

Small Business Group
SELECT POS 20· Plan 550

Summary of

benefits

and Disclosure Form

Dear Prospective Health Net Member,

Thank you for considering Health Net as your health care plan. We look forward to the opportunity to care for your family should you select our plan. This Health Net Summary of Benefits has all the information you need to learn about receiving care with coverage from Health Net. Please review it carefully.

At Health Net, we work hard to make sure that our members get the care they need when they need it. We are always working to make medical care delivery better through our health plan.

Remember, if you have further questions about Health Net, call the Member Services Department at **1-800-361-3366**. We're always glad to help.

Thank you for considering Health Net!

Delivering choices

When it comes to your health care, the best decisions are made with the best choices. Health Net of California, Inc. (Health Net) provides you with ways to help you receive the care you deserve. This Summary of Benefits / Disclosure Form (SB/DF) answers basic questions about this versatile plan. If you have further questions, just contact the Member Services Department at **1-800-361-3366**. Our friendly, knowledgeable representatives will be glad to help.

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

Table of contents

- How the plan works 3
- Schedule of benefits and coverage..... 5
- Limits of coverage 11
- Benefits and coverage..... 12
- Utilization management processes..... 15
- Payment of fees and charges 16
- Facilities..... 18
- Renewing, continuing or ending coverage..... 19
- If you have a disagreement with our plan 21
- Additional plan benefit information..... 23
- Behavioral health services 23
- Prescription drug program 24

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). See your Health Net Directory of Contracting Physician Groups for detailed information about physicians and physician groups in the Health Net network. The provider directory is also available on the Health Net website at www.healthnet.com under "DocSearch."
- You do not have to choose the same physician group or PCP for all members of your family. The names of physicians and specialists, are listed in the Health Net Directory of Contracting Physician Groups.
- 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)

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

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

Specialists and Referral Care (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. Your physician group must authorize all treatments recommended by such provider.

HMO specialist access

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

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 your EOC and that you or your family member might need:

- Family planning;
- Contraceptive services; including emergency contraception;
- Sterilization, including tubal ligation at the time of labor and delivery;
- 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 Member Services Department at 1-800-361-3366 to ensure that you can obtain the health care services that you need.

This plan provides benefits required by the Newborns' and Mothers' Health Protection Act of 1996 and the Woman's Health and Cancer Right Act of 1998.

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.

Use this matrix to compare different coverage and benefit levels. This matrix is a summary only. The EOC and plan contract should be consulted for a detailed description of coverage benefits and limitations.

Medical benefits

Benefit levels	HMO ¹	PPO ¹	OON ²
<p>Features</p> <p>(For details on actual costs, see "Schedule of benefits and coverage" section)</p>	<p>(Primary Care Physician) Care provided or authorized by your PCP or physician group contracted with Health Net.</p>	<p>(Participating or Preferred providers) Care provided by a broader network of doctors and specialists contracted with Health Net.</p>	<p>(Out-of-Network providers) Care provided by any licensed physician not contracted with Health Net.</p>
	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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
<p>Deductibles</p>	<p>HMO¹</p>	<p>PPO¹</p>	<p>OON²</p>
<p><i>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 for covered services will also apply to the PPO deductible.</i></p>			
<p>Calendar year deductible</p>			
<p>Per member³</p>	<p>None</p>	<p>\$200</p>	<p>\$400</p>
<p>Per family³</p>	<p>None</p>	<p>\$600</p>	<p>\$1,200</p>

Plan maximums	HMO ¹	PPO ¹	OON ²
Calendar Year Out-of-Pocket Maximum (OOPM)^{3,4}			
Once your payments for covered services for each benefit level equals the amount shown below in any one calendar year, no additional copayment or coinsurance for covered services are required for the remainder of that calendar year for that benefit level. 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 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. You will need to continue making payments for any additional benefits as described in the "Additional plan benefit information" section of this SB/DF.			
One member	\$2,000	\$3,500	\$5,000
Two members	\$4,000	\$7,000	\$10,000
Family	\$6,000	\$10,500	\$15,000

Lifetime maximum

(Benefits for covered expenses incurred by you are limited to a maximum amount, shown below, during your lifetime.)

For each member ³	None	\$5,000,000 ³	\$5,000,000 ³
------------------------------	------	--------------------------	--------------------------

Type of service, benefit maximums and what you pay	HMO ¹	PPO ¹	OON ²
Professional services			
Visit to physician	\$20	\$35	40%
Visit to physician for treatment of severe mental illness or serious emotional disturbances of a child ^{5***}	\$20	Not covered	Not covered
Specialist consultations ⁶	\$20	\$35	40%
Physician visit to a member's home (at your physician's discretion and in accordance with criteria set by Health Net)	\$40	\$50	40%
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders)	Covered in full	20%	40%
Immunizations (occupational or foreign travel purposes)	20%	Not covered	Not covered
Allergy injection services	Covered in full	20%	40%
Allergy testing	Covered in full	\$35	40%
Allergy serum	Covered in full	20%	40%
Self injectable drugs	30%	30%	40%
All other injections (excluding infertility injection)	Covered in full	20%	40%
Surgeon or assistant surgeon services ^{7,8}	Covered in full	20%	40%
Administration of anesthetics	Covered in full	20%	40%
X-ray and laboratory procedures ⁸	Covered in full	20%	40%
Rehabilitative therapy (including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)	Covered in full	\$35	40%
<i>Calendar year maximum³</i>	<i>Unlimited</i>	<i>60 visits</i>	<i>60 visits</i>
Adult preventive care			
Periodic health evaluations, including well-woman exam (age 18 and older) ^{6,9}	\$20	\$35	Not covered

Vision and hearing examinations (age 18 and older)	\$20	Not covered	Not covered
Immunizations (age 18 and older)	Covered in full	\$35	Not covered
Child preventive care			
Periodic health evaluations, including newborn, well-baby care and immunizations (birth through age 17) ^{6,9}	\$20	\$35	40%
Vision and hearing examinations (birth through age 17)	\$20	Not covered	Not covered
Family planning (professional services)¹⁰			
Prenatal and postnatal office visits	\$20	20%	40%
Normal delivery, cesarean section, newborn inpatient professional care ⁸	Covered in full	20%	40%
Treatment of complications of pregnancy, including medically necessary abortions ⁸	Covered in full	20%	40%
Elective abortions	\$150	50%	50%
Genetic testing of a fetus	Covered in full	20%	40%
Circumcision of newborn males	Covered in full	20%	40%
Injectable contraceptives (including but not limited to Depo Provera)	Covered in full	20%	40%
Infertility services and supplies (including injections related to covered infertility services)	50%	Not covered	Not covered
Sterilization			
Vasectomy	\$50	\$100	Not covered
Tubal ligation	\$150	\$300	Not covered
Hospitalization services			
Semi-private hospital room or intensive care unit with ancillary services, including delivery and maternity care (unlimited days) ⁸	\$250	20%	40%
<i>Maximum allowable amount per day</i>	<i>Unlimited</i>	<i>Unlimited</i>	<i>\$1,000</i>
Semi-private hospital room or intensive care unit with ancillary services for treatment of severe mental illness or severe emotional disturbances of a child ^{5,11}	\$250	Not covered	Not covered
Hospitalization for infertility services	50%	Not covered	Not covered
Skilled nursing facility stay ⁸	\$250	20%	40%
<i>Calendar year maximum³</i>	<i>100 days</i>	<i>60 days</i>	<i>60 days</i>
Outpatient facility services (other than surgery) ⁸	Covered in full	20%	40%
Outpatient surgery (hospital or outpatient surgery center charges only) ⁸	\$250	20%	40%
Emergency health coverage			
Emergency room (facility charges) ^{12,11}	\$100	\$150	40%
Urgent care (facility charges) ^{12,11}	\$50	\$100	40%
Professional services in an emergency room or urgent care facility ¹²	Covered in full	20%	40%

Ground ambulance <i>Maximum per incident</i> ³	Covered in full <i>Unlimited</i>	20% <i>75 miles</i>	40% <i>75 miles</i>
Air ambulance ⁸ <i>Maximum per incident</i> ³	Covered in full <i>Unlimited</i>	20% <i>\$750</i>	40% <i>\$750</i>
Other services			
Durable medical equipment ⁸ <i>Calendar year maximum</i> ³	Covered in full <i>No maximum</i>	20% <i>\$2,000</i>	40% <i>\$2,000</i>
Diabetic equipment (Coverage under the medical benefit includes blood glucose monitors, insulin pumps and podiatric devices. See the "Prescription Drug Program" section of the SB/DF for diabetic supplies benefit information.) ^{8, 13}	Covered in full	20%	40%
Chiropractic care <i>Calendar year maximum</i> ³	\$20 <i>Unlimited</i>	20% <i>15 visits</i>	40% <i>15 visits</i>
Prosthetic devices ⁸	Covered in full	50%	Not covered
Blood, blood plasma, blood derivatives and blood factors	Covered in full	20%	40%
Nuclear medicine	Covered in full	20%	40%
Organ and bone marrow transplants (nonexperimental and noninvestigational) ⁸	Covered in full	20%	Not covered
Chemotherapy	Covered in full	\$35	40%
Renal dialysis	Covered in full	\$35	40%
Home health visits, part-time or intermittent care only (Through HMO and PPO, the copayment starts the 31 st calendar day after the first visit. Through OON, the coinsurance is applicable as of the first visit.) ⁸ <i>Calendar year maximum</i> ³	\$20 <i>Unlimited</i>	\$35 <i>100 visits</i>	40% <i>100 visits</i>
Hospice services ⁸	Covered in full	20%	40%

Additional plan benefit information (supplemental)

Behavioral health services

Benefits are administered by Managed Health Network (MHN). Please refer to the "Behavioral health services" section of this SB/DF for the definitions, benefits and limitations.

Nonsevere mental disorder benefits^{5***}

Outpatient consultation (20-visit maximum each calendar year)^{5†}:

Individual session

\$30

Group session

\$15

Inpatient (30-day maximum each calendar year)^{5**}

\$250

Chemical dependency benefits

Acute care detoxification

\$250

Prescription drugs ⁴

Please refer to the "Prescription drug program" section of this SB/DF for the definitions, benefits and limitations.

Retail pharmacy (up to a 30-day supply)¹⁴

Level I drugs listed on the Health Net Recommended Drug List (primarily generic)	\$15
Level II drugs listed on the Health Net Recommended Drug List (primarily brand name) and diabetic supplies (including insulin) ¹⁵	\$30
Level III drugs (drugs not listed on the Health Net Recommended Drug List) ¹⁵	\$50
Lancets	Covered in full
Smoking cessation drugs (covered up to a 12-week course of therapy per calendar year if you are currently enrolled in a comprehensive smoking cessation program) ¹⁷	50%
Contraceptive devices	\$30
Sexual dysfunction drugs, including injections (limited to two doses per week or eight tablets per month) ¹⁶	50%

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

Level I drugs listed on the Health Net Recommended Drug List (primarily generic)	\$30
Level II drugs listed on the Health Net Recommended Drug List (primarily brand name) and diabetic supplies (including insulin) ¹³	\$60
Level III drugs (drugs not listed on the Health Net Recommended Drug List) ¹⁵	\$100
Lancets	Covered in full

The HMO level of benefits of this plan provide coverage required by the Newborns' and Mothers' Health Protection Act of 1996 and the Women's Health and Cancer Right Act of 1998. Specifically, the Newborns' and Mothers' Health Protection Act requires group health plans to provide a minimum hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after delivery by cesarean section unless the attending physician, in consultation with the mother, determines a shorter hospital length of stay is adequate. If you are discharged earlier, your Physician may decide, at his or her discretion, that you should be seen at home or in the office, within 48 hours of the discharge, by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The Women's Health and Cancer Right Act of 1998 applies to medically necessary mastectomies and requires coverage for prosthetic devices and reconstructive surgery on either breast provided to restore and achieve symmetry.

Endnotes:

- For the HMO level of benefits, the percentages that appear in this matrix are based on amounts agreed to in advance by Health Net and the member's medical group or other authorized health care providers. For the PPO level of benefits, the percentages that appear in this chart are based on allowable charges and contracted rates with providers.
- For Out-of-Network level of benefits, the percentages that appear in this chart are based on Customary and Reasonable (C&R) charges (what is typically charged in the geographic area where services are provided). The member is responsible for charges in excess of C&R fees in addition to the coinsurance shown even after the out-of-pocket-maximum has been reached.
- Combined for PPO and Out-of-Network.
- 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 diabetic supplies), chiropractic, acupuncture 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; or services for which certification was required but not obtained.

- ⁵ Please refer to the "Behavioral health services" section of this SB/DF for the definitions of severe mental illness and serious emotional disturbances of a child and for non severe mental disorder benefits. Benefits are administered through Managed Health Network (MHN).
- * Applicable only for outpatient counseling defined as individual office visits and group therapy sessions. Group sessions are equal to half of an individual session and count towards the visit maximum. In addition, outpatient mental health and chemical dependency are limited to a combined maximum number of visits each calendar year.
 - **Inpatient admission means any admission to a hospital, day treatment program, residential treatment center or structured outpatient program. In addition, inpatient mental health and chemical dependency are limited to a combined maximum number of days each calendar year.
 - ***The mental disorder copayments and day or visit limits will not apply for severe mental illness or serious emotional disturbances of a child as defined. Services for these conditions require whatever copayment would be required if the services were provided for a medical condition. Refer to the "Schedule of benefits and coverage" section of this SB/DF to determine the applicable copayment. All other mental disorders will be subject to the copayments shown under the heading "Non severe mental disorder services."
- ⁶ 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.
- ⁷ Surgery includes surgical reconstruction of a breast incident to mastectomy, including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema. While Health Net and your physician group will determine the most appropriate services, the length of hospital stay will be determined solely by your PCP.
- ⁸ 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. If certification is required but not obtained, your benefit reimbursement level will be reduced, both in-network and out-of-network, to 50% of covered expenses and a \$250 penalty will also be charged for each inpatient admission. Maternity care and dialysis services do not require certification, however please notify Health Net upon initiation of dialysis services or at the time of the first prenatal visit.
- ⁹ For preventive health purposes, a periodic health evaluation and diagnostic preventive procedures are covered, based on recommendations published by the U.S. Preventive Services Task Force.
- ¹⁰ These copayments apply to professional services only. Services that are rendered in a hospital are also subject to the hospital services copayment. See "Hospital services" in this section to determine if any additional copayments may apply.
- ¹¹ Copayments for emergency room and urgent care center visits will not apply if the member receives care from a facility owned and operated by the member's physician group or if admitted as an inpatient directly from the emergency room or urgent care center. A visit to one of the physician group's facility will be considered an office visit and the office visit copayment, if any will apply.
- ¹² 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.
- ¹³ Diabetic equipment covered under the medical benefit includes blood glucose monitors (limited to specific brands), insulin pumps and podiatric devices
- ¹⁴ Members may purchase covered prescription drugs at a nonparticipating pharmacy located outside of California or a Health Net participating pharmacy. When prescription drugs are dispensed by a nonparticipating pharmacy, each member is responsible for a \$100 deductible per calendar year, a 50% copayment per prescription and any charges in excess of the prescription drug covered expenses (the lesser of the maximum allowable cost or the average wholesale price). However, in an emergency or urgent care situation, the member is only responsible for the applicable deductible and the copayment.
- ¹⁵ Generic drugs will be dispensed when a generic drug equivalent is available. If the member requests a brand name drug when a generic equivalent is available, the member must pay the difference between the generic equivalent and the brand name drug plus the Level I drug copayment. However, if the prescription drug order states "dispense as written," "do not substitute" or words of similar meaning in the physician's handwriting, only the Level II or Level III drug copayment, as appropriate will be applicable.
- ¹⁶ Drugs prescribed for treating sexual dysfunction are covered when medically necessary, and are limited to two doses per week or eight tablets per month.
- ¹⁷ Must be approved by Health Net and the member's physician group. These drugs are not covered when prescribed by a physician under the PPO and OON levels of benefits.

Limits of coverage

What's not covered (exclusions and limitations)

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

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 include¹:

Inpatient admissions, any facility²

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

Ambulance

- Air Ambulance

Ambulatory services

- Durable Medical Equipment over the purchase price or the per month rental price of \$500
- Home Health Care Agency Services including nursing, physical therapy, occupational therapy, speech therapy, home I.V. therapy, Hospice Care, tocolytic services (intravenous drugs used to decrease or stop uterine contractions in premature labor) and home uterine monitoring
- Prosthesis or orthotics over \$500

Orthognatic procedures (surgery performed to correct or straighten jaw and/or other facial bone misalignments to improve function.)

Outpatient Diagnostic Imaging:

- MRI (Magnetic Resonance Imaging)
- MUGA Cardiac Scan (Multiple Gated Acquisition)
- PET (Positron Emission Tomography)
- SPECT (Single Photon Emission Computed Tomography)

Surgical procedures including:

- Abdominal, ventral, umbilical, incisional hernia repair
- Blepharoplasty
- Breast reductions
- Rhinoplasty
- Sclerotherapy
- Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP

Transplant-related services including pre-evaluation and pre-treatment services, and the transplant procedure

¹ For groups effective October 1st 2004 and later, in addition to the above list, the following services will also require Certification in the manner described in your *Evidence of Coverage*:

Non-emergent ambulance transport; All Durable Medical Equipment; Prosthesis for major limbs; Experimental services; New technology and evolutionary changes in proven technology; CT Scans; MRA (Magnetic Resonance Angiography); Breast augmentations; Mastectomy for gynecomastia; and Temporomandibular Joint (TMJ) Disorder treatment.

²Certification is not required for the length of a hospital stay for reconstructive surgery incident to a mastectomy. 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.

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 you are injured, feel severe pain, begin active labor or experience an unexpected illness that a reasonable person with an average knowledge of health and medicine would believe requires immediate treatment to prevent serious threat to your health (including severe mental illness and serious emotional disturbances of a child), seek care where it is immediately available. Depending on your circumstances, you may seek this care by going to your physician group (medical) or the Behavioral Health Administrator (mental illness and chemical dependency), or to the nearest emergency facility or by calling **911**.

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

All follow-up care (including severe mental illness and serious emotional disturbances of a child) after the urgency has passed and your condition is stable, must be provided or authorized by your physician group (medical) or the Behavioral Health Administrator (mental illness and chemical dependency); in order to receive the highest level of care benefits under this plan.

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 your EOC; any other services or supplies are not covered.

Second opinions

You have the right to request a second opinion when:

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

To obtain a copy of Health Net's second opinion policy, contact the Health Net Member Services Department at **1-800-361-3366**.

Clinical trials

Routine patient care costs for patients diagnosed with cancer 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 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.

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

Confidentiality and release of member information

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

Privacy practices

For description of how protected health information (including but not limited to medical records, enrollment data and claims information) about you may be used and disclosed, and how you can get access to this information, please see the notice of privacy practices in your plan EOC. The notice of privacy practices is also available on the Health Net website at www.healthnet.com under "Privacy Information" or you may contact the Member Services Department at 1-800-361-3366 to obtain a copy.

Technology assessment

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

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

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

Utilization management processes

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

Pre-Authorization

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

Concurrent Review

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

Discharge Planning

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

Retrospective Review

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

Care or Case Management

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

If you would like additional information regarding Health Net's utilization management process, please call the Health Net Member Services Department at **1-800-361-3366**.

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

Other charges

You are responsible for payment of your share of the cost of services covered by this plan. Amounts paid by you are 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.

When the total amount of HMO, PPO and OON copayments and coinsurance paid equals the out-of-pocket maximum (OOPM), you will not have to pay additional copayments or coinsurance for the rest of the year, for most services provided or authorized by your HMO physician group and authorized services 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 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 Customary and Reasonable fees (Out-of-Network benefit level only);
- Services for which the member is required to pay a 50 percent coinsurance;
- Services for which certification was required but not obtained; and
- Payment for services not covered by this plan.

Coordination of benefits

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

Medicare coordination

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

Liability of subscriber or enrollee for payment

If you receive health care services from doctors without receiving required authorization from your PCP or physician group, 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 Physician Groups* for a full listing of Health Net–contracting physicians.

Third-party liability

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

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 Member Services Department 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 Member Services Department at **1-800-361-3366** to obtain claim forms, and to find out whether you should send the completed form to your physician group (medical) or the Behavioral Health Administrator (mental illness and chemical dependency) or to Health Net. Medical claims must be received by Health Net within one year of the date of service to be eligible for reimbursement. If you need to file a claim for

Mental Disorders and Chemical Dependency emergency services or for services authorized by MHN, you must file the claim with MHN. You must use MHN's forms in filing the claim, and you should send the claim to MHN at the address listed on the claims form or to MHN at:

Managed Health Network
P.O. Box 14621
Lexington, KY 40512-4621

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 Member Services Department at **1-800-361-3366** and request information 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 selected 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 *Health Net Directory of Contracting Physician Groups*.

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 *Health Net Directory of Participating Physician Groups*.

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 contact the Health Net Member Services Department at **1-800-361-3366**.)

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.

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.

In addition, a member 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;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- A newborn (up to age 36 months);
- A terminal illness;
- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment.

If you would like more information on how to request continued care or to request a copy of Health Net's continuity of care policy, please contact the Health Net Member Services Department at **1-800-361-3366**.

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.

Small employer Cal-COBRA coverage

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

Individual continuation of benefits

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

- COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). 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 are eligible.
- Cal-COBRA Continuation Coverage. If you began receiving federal COBRA coverage on or after January 1, 2003, have exhausted federal COBRA coverage and have had less than 36 months of COBRA coverage, you have the opportunity to continue group coverage under this plan through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.
- Additional COBRA-like Coverage ("Senior"-COBRA): California law provides that an employee and his or her spouse who elected COBRA or Cal-COBRA coverage following termination of employment may be entitled to additional COBRA-like coverage.

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

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

- **USERRA Coverage:** Under a federal law known as the Uniformed Services Employment and Reemployment Rights Act (USERRA), employers are required to provide employees who are absent from employment to serve in the uniformed services and their dependents who would lose their group health coverage the opportunity to elect continuation coverage for a period of up to 18 months. Please check with your Group to determine if you are eligible.
- **HIPAA Guaranteed Issue Coverage:** The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people covered under existing group health plans to maintain coverage regardless of pre-existing conditions when they change jobs or are unemployed for brief periods of time. California law provides similar and additional protections. Applicants who meet the following requirements are eligible to enroll in a guaranteed issue individual health plan from any health plan that offers individual coverage, including Health Net's Guaranteed HMO Plans, without medical underwriting. A health plan cannot reject your application for guaranteed issue individual health coverage if you meet the following requirements, agree to pay the required premiums and live or work in the plan's service area. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance. To be considered an eligible individual:
 1. The applicant must have a total of 18 months of coverage (including COBRA, if applicable) without a significant break (excluding any employer-imposed waiting periods) in coverage of more than 63 days.
 2. The most recent coverage must have been under a group health plan. COBRA and Cal-COBRA coverage are considered group coverage.
 3. The applicant must not be eligible for coverage under any group health plan, Medicare or Medicaid, and must not have other health insurance coverage.
 4. The individual's most recent coverage could not have been terminated due to fraud or nonpayment of premiums.
 5. If COBRA or Cal-COBRA coverage was available, it must have been elected and such coverage must have been exhausted.

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

Also, if you become ineligible for group coverage you may convert from group coverage to a type of individual coverage called conversion coverage. Application must be made within 63 days of the date group coverage ends. Please contact Health Net Member Services Department at **1-800-361-3366** for information about conversion plan coverage. Furthermore, you may be eligible for continued coverage for a disabling condition (for up to 12 months) if your employer terminates its agreement with Health Net. Please refer to the "Extension of benefits" section of this SB/DF for more information.

Termination of benefits

Health Net can terminate your coverage when:

- The agreement between the employer covered under this 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
- The employer covered under this Health Net SELECT POS Plan fails to pay subscription charges.

Also, coverage under this Health Net SELECT POS Plan may be terminated upon the date the notice of termination is mailed for an enrollee who:

- Repeatedly or materially disrupts the operations of the physician group or Health Net to the extent that your behavior substantially impairs Health Net's ability to furnish or arrange services for you or other Health Net members, or the physician's office or contracting physician group's ability to provide services to other patients;
- Threatens the safety of the health care provider, his or her office staff, the contracting physician group or Health Net personnel if such behavior does not arise from a diagnosed illness or condition; or
- Knowingly omits or misrepresents a meaningful fact on your enrollment form or fraudulently or deceptively uses services or facilities of Health Net, its contracting Physician Group or other contracting providers (or knowingly allow another person to do so), including altering a prescription.

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

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

- You apply for conversion coverage within 63 days of that date;
- You are hospitalized (coverage will continue until you are discharged from the hospital); or
- You are totally disabled and apply for an extension of benefits for the disabling condition within 90 days.

If you have a disagreement with our plan

The California Department of Managed Health Care is responsible for regulating health care service plans. (Health Net is a health care service plan)

If you have a grievance against Health Net, you should first telephone Health Net at **1-800-361-3366**, 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.

To file a grievance or appeal you may call **1-800-361-3366** 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 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 your plan's EOC.

Behavioral health services

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

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 is located in the plan's service area. If you would like more information on how to request continued care, or to request a copy of our continuity of care policy, please call the Health Net Member Services Department at **1-800-361-3366**.

Serious emotional disturbances of a child

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

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

Severe mental illness

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

Continuation of treatment

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

Health Net and your EAP

If your employer offers an Employee Assistance Program (EAP), Health Net's mental health and chemical dependency program works in coordination with your company's EAP. You may be able to obtain a referral

to a network provider from either the mental health and chemical dependency program or with the assistance of your EAP counselor.

What's not covered (exclusions and limitations)

Services or supplies excluded under behavioral health services may be covered under the medical benefits portion of your plan. Consult your plan's EOC for more information.

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

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

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

Prescription drug program

Health Net is contracted with many major 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 under the Pharmacy Info portal or call the Health Net Member Services Department at **1-800-361-3366**.

Prescriptions by Mail Drug Program

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period), you have the option of filling it through our convenient Prescriptions By Mail Drug Program. This program allows you to receive up to a 90-consecutive-calendar-day supply of maintenance medications. For complete information, call the Health Net Member Services Department at **1-800-361-3366**.

Note: Schedule II narcotic drugs are not covered through mail order. For further information, please refer to the EOC.

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

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

We specifically suggest to all Health Net contracting PCP's 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 Member Services Department at 1-800-361-3366.

Drugs not on the List: Level III drugs

Level III drugs are prescription drugs that are not listed on the Recommended Drug List and are not excluded from coverage. Some Level III drugs require prior authorization from Health Net.

What is "prior authorization?"

Some prescription medications require prior authorization. This means that your doctor must contact Health Net in advance to provide the medical reason for prescribing the medication. Urgent requests from physicians are handled in a timely fashion, not to exceed 72 hours, as appropriate and medically necessary, for the nature of the member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 5 days, as appropriate and medically necessary, for the nature of the member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination. Upon receiving your physician's request for prior authorization, Health Net will evaluate the information submitted and make a determination based on established clinical criteria for the particular medication.

The criteria used for prior authorization are developed and based on input from the Health Net P&T Committee as well as physician specialist experts. Your physician may contact Health Net to obtain the usage guidelines for specific medications.

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

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

To submit an appeal:

- Call the Health Net Member Services Department at **1-800-361-3366**;
- Visit www.healthnet.com for information on e-mailing the Health Net Member Services Department; or
- Write to:
Health Net Member Services
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 copayments.

Outpatient prescription medication:

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

Note:

- Prescription drug covered expenses for participating pharmacies are the lesser of Health Net's contracted pharmacy rate or the pharmacy's usual and customary charges 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 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. 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 usual and customary charge is less than the applicable copayment; the member will pay the pharmacy's usual and customary charge;
- Mail order drugs are covered up to a 90-consecutive-calendar-day supply. 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;
- Oral contraceptives and emergency contraceptives are covered. Vaginal contraceptives are limited to diaphragms and cervical caps and are only covered when a physician performs a fitting examination and prescribes the device. Such devices are only available through a prescription from a pharmacy and are limited to one fitting and prescription per calendar year, unless additional fittings or devices are medically necessary. Injectable contraceptives are covered when administered by a physician. Refer to your plan's EOC for information on contraceptives covered under the medical benefit. If your physician determines that none of the methods specified as covered by the plan are medically appropriate, then the plan will provide coverage for another FDA prescription or contraceptive method as prescribed by your physician;
- Diabetic supplies (blood glucose testing strips, lancets, needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (that is opened in order to dispense the product in quantities other than those packaged). When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times your physician has prescribed for a 30-day period.

What's not covered (exclusions and limitations)

Services or supplies excluded under pharmacy services may be covered under the medical benefits portion of your plan. Consult your plan's EOC for more information.

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

- Allergy serum. (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 and diabetic supplies. No other devices are covered even if prescribed by a participating physician;
- Drugs that require a prescription in order to be dispensed for the relief of nicotine withdrawal symptoms are covered up to a twelve week course of therapy per calendar year if the member is concurrently enrolled in a comprehensive smoking cessation behavioral support program. The prescribing physician must request prior authorization for coverage. For information regarding smoking cessation behavioral support programs available through Health Net, contact Member Services at the telephone number on your Health Net ID card or visit the Health Net website at www.healthnet.com (see "Wellsite");
- Drugs that are prescribed for the treatment of obesity are not covered, except 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 reusable 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 standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If medically necessary, your physician may request a larger quantity from Health Net;
- Medical equipment and supplies (including insulin), that are available without a prescription are covered when prescribed by a physician for the management and treatment of diabetes. Any other nonprescription drug, medical equipment or supply that can be purchased without a prescription drug order is not covered even if a physician writes a prescription drug order for such drug, equipment or supply. However, if a higher dosage form of a prescription drug or over-the counter (OTC) drug is only available by prescription, that higher dosage drug will be covered. If a drug that was previously available by prescription becomes available in an OTC form in the same prescription strength, then any prescription drugs that are similar agents and have comparable clinical effect(s) will only be covered when medically necessary and prior authorization is obtained from Health Net;
- Prescription drugs filled at pharmacies 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 your plan's EOC to determine the exact term and conditions of your coverage.

For more information, please contact us at:

Health Net
Post Office Box 10348
Van Nuys, California 91409-10348

Member Services

1-800-522-0088 – HMO/Elect Open Access

1-800-676-6976 – PPO/Point-of-Service

(SELECT/ELECT)

Spanish

1-800-331-1777

Mandarin

1-877-891-9053

Cantonese

1-877-891-9050

Korean

1-877-339-8596

Tagalog

1-877-891-9051

Vietnamese

1-877-339-8621

**Telecommunications Device
for the Hearing Impaired**

1-800-995-0852

www.healthnet.com