

SUMMARY OF BENEFITS AND DISCLOSURE FORM

HMO • Plan S54



Health Net[®]
A Better Decision

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 Health Net Member Services Department at **1-800-539-4102**. Our friendly, knowledgeable representatives will be glad to help.

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

This *Summary of benefits/disclosure form (SB/DF)* is only a summary of your health plan. Your *Evidence of Coverage (EOC)*, which you will receive after you enroll, contains the exact terms and conditions of your Health Net coverage. You 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."

PLEASE READ THIS IMPORTANT NOTICE ABOUT THE HEALTH NET HMO SILVER NETWORK HEALTH PLAN SERVICE AREA AND OBTAINING SERVICES FROM SILVER NETWORK PHYSICIAN AND HOSPITAL PROVIDERS

Except for emergency care, benefits for physician and hospital services under this **Health Net HMO Silver Network** ("Silver Network") plan are only available when you live or work in the Silver Network service area and use a Silver Network physician or hospital. When you enroll in this Silver Network plan, you may only use a physician or hospital who is in the Silver Network and you must choose a Silver Network Primary Care Physician. You may obtain ancillary or pharmacy covered services and supplies from any Health Net participating ancillary or pharmacy provider.

Obtaining Covered Services Under the Health Net HMO Silver Network Plan

TYPE OF PROVIDER	HOSPITAL	PHYSICIAN	ANCILLARY	PHARMACY
AVAILABLE FROM	*Only Silver Network hospitals	*Only Silver Network physicians	All Health Net contracting ancillary providers	All Health Net participating pharmacies
*The benefits of this plan for physician and hospital services are only available for covered services received from a Silver Network physician or hospital, except for (1) when you need emergency care; (2) referrals to non-Silver Network providers are covered when the referral is issued by your Silver Network physician group; and (3) covered services provided by a non-Silver Network provider when authorized by Health Net. Please refer to "Specialists and referral care" in the "How the plan works" section and "Emergencies" in the "Benefits and coverage" section for more information.				

The service area and a list of Silver Network Physician and Hospital providers are shown in the Health Net *Silver Network Provider Directory*. In addition, Silver Network physicians and hospitals are listed online at our website www.healthnet.com/wellsfargoca. The *Silver Network Provider Directory* is different from other Health Net provider directories. A copy of the Health Net *Silver Network Provider Directory* may be ordered online or by calling Health Net Member Services at **1-800-539-4102**.

Note: Not all physicians and hospitals who contract with Health Net are Silver Network providers. Only those physicians and hospitals specifically identified as participating in the Silver Network may provide services under this plan, except as described in the chart above.

Unless specifically stated otherwise, use of the following terms in this Summary of benefits/disclosure form (SB/DF) solely refer to the Silver Network as explained above.

- Health Net
- Health Net service area and service area
- Hospital
- Member physician, participating physician group, primary care physician, physician, participating provider, contracting physician groups and contracting providers
- Network
- Provider directory

If you have any questions about the Silver Network Service Area, choosing your Silver Network Primary Care Physician, how to access specialist care or your benefits, please contact Health Net Member Services at 1-800-539-4102.

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How the plan works

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

Selection of physicians and physician groups

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

How to choose a physician

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

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

Specialists and referral care

If you need medical care that your PCP cannot provide, 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 HMO Directory* to see if your physician group allows "self-referrals" or "direct referrals" to specialists within the same group. Self-referral allows you to contact a specialist directly for consultation and evaluation. Direct referral allows your doctor to refer you directly to a specialist without the need for physician group authorization. Information about your physician group's referral policies is also available to you on our Internet web site, www.healthnet.com/wellsfargoca.

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

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

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic, or call Health Net Member Services Department at 1-800-539-4102 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

Medical benefits

Deductibles & plan maximums

Deductible	None
Lifetime maximum	None
Calendar Year Out-of-Pocket Maximum (OOPM)	
<p>Once your payments for covered services equals the amount shown below in any one calendar year, no additional copayments for covered services are required for the remainder of the calendar year. Once an individual member in a family 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 any supplemental benefits or services not covered by this plan will not be applied to this calendar year out-of-pocket maximum, unless otherwise noted. You will need to continue making payments for any additional benefits as described in the "Additional plan benefits information" section of this SB/DF.</p>	
One member	\$2000
Family	\$4000

Type of service & what you pay for services (medical benefits)¹

Professional services

Visit to physician	\$20
Visit to physician for treatment of severe mental illness or serious emotional disturbances of a child ^{2***}	See endnote 2
Specialist consultations ³	\$20
Physician visit to member's home at your physician's discretion and in accordance with criteria set by Health Net	\$20
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders)	Covered in full
Immunization for occupational purposes	20%
Immunization for foreign travel	20%
Allergy testing	\$20
Allergy serum	Covered in full
Allergy injection services	Covered in full
All other injections (excluding infertility injection)	
Injectable drugs administered by a physician (per dose)	Covered in full
Self injectable drugs	Covered in full
Surgeon services ⁴	Covered in full
Assistant surgeon services ⁴	Covered in full
Administration of anesthetics	Covered in full
Laboratory procedures and diagnostic imaging (including x-ray) services	Covered in full

Rehabilitative therapy (includes physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)	\$20
Adult preventive care	
Periodic health evaluations, including well-woman exam (age 18 and older) ^{3, 5}	\$20
Vision and hearing examinations (age 18 and older)	\$20
Immunizations (age 18 and older)	Covered in full
Child preventive care	
Periodic health evaluations, including newborn, well-baby care, and immunizations (birth through age 17) ^{3, 5}	\$20
Vision and hearing examinations (birth through age 17)	\$20
Family planning (professional services)⁶	
Prenatal and postnatal office visits	Covered in full
Normal delivery, cesarean section, newborn inpatient care	Covered in full
Treatment of complications of pregnancy, including medically necessary abortions	Covered in full
Elective abortions	\$150
Genetic testing of fetus	Covered in full
Circumcision of newborn males (birth through 30 days)	Covered in full
Intrauterine device (IUD)	Covered in full
Injectable contraceptives (including but not limited to Depo Provera)	Covered in full
Sterilization	
Vasectomy	Covered in full
Tubal Ligation	Covered in full
Hospital services	
Semi-private hospital room or intensive care unit with ancillary services, including maternity care (unlimited days)	10%
Semi-private hospital room or intensive care unit with ancillary services for treatment of severe mental illness or serious emotional disturbances of a child (unlimited) ^{2***}	See endnote 2
Skilled nursing facility stay (<i>limited to 100 days each calendar year</i>)	Covered in full
Outpatient facility services (other than surgery)	10%
Outpatient surgery (surgery performed in a hospital or outpatient surgery center only) ⁸	10%
Emergency health coverage	
Emergency room (professional and facility charges) ⁷	\$100
Urgent care center (professional and facility charges) ⁷	\$40
Ground ambulance	Covered in full
Air ambulance	Covered in full
Other services	
Medical social services	Covered in full
Patient education	Covered in full

Durable medical equipment (including nebulizers, face masks and tubing for the treatment of asthma)	Covered in full
Orthotics (such as bracing, supports and casts)	Covered in full
Diabetic equipment. See the "Prescription drug program" section of this SB/DF for diabetic supplies benefit information. ⁹	Covered in full
Diabetic footwear ⁹	Covered in full
Prostheses ⁹	Covered in full
Blood, blood plasma, blood derivatives and blood factors	Covered in full
Nuclear medicine	Covered in full
Organ and bone marrow transplants (nonexperimental and noninvestigational)	Covered in full
Chemotherapy	\$20
Renal dialysis	Covered in full
Home health services	Covered in full
Hospice services	Covered in full

Additional plan benefit information (supplemental)

Prescription drug coverage ¹⁰

(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)

Level I drugs listed on the Health Net Recommended Drug List (primarily generic)	\$10
Level II drugs listed on the Health Net Recommended Drug List (primarily brand name), peak flow meters, inhaler spacers and diabetic supplies (including insulin) ¹⁰	\$25
Level III drugs listed on the Health Net Recommended Drug List (or drugs not listed on the Health Net Recommended Drug List) ¹¹	\$50
Smoking cessation drugs (covered up to a 12-week course of therapy per calendar year if you are currently enrolled in a comprehensive smoking cessation program) ¹²	50%
Appetite Suppressants	50%
Lancets	Covered in full
Sexual dysfunction drugs, including injectable drugs (limited to quantities as specified in the Recommended Drug List) ¹¹	50%
Contraceptive devices (including diaphragms and cervical caps)	\$25
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)	\$20
Level II drugs listed on the Health Net Recommended Drug List (primarily brand name) and diabetic supplies (including insulin) ¹¹	\$50

Level III drugs listed on the Health Net Recommended Drug List (or drugs not listed on the Health Net Recommended Drug List) ¹¹	\$100
Lancets	Covered in full

Chiropractic services¹⁰

(Benefits are administered by American Specialty Health Plans of California, Inc. (ASH Plans). Please refer to the "Chiropractic care program" section of this SB/DF for the benefits and limitations.)

Office visits (20-visit maximum per calendar year)	\$15
Annual chiropractic appliance allowance	\$50

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

- ¹ The percentages that appear in this chart are based on amounts agreed to in advance by Health Net and the member's physician group or other authorized health care provider.
- ² Please refer to the "Behavioral health services" section of this SB/DF for the definitions of severe mental illness and serious emotional disturbances of a child. Benefits are administered through United Behavioral Health at **1-800-720-4158**.
- ³ Self-referrals are allowed for obstetrics and gynecological services including preventive care, pregnancy and gynecological ailments. Copayment requirements may differ depending on the services provided.
- ⁴ 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.
- ⁵ 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. In addition, a covered annual cervical cancer screening test includes a Pap test, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA.
- ⁶ 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.
- ⁷ Copayments for emergency room or urgent care center visits will not apply if the member is admitted as an inpatient directly from the emergency room or urgent care center. A visit to one of the urgent care centers that is owned and operated by the member's physician group will be considered an office visit and the office visit copayment, if any, will apply.
- ⁸ Diagnostic endoscopic procedures, such as diagnostic colonoscopy, performed in an outpatient facility require the copayment applicable for outpatient facility services. If, during the course of a diagnostic endoscopic procedure performed in a hospital or outpatient surgical center, a therapeutic (surgical) procedure is performed, then the copayment applicable for outpatient surgery will be required instead of the copayment for outpatient facility services.
- ⁹ Diabetic equipment covered under the medical benefit (through "Diabetic Equipment"), includes blood glucose monitors designed for the visually impaired, insulin pumps and related supplies, corrective footwear. In addition, the following supplies are covered under the medical benefit as specified: visual aids (excluding eyewear) to assist the visually impaired with the proper dosing of insulin are provided through the prostheses benefit; Glucagon is provided through the self-injectable benefit. Self-management training, education and medical nutrition therapy will be covered only when provided by licensed health care professionals with expertise in the management or treatment of diabetes (provided through the patient education benefit).

Diabetic equipment and supplies covered under the prescription drug benefit include insulin, specific brands of blood glucose monitors and testing strips, Ketone urine testing strips, lancets and lancet puncture devices, specific brands of pen delivery systems for the administration of insulin (including pen needles) and specific brands of insulin syringes.

¹⁰ Copayments for the following services and supplies do not apply to the out-of-pocket maximum:

- Outpatient prescription drugs, except copayments for peak flow meter and inhaler spacers used for the treatment of asthma, and diabetic supplies
- Chiropractic care

¹¹ Generic drugs will be dispensed when a generic drug equivalent is available. When a brand name drug is dispensed and a generic equivalent is commercially available, the member must pay the difference between the generic equivalent and the brand name drug plus the Level I drug copayment.

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

¹² Must be approved by Health Net and the member's physician group.

Limits of coverage

What's not covered (exclusions and limitations)

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

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

Benefits and coverage

What you pay for services

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

Coverage for newborns

Children born after your date of enrollment are automatically covered at birth. To continue coverage, the child must be enrolled through your employer before the 60th day of the child's life. A newborn can be added to your benefits by calling the Wells Fargo HR Service Center, 1-877-HRWELLS (1-877-479-3557) within 60 days of your child's birth. Do not call your health plan directly. If you do not call the HR Service Center within 60 days of your child's birth to enroll your child:

- 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.
- Coverage will not be available until the next annual benefits enrollment period except for reasons stated under "Exceptions to Late Enrollment Rule" or "Special Enrollment For Newly Acquired Dependents" in the member Evidence of Coverage.

Emergencies

Health Net covers emergency and urgently needed care throughout the world. If you are injured, feel severe pain, begin active labor or experience an unexpected illness that a reasonable person with an average knowledge of health and medicine would believe requires immediate treatment to prevent serious threat to your health, seek care where it is immediately available. Depending on your circumstances, you may seek this care by going to your physician group 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 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.

An emergency means any otherwise covered service that a reasonable person with an average knowledge of health and medicine would believe requires immediate treatment (including severe mental illness and serious emotional disturbances of a child), and without immediate treatment, any of the following would occur: (a) his or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger); (b) his or her bodily functions, organs or parts would become seriously damaged; or (c) his or her bodily organs or parts would seriously malfunction. Emergency Care also includes treatment of severe pain or active labor. Active labor means labor at the time that either of the following would occur: (a) there is inadequate time to effect safe transfer to another hospital prior to delivery; or (b) a transfer poses a threat to the health and safety of the member or her unborn child.

All follow-up care after the urgency has passed and your condition is stable, must be provided or authorized by your physician group, otherwise, it will not be covered by Health Net.

Medically necessary care

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

Second opinions

You have the right to request a second opinion when:

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

To obtain a copy of Health Net's second opinion policy, contact the Health Net Member Services Department at **1-800-539-4102**.

Clinical trials

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

Extension of benefits

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

- A maximum of 12 consecutive months elapses from the termination date;
- Available benefits are exhausted;
- The disability ends; or
- The member becomes enrolled in another plan that covers the disability.

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

Confidentiality and release of member information

Health Net knows that personal information in your medical records is private. Therefore, we protect your personal health information in all 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, such as for court order or subpoena. We will not release your confidential claims details to your employer or their agent. Often Health Net is required to comply with aggregated measurement and data reporting requirements. In those cases, we protect your privacy by not releasing any information that identifies our members.

Privacy practices

Once you become a Health Net member, Health Net uses and discloses a member's protected health information for purposes of treatment, payment, health care operations, and where permitted or required by law. Health Net provides members with a Notice of Privacy Practices that describes how it uses and discloses protected health information; the individual's rights to access, to request amendments, restrictions, and an accounting of disclosures of protected health information; and the procedures for filing complaints. Health Net will provide you the opportunity to approve or refuse the release of your information for non-routine releases such as marketing. Health Net provides access to members to inspect or obtain a copy of the member's protected health information in designated record sets maintained by Health Net.

Health Net protects oral, written and electronic information across the organization by using reasonable and appropriate security safeguards. These safeguards include limiting access to an individual's protected health information to only those who have a need to know in order to perform payment, treatment, health care operations or where permitted or required by law. Health Net releases protected health information to plan sponsors for administration of self-funded plans but does not release protected health information to plan sponsors/employers for insured products unless the plan sponsor is performing a payment or health care operation function for the plan. Health Net's entire Notice of Privacy Practices can be found in your plan's EOC, at www.healthnet.com/wellsfargoca under "Privacy" or you may contact the Member Services Department at **1-800-539-4102** to obtain a copy.

Experimental or Investigational Technology

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 **1-800-539-4102**.

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 called copayments, which are described in the "Schedule of benefits and coverage" section of this SB/DF. Beyond these charges the remainder of the cost of covered services will be paid by Health Net.

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

Certain copayments paid will not be applied to the out-of-pocket maximum as shown in the "Schedule of benefits and coverage" section. Payment for services not covered by this plan will not be applied to the calendar year out-of-pocket maximum. Additionally, deductibles and copayments for any covered supplemental benefits purchased by your employer, such as for prescription drugs or eyewear will also not be applied to the limit with the exception of copayments inhaler spacers, peak flow meters used for the treatment of asthma, and for diabetic supplies. For further information please refer to the EOC.

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, you are responsible for payment of expenses for these services. Remember, services are only covered when provided or authorized by a PCP or physician group, except for emergency or out-of-area urgent care. Consult the *Health Net HMO Directory* for a full listing of Health Net-contracted physicians.

Reimbursement provisions

Payments that are owed by Health Net for services provided by or through your physician group will never be your responsibility.

If you have out-of-pocket expenses for covered services, call the Health Net Member Services Department at **1-800-539-4102** for a claim form and instructions. You will be reimbursed for these expenses less any required copayment, coinsurance or deductible. (Remember, you do not need to submit claims for medical services provided by your PCP or physician group.)

If you receive emergency services not provided or directed by your physician group, you may have to pay at the time you receive service. To be reimbursed for these charges, you should obtain a complete statement of the services received and, if possible, a copy of the emergency room report.

Please contact the Health Net Member Services Department at **1-800-539-4102** to obtain claim forms, and to find out whether you should send the completed form to your physician group or directly to Health Net. 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 emergency medical services or for services authorized by your physician group or PCP with Health Net, please send a completed claim form within one year of the date of service to:

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

If you need to file a claim for outpatient prescription drugs, please send a completed prescription drug claim form to:

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

Please call Health Net Member Services at **1-800-539-4102** or visit our website at www.healthnet.com/wellsfargoca to obtain a prescription drug claim form.

If you need to file a claim for emergency chiropractic service or for the other approved services, please send your completed claim form with in one year of the date of services to:

American Specialty Health Plans of California, Inc.
Attention: Member Services Department
P.O. Box 509002
San Diego, CA 92150-9002

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

Provider referral and reimbursement disclosure

If you are considering enrolling in our plan, you are entitled to ask if the plan has special financial arrangements with our physicians that can affect the use of referrals and other services you may need. Health Net uses financial incentives and various risk sharing arrangements when paying providers. To get this information, call the Health Net Member Services Department at **1-800-539-4102**, your physician group or your PCP and request information about our physician payment arrangements.

Facilities

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

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

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

The physician group you choose will also have a contractual relationship with local hospitals (for acute, subacute and transitional care) and skilled nursing facilities.

Physician group transfers

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

Transfer requests will generally be honored unless you are confined to a hospital. (However, Health Net may approve transfers under this condition for certain unusual or serious circumstances. Please contact the Health Net Member Services Department at **1-800-539-4102**.)

Continuity of Care

Transition of Care for New Enrollees

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

Continuity of Care Upon Termination of Provider Contract

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

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

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

The following conditions are eligible for continuation of care:

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

If you would like more information on how to request continued care or to request a copy of Health Net's continuity of care policy, please contact the Health Net Member Services Department at **1-800-539-4102**.

Renewing, continuing or ending coverage

Renewal provisions

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

Individual continuation of benefits

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

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

- COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside of California. Please check with your group to determine if you and your covered dependents are eligible.
- 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 employee and spouse are eligible for Senior-COBRA prior to January 1, 2005.

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

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

- USERRA Coverage: Under a federal law known as the Uniformed Services Employment and Reemployment Rights Act (USERRA), employers are required to provide employees who are absent from employment to serve in the uniformed services and their dependents who would lose their group health coverage the opportunity to elect continuation coverage for a period of up to 24 months. Please check with your group to determine if you are eligible.

- **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 the Health Net Member Services Department for information about conversion plan coverage. Furthermore, you may be eligible for continued coverage for a disabling condition (for up to 12 months) if your employer terminates its agreement with Health Net. Please refer to the "Extension of benefits" section of this SB/DF for more information.

Termination of benefits

Health Net can terminate your coverage when:

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

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

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

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

members, or the physician's office or contracting physician group's ability to provide services to other patients.

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 you have a disagreement with our plan

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

If you have a grievance against Health Net, you should first telephone Health Net at **1-800-539-4102** and use the plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, or a grievance that has not been satisfactorily resolved by Health Net, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

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

Member grievance and appeals process

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

To file a grievance or appeal you may call **1-800-539-4102** or submit a Member Grievance Form through the Health Net website at www.healthnet.com/wellsfargoca:

You may also write to:

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

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

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

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

Arbitration

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

Additional plan benefit information

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

Behavioral health services

Your employer has independently contracted with United Behavioral Health, a specialized health care service plan, to provide mental health and substance abuse benefits. Covered services may be obtained by receiving a referral through United Behavioral Health at **1-800-720-4158**. Care must be provided by a United Behavioral Health participating provider and approved by United Behavioral Health.

Please contact United Behavioral Health at **1-800-720-4158** for a complete schedule of your Mental Health and substance abuse benefits.

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/wellsfargoca or call the Health Net Member Services Department at **1-800-539-4102**.

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 **1-800-539-4102**.

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

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

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

To obtain a copy of Health Net's most current Recommended Drug List, please visit our web site at www.healthnet.com/wellsfargoca, under the pharmacy information, or call the Health Net Member Services Department at **1-800-539-4102**.

Level III drugs

Level III drugs are prescription drugs that are listed as Level III or not listed on the Recommended Drug List and are not excluded from coverage.

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 **1-800-539-4102**;
- Visit www.healthnet.com/wellsfargoca for information on e-mailing the Member Services Department; or

- Write to:

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

What's covered

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

Outpatient prescription medication:

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

Note:

- Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's usual and customary charges for covered prescription drugs.
- Prescription drug refills are covered, up to a 30-consecutive-day supply per prescription at a Health Net contracted pharmacy for one copayment. A copayment is required for each prescription. 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 only pay the pharmacy's usual and customary charge.
- Percentage copayments will be based on Health Net's contracted pharmacy rate.
- For Level III Drugs, you will pay the greater of the Level II Drug copayment or the Level III copayment.
- Mail order drugs are covered up to a 90-consecutive-calendar-day supply. When the retail pharmacy copayment is a percentage, the mail order copayment is the same percentage of the cost to Health Net as the retail pharmacy copayment.
- Prescription drugs for the treatment of asthma are covered as stated in the Recommended Drug List. Inhaler spacers and peak flow meters under the pharmacy benefit are covered when medically necessary. Nebulizers (including face masks and tubing) are covered under "Durable Medical Equipment" and educational programs for the management of asthma are covered under "Patient Education" through the medical benefit. For information about copayments required for these benefits, please see the "Schedule of benefits and coverage" section of this SB/DF.
- Oral contraceptives and emergency contraceptives are covered. Vaginal contraceptives include diaphragms and cervical caps are only covered when a member 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. For a complete list of contraceptive products covered by Health Net, please refer to the Recommended Drug List. Injectable contraceptives are covered when administered by a physician. Refer to your plan's EOC for more information on contraceptives covered under the medical benefit. If your physician determines that none of the methods specified as covered by the plan are medically appropriate, then the plan will provide coverage for another FDA approved 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 up to a 30-day period. For more information about diabetic equipment and supplies, please see "Endnotes" in the "Schedule of benefits and coverage" section of this SB/DF.

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 is covered as a medical benefit. See "allergy serum" benefit in the "Schedule of benefits and coverage" for details;
- Coverage for devices is limited to vaginal contraceptive devices, peak flow meters, spacer inhalers and diabetic supplies. No other devices are covered even if prescribed by a participating physician;
- Drugs that require a prescription in order to be dispensed for the relief of nicotine withdrawal symptoms are covered up to a twelve week course of therapy per calendar year if the member is concurrently enrolled in a comprehensive smoking cessation behavioral support program. The prescribing physician must request prior authorization for coverage. For information regarding smoking cessation behavioral support programs available through Health Net, contact Member Services at the telephone number on your Health Net ID card or visit the Health Net website at www.healthnet.com/wellsfargoca;
- Drugs prescribed for the treatment of obesity are covered, when medically necessary for the treatment of morbid obesity. In such cases, the drugs will be subject to prior authorization from Health Net;
- Drugs or medicines administered by a physician or physician's staff member;
- Drugs prescribed for routine dental treatment;
- Drugs prescribed to shorten the duration of the common cold;
- Drugs prescribed for sexual dysfunction when not medically necessary, including drugs that establish, maintain, or enhance sexual function or satisfaction;
- Experimental drugs (those that are labeled "Caution - Limited by Federal Law to investigational use only"). If you are denied coverage of a drug because the drug is investigational or experimental you will have a right to independent medical review. See "If you have a disagreement with our plan" section of this SB/DF for additional information;
- Hypodermic needles or syringes, except for insulin needles, syringes and specific brands of pen devices;
- Immunizing agents, injections (except for insulin), agents for surgical implantation, biological sera, blood, blood derivatives or blood plasma obtained through a prescription;
- Individual doses of medication dispensed in plastic, unit dose or foil packages unless medically necessary or only available in that form;
- Limits on quantity, dosage and treatment duration may apply to some drugs. Medications taken on an "as-needed" basis may have a copayment based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If medically necessary, your physician may request a larger quantity from Health Net;
- Medical equipment and supplies (including insulin), that are available without a prescription are covered when prescribed by a physician for the management and treatment of diabetes. 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;
- Oral infertility drugs are not covered;

- Prescription drugs filled at pharmacies that are not in the Health Net pharmacy network or are not in California except in emergency or urgent care situations;
- Prescription drugs prescribed by a physician who is not a member physician or an authorized specialist are not covered, except when the physician's services have been authorized, or because of a medical emergency condition, illness or injury, for urgently needed care or as specifically stated;
- Replacement of lost, stolen or damaged medications;
- Supply amounts for prescriptions that exceed the FDA's or Health Net's indicated usage recommendation are not covered unless medically necessary and prior authorization is obtained from Health Net; and
- Drugs prescribed for a condition or treatment not covered by this plan are not covered. However, the plan does cover drugs for medical conditions that result from nonroutine complications of a noncovered service.

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

Chiropractic care program

Health Net has partnered with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable chiropractic coverage. With this program, you are free to obtain this care by selecting a contracted chiropractor from our *ASH Plans Contracted Chiropractor Directory*. Although you are always welcome to consult your PCP, you will not need a referral to see a contracted chiropractor.

What's covered

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

- Office visits;
- Chiropractic 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; and
- 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 (exclusions and limitations)

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

- Air conditioners, air purifiers, therapeutic mattresses, vitamins, minerals, nutritional supplements, durable medical equipment, appliances or comfort items;
- Charges for hospital confinement and related services;
- Charges for anesthesia;
- Conjunctive physical therapy not associated with spinal, muscle or joint adjustment;
- Diagnostic scanning, MRI, CAT scans or thermography;
- Exams or treatment of strictly non-neuromusculoskeletal disorders;
- Experimental or investigational chiropractic services. Only chiropractic services that are non-investigational, proven and meet professionally recognized standards of practice in the chiropractic provider community are covered. ASH Plans will determine what will be considered experimental or investigational;
- Hypnotherapy, behavioral training, sleep therapy, weight programs, educational programs, nonmedical self-help or self-care, or any self-help physical exercise training;

- Lab tests, x-rays, adjustments, physical therapy or other services not chiropractically necessary or classified as experimental;
- Pre-employment physicals or vocational rehabilitation arising from employment or covered under any public liability insurance;
- Treatment for temporomandibular joint syndrome (TMJ); and
- Treatment or services not authorized by ASH Plans or delivered by an ASH Plans contracted provider (except emergency chiropractic services or upon a referral to a non-contracted provider approved by ASH Plans).

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

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**For more information,
please contact us at:**

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

Customer Contact Center

Large Group:

1-800-539-4102 – HMO

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

Telecommunications Device
for the Hearing and Speech Impaired:

1-800-995-0852

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