Summary *of* Benefits *and* Disclosure *Form*

Large Business Group (51-100)
POS 20 • Plan AAZ

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 and disclosure form (SB/DF) answers basic questions about this versatile plan.

If you have further questions, contact us.

By phone at 1-800-522-0088,

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.

This *Summary of benefits/disclosure form* (SB/DF) is only a summary of your health plan. The plan's *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 the plan's 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 or what group of providers health care may be obtained.

SELECTION OF PHYSICIANS AND PHYSICIAN GROUPS

With Health Net SELECT Point-of-Service (POS), you have the option to:

- Choose a physician from a POS network of doctors and hospitals affiliated with Health Net that's broader than our HMO network; and
- Take advantage of cost savings and the highest level of benefits when you use doctors affiliated with Health Net.

When you enroll,

- You choose a contracting physician group for the HMO level of care. From your physician group, you select one doctor to provide basic health care; this is your Primary Care Physician (PCP).
- Health Net requires the designation of a Primary Care Physician. A primary care physician provides and coordinates your medical care. You have the right to designate any Primary Care Physician who participates in our network and who is available to accept you or your family members, subject to the requirements of the physician group. For children, a pediatrician may be designated as the Primary Care Physician. Until you make this Primary Care Physician designation, Health Net designates one for you. For information on how to select a Primary Care Physician and for a list of the participating Primary Care Physicians in the Health Net Service Area, refer to your Health Net directory of participating physicians. The provider directory is also available on the Health Net website at www.healthnet.com. You can also call the Customer Contact Center at the number shown on your Health Net I.D. Card to request provider information.
- You do not have to choose the same physician group or PCP for all members of your family. The names of physicians are listed in the Health Net directory of participating providers.
- At any time, you may seek care from other doctors and specialists contracted with Health Net (our preferred providers), or you may go out of network to see providers not contracted with Health Net. Your coverage and benefits are different at the Preferred Provider Organization (PPO) and Out-of-Network (OON) levels of care.

HOW TO CHOOSE A PHYSICIAN (HMO BENEFIT LEVEL)

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;
- Ask your PCP or the physician group about the specialist referral policies and hospitals used by the physician group; and

- Be sure that you and your family members have adequate access to medical care, by choosing a doctor located within 30 miles of your home or work.

If you reside outside the Health Net Service Area, then you may enroll based on the subscriber's work address that is within the Health Net Service Area. Family members who reside outside the Health Net Service Area may also enroll based on the subscriber's work address that is within the Health Net Service Area. If you choose a physician group based on its proximity to the subscriber's work address, you will need to travel to that physician group for any non-emergency or non-urgent care that you receive. Additionally, some physician groups may decline to accept assignment of a member whose home or work address is not close enough to the physician group to allow reasonable access to care.

SPECIALISTS AND REFERRAL CARE (HMO BENEFIT LEVEL)

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. Refer to the "Mental Disorders and Chemical Dependency Care" section below for information about receiving care for Mental Disorders and Chemical Dependency.

You do not need prior authorization from Health Net or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, refer to your Health Net directory of participating physicians. The provider directory is also available on the Health Net website at www.healthnet.com.

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 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 on our Internet web site, www.healthnet.com.

MENTAL DISORDERS AND CHEMICAL DEPENDENCY CARE

Health Net contracts with MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator), which administers behavioral health services for mental disorders and chemical dependency conditions. For more information about how to receive care and the Behavioral Health Administrator's prior authorization requirements, please refer to the "Behavioral Health Services" section of this SB/DF.

PPO OR OUT-OF-NETWORK SPECIALISTS

At any time, you may self-refer to specialists using your PPO or Out-of-Network (OON) benefits. Your coverage and benefits will be different, depending on whether you use the services of a PPO or OON specialist.

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 the plan's 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;**
- **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 the Health Net Customer Contact Center at the phone number on the back cover to ensure that you can obtain the health care services that you need.

Schedule of benefits and coverage

Health Net SELECT[SM], a product of Health Net, combines three types of coverage into one health plan. The services covered and amount you must pay will depend upon which option you choose each time you need health care. The following charts show what you pay for most types of service under this plan.

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

Benefit levels *Features*	HMO (**Primary Care Physician**) Care provided or authorized by your PCP or physician group contracted with Health Net.	PPO (**Preferred providers**) Care provided by a broader network of doctors and specialists contracted with Health Net.	OON (**Out-of-Network providers**) Care provided by any licensed physician not contracted with Health Net.
	• Highest level of benefits available at lowest cost • Convenience of having all your health care services coordinated by your Health Net doctor • Coverage for preventive care services available • No claim forms	• Higher out-of-pocket costs • Greater freedom of choice • Certification from Health Net required for certain services • Claim forms usually not required for reimbursement • Coverage for preventive care services available • Must meet annual deductible	• Most expensive out-of-pocket costs • Greatest freedom of choice • Certification from Health Net required for certain services • Must meet annual deductible and coinsurance • Claim forms required for reimbursement

For the HMO level of benefits, the change to all small copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments are usually billed after the service is received.

For the PPO level of benefits, the percentages that appear in this chart are based on the contracted rate.

For Out-of-Network level of benefits, the percentages that appear in this chart are based on the Maximum Allowable Amount. The member is responsible for charges in excess of the Maximum Allowable Amount in addition to the coinsurance shown even after the Out-of-Pocket-Maximum has been reached.

Deductibles	HMO	PPO	OON

You must pay this amount for covered services before Health Net begins to pay. Any amount applied toward the calendar year deductible for covered services provided by a PPO provider will apply toward the deductible for OON providers; any amount applied toward the OON calendar year deductible will also apply to the PPO deductible.

Calendar year deductible

Per member	None	$500	$1000
Per family	None	$1000	$2000

Plan maximums	HMO	PPO	OON

Calendar Year Out-of-Pocket Maximum (OOPM) [ð]

Once your payments for covered services and supplies for each benefit level equals the amount shown below in any one calendar year, no additional copayment or coinsurance for covered services and supplies are required for the remainder of that calendar year for that benefit level, except as specifically stated. Once an individual member in a family satisfies the individual out-of-pocket maximum, the remaining enrolled family members must continue to pay copayments for covered services and supplies until the total amount of copayments paid by the family reaches the family out-of-pocket maximum or each enrolled family member individually satisfies the individual out-of-pocket maximum.

Payments for services not covered by this plan, or for certain services as specified in the "Payment of fees and charges" section of this SB/DF, will not be applied to the yearly out-of-pocket maximum, unless otherwise noted. Also, copayments and deductibles for prescription drugs do not apply to the out-of-pocket maximum, unless otherwise noted. You must continue to pay copayments for any services and supplies that do not apply to the out-of-pocket maximum.

One member	$2000	$3500	$7000
Family	$4000	see note below*	see note below*

For the HMO level of benefits, payments for the following items will not be applied to the annual out-of-pocket maximum: copayments and deductibles for supplemental benefits, such as prescription drugs (except for copayments for peak flow meter and inhaler spacers used for the treatment of asthma, and diabetic supplies), and vision care. For the PPO and Out-of-Network level of benefits, payments for the following items will not be applied to the combined annual out-of-pocket maximum: charges applied to the annual deductible or any additional deductibles; amounts paid by the member for services which require 50 percent coinsurance; (expenses paid by the member for services that require a copayment,) or services for which certification was required but not obtained.

** To satisfy the family OOPM, two individual members of the family must statisfy their individual OOPMs.*

[ð] *Combined for PPO and Out-of-Network.*

Type of service, benefit maximums and what you pay			
Professional services	**HMO**	**PPO**	**OON**
The copayments and coinsurances 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 or coinsurance. See "Hospitalization services" and "Outpatient services" in this section to determine if any additional payments may apply.			
Visit to physician	$20	$30	50%
Specialist consultations■	$20	$30	50%
Prenatal and postnatal visits*	$20	20%	50%
Normal delivery, cesarean section, newborn inpatient professional care*	Covered in full	20%	50%
Treatment of complications of pregnancy, including medically necessary abortions*	See note below**	See note below**	See note below**
Surgeon or assistant surgeon services▲*	Covered in full	20%	50%
Administration of anesthetics	Covered in full	20%	50%
Laboratory procedures and diagnostic imaging (including x-ray) services*	Covered in full	20%	50%
Rehabilitative therapy (including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)*	$20	20%	50%
Calendar year maximum[1]	*No maximum*	*12 visits*	*12 visits*
Organ and stem cell transplants (nonexperimental and noninvestigational)*	Covered in full	20%	Not covered
Chemotherapy	Covered in full	$30	50%
Radiation therapy	Covered in full	$30	50%
Vision and hearing examinations (for diagnosis or treatment) (birth through age 17)	$20	Not covered	Not covered
Vision and hearing examinations (for diagnosis or treatment) (age 18 and older)	$20	Not covered	Not covered

[1] *Combined for PPO and Out-of-Network.*

■ *For the HMO level of benefits, self-referrals are allowed for obstetrician and gynecological services including preventive care, pregnancy and gynecological ailments. Copayment requirements may differ depending on the service provided. Chiropractor and acupuncture services may be covered under "Specialist consultation" under SELECT 1, as authorized by your physician group. The office visit copayment applies to visits to a primary care physician at a contracting physician group. The specialist copayment for specialist consultations will apply for visits to a member physician who is not a primary care physician.*

**Prenatal, postnatal and newborn care that are preventive care services are covered in full under SELECT 1 and 2. See copayment listings for preventive care services below. If other non-preventive care services are received during the same office visit, the above copayment or coinsurance will apply for the non-preventive care services.*

*** Applicable deductible, copayment or coinsurance requirements apply to any services and supplies required for the treatment of an illness or condition, including but not limited to, complications of pregnancy. For example, if the complication requires an office visit, then the office visit copayment or coinsurance will apply.*

▲ *Surgery includes surgical reconstruction of a breast incident to mastectomy (including lumpectomy), 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.*

***** *Some services require certification for PPO and OON coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB/DF. Routine care for condition of pregnancy does not require prior certification. However, notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced under the PPO and OON levels of benefits to 50% of covered expenses and a $250 penalty will also be charged for each inpatient admission.*

Preventive Care	HMO	PPO	OON
Preventive care services	Covered in full	Covered in full	Not covered

Preventive care services are covered for children and adults, as directed by your physician, based on the guidelines from the U.S. Preventive Services Task Force Grade A&B recommendations, the Advisory Committee on Immunization Practices that have been adopted by the Center for Disease Control and Prevention, the guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA).

For the HMO level of benefits, self-referrals are allowed for obstetrician and gynecological services including preventive care, pregnancy and gynecological ailments. Copayment requirements may differ depending on the service provided.

Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures and preventive vision and hearing screening examinations, 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.

One breast pump and the necessary supplies to operate it (as prescribed by your Physician) will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it. Breast pumps can be obtained by calling the Customer Contact Center at the phone number listed on the back cover of this booklet.

Allergy treatment and other injections (except for infertility injections)	HMO	PPO	OON
Allergy testing	$20	$30	50%
Allergy serum	Covered in full	20%	50%
Allergy injection services	$20	20%	50%
Injections (except for infertility)			
Injectable drugs administered by a physician (per dose)	Covered in full	20%	50%
Self-injectable drugs■	30%	30%	50%

■ *Self-injectable drugs (other than insulin) are considered specialty drugs, which require prior authorization and must be obtained from a contracted specialty pharmacy vendor. Specialty drugs require prior authorization. Please refer to the plan's EOC for additional information.*

Injections for the treatment of infertility are described below in the "Infertility services" section.

Outpatient services	HMO	PPO	OON
Outpatient facility services (other than surgery) *	20%	20%	50%
Outpatient surgery (surgery performed in a hospital or outpatient surgery center only) *	$250	$250 + 20%	$250 + 50%

***** *Some services require certification for PPO and OON coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB/DF. Routine care for condition of pregnancy does not require prior certification. However, notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced under the PPO and OON levels of benefits to 50% of covered expenses and a $250 penalty will also be charged for each inpatient admission.*

Outpatient surgery requires a $250 calendar year deductible for the first outpatient surgery session only under the PPO and OON level of benefits

Outpatient care for infertility is described below in the "Infertility services" section.

Hospital services	HMO	PPO	OON
Semi-private hospital room or special care unit with ancillary services, including delivery and maternity care (unlimited days) ◊*	$250 per day with a maximum of 3 days per admission	20%	50%
Skilled nursing facility stay*			
Days 1-10	*Covered in full*	*20%*	*50%*
Days 11- 100	*$25 per day*	*20%*	*50%*
Maximum allowable amount per day	*No maximum*	*No maximum*	*$250*
Physician visit to hospital or skilled nursing facility	Covered in full	20%	50%

◊ *Combined for PPO and Out-of-Network.*

• *Under the PPO and OON level of benefits a $250 deductible is required only for the first inpatient hospital or skilled nursing facility admission each calendar year. Once the deductible is satisfied, no deductible is required for subsequent admissions in the same calendar year*

***** *Some services require certification for PPO and OON coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB/DF. Routine care for condition of pregnancy does not require prior certification. However, notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced under the PPO and OON levels of benefits to 50% of covered expenses and a $250 penalty will also be charged for each inpatient admission.*

The above inpatient hospitalization copayment or coinsurance is applicable for each admission of hospitalization for an adult, pediatric or newborn patient. If a newborn patient requires admission to a special care unit, a separate copayment for inpatient hospital services will apply.

Inpatient care for infertility is described below in the "Infertility services" section.

Emergency health coverage	HMO	PPO	OON
Professional services	Covered in full	20%	50%
Emergency room (facility charges)	$100	$100 + 20%	$100 + 50%
Urgent care (facility charges)	$50	$50 + 20%	$50 + 50%

The copayment shown for HMO emergency health care coverage will be applied for all emergency care, regardless of whether or not the health care provider is an HMO, PPO, or noncontracting provider. The copayments shown for PPO and OON providers are applicable only if non-emergency care is provided at an emergency room or urgent care center. 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	HMO	PPO	OON
Ground ambulance	$100	$50 + 20%	$50 + 50%
Maximum per incident	*Unlimited*	*75 miles*	*75 miles*
Air ambulance*	$100	$50 + 20%	$50 + 50%
Maximum per incident[a]	*Unlimited*	*$750*	*$750*

[a] *Combined for PPO and Out-of-Network.*

* *Some services require certification for PPO and OON coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB/DF. Routine care for condition of pregnancy does not require prior certification. However, notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced under the PPO and OON levels of benefits to 50% of covered expenses and a $250 penalty will also be charged for each inpatient admission.*

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 preferred brand name drugs, peak flow meters, inhaler spacers and diabetic supplies, including insulin) ◆	$30
Level III drugs or non-preferred drugs not on the Recommended Drug List ◆	$50
Smoking Cessation Drugs [9] (covered up to a 12 week course of therapy per calendar year if you are concurrently enrolled in a comprehensive smoking cessation behavioral modification support program.)	50%
Appetite Suppressants	50%
Lancets	Covered in full
Preventive drugs and women's contraceptives*	Covered in full

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

Level I drugs (primarily generic)	$30
Level II (primarily preferred brand name drug and diabetic supplies, including insulin) ◆	$60
Level III drugs or non-preferred drugs not on the Recommended Drug List ◆	$100
Lancets	Covered in full
Preventive drugs and women's contraceptives*	Covered in full

For information about Health Net's Recommended Drug List, please call the Customer Contact Center at the telephone number on the back cover.

◆ *Generic drugs will be dispensed when a generic drug equivalent is available unless a brand name drug is specifically requested by the physician or the member. 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 to indicate medical necessity, only the Level II or Level III drug copayment, as appropriate, will be applicable.

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

* *Preventive drugs and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations.*

If a brand name drug is dispensed, and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand name drug. However, if a brand name drug is medically necessary and the physician obtains prior authorization from Health Net, then the brand name drug will be dispensed at no charge.

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.

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.

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

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 for authorization are processed as soon as possible, not to exceed 72 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary 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 the Customer Contact Center at the number listed on the back cover of this booklet or visit our website at www.healthnet.com.

Medical supplies	HMO	PPO	OON
Durable medical equipment (including nebulizers, face masks and tubing for the treatment of asthma)*	50%	50%	50%
Orthotics (such as bracing, supports and casts)*	Covered in full	20%	50%
Diabetic equipment See the "Prescription Drug Program" section of the SB/DF for diabetic supplies benefit information.*	20%	20%	50%
Diabetic footwear*	Covered in full	20%	50%
Prostheses*	Covered in full	20%	Not covered

***** *Some services require certification for PPO and OON coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB/DF. Routine care for condition of pregnancy does not require prior certification. However, notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced under the PPO and OON levels of benefits to 50% of covered expenses and a $250 penalty will also be charged for each inpatient admission.*

Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under "Preventive care" in this section.

Durable medical equipment is covered when medically necessary and acquired or supplied by a Health Net designated contracted vendor for durable medical equipment. Preferred Providers through SELECT 2 that are not designated by Health Net as a contracted vendor for durable medical equipment are considered Out-of-Network Providers for purposes of determining coverage and benefits. Durable medical equipment is not covered if provided by an Out-of-Network Provider. For information about Health Net's designated contracted vendors for durable medical equipment, please contact the Health Net Customer Contact Center at the phone number on the back cover.

Diabetic equipment covered under the medical benefit (through "Diabetic equipment") includes blood glucose monitors designed for the visually impaired, insulin pumps and related supplies, corrective footwear. In addition, the following supplies are covered under the medical benefit as specified: 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 disorders and chemical dependency benefits

HMO 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 the behavioral health section of this SB/DF, or call the Customer Contact Center at the number listed on the back cover of this booklet.

MENTAL DISORDERS and CHEMICAL DEPENDENCY SERVICES THROUGH MHN SERVICES

Severe mental illness and serious emotional disturbances of a child	**MHN SERVICES**
Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting) ◆	$20
Outpatient professional consultation (psychological evaluation or therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day) ◆	$20
Inpatient services	$250 per day for a maximum of 3 days per admission

Other mental disorders	**MHN SERVICES**
Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting) ◆	$20
Inpatient services	$250 per day for a maximum of 3 days per admission

Chemical dependency	**MHN SERVICES**
Acute care detoxification	$250 per day for a maximum of 3 days per admission

◆*Each group therapy session requires only one half of a private office visit copayment. If two or more members in the same family attend the same outpatient treatment session, only one copayment will be applied.*

MENTAL DISORDERS and CHEMICAL DEPENDENCY SERVICES THROUGH HEALTH NET

Mental disorders and chemical dependency benefits	**PPO**	**OON**
Severe mental illness and serious emotional disturbances of a child		
Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting)◆	$30	50%
Outpatient professional consultation (psychological evaluation or therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day)*	$30	50%
Inpatient services*	20%	50%
Other mental disorders		
Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting)◆	$30	50%
Inpatient services*	20%	50%
Chemical dependency		
Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting)◆	$30	50%
Inpatient services*	20%	50%
Acute care detoxification*	20%	50%

◆*Each group therapy session requires only one half of a private office visit Copayment. If two or more Members in the same family attend the same outpatient treatment session, only one Copayment will be applied.*

*****Some services require certification for PPO and OON coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB/DF. Routine care for condition of pregnancy does not require prior certification. However, notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced under the PPO and OON levels of benefits to 50% of covered expenses and a $250 penalty will also be charged for each inpatient admission.

Home health services	**HMO**	**PPO**	**OON**
Home health visits, part-time or intermittent care only (Through HMO and PPO, the copayment starts the 31st calendar day after the first visit. Through OON, the coinsurance is applicable as of the first visit.)*	$20	20%	50%
*Calendar year maximum*ϑ	*100 visits*	*No maximum*	*No maximum*

Maximum allowable per visit[ß]	*No maximum*	*$110*	*$110*

[ß] *Combined for PPO and Out-of-Network.*

***** *Some services require certification for PPO and OON coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB/DF. Routine care for condition of pregnancy does not require prior certification. However, notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced under the PPO and OON levels of benefits to 50% of covered expenses and a $250 penalty will also be charged for each inpatient admission.*

Other services	HMO	PPO	OON
Vasectomy	Covered in full	20%	50%
Tubal ligation	Covered in full	Covered in full	Not covered
Blood, blood plasma, blood derivatives and blood factors	Covered in full	20%	50%
Renal dialysis	Covered in full	$30	50%
Hospice services*	Covered in full	20%	50%
Chiropractic care	$20	$30	Not covered
Calendar year maximum[ß]	*No maximum*	*12 visits*	*Not applicable*
Acupuncture	$20	Not covered	Not Covered

***** *Some services require certification for PPO and OON coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB/DF. Routine care for condition of pregnancy does not require prior certification. However, notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced under the PPO and OON levels of benefits to 50% of covered expenses and a $250 penalty will also be charged for each inpatient admission.*

Infertility services and supplies are described below in the "Infertility services" section.

[ß] *Combined for PPO and Out-of-Network.*

Sterilization of females and women's contraception methods and counseling, as supported by HRSA guidelines, are covered under "Preventive care" in this section.

Infertility services	HMO	PPO	OON
Infertility services and supplies (all covered services that diagnose, evaluate or treat infertility)	50%	50%	50%

Infertility services include Prescription Drugs, professional services, inpatient and outpatient care and treatment by injections.

Infertility services are covered only for the Health Net member.

Injections for infertility are covered only when provided in connection with services that are covered by this plan.

Limits of coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- Ambulance and paramedic services that do not result in transportation or that do not meet the criteria for emergency care, unless such services are medically necessary and prior authorization has been obtained.
- Artificial insemination for reasons not related to infertility;
- Biofeedback therapy is limited to medically necessary treatment of certain physical disorders such as incontinence and chronic pain.
- Care for mental health care as a condition of parole or probation, or court-ordered treatment and testing for mental disorders, except when such services are medically necessary;
- Chiropractic or acupuncture services, except as referred by your Physician Group and/or as shown in the "Schedule of benefits and coverage" section of this SB/DF;
- Conception by medical procedures (IVF, GIFT and ZIFT);
- Except for podiatric devices to prevent or treat diabetes-related complications, corrective footwear is not covered unless medically necessary, custom made for the member and permanently attached to a medically necessary orthotic device that is also a covered benefit under this plan
- Cosmetic services and supplies;
- Custodial or live-in care;
- Dental services. However, medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures are covered. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate;
- 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;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder;
- 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 plan's 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);
- Outpatient prescription drugs or medications (except as noted under "Prescription drug program");
- Personal or comfort items;
- Physician self-treatment;
- Physician treating immediate family members;
- Physician visit to 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 foot care for treatment of corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes;
- Routine physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp or other nonpreventive purposes;
- 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 for the treatment of chemical dependency (other than detoxification) are not covered.
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the plan's EOC;
- Services related to education or training, including for employment or professional purposes, except for behavioral health treatment for pervasive developmental disorder or autism;
- 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 jaw joint disorders or surgical procedures to reduce or realign jaw, unless medically necessary; and
- Treatment of obesity, weight reduction or weight management, except for morbid obesity.

The above is a partial list of the principal exclusions and limitations applicable to the medical portion of your Health Net SELECT POS 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.

TIMELY ACCESS TO NON-EMERGENCY HEALTH CARE SERVICES

The California Department of Managed Health Care (DMHC) has issued regulations (Title 28, Section 1300.67.2.2) with requirements for timely access to non-emergency health care services.

You may contact Health Net at the number shown on the back cover, 7 days per week, 24 hours per day to access triage or screening services. Health Net provides access to covered health care services in a timely manner. For further information, please refer to the plan's EOC or contact the Health Net Customer Contact Center at the phone number on the back cover.

SPECIAL ENROLLMENT RIGHTS UNDER CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

The Children's Health Insurance Program (CHIP) is a joint federal and state funded program that provides comprehensive health care coverage for qualified uninsured children under the age of 19. In California, the CHIP plans are known as the Healthy Families Program and the Access for Infants and Mothers Program (AIM). The Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) creates a special enrollment period in which individuals and their dependent(s) are eligible to request enrollment in this plan within 60 days of becoming ineligible and losing coverage from the Healthy Families Program, Access for Infants and Mothers Program (AIM) or a Medi-Cal plan.

NOTICE OF REQUIRED COVERAGE

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

The Newborns' and Mothers' Health Protection Act of 1996 sets requirements for a minimum hospital length of stay following delivery. Specifically, group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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.

SERVICES REQUIRING CERTIFICATION

The following services require certification for both PPO and OON coverage. If you do not contact Health Net prior to receiving certain services, your benefit reimbursement level will be reduced as shown in the "Schedule of benefits and coverage" section of this SB/DF. A penalty will also be charged for uncertified inpatient admissions. These penalties do not apply to your out-of-pocket maximum (OOPM). (Note: If certification is not obtained after the OOPM has been reached, benefits for that service(s) will not be paid at 100%.) Services provided as a result of an emergency do not require certification.

Services that require certification include:

All inpatient admissions, any facility[1]:

- Acute rehabilitation center
- Chemical dependency facility
- Hospice
- Hospital
- Mental health facility
- Skilled nursing facility

Ambulance

- Non-emergency, air or ground ambulance services

Chondrocyte implants

Cochlear implants

Clinical trials

Custom orthotics

Durable medical equipment

- Bone growth stimulator

- Continuous positive airway pressure (CPAP)
- Custom-made items
- Hospital beds
- Power wheelchairs
- Scooters

Experimental/investigational services and new technologies

Genetic testing

Home health care services including home uterine monitoring, hospice, occupational therapy, physical therapy, speech therapy and tocolytic services

Neuro or spinal cord stimulator

Occupational and speech therapy

Organ, tissue and stem cell transplant services, including pre-evaluation and pre-treatment services and the transplant procedure

Outpatient diagnostic Procedures:
- CT (Computerized Tomography)
- MRA (Magnetic Resonance Angiography)
- MRI (Magnetic Resonance Imaging)
- Nuclear cardiology procedures, including SPECT (Single Photon Emission Computed Tomography)
- PET (Positron Emission Tomography)
- Sleep studies

Outpatient physical therapy (exceeding 12 visits), subject to any benefit limitations stated in the "Schedule of benefits and coverage" section.

Outpatient pharmaceuticals
- Self-injectables
- Hemophilia factors and intravenous immunoglobulin (IVIG)
- Certain physician-administered drugs, whether administered in a physician office, free-standing infusion center, outpatient surgery center, outpatient dialysis center, or outpatient hospital. Refer to the Health Net Life website, www.healthnet.com, for a list of physician-administered drugs that require certification.

Outpatient surgical procedures including:
- Blepharoplasty
- Bariatric procedures
- Breast reductions and augmentations
- Mastectomy for gynecomastia
- Orthognathic procedures (includes TMJ treatment)
- Rhinoplasty
- Septoplasty
- Treatment of varicose veins
- Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP

- Medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

Prosthesis and orthotics over $2,500 in billed charges

Radiation therapy

- Intensity modulated radiation therapy (IMRT)
- Proton beam therapy
- Stereotactic radiosurgery and stereotactic body radiotherapy (SBRT)

X-Stop

[1]*Certification is not required for the length of a hospital stay for reconstructive surgery incident to a mastectomy (including lumpectomy) or for renal dialysis. Certification is also not required for the length of stay for the first 48 hours following a normal delivery or 96 hours following cesarean delivery or for behavioral health treatment for pervasive developmental disorder or autism.*

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 SELECT POS covers emergency and urgently needed care throughout the world at the HMO level of benefits.

If your situation is life-threatening, immediately call 911 if you are in an area where the system is established and operating. If your situation is not so severe, call your primary care physician or physician group (medical) or the Behavioral Health Administrator (severe mental illness and chemical dependency). If you are unable to call and you need medical care right away, go to the nearest medical center or hospital.

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); in order to receive the highest level of care benefits under this plan.

***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, 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. Emergency care will also include additional screening, examination and evaluation by a physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if a psychiatric emergency medical condition exists and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, either within the capability of the facility or by transferring the member to a psychiatric unit within a general acute hospital or to an acute psychiatric hospital as medically necessary.

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).

***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.*

If you go to an emergency facility for condition that is not of an urgent or emergency nature, it will be covered at whichever level (PPO or OON) it qualifies for, subject to your plans exclusions and limitations.

MEDICALLY NECESSARY CARE

All services that are medically necessary will be covered by your Health Net SELECT POS Plan (unless specifically excluded under the plan). All covered services or supplies are listed in the plan's 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 Health Net Customer Contact Center at the phone number on the back cover.

CLINICAL TRIALS

Routine patient care costs for patients diagnosed with cancer or other life-threatening disease or condition who are accepted in to 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 plan's EOC.

EXTENSION OF BENEFITS

If you or a covered family member is totally disabled when your employer ends its 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.

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 for 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 and nonpublic personal financial 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 the plan's EOC, at www.healthnet.com under "Privacy" or you may contact the Customer Contact Center at the phone number on the back cover of this booklet to obtain a copy.

** Nonpublic personal financial information includes personally identifiable financial information that you provided to us to obtain health plan coverage or we obtained in providing benefits to you. Examples include Social Security numbers, account balances and payment history. We do not disclose any nonpublic personal information about you to anyone, except as permitted by law.*

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. If Health Net denies or delays coverage for your requested treatment on the basis that it is experimental or investigational, you may be able to request an independent medical review (IMR) of Health Net's decision from the Department of Managed Health Care. Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" in the *Evidence of Coverage* for additional details.

Utilization management

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 Customer Contact Center at the phone number on the back cover.

Payment of fees and charges

YOUR COINSURANCE, COPAYMENT AND DEDUCTIBLES

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 subscription charges 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 the copayments, coinsurance and deductibles, 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 SELECT POS except that the member remains responsible for charges above allowable expenses for OON benefit level. Additionally, the Out-of-Network Provider may request that you pay the billed charges when the service is rendered. In this case, you are responsible for paying the full cost and for submitting a claim to Health Net. Health Net will determine what portion of the billed charges is reimbursable to you.

Under the HMO level of benefits, when the total amount of copayments and coinsurance you pay equals the HMO out-of-pocket maximum (OOPM) shown under “Schedule of benefits and coverage,” you will not have to pay additional copayments or coinsurance for the rest of the year for most services provided or authorized by your physician group.

When the total amount of PPO and OON copayments and coinsurance paid equals the OOPM, you will not have to pay additional copayments or coinsurance for the rest of the year for most services provided and authorized under the PPO and OON levels of benefits.

Deductibles, copayments, and coinsurance for supplemental benefits such as prescription drugs (with the exception of copayments for inhaler spacers, peak flow meters used for the treatment of asthma, and diabetic supplies), eyewear, chiropractic services and acupuncture services will not be applied to the OOPM amount, as well as:

- Any additional deductibles;
- Charges applied to the deductible;
- Charges in excess of the Maximum Allowable Amount (Out-of-Network benefit level only);
- Services for which certification was required but not obtained; and
- Payment for services not covered by this plan.

CONTRACTED RATE

The contracted rate is the rate that preferred providers are allowed to charge you, based on a contract between Health Net and such provider. Covered expenses for services provided by a preferred provider will be based on the Contracted Rate.

MAXIMUM ALLOWABLE AMOUNT

The Maximum Allowable amount is the amount on which Health Net bases its reimbursement for covered services and supplies provided by an Out-of-Network Provider, which may be less than the amount billed for those services and supplies. Health Net calculates Maximum Allowable Amount as the lesser of the amount billed by the Out-of-Network Provider or the amount determined as set forth herein. Maximum Allowable Amount is not the amount that Health Net pays for a covered service; the actual payment will be reduced by applicable coinsurance, copayments, deductibles and other applicable amounts. Please refer to the plan's *Evidence of Coverage* for additional information.

- Maximum Allowable Amount for physician services is determined by applying a designated percentile from the database of physician charges from the FAIR Health RV Benchmarks or a similar type of database of physician charges.

- For hospital services, Maximum Allowable Amount is calculated using a method developed by Viant Inc., a data service that applies a hospital profit margin factor for hospitals, to the estimated costs of the services rendered by the Out-of-Network hospital or a similar type of hospital data service.

- For all other types of services, Maximum Allowable Amount is determined by applying a percentage of what Medicare would allow (known as the Medicare allowable amount). The Maximum Allowable Amount for such services is 190% of the Medicare allowable amount.

- In the event the applicable service or database does not include an amount for the service or supply provided, Maximum Allowable Amount shall be deemed to be 75% of the covered charges billed by the provider for the same services or supplies. The Maximum Allowable Amount determined under the databases described above may be more or less than 75% of the amount normally charged by the provider for the same services or supplies.

- The Maximum Allowable Amount may also be subject to other limitations on Covered Expenses See the plan's *Evidence of Coverage* under "Schedule of Benefits," "Covered Services and Supplies" and "Exclusions and Limitations" sections for specific benefit limitations, maximums, pre-certification requirements and payment policies that limit the amount Health Net pays for certain covered services and supplies. Health Net uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement.

In addition to the above, from time to time, Health Net also contracts with vendors that have contracted fee arrangements with providers ("Third Party Networks"). In the event Health Net contracts with a Third Party Network that has a contract with the Out-of-Network Provider, Health Net may, at its option, use the rate agreed to by the Third Party Network as the Maximum Allowable Amount, in which case You will not be responsible for the difference between the Maximum Allowable Amount and the billed charges. You will be responsible for any applicable deductible, copayment and/or coinsurance at the Out-of-Network level.

In addition, Health Net may, at its option, refer a claim for Out-of-Network Services to a fee negotiation service to negotiate the Maximum Allowable Amount for the service or supply provided directly with the Out-of-Network Provider. In that situation, if the Out-of-Network Provider agrees to a negotiated Maximum Allowable Amount, You will not be responsible for the difference between the Maximum

Allowable Amount and the billed charges. You will be responsible for any applicable deductible, copayment and/or coinsurance at the Out-of-Network level.

In the event that the billed charges for the Out-of-Network Provider are more than the Maximum Allowable Amount, You are responsible for any amounts charged in excess of the Maximum Allowable Amount, except where the Out-of-Network Provider's fee is determined by reference to a Third Party Network agreement or the Out-of-Network Provider agrees to a negotiated Maximum Allowable Amount.

Please note that whenever you obtain covered services and supplies from an Out-of-Network Provider, you are responsible for applicable deductibles, copayments and coinsurance.

For more information on the determination of Maximum Allowable Amount, or for information, services and tools to help you further understand your potential financial responsibilities for covered Out-of-Network services and supplies please log on to www.healthnet.com or contact Health Net Customer Service at the number on Your member identification card.

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, covered services will be paid at the PPO benefit level (if the doctor is a Health Net provider) or at the OON benefit level (if the doctor is not a member of Health Net's network). You are responsible for any copayments and coinsurance for these services. Remember, under Health Net SELECT POS, HMO services are covered only when provided or authorized by a Health Net contracting physician or physician group, except for emergency or out-of-area urgent care. Consult the Health Net directory of participating providers for a full listing of Health Net contracting physicians.

REIMBURSEMENT PROVISIONS

Under the HMO level of benefits, 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 Customer Contact Center at the phone number on the back cover for a claim form and instructions. You will be reimbursed for these expenses less any required copayment, deductible or coinsurance. Remember, you do not need to submit claims for medical services provided by your PCP or physician group (medical) or the Behavioral Health Administrator (mental illness and chemical dependency).

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 the services. 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 Customer Contact Center 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 chemical dependency) or directly to Health Net.

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's Customer Contact Center 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 chemical dependency 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 claim 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.

How to file a claim:

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

Health Net
P.O. Box 52136
Phoenix, AZ 85072

Please call Health Net's Customer Contact Center 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 at the HMO level of benefits. To get this information call the Health Net Customer Contact Center at the phone number on the back cover and request information about our physician payment arrangements. You can also contact your physician group or your PCP to find out about our physician payment arrangements.

Facilities

For the HMO level of benefits, 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-contracting 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.

HMO: 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 directory of participating providers.

PPO: health care will be provided at the facilities used by the doctor you choose at the time you seek care. These are also listed in the directory of participating providers.

OON: you may choose any hospital or facility, if hospitalization is required.

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 SELECT POS 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 Customer Contact Center 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 the 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 is terminated, Health Net will transfer any affected members to another contracted physician group or provider to ensure that care continues. Health Net will provide 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 terminate their contract with Health Net, a written notice will be provided to affected members within 5 days after the effective date of the contract termination.

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, 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 Customer Contact Center 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 the contract is either amended or terminated, your employer will notify you in writing.

INDIVIDUAL CONTINUATION OF BENEFITS

 ***Please examine your options carefully before declining coverage.***

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.
- **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 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.

- **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.

  Also, 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

The following information describes circumstances when your coverage in this plan may be terminated. For a more complete description of termination of benefits, please see the plan's EOC.

Termination for Nonpayment of Subscription Charges

Your coverage under this plan ends when the agreement between the employer and Health Net terminates due to nonpayment of the subscription charges by the employer. Health Net will provide your employer a 30-day grace period to submit the delinquent subscription charges. If your employer fails to pay the required subscription charges by the end of the 30-day grace period, the agreement between Health Net and your employer will be cancelled and Health Net will terminate your coverage at the end of the grace period.

Termination for Loss of Eligibility

Your coverage under this plan ends on the date you become ineligible. Some reasons that you may lose eligibility in this plan include, but are not limited to, the following situations:

- The agreement between the employer covered under this Health Net SELECT POS Plan and Health Net ends;
- You cease to either live or work within Health Net's service area;
- You no longer work for the employer covered under this Health Net SELECT POS Plan; or

Termination for Cause

Coverage under this Health Net SELECT POS Plan may be terminated for good cause with a 30-day written notice for a member who commits any act or practice, which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the agreement, including:

- Misrepresenting eligibility information about yourself or a dependent;
- Presenting an invalid prescription or physician order;
- Misusing a Health Net Member I.D. Card (or letting someone else use it); or
- Failing to notify us of changes in family status that may affect your eligibility or benefits.

We may report criminal fraud and other illegal acts to the authorities for prosecution.

How to Appeal Your Termination

You have a right to appeal Health Net's decision to terminate your coverage for the reasons described above file a complaint if you believe that your coverage is improperly terminated or not renewed. A complaint is also called a grievance or an appeal. Refer to the "If You Have a Disagreement With Our Plan" section for information about how to appeal Health Net's decision to terminate your coverage.

If your coverage is terminated based on any reason other than for nonpayment of subscription charges and your coverage is still in effect when you submit your complaint, Health Net will continue your coverage until the review process is completed, subject to Health Net's receipt of the applicable subscription charges. You must also continue to pay the deductible and copayments for any services and supplies received while your coverage is continued during the review process.

If your coverage has already ended when you submit your request for review, Health Net is not required to continue coverage. However, you may still request a review of Health Net's decision to terminate your coverage by following the complaint process described in the "If You Have a Disagreement With Our Plan" section.

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. (Health Net is a health care service plan).

If you have a grievance against Health Net, you should first telephone Health Net at the phone number on the back cover, and use our 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, 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 Customer Contact Center 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 the 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 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 eligibility criteria set out in the plan's 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 supplemental benefits available with your medical plan. For a more complete description of copayments and exclusions and limitations of service, please see the plan's EOC.

Behavioral health services

Health Net contracts with MHN Services, an affiliate behavioral health administrative services company (the Behavioral Health Administrator) which administers behavioral health services through a personalized, confidential and affordable mental health and chemical dependency care program.

Contact the Behavioral Health Administrator by calling the Health Net Customer Contact Center at the phone number on the back cover. The Behavioral Health Administrator will help you identify a participating mental health professional, a participating independent physician or a sub-contracted provider association (IPA) within the network, close to where you live or work, with whom you can make an appointment.

Certain services and supplies for mental disorders and chemical dependency may require prior authorization by the Behavioral Health Administrator in order to be covered. No prior authorization is required for outpatient office visits, but a voluntary registration with the Behavioral Health Administrator is encouraged.

Please refer to the plan's EOC for a more complete description of mental disorder and chemical dependency services and supplies, including those that require prior authorization by the Behavioral Health Administrator.

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 Customer Contact Center 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, as amended to date, 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 professionally recognized standards, including, but not limited to, the most recent edition the *Diagnostic and Statistical Manual for Mental Disorders* as amended to date), 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.

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 for the treatment of mental health and chemical dependency are subject to the plan's general exclusions and limitations. Please refer to the "Limits of coverage" section of this SB/DF for a list of what's not covered under this plan.

This is only a summary. Please consult the plan's EOC for specific information regarding your plan.

Prescription drug program

Health Net is contracted 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 Customer Contact Center 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 Customer Contact Center 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. For further information, please refer to the plan's EOC.

The Health Net Recommended Drug List

This plan uses the Recommended Drug List. The Health Net Recommended Drug List (or 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 become available.

The drug usage guidelines are reviewed and updated as new clinical information becomes 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 Customer Contact Center 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. You may obtain a list of drugs requiring prior authorization by visiting our website at www.healthnet.com or call the Health Net Customer Contact Center at the phone number on the back cover.

How to request prior authorization:

Requests for prior authorization may be submitted by telephone or facsimile. 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 the Health Net EOC for details regarding your right to appeal.

To submit an appeal:

- Call the Health Net Customer Contact Center at the phone number on the back cover;
- Visit www.healthnet.com for information on e-mailing the Health Net Customer Contact Center; or
- Write to: Health Net Customer Contact Center
  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.

This plan covers the following:

- 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 not listed on the Recommended Drug List).
- Preventive drugs and women's contraceptives

MORE INFORMATION ABOUT DRUGS THAT WE COVER

- Prescription drug covered expenses for participating pharmacies are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs;
- Prescription drug covered expenses for nonparticipating pharmacies are the lesser of the maximum allowable cost, as determined by Health Net, or the average wholesale price. For further information, please refer to the plan's EOC;
- Prescription drug refills are covered, up to a 30-consecutive-calendar-day supply per prescription at a Health Net contracting pharmacy for one copayment. A copayment is required for each prescription. In some cases, a 30-consecutive-calendar-day supply of medication may not be an appropriate drug treatment plan according to the Food and Drug Administration (FDA) or Health Net's usage guidelines. If this is the case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply;
- If the pharmacy's retail price is less than the applicable copayment, the member will 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 neces-

sary. 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;

- Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over-the-counter or are only available with a prescription. Vaginal, oral, transdermal and emergency contraceptives are covered under this pharmacy benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit. Refer to the plan’s EOC for more 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). 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 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.

- Self-injectable drugs (other than insulin) are considered specialty drugs and must be obtained through a Specialty pharmacy vendor. Specialty Drugs require Prior Authorization and upon approval, the specialty pharmacy vendor will arrange for the dispensing of the drugs. Please refer to the plan's EOC for additional information.

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 the plan’s EOC for more information.

- Allergy serum (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 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 modification support program. The prescribing physician must request prior authorization for coverage. For information regarding smoking cessation behavioral modification support programs available through Health Net, call The Customer Contact Center at the telephone number on your Health Net ID card or visit the Health Net website at www.healthnet.com;
- Drugs that are prescribed for the treatment of obesity are covered 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;

- Hypodermic needles or syringes, except for insulin needles, syringes and specific brands of pen devices;
- 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 or for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations or for female contraception as approved by the FDA. 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 in California that are not in the Health Net pharmacy network except in emergency or urgent care situations;
- 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 noncovered services.

This is only a summary. Consult the plan's EOC to determine the exact term 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 on your ID card. For Individual and Family or Farm Bureau members please call 800-839-2172. Employer group members please call 800-522-0088. PPO members: for more help call the CA Dept. of Insurance at 1-800-927-4357. HMO members: for more help call the Department of Managed Health Care HMO Help Line at 1-888-HMO-2219. **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 solicitar ayuda, llámenos al número que aparece en su tarjeta de identificación. Para los afiliados de Individual y Familiar o de la Oficina Agrícola, llame al número 800-839-2172. Los afiliados de un grupo del empleador deben llamar al 800-522-0088. Afiliados de PPO: para obtener más ayuda llame al Departamento de Seguros de CA al 1-800-927-4357. Afiliados de HMO: para obtener más ayuda llame a la Línea de Ayuda del Departamento de Cuidado Médico de HMO al 1-888-HMO-2219. **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。欲取得協助，請撥打您會員卡上的電話號碼與我們聯絡。個人與家庭計畫或農業協會的會員請撥打 800-839-2172。僱主團體會員請撥打 800-522-0088。PPO 會員：欲取得更多協助，請致電加州保險局 1-800-927-4357。HMO 會員：欲取得更多協助，請致電醫療保健計畫管理局 HMO 協助專線 1-888-HMO-2219。 **Chinese**

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, xin gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị. Các hội viên Individual and Family hoặc Farm Bureau có thể gọi số 800-839-2172. Các hội viên trong chương trình bảo hiểm theo nhóm của hãng sở xin gọi số 800-522-0088. Các hội viên PPO: để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Các hội viên HMO: để được giúp đỡ thêm, xin gọi Đường Dây Trợ Giúp HMO của Sở Điều Quản Y Tế tại số 1-888-HMO-2219. **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 주십시오. 개인 및 가족 회원 혹은 Farm Bureau 회원께서는 800-839-2172번으로 전화해 주십시오. 고용주 그룹 회원께서는 800-522-0088번으로 전화해 주십시오. PPO 가입자: 보다 많은 도움이 필요하신 분은 캘리포니아 보험 담당국, 안내번호 1-800-927-4357번으로 문의하십시오. HMO 가입자: 보다 많은 도움이 필요하신 분은 보건관리부 (the Department of Managed Health Care)의 HMO 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오. **Korean**

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipabasa mo sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card. 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 PPO members: para sa karagdagang tulong, tumawag sa CA Dept. of Insurance sa 1-800-927-4357. Para sa HMO members: para sa karagdagang tulong, tumawag sa Department of Managed Health Care HMO Help Line sa 1-888-HMO-2219. **Tagalog**

Անվճար Լեզվական ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեր լեզվով: Օգնության համար, մեզ զանգահարեք ձեր ինքնության տոմսի վրա նշված համարով: Եթե անդամ եք Անհատական և Ընտանեկան կամ Ագարակային Գրասենյակի (Farm Bureau), զանգահարեք 800-839-2172 համարով: Գործատիրոջ խմբի անդամներից խնդրում է զանգահարել 800-522-0088 համարով: PPO-ի անդամներ՝ լրացուցիչ տեղեկության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: HMO-ի անդամներ՝ լրացուցիչ տեղեկության համար 1-888-HMO-2219 համարով զանգահարեք Կառավարված Առողջական Խնամքի Օգնության Գծին: **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, а также планов страхования Фермерского бюро могут позвонить по телефону 800-839-2172. Участники плана группового страхования по месту работы могут позвонить по телефону 800-522-0088. Участники системы предпочтительного выбора (Preferred Provider Organization, PPO): для получения дополнительной помощи звоните в Министерство страхования штата Калифорния по телефону 1-800-927-4357. Участники организаций медицинского обслуживания (Health Maintenance Organizations, HMO): для получения дополнительной помощи звоните в справочную службу HMO Департамента организованного медицинского обслуживания по телефону 1-888-HMO-2219. **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、または、ファーム・ビューロー会員の方は、800-839-2172 まで、雇用者団体会員の方は、800-522-0088 までご連絡ください。PPO会員の方：更なるお問い合わせは、カリフォルニア州保険庁、 1-800-927-4357 までご連絡ください。HMO会員の方：更なるお問い合わせは、カリフォルニア州管理医療庁のHMO相談窓口、 1-888-466-2219 までご連絡ください。 **Japanese**

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی برخوردار شده و بگذارید مدارک به زبان خودتان برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است تماس بگیرید. اعضای «طرح افراد و خانواده ها» یا «طرح اداره مزارع» لطفا به شماره 800-839-2172 تلفن کنند. اعضای گروههای کارفرمایان لطفا با شماره 800-522-0088 تماس بگیرند. اعضای PPO: برای کسب اطلاعات بیشتر لطفا با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. اعضای HMO: برای کسب اطلاعات بیشتر به خط کمکی HMO در Department of Managed Health Care به شماره 1-888-HMO-2219 تلفن کنید. **Farsi**

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਜਾਂ ਫਾਰਮ ਬਿਊਰੋ ਮੈਂਬਰ ਕਿਰਪਾ ਕਰਕੇ 800-839-2172 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਇੰਪਲਾਇਰ ਗਰੁੱਪ ਦੇ ਮੈਂਬਰ ਕਿਰਪਾ ਕਰਕੇ 800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। PPO ਮੈਂਬਰ: ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। HMO ਮੈਂਬਰ: ਵਧੇਰੇ ਮਦਦ ਲਈ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਮੈਨੇਜਡ ਹੈਲਥ ਕੇਅਰ ਦੀ HMO ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। **Punjabi**

ការកកន់ប្រភាសាដោយឥតគិតថ្លៃ ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងស្ទូចេនានាឯកសារជូនអ្នកជាភាសាខ្មែរក្នុង ។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកលើ លេខដែលមានចែងនៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក ។ សំរាប់សមាជិក ផ្ទៀងៗខ្លួន និងជាក្រុមគ្រួសារ ឬសមាជិក Farm Bureau សូមទូរស័ព្ទទៅលេខ 800-839-2172 ។ សមាជិកក្រុមប្រាស់ក្រុមប៉ុនការងារ សូមទូរស័ព្ទមកលេខ 800-522-0088 ។ សមាជិក PPO : សំរាប់ជំនួយបន្ថែម សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រង នៃរដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357 ។ សមាជិក HMO : សំរាប់ជំនួយបន្ថែម សូមទូរស័ព្ទទៅក្រសួងគ្រប់គ្រងសុខាភិបាល ខែរដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-888-HMO-2219 ។ **Khmer**

خدمات ترجمة بدون تكلفة يمكنك الاستعانة بمترجم. يمكنك طلب قراءة وثائق وإرسال بعضها لك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك (ID) بالنسبة للأفراد وأعضاء الأسرة أو أعضاء Farm Bureau رجاء الاتصال بالرقم 800-839-2172. وبالنسبة لأعضاء مجموعات صاحب العمل رجاء الاتصال بالرقم 800-522-0088. أعضاء PPO للحصول على المساعدة الإضافية يرجى الاتصال بالخط الخاص بإدارة التأمين الصحي لولاية كاليفورنيا على الرقم 1-800-927-4357. أعضاء HMO: للحصول على المساعدات الإضافية يرجى الاتصال بخط المساعدة لـ Department of Managed Health Care على الرقم 1-888-HMO-2219. **Arabic**

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi. Koj kom muaj ib tug neeg txhais lus rau koj los tau. Koj kom nyeem cov ntaub ntawv thiab xa ib co ntaub ntawv ua koj hom lus tuaj rau koj los tau. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID. Rau cov tswv cuab hauv pawg Tus Kheej thiab Tsev Neeg los sis Farm Bureau thov hu rau 800-839-2172. Cov tswv cuab hauv pawg tom chaw ua hauj lwm thov hu rau 800-522-0088. Cov tswv cuab hauv PPO: yog xav tau kev pab ntxiv hu rau CA Lub Koom Haum Saib Xyuas Txog Kev Tuav Pov Hwm ntawm 1-800-927-4357. Cov tswv cuab hauv HMO: yog xav tau kev pab ntxiv hu rau Lub Caj Meem Fai Saib Xyuas Txog Kev Tswj Txoj Kev Kho Mob (Department of Managed Health Care) HMO Tus Xov Tooj Muab Kev Pab ntawm 1-888-HMO-2219. **Hmong**

ບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດໄດ້ຮັບບໍລິການແປພາສາແລະມີຜູ້ອ່ານເອກກະສານໃຫ້ທ່ານຟັງເປັນພາສາຂອງທ່ານເອງ. ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມໝາຍເລກທີ່ລະບຸໄວ້ໃນບັດປະກັນໄພຂອງທ່ານ. ຂໍໃຫ້ສະມາຊິກລາຍບຸກຄົນແລະຄອບຄົວ ຫລືສະມາຊິກ Farm Bureau ໂທຕາມໝາຍເລກ 800-839-2172. ຂໍໃຫ້ສະມາຊິກການລູກຈ້າງໂທຕາມໝາຍເລກ 800-522-0088. ສະມາຊິກ PPO: ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອເພີ່ມຕື່ມ ໃຫ້ໂທໄປຫາກົມປະກັນໄພແຫ່ງລັດຄາລິຟໍເນຍຕາມໝາຍເລກ 1-800-927-4357. ສະມາຊິກ HMO: ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອເພີ່ມຕື່ມ ໃຫ້ໂທຕາມສາຍດ່ວນ HMO ແຫ່ງກົມກຳກັບລະບົບຄຸ້ມຄອງການຮັກສາສຸຂະພາບ (Department of Managed Health Care) ຕາມໝາຍເລກ 1-888-HMO-2219. **Laotian**

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