HMO • Plan 52Y

Summary of

benefits

and Disclosure Form

Dear Prospective Health Net Member,

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

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

Remember, if you have further questions about Health Net, call the Member Services Department at **1-800-522-0088**. We're always glad to help.

Thank you for considering Health Net!

Delivering choices

When it comes to your health care, the best decisions are made with the best choices. Health Net of California, Inc. (Health Net) provides you with ways to help you receive the care you deserve. This Summary of benefits/disclosure form SB/DF answers basic questions about this versatile plan. If you have further questions, just contact the Health Net Member Services Department at **1-800-522-0088**. Our friendly, knowledgeable representatives will be glad to help.

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."

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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**.
- Whenever you or a covered family member needs health care, your PCP will provide the medically necessary treatment. Specialist care is also available through your Health Net plan, when authorized in advance through your PCP or physician group.
- You do not have to choose the same physician group or PCP for all members of your family. Physician groups, with names of physicians and specialists, are listed in the *Health Net 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**.

How to enroll

Complete the enrollment form found in the enrollment packet and return the form to your employer. If a form is not included, your employer may require you to use an electronic enrollment form or an interactive voice response enrollment system. Please contact your employer for more information.

Some hospitals and other providers do not provide one or more of the following services that may be covered under your *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 1-800-522-0088 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)	

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. You will need to continue making payments for any additional benefits as described in the "Additional plan benefits information" section of this SB/DF.

One member	$1500
Two members	$3000
Family (three members or more)	$4500

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

Professional services

Visit to physician	$10
Visit to physician for treatment of severe mental illness or serious emotional disturbances of a child[3***]	$10
Specialist consultations[3]	$10
Physician visit to member's home at your physician's discretion and in accordance with criteria set by Health Net	$10
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders)	Covered in full
Immunization for occupational purposes	Covered in full
Immunization for foreign travel	Covered in full
Allergy testing	$10
Allergy serum	Covered in full
Allergy injection services	$10
All other injections (except self-injectibles) **This plan covers hormonal therapy treatment related to Gender Identity Disorder (GID)**	Covered in full
Self injectible drugs	20% of contracted rate (up to $100 per prescription)
Surgeon services[4]	Covered in full
Assistant surgeon services[4]	Covered in full

Transgender surgery and services[2]	Covered in full
Administration of anesthetics	Covered in full
X-ray and laboratory procedures	Covered in full
Rehabilitative therapy (includes physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)	$10
Adult preventive care	
Periodic health evaluations, including well-woman exam (age 18 and older)[4,6]	$10
Vision and hearing examinations	$10
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)[4,6]	$10
Vision and hearing examinations (birth through age 17)	$10
Family planning (professional services)[7]	
Prenatal office visits	$0
Postnatal office visits	$10
Normal delivery, cesarean section, newborn inpatient care	Covered in full
Treatment of complications of pregnancy, including medically necessary abortions	Covered in full
Elective abortions	$10
Genetic testing of fetus	Covered in full
Circumcision of newborn males (birth through 30 days)	Covered in full
Injectable contraceptives (including but not limited to Depo Provera)	Covered in full
Infertility services and supplies (including injections related to covered infertility services and IVF, GIFT, and ZIFT)	50% (Combined lifetime maximum of one treatment cycle for all procedures)
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)	Covered in full
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)[3***]	Covered in full
Hospitalization for infertility services	50%
Skilled nursing facility stay *(limited to 100 days each calendar year)*	Covered in full
Outpatient facility services (other than surgery)	Covered in full
Outpatient surgery (Surgery performed in a hospital or outpatient surgery center only)	Covered in full

Emergency health coverage	
Emergency room (professional and facility charges)[8]	$35
Urgent care center (professional and facility charges)[8]	$15
Ground ambulance	Covered in full
Air ambulance	Covered in full
Other services	
Durable medical equipment (includes foot orthotic devices only when incorporated into a cast, brace or strapping of the foot)	Covered in full
Corrective footwear (Includes one pair of extra depth or custom molded shoes with three pairs of shoe inserts each calendar year)	Covered in full
Diabetic equipment. See the "Prescription drug program" section of this SB/DF for diabetic supplies benefit information.[9]	Covered in full
Prosthetic devices	Covered in full
Hearing aids (2 aid(s),1 per ear) and $2500 max every 36 months), includes coverage for digital hearing aids[12]	Covered in full
Blood, blood plasma, blood derivatives and blood factors	Covered in full
Nuclear medicine	Covered in full
Organ and bone marrow transplants (nonexperimental and noninvestigational)	Covered in full
Chemotherapy	Covered in full
Renal dialysis	Covered in full
Home health services	Covered in full
Hospice services	Covered in full

Additional plan benefit information (supplemental)

Behavioral health services

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

Nonsevere mental disorder benefits[3***]	
Outpatient consultation *(unlimited visits)*[3,14*]	
Individual session	$10
Group session	$5
Chemical dependency benefits[3***]	
Outpatient consultation *(60-visit maximum each calendar year)*[3*]:	
Individual session	$20
Group session	$10
Inpatient *(30-day maximum each calendar year)*[3**]	Covered in full
Acute care detoxification[3**]	Covered in full

Prescription drug coverage

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

Retail pharmacy (up to a 34-day supply)	
Level I drugs listed on the Health Net Recommended Drug List (primarily generic)	$5
Level II drugs listed on the Health Net Recommended Drug List (primarily brand name) and diabetic supplies (including insulin)[11]	$15
Level III drugs (drugs not listed on the Health Net Recommended Drug List)[11]	$25
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)[13]	50%
Lancets	Covered in full
Sexual dysfunction drugs, including injections *(limited to two doses per week or eight tablets per month)*[13]	50%
Oral infertility drugs[13]	50%
Contraceptive devices (including diaphragms and cervical caps)	$15
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)	$10
Level II drugs listed on the Health Net Recommended Drug List (primarily brand name) and diabetic supplies (including insulin)[11]	$30
Level III drugs (drugs not listed on the Health Net Recommended Drug List)[11]	$50
Lancets	Covered in full

Chiropractic services

(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 *(30-visit maximum per calendar year)*	$10
Annual chiropractic appliance allowance	$50

Acupuncture services

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

Office visits *(30-visit maximum per calendar year)*	$10

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] Transgender surgery requires a prior authorization from Health Net. Transgender surgery and services related to the surgery that are authorized by Health Net are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member. Inpatient and Outpatient Hospital Services for transgender surgery and services related to the surgery require prior authorization by Health Net.

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

* Applicable only for outpatient counseling defined as individual office visits and group therapy sessions. Group sessions are equal to half of an individual session and count towards the visit maximum. In addition, outpatient mental health and chemical dependency are limited to a combined maximum number of visits each calendar year.

* Applicable only for outpatient counseling defined as individual office visits and group therapy sessions. Group sessions are equal to half of an individual session and count towards the visit maximum.

**Inpatient admission means any admission to a hospital, day treatment program, residential treatment center or structured outpatient program. The copayment is applicable for each admission.

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

[4] Self-referrals are allowed for obstetrics and gynecological services including preventive care, pregnancy and gynecological ailments. Copayment requirements may differ depending on the services provided.

[5] Surgery includes surgical reconstruction of a breast incident to mastectomy, including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema. While Health Net and your physician group will determine the most appropriate services, the length of hospital stay will be determined solely by your PCP.

[6] 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.

[7] 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.

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

[9] Diabetic equipment covered under the medical benefit includes insulin pumps, podiatric devices and blood glucose monitors designed for the visually impaired. 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 prosthetics benefit; Glucagon is provided through the self-injectible 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. 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, reusable pen delivery systems for the administration of insulin (including pen needles) and 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 diabetic supplies
- Chiropractic care
- Acupuncture care

[11]Generic drugs will be dispensed when a generic drug equivalent is available. If the member requests a brand name drug when a generic equivalent is 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]The hearing aid copayment will apply to the purchase of the hearing aid. Coverage includes repair and maintenance of the hearing aid. The initial hearing exam and fitting may also be subject to a copayment: see "Vision and hearing examinations" under "Adult preventive care" and "Child preventive care" to determine if any copayment applies. Additional charges for batteries or other equipment related to the hearing and or replacement of the hearing aid are not covered.

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

[14] Effective 1/1/2003, Gender dysphoria is covered as any other mental illness

Limits of coverage

What's not covered (exclusions and limitations)

- Artificial insemination for reasons not related to infertility;
- 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;
- 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);
- 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. 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;
- 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 30th day of the child's life. If the child is not enrolled within 30 days of the child's birth:

- Coverage will end the 31st day after birth; and
- You will have to pay your physician group for all medical care provided after the 30th day of your baby's life.

Emergencies

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

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

All follow-up care (including severe mental illness and serious emotional disturbances of a child*)* after the urgency has passed and your condition is stable, must be provided or authorized by your physician group (medical) or the Behavioral Health Administrator (mental illness and chemical dependency); otherwise, it will not be covered by Health Net.

Medically necessary care

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

Second opinions

You have the right to request a second opinion when:

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

To obtain a copy of Health Net's second opinion policy, contact the Health Net Member Services Department at **1-800-522-0088**.

Clinical trials

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

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

For a 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's EOC. The notice of privacy practices is also available on the Health Net website at **www.healthnet.com** under "Privacy" or you may contact the Member Services Department at **1-800-522-0088** to obtain a copy.

Technology assessment

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

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

order to determine medical appropriateness or investigational or experimental status of a technology or procedure.

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

Utilization management processes

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

Pre-Authorization

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

Concurrent Review

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

Discharge Planning

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

Retrospective Review

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

Care or Case Management

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

If you would like additional information regarding Health Net's utilization management process, please call the Health Net Member Services Department at **1-800-522-0088**.

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 prescription drugs or eyewear will also not be applied to the limit with the exception of copayments for diabetic supplies. For further information please refer to the EOC.

Coordination of benefits

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

Medicare coordination

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

Liability of subscriber or enrollee for payment

If you receive health care services from doctors without receiving required authorization from your PCP or physician group (medical) or the Behavioral Health Administrator (mental illness and chemical dependency), you are responsible for payment of expenses for these services. Remember, services are only covered when provided or authorized by a PCP or physician group or the Behavioral Health Administrator, except for emergency or out-of-area urgent care. Consult the *Health Net HMO Directory* for a full listing of Health Net-contracted physicians.

Third-party liability

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

Reimbursement provisions

Payments that are owed by Health Net for services provided by or through your physician group (medical) or the Behavioral Health Administrator (mental illness and chemical dependency) will never be your responsibility.

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

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

Please contact the Health Net Member Services Department at **1-800-522-0088** to obtain claim forms, and to find out whether you should send the completed form to your physician group (medical) or the Behavioral Health Administrator (mental illness and chemical dependency) or to Health Net. Medical claims must be received by Health Net within one year of the date of service to be eligible for reimbursement.

If you need to file a claim for 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 Mental Disorders and Chemical Dependency emergency services or for services authorized by MHN, you must use MHN's forms. Please send the claim to MHN within one year of the date of service at the address listed on the claims form or to MHN at:

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

Please call MHN at **1-800-730-6191** to obtain a claim form.

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 853901
Richardson, TX 75085-3901

Please call Health Net Member Services at **1-800-522-0088** or visit our website at **www.healthnet.com** to obtain a prescription drug claim form.

If you need to file a claim for emergency chiropractic or acupuncture 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

Provider referral and reimbursement disclosure

If you are considering enrolling in our plan, you are entitled to ask if the plan has special financial arrangements with our physicians that can affect the use of referrals and other services you may need. Health Net uses financial incentives and various risk sharing arrangements when paying providers. To get this information, call the Health Net Member Services Department at **1-800-522-0088**, your physician group or your PCP and request information about our physician payment arrangements.

Facilities

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

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

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

The physician group you choose will also have a contractual relationship with local hospitals (for acute, subacute and transitional care) and skilled nursing facilities. These are listed in your *Health Net HMO Directory*.

Physician group transfers

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

Transfer requests will generally be honored unless you are confined to a hospital. (However, Health Net may approve transfers under this condition for certain unusual or serious circumstances. Please contact the Health Net Member Services Department at **1-800-522-0088**.)

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 and 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 provided 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 upon receiving notification of the provider's date of termination.

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;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- A newborn (up to 36 months of age with a maximum duration of coverage of 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 **1-800-522-0088**.

Renewing, continuing or ending coverage

Renewal provisions

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

Individual continuation of benefits

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

- COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). 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 18 months. Please check with your Group to determine if you are eligible.
- HIPAA Guaranteed Issue Coverage: The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people covered under existing group health plans to maintain coverage regardless of pre-existing conditions when they change jobs or are unemployed for brief periods of time. California law provides similar and additional protections. Applicants who meet the following requirements are eligible to enroll in a guaranteed issue individual health plan from any health plan that offers individual coverage, including Health Net's Guaranteed HMO Plans, without medical underwriting. A health plan cannot reject your application for guaranteed issue individual health coverage if you meet the following requirements, agree to pay the required premiums and live or work in the plan's service area. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance. To be considered an eligible individual:

  1. The applicant must have a total of 18 months of coverage (including COBRA, if applicable) without a significant break (excluding any employer-imposed waiting periods) in coverage of more than 63 days.
  2. The most recent coverage must have been under a group health plan. COBRA and Cal-COBRA coverage are considered group coverage.
  3. The applicant must not be eligible for coverage under any group health plan, Medicare or Medicaid, and must not have other health insurance coverage.
  4. The individual's most recent coverage could not have been terminated due to fraud or nonpayment of premiums.
  5. If COBRA or Cal – COBRA coverage was available, it must have been elected and such coverage must have been exhausted.

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

Also, if you become ineligible for group coverage, you may convert from group coverage to a type of individual coverage called conversion coverage. Application must be made within 63 days of the date group coverage ends. Please contact 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 the employer covered under this plan does not pay appropriate subscription charges, benefits will end on the last day for which subscription charges have been made, unless:

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

If you have a disagreement with our plan

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

If you have a grievance against Health Net, you should first telephone Health Net at **1-800-522-0088** 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 **1-800-522-0088** or submit a Member Grievance Form through the Health Net website at **www.healthnet.com**:

You may also write to:

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

Please include all the information from your Health Net identification card as well as 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

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

Transition of Care for New Enrollees

If you are receiving ongoing care for an acute, serious, or chronic mental health condition from a provider not affiliated with the Behavioral Health Administrator when you enroll with Health Net, we may temporarily cover services provided by that provider, subject to applicable copayments and any other exclusions and limitations of this plan.

Your non-participating mental health professional must be willing to accept the Behavioral Health Administrator's standard mental health provider contract terms and conditions and 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 Member Services Department at **1-800-522-0088**.

Serious emotional disturbances of a child

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

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

Severe mental illness

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

Continuation of treatment

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

Health Net and your EAP

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

What's covered

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

What's not covered (exclusions and limitations)

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

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

- Congenital or organic disorders, including organic brain disease and mental retardation, except for some conditions when the level of severity meets the criteria of severe mental illness or serious emotional disturbances of a child as described in the EOC;
- Experimental or investigational therapies;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder;
- Nontreatable mental disorders;

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

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

Prescription drug program

Health Net is contracted with many major pharmacy chains, supermarket based pharmacies and privately owned neighborhood pharmacies in California. For a complete and up-to-date list of participating pharmacies, please visit our website at **www.healthnet.com** or call the Health Net Member Services Department at **1-800-522-0088**.

Prescriptions By Mail Drug Program

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period), you have the option of filling it through our convenient Prescriptions By Mail Drug Program. This program allows you to receive up to a 90-consecutive-calendar-day supply of maintenance medications. For complete information, call the Health Net Member Services Department at **1-800-522-0088**.

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**, under the pharmacy information, or call the Health Net Member Services Department at **1-800-522-0088**.

Drugs not on the List: Level III drugs

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

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 **1-800-522-0088;**
- Visit **www.healthnet.com** 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 (drugs not listed on the Recommended Drug List).

Note:

- Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's usual and customary charges for covered prescription drugs.
- Prescription drug refills are covered, up to a 34-consecutive-day supply per prescription at a Health Net contracted pharmacy for one copayment.
- If the pharmacy's usual and customary charge is less than the applicable copayment, the member will only pay the pharmacy's usual and customary charge.
- Mail order drugs are covered up to a 90-consecutive-calendar-day supply. When the retail pharmacy copayment is a percentage, the mail order copayment is the same percentage of the cost to Health Net as the retail pharmacy copayment.
- Prescription drugs for the treatment of asthma are covered as stated in the Recommended Drug List. Inhaler spacers and peak flow meters are covered when medically necessary. Nebulizers (including face masks and tubing) are covered under the medical benefit.
- Oral contraceptives and emergency contraceptives are covered. Vaginal contraceptives include diaphragms and cervical caps and 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. Injectible 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 a 30-day period. See diabetic equipment under the 'Schedule of benefits and coverage' section of this SB/DF for additional benefit information.

What's not covered (exclusions and limitations)

Services or supplies excluded under pharmacy services may be covered under the medical benefits portion of your plan. 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**;
- 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 to shorten the duration of the common cold;
- Drugs prescribed for sexual dysfunction when not medically necessary, including drugs that establish, maintain, or enhance sexual function or satisfaction;
- Experimental drugs (those that are labeled "Caution - Limited by Federal Law to investigational use only"). If you are denied coverage of a drug because the drug is investigational or experimental you will have a right to independent medical review. See "If you have a disagreement with our plan" section of this SB/DF for additional information;
- Hypodermic needles or syringes, except for insulin needles, syringes and reusable pen devices;
- Immunizing agents, injections (except for insulin), agents for surgical implantation, biological sera, blood, blood derivatives or blood plasma obtained through a prescription;
- Individual doses of medication dispensed in plastic, unit dose or foil packages unless medically necessary or only available in that form;
- Limits on quantity, dosage and treatment duration may apply to some drugs. Medications taken on an "as-needed" basis may have a copayment based on a standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If medically necessary, your physician may request a larger quantity from Health Net;
- Medical equipment and supplies (including insulin), that are available without a prescription are covered when prescribed by a physician for the management and treatment of diabetes. Any other nonprescription drug, medical equipment or supply that can be purchased without a prescription drug order is not covered even if a physician writes a prescription drug order for such drug, equipment or supply. However, if a higher dosage form of a prescription drug or over-the-counter (OTC) drug is only available by prescription, that higher dosage drug will be covered. If a drug that was previously available by prescription becomes available in an OTC form in the same prescription strength, then any prescription drugs that are similar agents and have comparable clinical effect(s) will only be covered when medically necessary and prior authorization is obtained from Health Net;
- Prescription drugs filled at pharmacies 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.

Acupuncture care program

Health Net has partnered with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable acupuncture coverage. Although you are always welcome to consult your PCP, you will not need a referral to see a contracted acupuncturist.

With this program, you are free to obtain care by self-referring to a contracted acupuncturist from the *ASH Plans Contracted Acupuncturist Directory*. All covered services require pre-approval by ASH Plans except for:

- A new patient examination by a contracted acupuncturist and the provision or commencement, in the new patient examination, of medically necessary services that are covered acupuncture services, to the extent consistent with professionally recognized standards of practice; and
- Emergency acupuncture services.

When ASH Plans approves a treatment plan, the approved services for the subsequent office visits covered by the treatment plan include not only the approved services but also a re-examination in each subsequent office visit, if deemed necessary by the contracted acupuncturist, without additional approval by ASH Plans.

Definition of acupuncture covered services

Medically necessary services provided by a contracted acupuncturist (or a non-contracted acupuncturist, when emergency acupuncture services are provided or a referral is approved by ASH Plans) for the following injuries, illnesses, diseases, functional disorders or conditions, when determined medically necessary.

What's covered

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

- Office visits for treatment of the following conditions:
  - -Neuromusculoskeletal conditions, including conditions such as fibromyalgia and myofascial pain
  - -Pain, including low back pain, post-operative pain, and post-operative dental pain
  - -Nausea, including adult post-operative nausea and vomiting, chemotherapy nausea and vomiting, and nausea of pregnancy
  - -Carpal tunnel syndrome
  - -Headaches
  - -Menstrual cramps
  - -Osteoarthritis
  - -Stroke rehabilitation
  - -Tennis elbow

What's not covered (exclusions and limitations)

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

- Charges for hospital confinement and related services;
- Charges for anesthesia;
- Devices, personal and comfort items;
- Diagnostic scanning, MRI, CAT scans or thermography;
- X-rays, laboratory tests, and x-ray second opinions;
- Exams or treatment other than for neuromusculoskeletal conditions, pain, nausea, or other covered conditions, as described under the definition of acupuncture services above;
- Experimental or investigational acupuncture services. Only acupuncture services that are non-investigational, proven and meet professionally recognized standards of practice in the acupuncture provider community are covered. ASH Plans will determine what will be considered experimental or investigational;
- Treatment for asthma or addiction (including but not limited to drugs, alcohol, nicotine addiction, or smoking cessation);
- Hypnotherapy, behavioral training, sleep therapy, weight programs, educational programs, self-help items or services, or physical exercise training;
- Physical therapy services classified as experimental or investigational;
- Physicals or vocational rehabilitation for employment or those covered under any public liability insurance; and
- Treatment or services not authorized by ASH Plans or not delivered by a contracted acupuncturist when authorization is required; treatment not delivered by a contracted acupuncturist (except emergency acupuncture services or upon referral to a non-contracted acupuncturist approved by ASH Plans).

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

For more information, please contact us at:
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