Summary of

benefits

and Disclosure Form

University of California
HMO · Plan 18Y

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 SB/DF answers basic questions about this versatile plan. If you have further questions, just contact the Member Services Department at **1-800-522-0088**. Our friendly, knowledgeable representatives will be glad to help.

This *Summary of benefits and 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 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 Contracting Physician Groups* for detailed information about physicians and physician groups in the Health Net network.)
- 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 and specialists, are listed in the *Health Net Directory of Contracting Physician Groups.*

How to choose a physician

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

- Discuss any important health issues with your selected physician group;
- 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, you may be referred by your PCP to a specialist or other health care provider for that care. All treatments recommended by such provider must be authorized by your physician group.

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 your *Health Net Directory of Contracting Physician Groups* 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 Internet web site, **www.healthnet.com/uc.**

How to enroll

We have enclosed an enrollment form in the enrollment packet. If a form is not included, please obtain one from your employer. Then, just complete the enrollment form and return it to your employer.

Some hospitals and other providers do not provide one or more of the following services that may be covered under your EOC 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 and delivery of a child**
- **Infertility treatments**
- **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 1-800-522-0088 to ensure that you can obtain the health care services that you need.

Schedule of benefits and coverage

Medical benefits	
Deductibles	None
Lifetime maximum	None
Maximum copayment liability (MCL) Payments for services not covered by this plan will not be applied to this yearly maximum copayment. You will need to continue making payments for any additional benefits as described in the "Additional plan benefits information" section of this SB/DF.	One member, $1,000 Two members, $2,000 Family (three members or more), $3,000
Type of service	**What you pay for services** [1] The following shows the copayments that are required for services received under this plan.
Professional services	
Visit to physician	$10
Visit to physician for treatment of severe mental illness or serious emotional disturbances of a child [2***]	$10
Specialist consultations [4]	$10
Physician visit to members home	$10
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders)	Covered in full
Immunizations (occupational or foreign travel purposes)	20%
Allergy testing	$10
Allergy serum administered at the physician group	Covered in full
Allergy serum not administered at the physician group	$10
Allergy injection services	$10
All other injections (excluding infertility injection) [3]	$10
Surgeon or assistant surgeon services in hospital setting [5]	Covered in full
Surgeon or assistant surgeon services in the physician group's office [5]	$10
Administration of anesthetics	Covered in full
X-ray and laboratory procedures	Covered in full
Rehabilitative therapy (includes physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)	$10
Adult preventive care [6]	
Periodic health evaluations (age 18 and older) [4]	$10
Vision screenings and examinations	$10
Hearing screenings and examinations	$10
Immunizations (age 19 and older)	$10
Child preventive care [6]	
Periodic health evaluations, including well-baby care (birth to age 2)	Covered in full
Periodic health evaluations (age 2 through age 17) [4]	$10
Vision screenings and examinations	$10
Hearing screenings and examinations	$10
Immunizations (birth to age 2)	Covered in full
Immunizations (age 2 through age 18)	Covered in full
Family planning (professional)	
Prenatal and postnatal office visits	Covered in full
Normal delivery, cesarean section, newborn inpatient care	Covered in full
Treatment of complications of pregnancy, including medically necessary abortions	Covered in full
Elective abortions performed in a hospital	Covered in full
Elective abortions performed in a setting other than a hospital	$10
Genetic testing of fetus	Covered in full
Circumcision of newborn males	Covered in full
Injectable contraceptives (including but not limited to Depo Provera)	$10
Infertility services and supplies	50%

Medical benefits	
Infertility injection (injections related to covered infertility services)	50%
Norplant (copayments not to exceed $200 per treatment)	
Insertion, including the cost of the device	$60
Medically necessary removal	$60
Voluntary removal	50%
Sterilization	
Vasectomy performed in a hospital	Covered in full
Vasectomy performed in a setting other than a hospital	$10
Tubal ligation performed in a hospital	Covered in full
Tubal ligation performed in a setting other than a hospital	$10
Hospitalization services	
Semi-private hospital room or intensive care unit with ancillary services, including maternity care (unlimited)	$250
Semi-private hospital room or intensive care unit with ancillary services for treatment of severe mental illness or serious emotional disturbances of a child (unlimited) [2***]	$250
Hospitalization for infertility services	50%
Skilled nursing facility stay (limited to 100 days each calendar year)	Covered in full
Outpatient facility services (other than surgery)	Covered in full
Outpatient surgery (hospital or outpatient surgery center charges only)	Covered in full
Emergency health coverage	
Emergency room (professional and facility charges)	$50 [7]
Urgent care center (professional and facility charges)	$50 [7]
Ground ambulance	Covered in full
Air ambulance	Covered in full
Other services	
Durable medical equipment	Covered in full
Corrective footwear (Includes one pair of therapeutic shoes and three pairs of shoe inserts each calendar year.)	50%
Diabetic equipment (coverage under the medical benefit includes blood glucose monitors, insulin pumps and podiatric devices). See the "Prescription drug program" section of this SB/DF for diabetic supplies benefit information.	Covered in full
Hearing Aids (Includes 2 standard hearing aid devices with a $2000 benefit maximum every 36 months.)	50%[10]
Prosthetic devices	Covered in full
Blood, blood plasma, blood derivatives and blood factors	Covered in full
Nuclear medicine	Covered in full
Organ and bone marrow transplants (nonexperimental and noninvestigational)	Covered in full
Chemotherapy	Covered in full
Renal dialysis	Covered in full
Home health visits	Covered in full
Hospice services	Covered in full

Additional plan benefit information (supplemental)	
Non severe mental disorder services [2***]	Benefits are administered by Managed Health Network (MHN). Please refer to the "Behavioral health services" section of this SB/DF for the definitions, benefits and limitations.
Outpatient consultation	$10 (individual session); $5 (group session) [2**]
Inpatient	$250 [2*]
Chemical dependency rehabilitation[2]	Benefits are administered by Managed Health Network (MHN). Please refer to the "Behavioral health services" section of this SB/DF for the definitions, benefits and limitations

Additional plan benefit information (supplemental)	
Outpatient	$10 (individual session); $5 (group session) [2**]
Inpatient	$250 [2*]
Acute care detoxification	$250
Prescription drug coverage (up to a 30 day supply)	Please refer to the "Prescription drug program" section of this SB/DF for the definitions, benefits and limitations.
Level I drugs listed on the Health Net Recommended Drug List (primarily generic)	$10
Level II drugs listed on the Health Net Recommended Drug List (primarily brand name)	$20 [8]
Level III drugs (drugs not listed on the Health Net Recommended Drug List)	$35 [8]
Sexual dysfunction drugs	50% (limited to two doses per week or eight tablets per month) [9]
Oral infertility drugs	50% [9]

Footnotes

[1] The percentages that appear in this chart are based on amounts agreed to in advance by Health Net and the member's physician group or other authorized health care provider.

[2] Please refer to the "Behavioral health services" section of this SB/DF for the definitions of severe mental illness and serious emotional disturbances of a child. Benefits are administered through Managed Health Network (MHN).

*Inpatient admission means any admission to a hospital, day treatment program, residential treatment center or structured outpatient program. In addition, inpatient mental health and chemical dependency are limited to a combined maximum number of days each calendar year.

** Applicable only for outpatient counseling defined as individual office visits and group therapy sessions. Group sessions are equal to half of an individual session and count towards the visit maximum. A missed appointment may result in a copayment being charged and one of the counseling sessions being used. In addition, outpatient mental health and chemical dependency are limited to a combined maximum number of visits each calendar year.

***The mental disorder copayments and day or visit limits will not apply for severe mental illness or serious emotional disturbances of a child as defined. Services for these conditions require whatever copayment would be required if the services were provided for a medical condition. Refer to the "Schedule of benefits and coverage" section of this SB/DF to determine the applicable copayment. All other mental disorders will be subject to the copayments shown under the heading "Non severe mental disorder services."

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[3]. Injections include, but are not limited to hormonal therapy related to Gender Identity Disorder (GID).

[4] 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.

[5] 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.

[6] Provided on the basis of age, medical need and health status.

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

[8] If the member requests a brand name drug when a generic equivalent is commercially available, the member must pay the difference between the generic equivalent and the brand name drug in addition to the listed copayments or coinsurance. However, if the prescription drug order states "dispense as written" or "do not substitute" in the physician's handwriting, only the listed drug copayment will be applicable.

[9] Must be approved by Health Net and the member's physician group.

[10] Digital Hearing Aids are covered, however you will be required to pay the the difference between the cost of the Digital Hearing Aids and the cost of the Standard Analog Hearing Aids.

Limits of coverage

What's not covered (exclusions and limitations)

Note: Specific items excluded below may be covered under this plan if your employer has purchased them as supplemental benefits.

- Artificial insemination for reasons not related to infertility
- Conception by medical procedures (IVF, GIFT and ZIFT)
- Corrective or support appliances or supplies
- Cosmetic services and supplies, however, services and supplies for hormonal therapy for individuals who have been diagnosed with a covered Gender Identity Disorder (GID) may be covered.
- 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
- Food supplements
- Genetic testing and diagnostic procedures, except for prenatal diagnosis of fetal genetic disorders in cases of high-risk pregnancy
- Non-eligible institutions
- Orthoptics (eye exercises)
- Personal or comfort items
- Physician self-treatment
- Physician treating immediate family members
- Pregnancy under surrogate arrangement when compensation is obtained for the surrogacy
- Private rooms when hospitalized, unless medically necessary
- Private-duty nursing
- Refractive eye surgery
- Reversal of surgical sterilization
- Routine physical examinations for insurance, licensing, employment, school, camp or other nonpreventive purposes
- Services and supplies not authorized according to procedures Health Net and the physician group have established
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of member's EOC
- Surgical procedures related to sex change services
- Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary
- Treatment of obesity, weight reduction or weight management, except for treatment of morbid obesity as determined by Health Net

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 comprehensive benefits of your Health Net plan are described in the "Schedule of benefits and coverage" section. Please take a moment to look it over.

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 Health Net does not receive a newborn's enrollment form 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 are injured, feel severe pain, begin active labor or experience an unexpected illness that a reasonable person with an average knowledge of health and medicine would believe requires immediate treatment to prevent serious threat to your health (including severe mental illness and serious emotional disturbances of a child), 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 chemical dependency), 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.

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, contact the Member Services Department at **1-800-522-0088**.

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.

Continuity of care

If you are receiving ongoing medical care at the time of your enrollment with Health Net, and you are concerned about transferring your care to your selected physician group, we may temporarily cover all or part of your covered expenses for services from a provider not affiliated with Health Net, subject to applicable copayments and any other exclusions and limitations of this plan and under the following requirements:

- Changing providers right away may have a negative effect on your health; and
- Your non-participating provider is willing to accept the standard provider contract terms and conditions.

If you feel that your medical condition might require special attention as you switch to Health Net, tell your employer or a Health Net representative prior to enrollment, and no later than 15 days from the effective date of your Health Net coverage.

To request a copy of our continuity of care policy, please call the Health Net Member Services Department at **1-800-522-0088**.

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 settings. As part of the application or enrollment form, Health Net members sign a routine consent to obtain or release their medical information. This consent is used by Health Net to ensure notification to and consent from members for present and future routine needs for the use of personal health information.

This consent includes the obtaining or release of all records pertaining to medical history, services rendered or treatment given to all subscribers and members under the plan for the purpose of review, investigation or evaluation of an application, claim, appeals (including the release to an independent reviewer organization) or grievance, or for preventive health or health management purposes.

We will not release your medical records or other confidential information to anyone, such as employers or insurance brokers, who is not authorized to have that information. We will only release information if you give us special consent in writing. The only time we would release such information without your special consent is when we have to comply with a law, court order or subpoena. 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.

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 **1-800-522-0088**.

Payment of fees and charges

What your portion of coinsurance, copayment and deductibles are for services

The comprehensive benefits of your Health Net plan are described in the "Schedule of benefits and coverage" section. 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 maximum copayment liability limit 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.

Certain copayments paid will not be applied to the maximum copayment liability limit. Additionally, deductibles and copayments for any covered supplemental benefits purchased by your employer, such as prescription drugs or eyewear will also not be applied to the limit with the exception of copayments for diabetic supplies. For further information please refer to the EOC.

Coordination of benefits

When you are covered by another group health plan, Health Net will coordinate benefits with that plan. In doing so, we will comply with state laws that govern this activity. Both coverages combined will pay no more than the expenses that were incurred.

Medicare coordination

When, according to federal law, Medicare is the primary payor, Health Net or your physician group will coordinate payment with Medicare. If you have questions about Medicare eligibility rules, contact your local Social Security office.

Liability of subscriber or enrollee for payment

If you receive health care services from doctors without receiving required authorization from your PCP or physician group (medical) or the Behavioral Health Administrator (mental illness and chemical dependency), you are responsible for payment of expenses for 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 Contracting Physician Groups* for a full listing of Health Net-contracted physicians.

Third-party liability

If you receive medical services under this plan because of an injury caused by someone else and that person compensated you for the injury, you will be required to reimburse Health Net or your physician group for medical services received as a result of the injury.

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 chemical dependency) will never be your responsibility.

If you have out-of-pocket expenses for covered services, call the Health Net Member Services Department 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 chemical dependency), you may have to pay at the time you receive service. To be reimbursed for these charges, you should obtain a complete statement of the services received and, if possible, a copy of the emergency room report.

Please contact the Health Net Member Services Department at **1-800-522-0088** 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 chemical dependency) or to Health Net. Claims must be received by Health Net within one year of the date of service to be eligible for reimbursement.

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 **1-800-522-0088**, your physician group or your PCP and request information 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 selected 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 Contracting Physician Groups*.

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 contact the Health Net Member Services Department at **1-800-522-0088.**)

Termination of provider

If Health Net's contract with a physician group or other provider is terminated, Health Net will transfer any affected members to another contracted physician group or provider to ensure that care continues. Health Net will pay for services or supplies your plan covers until Health Net has been able to arrange medically appropriate care by another provider.

In addition, the member may elect continued care if, at the time of termination the member was receiving care for:

- An acute or serious chronic condition;
- A high-risk pregnancy; or
- A pregnancy that has reached the second trimester.

If you would like more information on how to request continued care, please contact the Health Net Member Services Department at **1-800-522-0088**.

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.

Individual continuation of benefits

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). If you are over age 60, an additional period of coverage may be available under state law. For more information, ask your employer.

Also, if you become ineligible for group coverage, you may convert from group coverage to a type of individual coverage called conversion coverage. Application must be made within 31 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

Health Net can terminate your coverage 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 for a member who:

- Acts in a disruptive manner while receiving care;
- Allows someone else to use his or her Health Net identification card;
- Fails to make appropriate copayments or payment for noncovered services;
- Knowingly provides incorrect information to Health Net or to his or her Health Net doctor; or
- Refuses to establish and maintain a relationship with his or her doctor to assure continuity of health care and appropriate use of covered services.

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

If the employer covered under this plan does not pay appropriate subscription charges, benefits will end on the last day for which subscription charges have been made, unless:

- You apply for conversion coverage within 31 days of that date;
- You are hospitalized (coverage will continue until you are discharged from the hospital); or
- You are totally disabled and apply for an extension of benefits for the disabling condition within 90 days.

If you have a disagreement with our plan

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free telephone number (**1-888-HMO-2219**) to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free numbers (**1-800-735-2929** [**TTY**] or **1-888-877-5378** [**TTY**]) to contact the Department. The Department's Internet web site (**http://www.hmohelp.ca.gov**) has complaint forms and instructions online.

If you have a grievance against your health plan, you should first telephone your plan at **1-800-522-0088** and use the plan's grievance process before contacting the Department. If you need help with a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. The plan's grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

You may also file an emergency appeal for conditions where there is an immediate and serious threat to your health, including severe pain or, the potential for loss of life, limb or major bodily function. Health Net must notify you of the status of your grievance no later than three days from receipt of the grievance.

Member grievance and appeals process

If you are dissatisfied with the quality of care that you have received or feel that you have been denied a service or claim in error, you may file a grievance or appeal.
To file a grievance or appeal you may call **1-800-522-0088** or write to:

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

Health Net will acknowledge your grievance or appeal within five days. If we cannot resolve your grievance or appeal within 30 days we will contact you by the 30th day and inform you of the reason for the delay.

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 Managed Health Network, a specialized health care service plan which provides behavioral health services through a personalized, confidential and affordable mental health and chemical dependency care program. Just call the toll-free number shown on your Health Net ID Card before receiving care.

Continuity of Care

If you are receiving ongoing care for an acute, serious, or chronic mental health condition from a non-participating mental health professional at the time you enroll with Health Net, we may temporarily cover services from a provider not affiliated with the Behavioral Health Administrator, subject to applicable copayments and any other exclusions and limitations of this plan and if the following apply:

- Changing to a participating mental health professional immediately will have a negative effect on your health; and
- Your non-participating mental health professional is willing to accept the Behavioral Health Administrator's standard mental health provider contract terms and conditions and is located in the plan's service area.

If you feel that your condition might require special attention as you switch to Health Net, contact Health Net as soon as possible, and no later than 15 days from the effective date of your Health Net coverage. To request a copy of our continuity of care policy, please call the Health Net Member Services Department at **1-800-522-0088**.

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, autism, anorexia nervosa, and bulimia nervosa.

Continuation of treatment

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

Health Net and your EAP

If your employer offers an Employee Assistance Program (EAP), Health Net's mental health and chemical dependency program works in coordination with your company’s EAP. You may be able to obtain a referral to a network provider from either the mental health and chemical dependency program or with the assistance of your EAP counselor.

What’s covered

Please refer to the “Schedule of benefits and coverage” section of this SB/DF for the 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. Consult your plan's EOC for more information.

In addition to the exclusion and limitations listed below, mental health and chemical dependency are subject to the plan's general exclusions and limitations.

- 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. Please consult your EOC for specific information regarding your plan.

Prescription drug program

Health Net is contracted with many major pharmacies including Longs, Rite Aid, Sav-On, Walgreens, and those located in the Albertsons, BelAir, Raley's, Ralphs, Safeway, Save Mart and Vons/Pavilions supermarket chains in California. There are many other neighborhood pharmacies that are also part of our network. For a complete and up-to-date list of participating pharmacies, call the Health Net Member Services Department at **1-800-522-0088**.

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 up to a 90-consecutive-calendar-day supply of maintenance medications. For complete information, call the Health Net Member Services Department at **1-800-522-0088**.

The Health Net Recommended Drug List: Level I drugs (primarily generic) and Level II drugs (primarily brand name)

The Health Net Recommended Drug List (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/uc, under the pharmacy information, or call the Member Services Department at **1-800-522-0088**.

Drugs not on the List: Level III drugs

Level III drugs are prescription drugs that are not listed on the Recommended Drug List and are not excluded from coverage. Some Level III drugs require prior authorization from Health Net. Health Net will approve a drug not on the List at the Level II drug copayment if the member's physician demonstrates medical necessity.

What is "prior authorization?"

Some prescription medications require prior authorization. This means that your doctor must contact Health Net in advance to provide the medical reason for prescribing the medication. 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 **1-800-522-0088;**
- Visit www.healthnet.com/uc 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 deductibles 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
- Level III drugs (drugs not listed on the Recommended Drug List).

Note:

- Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's usual and customary charges for covered prescription drugs.
- If a pharmacy calendar year deductible (per member) applies, you must pay this amount for prescription drug covered expenses before Health Net begins to pay. Diabetic supplies are not subject to the deductible. After the deductible is met the copayments or coinsurance amounts apply.
- Prescription drug refills are covered, up to a 30-consecutive-day supply per prescription at a Health Net contracted pharmacy for one copayment.
- If the pharmacy's usual and customary charge is less than the applicable copayment, the member will pay the pharmacy's usual and customary charge.
- Mail order drugs are covered up to a 90-consecutive-calendar-day supply. The member is responsible for twice the applicable retail pharmacy copayment. However, when the retail pharmacy copayment is a percentage, the mail order copayment is the same percentage as the retail pharmacy copayment.
- Oral contraceptives are covered. Vaginal contraceptives (diaphragms and cervical caps) are limited to one prescription per calendar year. Refer to your plan's EOC for more information on contraceptives covered under the medical benefit.
- The Level II drug copayment applies for each 30-day supply of insulin and diabetic supplies (including but not limited to blood glucose monitoring strips, pen delivery system, insulin needles and syringes) listed on the Recommended Drug List. Lancets are dispensed at no charge. See diabetic equipment under the "Schedule of benefits and coverage" section of this SB/DF for additional benefit information.
- 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).

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. Consult your plan's EOC for more information.

In addition to the exclusion and limitations listed below, prescription drug benefits are subject to the plan's general exclusions and limitations.

- Allergy serum
- Contraceptive foams, abortifacients or menstrual induction drugs
- Devices or appliances
- Drugs that are appetite suppressants or are indicated for and prescribed for body weight reduction, except when prescribed for the treatment of morbid obesity as the only alternative to surgery and approved by Health Net
- Drug products that help you reduce or quit smoking or for nicotine addiction (for example, nicotine patches)
- Drugs or medicines administered by a physician or physician's staff member
- Drugs prescribed for non-organically based sexual dysfunction, 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"), except as set out under the "If you have a disagreement with our plan" section of this SB/DF
- Hypodermic needles or syringes, except for insulin needles, syringes and reusable pen devices
- Immunizing agents, injections (except for insulin), agents for surgical implantation, biological sera, blood, blood derivatives or blood plasma
- 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
- Over-the-counter drugs, equipment, supplies or drugs where there is a non-prescription equivalent available, except for drugs and supplies used for the treatment or management of diabetes
- 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, or as specifically stated
- Replacement of lost, stolen or damaged medications
- Services or supplies which are covered in full or for which you are not legally required to pay
- Supply amounts (for any number of days) which exceed the Food and Drug Administration's or Health Net's indicated usage guidelines

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

For more information, please contact us at:

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

Member Services

1·800·522·0088 – HMO (groups with 51+ employees)
1·800·361·3366 – SBG (groups with 2-50 employees)
1·800·676·6976 – PPO/Point-of-Service (SELECT/ELECT) /ELECT Open Access

Spanish

1·800·331·1777

Mandarin

1·877·891·9053

Cantonese

1·877·891·9050

Korean

1·877·339·8596

Tagalog

1·877·891·9051

Vietnamese

1·877·339·8621

Telecommunications Device for the Hearing Impaired

1.800.995.0852

www.healthnet.com/uc