SUMMARY OF BENEFITS AND DISCLOSURE FORM

Health Net Seniority Plus•Plan 3LQ

Table of contents

Introduction to the Summary of Benefits

Thank you for your interest in Health Net Seniority Plus (Employer HMO). Our Plan is offered by Health Net of California, Inc. (Health Net), a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits and Disclosure Form (SB/DF) tells you some features of our Plan. It doesn't list every service that we cover, or every limitation or exclusion. To get a complete list of our benefits, please call Health Net Seniority Plus and ask for the "Evidence of Coverage." The information in this SB/DF is subject to change. The Evidence of Coverage contains the exact terms and conditions of your coverage.

How does Health Net Seniority Plus (Employer HMO) work for you?

The Centers for Medicare and Medicaid Services (CMS), with which Health Net contracts, pays a fixed monthly amount for each person who enrolls in Health Net Seniority Plus (Employer HMO), whether or not the enrollee uses medical services. In exchange for this payment, Health Net will provide each Seniority Plus member with all of the services he or she is entitled to under Medicare as well as many extras through Health Net Seniority Plus (Employer HMO).

You have choices in your health care

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Health Net Seniority Plus (Employer HMO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call Health Net Seniority Plus (Employer HMO) at the telephone number listed at the end of this introduction or **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day/7 days a week, for more information. TTY users should call **1-877-486-2048**.

How can I compare my options?

You can compare Health Net Seniority Plus (Employer HMO) and the Original Medicare Plan using this SB/DF. The charts in this SB/DF list some important health benefits. For each benefit, you can see what our Plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

Where is Health Net Seniority Plus (Employer HMO) available?

The service area for this Plan includes the following counties: Alameda, Contra Costa, Kern, Los Angeles, Orange, Placer*, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara*, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Yolo Counties, CA. You must live in one of these places to join the plan.

Placer* County Plan. The * indicates a partial county, in which you must live in one of the following zip codes to join the plan: 95602, 95603, 95604, 95631, 95648, 95650, 95658, 95661, 95663, 95677, 95678, 95681, 95701, 95703, 95713, 95714, 95715, 95717, 95722, 95736, 95746, 95747, 95765.

Santa Barbara* County Plan. The * indicates a partial county, in which you must live in one of the following zip codes to join the plan: 93013, 93014, 93067, 93101, 93102, 93103, 93105, 93106, 93107, 93108, 93109, 93110, 93111, 93116, 93117, 93118, 93120, 93121, 93130, 93140, 93150, 93160, 93190, 93199, 93252, 93427, 93436, 93437, 93438, 93440, 93441, 93460, 93463, 93464.

Can I choose my doctors?

Health Net Seniority Plus has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list. Our number is listed at the end of this introduction.

How to see your Primary Care Physician (PCP)

Simply call the contracting physician group or your Primary Care Physician (PCP) indicated on your Seniority Plus ID card that you selected and schedule an appointment — just as you've always done. On the day of your office visit, you'll be asked to show your Seniority Plus ID card. That's it.

If it becomes necessary to change your PCP — for example, if you move, or if you decide you'd prefer to see another PCP — you can always select a new PCP from a contracting physician group. Just call Health Net Seniority Plus (Employer HMO) Member Services Department for assistance. Health Net Seniority Plus (Employer HMO) Member Services will be able to make the PCP change for you and tell you when the change becomes effective.

The continued Seniority Plus participation of any participating provider cannot be guaranteed.

Transfers

Transfers between contracting physician groups can be made by notifying the Health Net Seniority Plus (Employer HMO) Member Services Department. Our number is listed at the end of this introduction.

Referrals to specialty care

If you need any specialist services, your PCP will refer you to a specialist. In this way, your personal PCP works with you and the specialist to be certain your care is coordinated and you receive timely and appropriate care. Information about your contracting physician group's referral policies is also available to you on our Internet website, www.healthnet.com.

To get more information regarding benefits that require no referral, please see your "Evidence of Coverage."

Second Opinion

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 the treatment you 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 learn more about Health Net Seniority Plus (Employer HMO)s second opinion policy, contact the Health Net Seniority Plus (Employer HMO) Member Services Department. Our number is listed at the end of this introduction.

You agree to use Plan providers

Health Net Seniority Plus (Employer HMO) shares an important requirement common among Medicare Advantage HMO Plans. This requirement is known as the "lock-in feature." When you become a Health Net Seniority Plus (Employer HMO) member, you agree to receive all your routine medical services, except for emergency, out-of-area urgent care (or, in area under unusual and extraordinary circumstances), or out-of-area renal dialysis from a Seniority Plus contracting physician in one of our contracting physician groups. If you go to a doctor, hospital, or other provider without the approval of your PCP --except for emergency or urgently needed care, out-of-area renal dialysis, or specific limited self-referral services (as indicated within this SB/DF)-- you will be responsible for paying all charges for these services. Neither Original Medicare nor Health Net will pay for them.

What happens if I go to a doctor who's not in your network?

If you choose to go to a doctor outside our network, you must pay for these services yourself. Neither Health Net of California nor the Original Medicare Plan will pay for these services.

PLEASE NOTE:

If you currently are a member of a Medicare Advantage (MA) plan, you must sign up for your Medicare Part D pharmacy plan through your MA plan. If you sign up for a different Medicare Part D pharmacy plan, Medicare automatically will disenroll you from your current MA plan.

Where can I get my prescriptions if I join this Plan?

Health Net Seniority Plus (Employer HMO) has formed a network of pharmacies. You can use any pharmacy in our network. The pharmacies in our network can change at any time. You can ask for a current Pharmacy Network List. Our number is listed at the end of this introduction.

What happens if I go to a pharmacy that's not in your network?

If you go to a pharmacy that's not in our network, you might have to pay more for your prescriptions. You also might have to follow special rules before getting your prescription in order for the prescription to be covered under our plan. For more information, call the telephone number at the end of this introduction.

Does my Plan cover Medicare Part B or Part D drugs?

Health Net Seniority Plus (Employer HMO) does cover both Medicare Part B prescription drugs and Part D prescription drugs.

Does my Plan have a prescription drug formulary?

Health Net Seniority Plus (Employer HMO) uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs. The Plan may periodically make changes to the formulary. If the formulary changes, affected enrollees will be notified, in writing, before the change is made. Contact Health Net Seniority Plus (Employer HMO) for details.

How can I get extra help with my prescription drug plan costs or get extra help with other Medicare costs?

Medicare provides "Extra Help" to pay Part D prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium and Part D prescription copayments and coinsurance. This Extra Help also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for getting Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or

- Your State Medicaid Office.

What is a Medication Therapy Management (MTM) program?
A Medication Therapy Management (MTM) Program is a benefit that your Plan may offer. You may be identified to participate in a program designed for your specific health and pharmacy needs. It is recommended that you take full advantage of this covered benefit if you are selected. Contact Health Net Seniority Plus (Employer HMO) for more details.

What types of drugs may be covered under Medicare Part B?
The following outpatient prescription drugs may be covered under Medicare Part B. This may include, but is not limited to, the following types of drugs. Contact Health Net Seniority Plus (Employer HMO) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin alpha or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and infusion drugs provided through DME.

What should I do if I have other insurance in addition to Medicare?
If you have Medicare supplemental insurance that fills gaps in the Original Medicare Plan, you may not need it if you join Health Net Seniority Plus (Employer HMO). If you drop your supplemental policy, you may not be able to get the same one back. You should check into this carefully before you drop your supplemental policy to make sure you have all of the coverage you need.

You or your spouse may have, or be able to get, employer group health coverage, such as this Health Net Seniority Plus (Employer HMO). If so, you should talk to the employer to find out how your benefits will be affected if you join Health Net Seniority Plus (Employer HMO). Get this information before you decide.

What are my protections in this Plan?

All health plans in the Medicare program agree to stay with the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Health plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for health care coverage in your area and give you information about your right to get Medicare supplemental insurance coverage. You can choose another health plan if one is available, or you can receive care from the Original Medicare Plan.

If Health Net ever denies your claim or a service, we will explain our decision to you. You always have the right to appeal and ask us to review the claim or service that was denied. If a decision is not made in your favor, your appeal will be reviewed by an independent organization that works for Medicare. Please note, Employer-Sponsored benefits are not subject to a review by CMS.

Please call Health Net of California for more information about this Plan.

Visit us a www.healthnet.com.

Customer Service Hours:

8:00 a.m. to 8:00 p.m., 7 days a week.

Current members should call **1-800-275-4737** for questions related to the Medicare Advantage and Medicare Part D Prescription Drug program. (TTY/TDD **1-800-929-9955)**

Prospective members should call **1-800-596-6565** for questions related to the Medicare Advantage and Medicare Part D Prescription Drug program. (TTY/TDD **1-800-929-9955**)

For more information about Medicare, call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the web.

If you have special needs, this document may be available in other formats.

Services and Supplies	Original Medicare	Seniority Plus EGHP
IMPORTANT INFORMATION		
Doctor and Hospital Choice (For more information, see Emergency and Urgently Needed Care.)	You may go to any doctor, specialist or hospital that accepts Medicare.	You must go to network doctors, specialists and hospitals. You need a referral to go to network hospitals and certain doctors, including specialists for certain services.
Out-of-PocketMaximum	There is no Out-of-Pocket Maximum.	As a member of our plan, the most you will have to pay out-of-pocket for covered Part A and Part B services in 2011 is $1,650. If you reach the maximum out-of-pocket payment amount of $1,650, you will not have to pay any out-of-pocket costs for the remainder of the year for covered Part A and Part B services**.**

Summary of Benefits

INPATIENT CARE		
Inpatient Hospital Care Includes Substance Abuse and Rehabilitation Services, Semiprivate room (private if medically necessary), meals, drugs and medication, laboratory test, x-ray and radiology services, medical social services, diagnostic and therapeu-	You pay for each benefit period (3): Days 1 - 60: an initial deductible of $1,100* Days 61 - 90: $275* each	There is no copayment for Inpatient Hospital services in a network hospital. You are covered for unlimited days each benefit pe-

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[4] Lifetime reserve days can only be used once.

** These values are for the 2010 CMS plan year and will change in 2011.*

Services and Supplies	Original Medicare	Seniority Plus EGHP
tic items or services, renal dialysis, dressings, casts, operating and recovery room time, oxygen and anesthesia, and use of appliances such as wheelchairs while hospitalized and radiation therapy.	day Days 91 - 150: $550* each lifetime reserve day. (4) Please call **1-800-MEDICARE (1-800-633-4227)** for information about lifetime reserve days. (4)	riod.(3) Except in an emergency, your provider must obtain authorization from Health Net of California.
Acute Care Detoxification	You pay 20% of Medicare-approved amounts.(1)(2)	There is no copayment for acute care detoxification services.
Blood, Blood Plasma, Blood Factors and Blood Derivatives	You pay for first 3 pints of unreplaced blood.	There is no copayment for Medicare-covered services.
Inpatient Mental Health Care	You pay the same deductible and copayments as inpatient hospital care (above) except there is a 190-day lifetime limit in a psychiatric hospital.	There is no copayment for services in a network hospital. You are covered for unlimited days each benefit period.(3) Except in an emergency, your provider must obtain authorization from Health Net of California.
Partial Hospitalization For Psychiatric Program	You pay 20% of Medicare-approved	There is no copayment for Medicare-covered services.

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Services and Supplies	Original Medicare	Seniority Plus EGHP
	amounts.(1)(2)	
Physician's Mental Health Visit to Hospital or Skilled Nursing Facility	You pay 20% of Medicare-approved amounts.(1)(2)	There is no copayment for Medicare-covered services.
Skilled Nursing Facility Care must be in a Medicare-certified skilled nursing facility. Care includes semiprivate room, nursing services, meals, physical therapy, occupational therapy and speech therapy, drugs and biologicals, medical supplies, use of appliances such as wheelchairs while in a skilled nursing facility.	You pay for each benefit period (3), following at least a 3-day covered hospital stay: Days 1 - 20: Covered in full for each day Days 21 - 100: $137.50* for each day There is a limit of 100 days for each benefit period.(3)	There is no copayment for services in a Skilled Nursing Facility. You are covered for 100 days each benefit period.(3) No prior hospital stay is required. Authorization rules may apply for services. Contact your Plan for details.
Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	There is no copayment for all covered home health visits.	There is no copayment for Medicare-covered home health visits. Authorization rules may apply for services. Contact your Plan for details.

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Services and Supplies	Original Medicare	Seniority Plus EGHP
Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must receive care from a Medicare-certified hospice.	You must receive care from a Medicare-certified hospice.
Home IV therapy	You pay 20% of Medicare-approved amounts.(1)(2)	There is no copayment for Medicare-covered services.
Renal Dialysis Services (while temporarily outside of service area)	You pay 20% of Medicare-approved amounts.(1)(2)	There is no copayment for Medicare-covered services.
OUTPATIENT CARE		

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Services and Supplies	Original Medicare	Seniority Plus EGHP
Doctor Office Visits Includes visit to physician's assistant or nurse practitioner.	You pay 20% of Medicare-approved amounts.(1)(2)	You pay $15 for each primary care doctor office visit for Medicare-covered services. You pay $15 for each specialist visit for Medicare-covered services. See Routine Physical Exams for more information.
Chiropractic Services	You pay 20% of Medicare-approved amounts.(1)(2) You are covered for manual manipulation of the spine to correct subluxation, provided by chiropractors or other qualified providers.	You pay $15 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).
Routine Chiropractic Care	You pay 100% for routine care.	You pay $15 per visit when using our chiropractic network (30-visits per calendar year).
Podiatry Services	You pay 20% of Medicare-approved amounts.(1)(2)	You pay: - $15 for each Medicare-covered visit (medi-

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Services and Supplies	Original Medicare	Seniority Plus EGHP
	You are covered for medically necessary foot care, including care for medical conditions affecting the lower limbs. You pay 100% for routine care.	cally necessary foot care). - $15 for each routine visit up to 1 visit per calendar month.
Outpatient Mental Health Care	You pay 50% of Medicare-approved amounts with the exception of certain situations and services for which you pay 20% of approved charges.(1)(2)	For Medicare-covered Mental Health services, you pay: - $15 for each individual/group therapy visit 1 and beyond. For Medicare-covered Mental Health services with a psychiatrist, you pay: - $15 for each individual/group therapy visit(s) 1 and beyond. Except in an emergency, your provider must obtain authorization from Health Net of California.
Outpatient Substance Abuse Care	You pay 20% of Medicare-approved amounts.(1)(2)	For Medicare-covered services, you pay: - $15 for each individual/group visit 1 and

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Services and Supplies	Original Medicare	Seniority Plus EGHP
		beyond. Except in an emergency, your provider must obtain authorization from Health Net of California.
Outpatient Services/Surgery	You pay 20% of Medicare-approved amounts for the doctor.(1)(2) You pay 20% of outpatient facility charges.(1)(2)	There is no copayment for Medicare-covered visits to an ambulatory surgical center and outpatient hospital facility. Authorization rules may apply for services. Contact plan for details.

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Services and Supplies	Original Medicare	Seniority Plus EGHP
Ambulance Services Medically necessary ambulance services only. Non-emergency ambulance must be Prior Authorized.	You pay 20% of Medicare-approved amounts or applicable fee schedule charge.(1)(2)	There is no copayment for Medicare-covered ambulance services.
Emergency Care (You may go to any emergency room if you reasonably believe you need emergency Care.)	You pay 20% of the facility charge or applicable Copayment for each emergency room visit; you do NOT pay this amount if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.(1)(2) You pay 20% of doctor charges.(1)(2) NOT covered outside the U.S. except under limited circumstances.	You pay $50 for each Medicare-covered emergency room visit; you do not pay this amount if you are immediately admitted to the hospital. Worldwide coverage.
Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	You pay 20% of Medicare-approved amounts or applicable Copayment.(1)(2) NOT covered outside the U.S. except under limited circumstances.	You pay $15 for each Medicare-covered urgently needed care visit; you do not pay this amount if you are immediately admitted to the hospital. Worldwide coverage.

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Services and Supplies	Original Medicare	Seniority Plus EGHP
Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	You pay 20% of Medicare-approved amounts.(1)(2)	There is no copayment for Medicare-covered Occupational Therapy visits. There is no copayment for Medicare-covered Physical Therapy and/or Speech/Language Therapy visits. Authorization rules may apply for services. Contact plan for details.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	You pay 20% of Medicare-approved amounts.(1)(2)	There is no copayment for Medicare-covered items. Authorization rules may apply for services. Contact plan for details.
Prosthetic Devices (includes pacemakers, braces, artificial limbs and eyes, etc.)	You pay 20% of Medicare-approved amounts.(1)(2)	There is no copayment for Medicare-covered items.

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Services and Supplies	Original Medicare	Seniority Plus EGHP
Diabetes Self-Monitoring Training and Supplies Includes coverage for blood glucose monitors (specific brands only), test strips, lancets, podiatric devices, insulin pumps and related supplies and self-management training.	You pay 20% of Medicare-approved amounts.(1)(2)	There is no copayment for Diabetes self-monitoring training. There is no copayment for Diabetes supplies.
Therapeutic Shoes (For those with diabetic foot disease, limited to one pair of shoes and a total of three inserts per calendar year)	You pay 20% of Medicare-approved amounts.(1)(2)	There is no copayment Medicare-covered services.
Diagnostic Tests, X-Rays, and Lab Services	You pay 20% of Medicare-approved amounts, except for approved lab services.(1)(2) There is no copayment for Medicare-approved lab services.	There is no copayment for the following Medicare-covered service(s): - clinical lab services - diagnosis lab services - x-ray visits
Radiation Therapy	You pay 20% of Medicare-approved amounts.(1)(2)	There is no copayment for each Medicare-covered radiation therapy service.
Injection Services	You pay 20% of Medicare-approved amounts.(1)(2)	There is no copayment for each Medicare-covered service provided by a physician or designee.
Allergy testing	You pay 20% of Medicare-approved amounts.(1)(2)	There is no copayment for each Medicare-covered service.

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Allergy desensitizing serum	You pay 20% of Medicare-approved amounts.(1)(2)	There is no copayment for each Medicare-covered service.
Bone Mass Measurement (for people with Medicare who are at risk)	You pay 20% of Medicare-approved amounts.(1)(2)	There is no copayment for each Medicare-covered Bone Mass Measurement.
PREVENTIVE SERVICES		
Human Immunodeficiency Virus (HIV) Screening (Voluntary Annual Screening)	There is no copayment for Medicare-covered HIV Screening.	There is no copayment for Medicare-covered HIV Screening.
Colorectal Screening Exams (for people with Medicare age 50 and older)	You pay 20% of Medicare-approved amounts.(1)(2)	There is no copayment for Medicare-covered Colorectal Screening Exams.
Immunizations (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)	There is no copayment for the Pneumonia and Flu vaccines. You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine.(1)(2) You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.	There is no copayment for the Pneumonia and Flu vaccines. There is no copayment for the Hepatitis B vaccine. No referral necessary for Medicare-covered influenza and pneumococcal vaccines.
Mammograms (Annual Screening) (for women with Medicare age 40 and	You pay 20% of Medicare-approved amounts.(2)	There is no copayment for Medicare-covered Screening Mammograms.

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[3] *A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.*

[4] *Lifetime reserve days can only be used once.*

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Services and Supplies	Original Medicare	Seniority Plus EGHP
older)	No referral necessary for Medicare-covered screenings.	
Pap Smears and Pelvic Exams (for women with Medicare)	There is no copayment for a Pap Smear once every 2 years, annually for beneficiaries at high risk.(2) You pay 20% of Medi-care-approved amounts for Pelvic Exams.(2)	There is no copayment for Medicare-covered Pap Smears and Pelvic Exams. No referral necessary for network providers.
Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	There is no copayment for approved lab services and a copayment of 20% of Medicare-approved amounts for other related services.(2)	There is no copayment for Medicare-covered Prostate Cancer Screening exams.
"Welcome to Medicare" Exam and Annual Wellness Visit	When you join Medicare Part B, then you are eligible as follows: During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare exam or an Annual Wellness visit. After your first 12 months you can get one Annual Wellness visit every 12 months.	There is no copayment for the Welcome to Medicare exam. There is no copayment for each Annual Wellness visit, limited to one vist every year.

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Services and Supplies	Original Medicare	Seniority Plus EGHP
	There is no coinsurance, copayment, or deductible for either the Welcome to Medicare exam or the Annual Wellness vist. The Welcome to Medicare exam does not include lab tests.	
ADDITIONAL BENEFITS (WHAT ORIGINAL MEDICARE DOES NOT COVER)		
Immunosuppressive Drugs (Following discharge after and approved transplant)	You pay 20% of Medicare-approved amounts.(1)(2)	The applicable Outpatient Prescription Drug copayments will apply. Please refer to the section below.
Smoking Cessation Drugs Limited to one treatment cycle (12 weeks) per calendar year with Prior Authorization.	You pay 100% for smoking cessation drugs.	The applicable Outpatient Prescription Drug copayments will apply. Please refer to the section below.
Outpatient Prescription Drugs This plan uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs at a lower cost. If the formulary changes, you will be notified, in writing if you are taking an affected medication, before the change. To view the plan's formulary, go to www.healthnet.com on the web.	You pay 100% for most prescription drugs, unless you enroll in the Medicare Part D Prescription Drug program.	People who have low incomes, who live in long term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact the Plan for details.

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Services and Supplies	Original Medicare	Seniority Plus EGHP
		After you have paid $1,050 in copayments for outpatient prescription medications, no further copayment will be required for the remainder of the calendar year. **One-month (30-day) supply of Part D Drugs purchased at local pharmacies:** - 10% Coinsurance – Tier 1 - 20% Coinsurance – Tier 2 - 20% Coinsurance – Tier 3 - 20% Coinsurance – Injectable - 20% Coinsurance – Specialty **Three-month (90-day) supply of Part D Drugs purchased at local pharmacies:** - 10% Coinsurance – Tier 1 - 20% Coinsurance – Tier 2 - 20% Coinsurance – Tier 3 - 20% Coinsurance – Injectable

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Services and Supplies	Original Medicare	Seniority Plus EGHP
		- 20% Coinsurance – Specialty **Three-month (90-day) supply of Part D Drugs purchased via mail order:** - 10% Coinsurance – Tier 1 - 20% Coinsurance – Tier 2 - 20% Coinsurance – Tier 3 - 20% Coinsurance – Injectable - 20% Coinsurance – Specialty After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: - $2.50 for generic or a preferred brand drug that is a multi-source drug and - $6.30 for all other drugs, or - 5% coinsurance. Certain Prescription Drugs will have maximum quantity limits and may have a pre-authorization requirement. Contact plan

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Services and Supplies	Original Medicare	Seniority Plus EGHP
		for details.
Oral Contraceptives		- $20 copayment per oral contraceptive prescription drug.
Diabetic Supplies (Insulin needles and syringes, pen needles and reusable pen devices)		- $20 copayment for each item up to a 30-day supply.
ADDITIONAL BENEFITS (WHAT ORIGINAL MEDICARE DOES NOT COVER)		
Immunizations for Foreign Travel and Occupational Purposes	You pay 100% of the charges for Immunizations that are for foreign travel and occupational purposes.	You pay 20% of the charges.
Dental Services	In general, you pay 100% for dental services.	In general, you pay 100% for dental services.
Hearing Services	You pay 100% for routine hearing exams and hearing aids. You pay 20% of Medicare-approved amounts for diagnostic hearing exams.(1)(2)	There is a maximum of Error standard hearing aids every 36 months. You pay: - $15 for each Medicare-covered hearing exam (diagnostic hearing exams).

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Services and Supplies	Original Medicare	Seniority Plus EGHP
		- $15 for each routine hearing test up to 1 test every year.
Vision Services	You are covered for one pair of eyeglasses or contact lenses after each cataract surgery.(1)(2) For people with Medicare who are at risk, you are covered for annual glaucoma screenings.(1)(2) You pay 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye.(1)(2) You pay 100% for routine eye exams and glasses.	There is no copayment for the following items: - Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery). - Medicare covered glaucoma screening. Limited to one screening every year. You pay: - $15 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). You pay $100 for routine eye exams and glasses.
Routine Physical Exams If your coverage to Medicare Part B begins on or after January 1, 2005, you may receive a one time physical exam within the first six months	You pay 100% for routine physical exams.	There is no copayment for each Medicare covered service. There is no copayment for

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Services and Supplies	Original Medicare	Seniority Plus EGHP
of your new Part B coverage. This will not include laboratory tests. Please contact your plan for further details.		routine physical exams. You are covered up to 1 exam every year.
Health/Wellness Education	You pay 100% for Health/Wellness Education services.	There is no copayment for the following: - Health Ed classes - Newsletter - Nutritional Training - Smoking Cessation - Congestive Heart Program - Disease Management - Decision Power Ask Health Net of CA for details. No referral necessary for network providers.

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Exclusions and limitations

This plan does not cover any medical treatment you received before coverage begins under this Plan or any services you may receive after your coverage under this Plan ends.

The following services are not covered by Health Net Seniority Plus (Employer HMO):

- Acupuncture;
- All items and services not medically necessary for the diagnosis and treatment of an illness or injury;
- Custodial care;
- Dental care, covered only for surgery of the jaw and related structures as covered by Medicare, unless additional benefits are offered under this plan;
- Hospice services (you may obtain hospice services covered by Medicare from any Medicare certified hospice while a member of Health Net Seniority Plus (Employer HMO));
- 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 Evidence of Coverage. 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;
- Personal or comfort items, or private rooms, unless medically necessary during inpatient stay;
- Physical examinations for non-medical purposes;
- Services prior to the member’s start date of coverage and subsequent to the time coverage ends;
- Treatment of obesity, weight reduction or weight management, except for morbid obesity.
- Vision exams.

The above is a partial list of the principal exclusions and limitations applicable to the medical portion of your Health Net Seniority Plus (Employer HMO). The Evidence of Coverage, which you will receive when you enroll in this Plan, contains the full list.

Prescription drug program

Health Net makes it easy and convenient for you to get the quality medications you need…at a low, affordable price! Your Health Net Seniority Plus card provides coverage for many medications commonly used by Medicare members including generic, brand, and some injectable medications. To obtain the most value for your prescription benefits coverage, you should ask your physician to prescribe medications on the

Health Net Medicare Drug List that has been approved by the Centers for Medicare and Medicaid Services (CMS). It's easy to fill your prescriptions, too. When making a prescription drug purchase, you may use your Health Net Seniority Plus card at any of our more than 4,600 Health Net participating pharmacies in California. Or, use our convenient Mail Order Service. For more information on the Mail Order Services, please call Health Net Seniority Plus at **1-800-275-4737** (TTY/TDD **1-800-929-9955**) 8:00 a.m. to 8:00 p.m., 7 days a week. For a list of participating pharmacies, please refer to your pharmacy directory. Prescription drugs may be purchased out-of-network in special circumstances. Refer to your Evidence of Coverage or call Health Net Seniority EGHP Member Services at the telephone number above for more information.

What Is the Health Net Medicare Drug List?

Health Net's Medicare Drug List – also called a formulary – is a list of medications for most medical conditions that are safe, effective and affordable. All the medications on the Drug List are covered under your prescription benefit. Physicians and specialists refer to this list when choosing drugs for their patients who are members of the Health Net Seniority Plus plan. This ensures that you receive a prescription medication of high quality and value. The list is updated quarterly, based on input from the Health Net Pharmacy and Therapeutics (P&T) Committee, a group of multi-specialty, including geriatrics, practicing physicians and clinical pharmacists. The list may also change as new clinical information becomes available and as new drugs are approved or re-evaluated by the U.S. Food and Drug Administration (FDA).

How do I find out if my prescription is on "The List"?

When your doctor prescribes a medication, ask if it is on the Health Net Medicare Drug List. If you already have the prescription, you can find out if it is on the list by calling Health Net Seniority EGHP Member Services at
1-800-275-4737 (TTY/TDD **1-800-929-9955**) 8:00 a.m. to 8:00 p.m., 7 days a week. For current members, you can also log on to www.healthnet.com, go to "View Prescription Coverage" and click on "Your Drug List." For prospective members, simply log on to www.healthnet.com, click on "View Our Drug List," then select your region.

Why should I use generic drugs?

Get the most out of prescription drug benefit coverage. To make sure your out-of-pocket costs are as low as possible, the Health Net Prescription Drug Program offers many generic medications. Preferred generic medications on the Drug List are available at the lowest copayment. Generic drugs are less expensive than brand name ones, but contain the same active ingredients and have the same medical benefit. Generic drugs must meet the same U.S. Food and Drug Administration standards for safety, purity, strength and effectiveness as their brand name counterparts. If you choose to fill your prescription with a brand name medication when a generic is available, you may have to pay more for your prescription.

How do I use the mail order drug program?

Medications ordered through the mail order program should be for treatment of long-term, ongoing medical problems in which the drug dosage has already been determined (referred to as "maintenance drugs"). Your medication is a maintenance medication if:

- Taken continuously to manage chronic or long-term conditions.
- You respond positively to drug treatment.
- Dosage adjustments are either no longer required or are made infrequently.

If you receive your medications from the mail order pharmacy in Health Net's network, you can receive up to a three month supply at a reduced copayment. Mail order is convenient, easy to use, offers less expensive copayments, and has free delivery to anywhere in the United States. For more information about the Mail Order Drug Program, please call Health Net Seniority EGHP Member Services at **1-800-275-4737** (TTY/TDD **1-800-929-9955**) 8:00 a.m. to 8:00 p.m., 7 days a week.

How is my copayment determined?

How much you will pay for your medications, also called your copayment or coinsurance level, is based on three key factors:

- Is it a generic or a brand name drug?
- Is it on the Health Net Medicare Drug List?
- What tier is your medication on?
- What Coverage Stage are you in?

Please refer to the schedule portion of the SB/DF for your copayments.

Retail pharmacies may provide up to a 30 day supply of maintenance medications. Some medications are available by a specific package size or course of therapy. Some pharmacies may provide up to a 90 day supply of maintenance medication for three times the monthly copayment. Please check with your retail pharmacy if the service is available to you. Most self-injectable drugs are covered at a percentage of the pharmacy cost. In some cases, your physician may be asked to submit Prior Authorization for a medication. Coverage of the medication is dependent on medical necessity as determined by the Plan.

Initial Coverage Stage

Once your total Part D drug costs reach $2,840, you will reach your initial coverage limit. Your initial coverage limit is calculated by adding payments made by this Plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay for your drugs under this Plan, the amount they spend may count towards your initial coverage limit. When you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

Coverage Gap Stage

After your total Part D drug costs reach $<xxx>, you, or others on your behalf, will continue to pay the applicable coinsurance/copayment for covered drugs as shown in the Initial Coverage Stage. Some Brand name drugs as determined by Medicare are subject to the Medicare Coverage Gap Discount Program, which helps lower your drug cost. (Refer to "Medicare Coverage Gap Discount Program For Part D Brand Name Drugs" below for more information.) Once your yearly out-of-pocket payments for Part D drugs reach $4,550, you move on to the Catastrophic Coverage Stage.

Medicare Coverage Gap Discount Program For Part D Brand Name Drugs

Beginning in 2011, the Medicare Coverage Gap Discount Program will provide manufacturer discounts on Part D brand name drugs as determined by Medicare to enrollees who have reached the coverage gap and are not already receiving "Extra Help." A discount will be applied to your share of the cost for Part D brand name drugs from manufacturers that have agreed to pay the discount.

We will automatically apply the discount when your pharmacy charges you for your drug and your Explanation of Benefits will show any discount provided. The amount discounted by the manufacturer counts toward your out-of-pockets costs as if you had paid this amount and moves you through the coverage gap.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Member Services (phone numbers are on the back cover).

Catastrophic Coverage Stage

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs for Part D drugs have reached the $4,550 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your Part D drugs.

Your share of the cost for a covered Part D drug will be either coinsurance or a copayment, whichever is the larger amount:

- –either – coinsurance of 5% of the cost of the Part D drug

- –or – $2.50 copayment for a Part D generic drug or a drug that is treated like a generic. Or a $6.30 copayment for all other Part D drugs.

Our plan pays the rest of the Part D drug cost.

You will continue to pay the applicable coinsurance/copayment, as shown in the Initial Coverage Stage for covered drugs that are not Medicare Part D drugs.

What's not covered

- Allergy serum (covered under medical benefits);
- Cosmetics, health or beauty aids, or drugs prescribed for cosmetic reasons, including drugs prescribed for baldness or to eliminate wrinkles;
- Devices or appliances whether or not prescribed by a plan physician (may be covered under your Durable Medical Equipment benefit.);
- Drugs that are appetite suppressants or are indicated for and prescribed for body weight reduction;
- Drugs that are prescribed by any physician who is not a plan physician, an authorized specialist, or is not a physician to whom you are referred by a plan physician, except in conjunction with an emergency or urgently needed services;
- Experimental drugs (those that are labeled "Caution – Limited by the Federal Law to investigational use only") unless covered by Original Medicare or under an approved clinical trial;
- Agents for surgical implantation, biological sera, blood, blood derivatives or blood plasma (covered under medical benefits);
- Over-the-counter drugs (OTC), equipment, supplies or drugs where there is a non-prescription equivalent available, except for drugs and supplies used for the treatment or management of diabetes;
- Oxygen (covered under the Durable Medical Equipment benefit);
- Limits on quantity, dosage, treatment duration, and prior approval may apply to some drugs.
- Medications on the Health Net Drug List (Formulary) specifically excluded by Medicare will not count towards your annual out of pocket costs.

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

Prescription limitations

Generic drugs will be dispensed by Seniority Plus participating pharmacies when the prescription order specifies a generic drug. Also, when a brand name drug is specified, but a generic drug equivalent exists, the generic drug will be substituted.

Brand name drugs will be dispensed when the prescription order specifies a brand name and no generic drug equivalent exists. (Not all plans cover brand name drugs, please refer to your Plan documents for additional information.) If the generic version exists, you can get the brand name drug at the Tier 3 copayment.

Behavioral health services

Health Net Seniority Plus contracts with MHN Services, 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 Seniority Plus 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 Seniority Plus, 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 Seniority Plus (Employer HMO) Member Services Department at **1-800-275-4737** (or **1-800-929-9955** TDD/TTY for the hearing impaired). Business hours are 8:00 a.m. to 8:00 p.m., 7 days a week.

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 Seniority Plus ID card to receive assistance in transferring your care to a network provider.

Health Net and your EAP

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

What’s covered

Please refer to the "Summary of Benefits" section of this document for the copayments.

What’s not covered (exclusions and limitations)

Services or supplies excluded under behavioral health services may be covered under the medical benefits portion of your plan. Consult your plan’s Evidence of Coverage 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 Evidence of Coverage;
- Experimental or investigational therapies;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder;

- Nontreatable mental disorders;
- Private-duty nursing;
- Services related to educational and professional purposes;
- Smoking cessation, weight reduction, obesity, stammering, sleeping disorders or stuttering;
- State hospital treatment, except as the result of an emergency or urgently needed care;
- Stress, except when rendered in connection with services provided for a treatable mental disorder;
- Treatment of detoxification in newborns;
- Treatment, testing or screening of learning disabilities, except for some conditions when the level of severity meets the criteria of severe mental illness or serious emotional disturbances of a child as described in the Evidence of Coverage; and

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.

Chiropractic care program

Health Net Seniority Plus has partnered with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable chiropractic coverage. With this program, you may obtain care by selecting a ASH contracted chiropractor from our Contracted Chiropractor directory. Although you're always welcome to consult your PCP, you won't need a referral to see an ASH contracted chiropractor.

What's covered

Office visits

$15 per visit

30 visits per year

There is a $50 annual chiropractic appliance allowance toward the purchase of chiropractically necessary items such as supports, collars, pillows, heel lifts, ice packs, cushions, orthotics, rib belts and home traction units prescribed by a ASH Plans contracted chiropractor and approved by ASH Plans.

All covered chiropractic services require pre-approval from ASH Plans except for a new patient examination by a contracted chiropractor and emergency chiropractic services.

What's not covered

Services or supplies excluded under the chiropractic care program may be covered under the medical benefits portion of your plan. Consult your plan's Evidence of Coverage for more information.

In addition to the exclusions and limitations listed below, chiropractic care benefits are subject to the plan's general exclusions and limitations.

- Prescription drugs and over-the-counter drugs are not covered.
- Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.
- Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all chiropractic appliances or durable medical equipment is not covered.
- Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing are not covered.
- Any services or treatments not delivered by Contracted Providers for the delivery of chiropractic care to Members, except for Emergency Services or services that are not available and accessible to a Member and are provided upon a referral by ASH Plans.
- Adjunctive therapy not associated with spinal, muscle or joint manipulation.
- Services other than an initial evaluation for the treatment of conditions unrelated to Neuromusculo-

skeletal Disorders are not covered.

- Hypnotherapy, behavior training, sleep therapy and weight programs are not covered.
- Services provided by chiropractors who do not contract with ASH Plans are not covered, except with regard to Emergency Chiropractic Services or upon a Referral by American Specialty Health Plans of California, Inc.
- Examinations or treatments for conditions unrelated to Neuromusculo-skeletal Disorders are not covered. This means physical therapy not associated with spinal, muscle and joint manipulation, is not covered.
- Services provided by a chiropractor practicing outside California are not covered, except with regard to Emergency Chiropractic Services.
- Services that are not within the scope of licensure for a licensed chiropractor in California.
- The diagnostic measuring and recording of body heat variations (thermography) are not covered.
- Transportation costs are not covered, including local ambulance charges.
- Services or treatments that are not documented as Medically Necessary chiropractic care are not covered.
- Vitamins, minerals, nutritional supplements or other similar products are not covered.
- Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, and any diagnostic radiology other than covered plain film studies.
- Services or treatments for pre-employment physicals or vocational rehabilitation.
- Any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance
- All auxiliary aids and services, including but not limited to interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids
- Hospitalization, anesthesia, manipulation under anesthesia, or other related services.

The Facts About Health Net Seniority Plus (Employer HMO)

The Health Net Seniority Plus (Employer HMO) difference

When we say “plus,” we mean additional services not available through traditional Medicare coverage. Such services as hearing exams, routine physical examinations, vision exams and some screenings not covered by Medicare for wellness and healthy aging are the plus that can make a noticeable difference in the quality of your life.

Seniority Plus wellness programs include:

- Healthy Aging programs offered at many contracting physician groups in our network on such topics as exercise, diet and stress reduction;
- Health/Wellness Education;
- Health and fitness literature;
- Online access to wellness tips and information on Health Net’s web site: www.healthnet.com; and

When you enroll in Health Net Seniority Plus, you will select a contracting physician group from our network. You’ll also choose a PCP from this contracting physician group.

Take a moment to review the Health Net Seniority Plus (Employer HMO) contracting physician group directory. This directory lists all contracting physician groups (and their hospital affiliations) from which you may choose. Health Net’s Seniority Plus contracting physician directory is updated regularly to ensure it includes the newest physicians in our network. Health Net Seniority Plus (Employer HMO) has made every attempt to ensure the accuracy of this directory, but we cannot guarantee the current availability of any provider listed here. To request a directory, confirm the availability of a provider or to ask about a specific PCP, please contact our Member Services Department at **1-800-275-4737** (or **1-800-929-9955** TDD/TTY for the hearing impaired). Business hours are 8:00 a.m. to 8:00 p.m., 7 days a week.

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. This oversight helps to maintain Health Net Seniority Plus (Employer HMO)'s high quality medical management standards.

Pre-Authorization

Certain proposed services may require an assessment prior to approval. Evidence-based criteria are used to determine that the procedure is medically necessary and planned for the appropriate setting (i.e., inpatient, ambulatory surgery, etc.).

Concurrent Review

This process continues to review and authorize inpatient and certain outpatient care 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 and their physicians and community resources. The Care Managers insure the members receive necessary services along the entire continuum of care helping to enhance the health and well being of the Health Net Seniority Plus (Employer HMO) membership.

If you need emergency or urgently needed care

Emergency services:

Emergency Services are covered services that are given by any qualified provider, and needed to evaluate or stabilize an emergency medical condition.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily function; or
- Serious dysfunction to any bodily organ or part.

In an emergency, go to the closest emergency room or call **911** for help. You do not need prior authorization for treatment of emergency medical conditions. It is best if you can have your ER doctor, a family member or

someone you know, contact your medical group as soon as possible. The number to call is located on your Health Net Seniority Plus ID card.

Urgently needed services:

Urgently needed services are services provided when you are temporarily out of your Plan's service area (or under extraordinary circumstances, when you are in your Plan service area but the Plan's provider network is temporarily unavailable or inaccessible) and when the services are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition, and it is unreasonable, given the circumstances, to obtain the services through Health Net's Health Net Seniority Plus (Employer HMO) providers.

Here's what you need to do in order to get emergency or urgent care.

- If you need immediate medical attention in an emergency, call **911**.
- If you are uncertain whether your condition is an emergency, there is always a physician within your contracting physician group on call 24 hours a day, seven days a week, to address and answer your questions, and to direct your care.
- If you are outside your Health Net Seniority Plus (Employer HMO) Plan service area, go to the nearest medical center or hospital, or call **911**.

Remember, if you go to a doctor, hospital, or other provider without the approval of your PCP --except for emergency or urgently needed care, out-of-area renal dialysis, or specific limited self-referral services (as indicated in this booklet)-- you are responsible for these services. Neither Original Medicare nor Health Net will pay for them. It is important to understand that, as a Health Net Seniority Plus (Employer HMO) member, you still retain your Medicare card but receive Medicare-covered benefits through Seniority Plus.

Post Stabilization Care

In the event you require emergency hospitalization in a non-contracting hospital, once your condition has stabilized, you will be provided medically necessary non-emergency services needed to ensure your condition remains stable.

As soon as possible after you receive emergency care, we ask that you notify your Seniority Plus contracting physician group or your PCP about the care you are receiving. Your PCP will resume direction of your care as soon as it is medically possible. Emergency care does not require authorization.

Facilities

Health care services for you and eligible members of your family will be provided through the contracting physician group you select when you enroll.

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. Should scheduled hospitalization be required, your con-

tracting physician group will admit you to a nearby hospital where the services you need can be provided. The Health Net Seniority Plus (Employer HMO) Contracting Physician Group Directory contains a list of hospitals affiliated with each contracting physician group. Health Net Seniority Plus (Employer HMO) has made every attempt to ensure accuracy of this directory, but we cannot guarantee the current availability of any provider listed here. To confirm the availability of a provider, please contact our Member Services Department at **1-800-275-4737** (or **1-800-929-9955** TDD/TTY for the hearing impaired). Business hours are 8:00 a.m. to 8:00 p.m., 7 days a week..

Out-of-Area Dialysis Services

For Health Net Seniority Plus members with end-stage renal disease (ESRD), renal dialysis services obtained while you are temporarily outside your contracting physician group service area are also covered. No pre-authorization is needed for these services.

Non-contracting providers

If you receive care from a non-contracting provider, either because of a referral from your PCP or because needed emergency or urgently needed services, or received care for renal dialysis out-of-area, you may be billed directly. In this instance, you should not pay the bill. Please contact the Seniority Plus Member Services Department to obtain claim forms. Send the completed form to Seniority Plus and Health Net will make a determination on your liability, if any. Payments that are owed by Health Net Seniority Plus (Employer HMO) for covered services or provided or authorized by your contracting physician group will never be your responsibility.

Reimbursement provisions

Present your Seniority Plus ID card to the medical staff at the time of care and have them bill Health Net Seniority Plus (Employer HMO) directly at the address on your ID card. You may be asked to pay at the time of receiving services for out-of-area urgent care or emergency care or out of-area renal dialysis. If that is the case, ask for an itemized statement of charges, including diagnosis, date and type of service, and submit this itemized bill to the Health Net Seniority Plus (Employer HMO) Claims department for reimbursement.

Completed claim forms must be submitted to this address:

Health Net Seniority Plus
Member Services Department
Post Office Box 10198
Van Nuys, CA 91410-0198

All Foreign or Cruise Claims must be mailed to:

Health Net Seniority Plus
"Attention Foreign Claims"
P.O. Box 10198
Van Nuys, CA 91410-0198

Coordination of benefits

When you have coverage under Health Net Seniority Plus (Employer HMO) and are entitled to benefits under an employer group health plan, workers' compensation or an automobile or liability insurance policy, services and benefits of your Seniority Plus Plan are coordinated with the other group insurance Plan so that the combination of the coverages will not provide benefits exceeding the expenses incurred.

Renewal provisions

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

Individual continuation of benefits

If you become ineligible for group coverage, you have the right to obtain coverage under the Seniority Plus Individual Agreement.

Obtaining this non-group coverage does not require the submission of a health statement. You must submit an application for this coverage within 31 days of the date group coverage ends. There must be no lapse in coverage between the group and the individual coverage. You must pay all required plan subscription charges to ensure that coverage is continuous.

Third-party liability

If you are injured and receive medical services and someone else is liable for your medical expenses and makes payment for these expenses, you will be required to reimburse Health Net Seniority Plus (Employer HMO) or the hospital or the contracting physician group for medical services received relating to that injury. Third-party liability includes services related to industrial injuries and illness.

Disenrollment from Health Net Seniority Plus (Employer HMO)

To disenroll from Health Net Seniority Plus (Employer HMO) you may submit a written request to Health Net, Social Security Administration or Railroad Retirement Board (if a railroad annuitant), or phone **1-800-MEDICARE** (or TDD/TTY **1-877-486-2048** for hearing impaired).

Requests to disenroll will be effective the first day of the month after the month the disenrollment request is received.

If you enroll in another Medicare Advantage Plan, you do not have to send us a request to disenroll. You will be disenrolled automatically from Seniority Plus at the time your membership in the new Medicare Advantage Plan becomes effective.

Reasons for termination

Health Net Seniority Plus (Employer HMO) may terminate your membership under the following conditions:

1. You fail to pay any required premium or copayment within 90 days after the date that Seniority Plus sends written notice of such failure;
2. You knowingly omit or misrepresent a material fact on the application for membership or fraudulently or deceptively uses services or facilities of Health Net, its contracting physician group or other contracting providers (or knowingly allows another person to do so), including altering a prescription;
3. You repeatedly or materially disrupt the operations of the Physician Group or Health Net to the extent that your behavior substantially impairs Health Net's ability to furnish or arrange services for you or other Health Net members, or the physician's office or contracting physician group's ability to provide services to other patients. (Subject to prior approval by Centers for Medicare and Medicaid Services); or
4. 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. (Subject to prior approval by Centers for Medicare and Medicaid Services.)

Health Net Seniority Plus (Employer HMO) must terminate your membership under the following conditions:

1. You are no longer entitled to both Medicare Part A and Part B;
2. You no longer reside in the Seniority Plus service area of the Plan in which you are enrolled. This means that you have permanently moved or have temporarily been out of the Seniority Plus service area for more than 6 months. If you move to the service area of another Health Net Seniority Plus (Employer HMO), you may continue your membership by completing an abbreviated election form;
3. You are no longer in the Seniority Plus service area because Health Net has decided to discontinue your Plan or to reduce your Plan's service area. Should this occur, we will provide you with the appropriate advance notice of the effective date of the termination and your alternatives for obtaining benefits;
4. Health Net's contract with CMS is not renewed;
5. Health Net's contract with your employer group is not renewed; or
6. You not longer work for the employer covered under this Health Net plan. If you are hospitalized when your coverage ends for any of the above reasons, your inpatient hospital coverage will continue until the discharge date. In case of total disability, when your coverage ends for any of the above reasons, your treatment for disability will continue until the disability ends.

Physician referral disclosure

Health Net Seniority Plus contracted physician groups and hospitals participate in programs that offer financial incentives based on compliance with certain care guidelines (such as frequency of immunizations and mammograms) and the attainment of goals related to access to care and Member satisfaction.

Confidentiality and release of member information

Health Net knows that personal information in your medical records is private. Therefore, we protect your personal health information in all setting (including oral, written and electronic information). The only time we would release your confidential information without your authorization is for payment, treatment, health care operations (including but not limited to utilization management, quality improvement, disease or case management programs) or when permitted or required to do so by law for things such as a court order or subpoena. 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 Evidence of Coverage. 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 Health Net Seniority Plus (Employer HMO) Member Services Department at **1-800-275-4737** (or **1-800-929-9955 TDD/TTY** for the hearing impaired) to obtain a copy. Business hours are 8:00 a.m. to 8:00 p.m., 7 days a week.

Clinical trials

Original Medicare covers routine costs of qualifying clinical trials. If you join a clinical trial, you will be responsible for any coinsurance under Original Medicare. For further information, please refer to the Evidence of Coverage.

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 from the Federal Drug Administration (FDA), CMS National Coverage Policies and Local Medical Review Policies are integrated into Health Net Seniority Plus (Employer HMO) Benefits.

Health Net Seniority Plus (Employer HMO) 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 Seniority Plus (Employer HMO) requests review of new technologies by the FDA, CMS National Coverage Policies and Local Medical Review Policies in order to determine medical appropriateness or investigational or experimental status of a technology or procedure.

The FDA, CMS National Coverage Policies and Local Medical Review Policies also advises Health Net Seniority Plus (Employer HMO) 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.

Payment of fees and charges

Prepayment fees your employer will pay Health Net Seniority Plus (Employer HMO) premiums for 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

The covered services and benefits described in this booklet will be arranged and paid for by Health Net Seniority Plus (Employer HMO). You will be responsible for any copayments, coinsurance, deductibles and/or penalty amounts as described in this booklet.

Our representatives aim to please

No matter how hard we try to explain everything, there is a lot to know about Health Net Seniority Plus (Employer HMO).

It's only natural that you'll have questions about your particular health care needs and benefits. Please feel free to contact Seniority Plus with any questions you may have about how to get the most from your coverage.

We're looking forward to the opportunity to serve you.

Health Net Seniority Plus (Employer HMO) is a product of Health Net of California, Inc., a federally qualified Health Maintenance organization (HMO) with a Medicare Advantage contract. Health Net Seniority Plus (Employer HMO) is available to persons with Medicare Parts A and B, including those with Medicare based on entitlement to Social Security Disability Benefits. You must continue to pay Medicare premiums; reside in your Plan service area; and use contracted providers for all routine care. If you have end stage renal disease (ESRD), you are not eligible to enroll in Health Net Seniority Plus (Employer HMO) unless you develop ESRD while a current Health Net member, or meet other regulatory exceptions.

Contact us

Health Net Seniority Plus (Employer HMO)
Post Office Box 10198
Van Nuys, California 91409-0198

Member Services
Business hours are 8:00 a.m. to 8:00 p.m., 7 days a week.
1-800-275-4737 – Seniority Plus Members
1-800-596-6565 – Seniority Plus Non-Members

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
1-800-929-9955

www.healthnet.com