day supply. When the retail pharmacy copayment is a percentage, the mail order copayment is the same percentage of the cost to Health Net as the retail pharmacy copayment.
- Prescription drugs for the treatment of asthma are covered as stated in the Recommended Drug List. Inhaler spacers and peak flow meters under the pharmacy benefit are covered when medically necessary. Nebulizers (including face masks and tubing) are covered under "Durable medical equipment" and educational programs for the management of asthma are covered under "Patient education" through the medical benefit. For information about copayments required for these benefits, please see the "Schedule of benefits and coverage" section of this SB/DF.
- Oral contraceptives and emergency contraceptives are covered. Vaginal contraceptives include diaphragms and cervical caps and are only covered when a physician performs a fitting examination and prescribes the device. Such devices are only available through a prescription from a pharmacy and are limited to one prescription per calendar year, unless additional fittings or devices are medically necessary. For a complete list of contraceptive products covered by Health Net, please refer tot he Recommended Drug List. Injectable contraceptives are covered when administered by a physician. Refer to your plan's EOC for more information on contraceptives covered under the medical benefit. If your physician determines that none of the methods specified as covered by the plan are medically appropriate, then the plan will provide coverage for another FDA approved contraceptive method as prescribed by your physician.
- Diabetic supplies (blood glucose testing strips, lancets, needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (that is, opened in order to dispense the product in quantities other than those packaged). When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times your physician has prescribed for a up to 30-day period. For more information about diabetic equipment and supplies, please see "Endnotes" in the "Schedule of benefits and coverage" section of this SB/DF.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

☞ *Services or supplies excluded under pharmacy services may be covered under the medical benefits portion of your plan.*

In addition to the exclusion and limitations listed below, prescription drug benefits are subject to the plan's general exclusions and limitations. Consult your plan's EOC for more information.

- Allergy serum is covered as a medical benefit. See "allergy serum" benefit in the "Schedule of benefits and coverage" for details;
- Coverage for devices is limited to vaginal contraceptive devices, peak flow meters, spacer inhalers and diabetic supplies. No other devices are covered even if prescribed by a participating physician;
- Drugs that require a prescription in order to be dispensed for the relief of nicotine withdrawal symptoms are covered up to a twelve week course of therapy per calendar year if the member is concurrently enrolled in a comprehensive smoking cessation behavioral support program. The prescribing physician must request prior authorization for coverage. For information regarding smoking cessation behavioral support programs available through Health Net, call Member Services at the telephone number on your Health Net ID card or visit the Health Net website at www.healthnet.com;
- Drugs prescribed for the treatment of obesity are covered when medically necessary for the treatment of morbid obesity. In such cases, the drugs will be subject to prior authorization from Health Net;
- Drugs or medicines administered by a physician or physician's staff member;
- Drugs prescribed for routine dental treatment;
- Drugs prescribed to shorten the duration of the common cold;

- Drugs prescribed for sexual dysfunction when not medically necessary, including drugs that establish, maintain, or enhance sexual function or satisfaction;
- Experimental drugs (those that are labeled "Caution - Limited by Federal Law to investigational use only"). If you are denied coverage of a drug because the drug is investigational or experimental you will have a right to independent medical review. See "If you have a disagreement with our plan" section of this SB/DF for additional information;
- Immunizing agents, injections (except for insulin), agents for surgical implantation, biological sera, blood, blood derivatives or blood plasma obtained through a prescription;
- Individual doses of medication dispensed in plastic, unit dose or foil packages unless medically necessary or only available in that form;
- Limits on quantity, dosage and treatment duration may apply to some drugs. Medications taken on an "as-needed" basis may have a copayment based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If medically necessary, your physician may request a larger quantity from Health Net;
- Medical equipment and supplies (including insulin), that are available without a prescription are covered when prescribed by a physician for the management and treatment of diabetes. Any other nonprescription drug, medical equipment or supply that can be purchased without a prescription drug order is not covered even if a physician writes a prescription drug order for such drug, equipment or supply. However, if a higher dosage form of a prescription drug or over-the counter (OTC) drug is only available by prescription, that higher dosage drug will be covered. If a drug that was previously available by prescription becomes available in an OTC form in the same prescription strength, then any prescription drugs that are similar agents and have comparable clinical effect(s) will only be covered when medically necessary and prior authorization is obtained from Health Net;
- Prescription drugs filled at pharmacies that are not in the Health Net pharmacy network or are not in California except in emergency or urgent care situations;
- Prescription drugs prescribed by a physician who is not a member physician or an authorized specialist are not covered, except when the physician's services have been authorized, or because of a medical emergency condition, illness or injury, for urgently needed care or as specifically stated;
- Replacement of lost, stolen or damaged medications;
- Supply amounts for prescriptions that exceed the FDA's or Health Net's indicated usage recommendation are not covered unless medically necessary and prior authorization is obtained from Health Net; and
- Drugs prescribed for a condition or treatment not covered by this plan are not covered. However, the plan does cover drugs for medical conditions that result from nonroutine complications of a noncovered service.

This is only a summary. Consult your plan's EOC to determine the exact terms and conditions of your coverage.

Notice of language services

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or Individual and Family members please call 800-839-2172. Employer group members please call 800-522-0088. Healthy Families members please call 888-231-9473.
English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que una persona le lea los documentos y que algunos se envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación, o si es afiliado Individual o Familiar llame al 800-839-2172. Los afiliados del grupo de empleadores deben llamar al 800-522-0088. Los afiliados de Healthy Families deben llamar al 888-231-9473.
Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，部分文件可以翻譯成您的語言並寄送給您。如需協助，請撥您會員卡上所列的電話號碼，個人與家庭計畫會員請撥 800-839-2172。
僱主團體會員請撥 800-522-0088。健康家庭計畫會員請撥 888-231-9473。
Chinese

Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được thông dịch viên trợ giúp và được đọc giúp các tài liệu bằng tiếng Việt. Để được giúp đỡ, xin gọi chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc các hội viên diện Cá Nhân hoặc Gia Đình xin gọi số 800-839-2172. Các hội viên tham gia chương trình bảo hiểm theo nhóm của hãng sở xin gọi số 800-522-0088. Các hội viên Healthy Families xin gọi số 888-231-9473.
Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 경우, 본인 ID 카드 상의 안내번호로 전화해 주시거나, 개인 및 가족 회원께서는 800-839-2172번으로 전화해 주십시오. 고용주 그룹 회원께서는 800-522-0088번으로 전화해 주십시오. Healthy Families 회원께서는 안내번호 888-231-9473번을 이용하십시오.
Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o para sa Individual at Family members, mangyaring tumawag sa 800-839-2172. Para sa employer group members, mangyaring tumawag sa 800-522-0088. Para sa Healthy Families members, mangyaring tumawag sa 888-231-9473.
Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար ձեր լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված համարով, կամ եթե Անհատական և Ընտանեկան անդամ եք, խնդրում ենք զանգահարել 800-839-2172 համարով: Գործատիրոջ Խմբի անդամներից խնդրվում է զանգահարել 800-522-0088 համարով: Healthy Families-ի անդամներից խնդրվում է զանգահարել 888-231-9473 համարով:
Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочесть документы на вашем языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте. Участники планов индивидуального или семейного страхования могут позвонить по телефону 800-839-2172. Участники плана группового страхования по месту работы могут позвонить по телефону 800-522-0088. Участники плана Здоровые семьи (Healthy Families) могут позвонить по телефону 888-231-9473.
Russian

無料の言語サービス。日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号までお問い合わせください。個人・家族会員の方は、800-839-2172まで、雇用者団体会員の方は、800-522-0088まで、また、Healthy Families 会員の方は、888-231-9473までご連絡ください。
Japanese

Contact us

Health Net
Post Office Box 9103
Van Nuys, California 91409-9103

Customer Contact Center
Large Group:
1-800-522-0088 – HMO/Elect Open Access
1-800-676-6976 – PPO/Point-of-Service (SELECT/ELECT)
(for companies with 51 or
more employees)

Small Business Group:
1-800-361-3366
(for companies with 2-50 employees)

1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

Telecommunications Device for
the Hearing and Speech Impaired
1-800-995-0852

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