Small Business Group
PPO Catastrophic Saver Plan · Plan 557

Summary of

benefits

and Disclosure Form

Dear Prospective Health Net Life Enrollee,

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

At Health Net Life, we work hard to make sure that you get the care you need when you 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 Life, please call the Member Services Department at 1-800-361-3366. We're always glad to help.

Thank you for considering Health Net Life!

Delivering choices

When you need health care, it's nice to have options. That's why Health Net Life* offers a Preferred Provider Organization (PPO) plan (called "Health Net PPO") — a plan that offers you flexibility and choice. This SB/DF answers basic questions about Health Net PPO. Please contact the Member Services Department at **1-800-361-3366** and talk to one of our friendly, knowledgeable representatives if you have additional questions.

**This plan is underwritten by Health Net Life Insurance Company and administered by Health Net of California, Inc. (Health Net.)*

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

Table of contents

How the plan works

Please read the following information so you will know from whom or what group of providers health care may be obtained.

Selection of physicians

This plan allows you to:

- Choose your own doctors and hospitals for all your health care needs; and
- Take advantage of significant cost savings when you use doctors contracted with our PPO.

Like most PPO plans, Health Net PPO offers two different ways to access care:

- In-network, meaning you choose a doctor (or hospital) contracted with our PPO.
- Out-of-network, meaning you choose a doctor (or hospital) not contracted with our PPO.

Your choice of doctors and hospitals may determine which services will be covered, as well as how much you will pay. In many instances, certification is required for full benefits (see “Schedule of benefits and coverage” section of this brochure). Preferred providers are listed on the HNL website at **www.health.net** under "DocSearch," or you can contact the Member Services Department at **1-800-361-3366** to obtain a copy of the Preferred Provider Directory.

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 *Certificate* 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;**
- **Infertility treatments; or**
- **Abortion.**

You should obtain more information before you enroll. Call your prospective doctor, participating or preferred provider or clinic or call the Member Services Department at 1-800-361-3366 to ensure that you can obtain the health care services that you need.

This Plan provides benefits required by the Newborns' and Mothers' Health Protection Act of 1996 and the Women's Health and Cancer Rights Act of 1998.

Schedule of benefits and coverage

The services covered and amount you pay depend upon the doctor or hospital you choose when you need health care. The following charts summarize what is covered and what you pay with Health Net PPO.

Medical benefits

Benefit levels	PPO[1]	OON (out-of network)[2]
Features	**(Preferred providers)** Care provided by doctors and hospitals contracted with our PPO	**(All other providers)** Care provided by licensed doctors and hospitals not contracted with our PPO
	• Lower out-of-pocket costs • Great freedom of choice • Certification from Health Net Life required for certain services • Claim forms usually not required for reimbursement • Must meet annual deductible • Coverage for preventive care services available	• Higher out-of-pocket costs • Greater freedom of choice • Certification from Health Net Life required for certain services • Claim forms required for reimbursement • Must meet annual deductible and coinsurance • Choice of any licensed physician
Deductibles	**PPO[1]**	**OON (out-of network)[2]**
You must pay this amount for covered services before HNL begins to pay		
Calendar year deductible		
For each covered individual[3]	$500	$500
For a family (the number of family members that must satisfy their individual deductible to satisfy the family deductible)[3]	2	2
Additional deductibles[3]		
Inpatient deductible (per calendar year)	$500	$500
Emergency room deductible (waived if admitted to a hospital)	$100	$100
Urgent care center deductible (waived if admitted to a hospital)	$50	$50
Plan maximums	**PPO [1]**	**OON (out-of network) [2]**
Yearly Out-of-pocket maximum (OOPM)[3]		
Once your payment of copayments or coinsurance equals the amount shown below in any one calendar year, no additional copayment or coinsurance for covered services are required for the remainder of that year. Payments for services not covered by this plan or for certain services as specified in the "Payment of fees and charges" section of this SB/DF, will not be applied to this yearly out-of-pocket maximum. You will need to continue making payments for any additional benefits as described in the "Additional plan benefit information" section of this SB/DF.		
Per covered individual	$5,000	$10,000
Lifetime maximum[3]		
(Benefits for covered expenses incurred by you are limited to a maximum amount, shown below, during your lifetime.)		
Per covered individual	$5,000,000	$5,000,000

Type of services, benefit maximums & what you pay	PPO [1]	OON (out-of network) [2]
(PPO and OON: certain services have a combined maximum for PPO and Out-of-Network		
OON: The percentage that appear in this chart for the Out-of-Network level of benefits are based on Customary and Reasonable (C&R) charges. The member is responsible for charges in excess of C&R fees in addition to the coinsurances shown.)		
Professional services		
Visit to physician[5]	$40 [4]	50%
Visit to physician for treatment of severe mental illness or serious emotional disturbances of a child[5, 6]	$40 [4]	50%
Specialist consultations[5]	$40 [4]	50%
Physician visit to hospital or skilled nursing facility	50%	50%
Allergy testing	50%	50%
Allergy injection services [4]	$40	50%
Self administered injectables	50%	50%
All other injections (excluding infertility injection)	$40 [4]	50%
Surgeon or assistant surgeon services[7, 8]	50%	50%
Administration of anesthetics	50%	50%
X-ray and laboratory procedures [8]	50%	50%
Adult preventive care		
Periodic health evaluations, including well-woman exam (age 17 and older)[4, 10]	$40	Not covered
Child preventive care		
Periodic health evaluations, including newborn, well-baby care and immunizations (birth through age 16)[4, 11]	$40	Not covered
Vision screenings and examinations (birth through age 16)[4]	$40	Not covered
Hearing screenings and examinations (birth through age 16)[4]	$40	Not covered
Family planning (professional services)		
Prenatal and postnatal office visits	50%	50%
Normal delivery, cesarean section, newborn inpatient professional care[8]	50%	50%
Treatment of complications of pregnancy, including medically necessary abortions[8]	50%	50%
Elective abortions	50%	50%
Genetic testing of a fetus	50%	50%
Circumcision of newborn males	50%	50%
Injectable contraceptives (including but not limited to Depo Provera)	$40 [4]	50%
Sterilization		
Vasectomy	50%	50%
Tubal ligation	50%	50%

Hospital services		
Semi-private hospital room or intensive care unit with ancillary services, including delivery and maternity care (unlimited days)[8]	50%	50%
Maximum allowable each day	*No maximum*	*$600*
Semi-private hospital room or intensive care unit with ancillary services for treatment of severe mental illness or severe emotional disturbances of a child[6, 8]	50%	50%
Maximum allowable each day	*No maximum*	*$600*
Skilled nursing facility stay[8]	50%	50%
Maximum days per calendar year[3]	*90*	*90*
Maximum allowable each day	*No maximum*	*$150*
Outpatient facility services (other than surgery)[8]	50%	50%
Maximum allowable each day	*No maximum*	*50% of C&R charges*
Outpatient surgery (hospital or outpatient surgery center charges only)[8]	50%	50%
Maximum allowable each day	*No maximum*	*50% of C&R charges*
Emergency health coverage		
Emergency room (professional services)[12]	50%	50%
Emergency room (facility services)[12]	50%	50%
Urgent care center (professional services)[12]	50%	50%
Urgent care center (facility services)[12]	50%	50%
Ground ambulance	50%	50%
Air ambulance[8]	50%	50%
Other services		
Durable medical equipment[8, 13]	50%	50%
Maximum amount allowable per calendar year[3]	*$1000*	*$1000*
Diabetic equipment[8]	50%	50%
Prosthetic devices[8]	50%	50%
Blood, blood plasma, blood derivatives and blood factors	50%	20%
Nuclear medicine	50%	50%
Organ and bone marrow transplants (nonexperimental and noninvestigational)[8]	50%	50%
Chemotherapy	50%	50%
Renal dialysis	50%	50%
Hospice services[8]	50%	50%
Lifetime maximum[3]	*$10,000*	*$10,000*
Home health visits[8]	50%	50%
Maximum amount allowable per day	*$75*	*$75*
Maximum visits per calendar year[3]	*90*	*90*

Non-severe mental disorders		
Outpatient consultation[5]	$40 [4]	50%
Maximum amount payable per visit	*$25*	*$25*
Inpatient[8]	50%	50%
Maximum days per calendar year[3]	*20*	*20*
Maximum amount allowable per day	*$175*	*$175*
Chemical dependency		
Acute detoxification[8]	50%	50%
Maximum amount allowable per day	*No maximum*	*$600*

Additional plan benefit information (supplemental benefits)[14]

Prescription drugs	Participating pharmacy	Nonparticipating pharmacy
(Please refer to the "Prescription drug program" section of this SB/DF for definitions, benefits and limitations.)		
Retail pharmacy (up to a 30-day supply)		
Calendar year maximum (per covered individual) (combined for participating and nonparticipating pharmacy)	$500	$500
Level I drugs listed on the Recommended Drug List (primarily generic)	30%	50%
Level II drugs listed on the Recommended Drug List (primarily brand name) and diabetic supplies (including insulin)[14, 15]	30%	50%
Contraceptive devices	30%	50%
Mail-order program (up to a 90-day supply of maintenance drugs)		
Calendar year maximum (per covered individual)	$500	N/A
Level I drugs listed on the Recommended Drug List (primarily generic)	30%	Not covered
Level II drugs listed on the Recommended Drug List (primarily brand name) and diabetic supplies (including insulin)[14]	30%	Not covered
Level III drugs not listed on the Recommended Drug List[15]	30%	Not covered

Endnotes

[1] For the PPO level of benefits, the percentages that appear in this chart are based on allowable charges and contracted rates with providers.

[2] For the Out-of-Network level of benefits, the percentages that appear in this chart are based on Customary and Reasonable (C&R) charges. You are responsible for charges in excess of C&R fees in addition to the coinsurance shown.

[3] Combined for PPO and Out-of-Network.

[4] These services are not subject to the calendar year deductible.

[5] Physician office visits, specialist consultations, second surgical opinion consultations, and outpatient mental health visits have a combined limit of four visits for subscriber and spouse, and eight visits for dependents children.

[6] 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.

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 chemical dependency disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one of the following: (a) 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; (b) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; and/or (c) 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.

[7] Surgery includes surgical reconstruction of a breast incident to mastectomy, including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema.

[8] These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB/DF. Routine care for condition of pregnancy do not require prior certification. However, notification of pregnancy is required. If certification is required but not obtained, your benefit reimbursement level will be reduced, both in-network and out-of-network, to 50% of covered expenses. In addition, a $250 penalty will also be charged for inpatient admissions.

[9] Additional visits are payable if precertified as medically necessary following neurological and orthopedic surgery, cerebral cardiovascular accident, third degree burns, head trauma or spinal cord injuries.

[10] Provided on the basis of age, medical need and health status. Adult preventive care includes: Mammography, cervical cancer screening test/pelvic and breast exams, and Sigmoidoscopy (refer to the *Certificate* for frequency and guidelines).

[11] Limited to evaluation and management of child's physical development for prevention of future medical problems, laboratory tests, x-rays and standard immunizations.

[12] The coinsurance shown for PPO emergency health care services will be applied for all emergency care, regardless of whether or not the health care provider is a PPO or noncontracting provider. The coinsurance shown for PPO and Out-of-Network providers are applicable only if non-emergency is provided at an emergency room or urgent care center.

[13] Diabetic equipment covered under the medical benefit include blood glucose monitors, insulin pumps and podiatric devices.

[14] Copayments for supplemental benefits do not apply to the out-of-pocket maximum.

[15] Generic drugs will be dispensed when a generic drug equivalent is commercially available. If you request 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 in addition to the listed copayments or coinsurance.

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

Limits of coverage

What's not covered (exclusions and limitations)

- Acupuncture;
- Allergy desensitizing serum;
- Artificial insemination;
- Charges in excess of rate negotiated between any organization and the physician, hospital or other provider;
- Chiropractic care;
- Conception by medical procedures (IVF, GIFT and ZIFT);
- Conditions resulting from the release of nuclear energy when government funds are available;
- Corrective or support appliances or supplies;
- Cosmetic services or 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 Life to be medically necessary. The prescribing physician must request prior authorization for coverage;
- Hearing aids;
- Hearing examination (age 17 and older);
- Hypnosis;
- Immunization (age 17 and older);
- Infertility services;
- Infusion therapy;
- 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 *Certificate*. 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;
- Non-emergency services received outside of the United States;
- 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;
- Personal or comfort items;
- Physician self-treatment;
- Physician treating immediate family members;
- Pre-existing conditions that occur during the first six months of your coverage, except as stated elsewhere;
- Private rooms when hospitalized, unless medically necessary;
- Private-duty nursing;
- Refractive eye surgery unless medically necessary, recommended by your treating physician and authorized by Health Net Life;
- Rehabilitation therapy;
- Reversal of surgical sterilization;
- Routine physical examinations for insurance, licensing, employment, school, camp or other nonpreventive purposes;
- Outpatient prescriptions drugs or medications (except as noted under "Prescription drug program");

- Services and supplies determined not to be medically necessary as defined in the *Certificate;*
- Services and supplies not specifically listed in the *Certificate* as covered expenses;
- Services and supplies that do not require payment in the absence of insurance;
- Services for an injury incurred in the commission (or attempted commission) of a crime;
- Services for a surrogate pregnancy are covered. However, when compensation is obtained for the surrogacy, the Plan shall have a lien on such compensation to recover its medical expense;
- Services not related to a covered illness or injury, except as provided under preventive care and annual routine exams;
- Services received before effective date or after termination of coverage, except as specifically stated in the “Extension of Benefits” section of the *Certificate;*
- Sex change services;
- Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary;
- Treatment of obesity, weight reduction or weight management, except for treatment of morbid obesity;
- Vision examination (age 17 and older).

The above is a partial list of the principal exclusions and limitations applicable to the medical portion of your Health Net PPO plan. The Certificate, 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 Life plan are described in the “Schedule of benefits and coverage” section. Please take a moment to look it over.

With Health Net PPO, you are responsible for paying a portion of the costs for your care. The amount you pay can vary from a flat amount to a significant percentage of the costs. It all depends on the doctor (and hospital) you choose.

- You must pay any applicable deductible before the plan begins to pay for covered services.
- You pay less when you receive care from doctors contracted with our PPO, since they have agreed in advance to provide services for a specific fee.
- When you receive care from Out-of-Network doctors and hospitals, you will be responsible for the applicable coinsurance, plus payment of any charges that are in excess of the covered expenses as defined in the *Certificate*.
- For some services, certification is necessary to receive full benefits. Please see the "Services requiring Certification" section of this brochure for details.
- To protect you from unusually high medical expenses, there is a maximum amount or out-of-pocket maximum, that you will be responsible for paying in any given year. Once you have paid this amount, the plan will pay 100% of covered expenses. (There are exceptions, see the *Certificate* for details.)

Services requiring certification

The following services require certification for both PPO and OON coverage. If you do not contact Health Net Life prior to receiving certain services, your benefit reimbursement level will be reduced to 50% of covered expenses as shown in the "Schedule of benefits and coverage" section of this SB/DF. A penalty will also be charged for uncertified inpatient admissions, and a penalty will be charged for uncertified outpatient services. These penalties do not apply to your out-of-pocket maximum. (Note: after the OOPM has been reached if certification is not obtained, benefits for that service(s) will not be paid at 100%). Services provided as a result of an emergency do not require certification.

Services that require certification include:

All inpatient admissions, any facility[1]

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

Surgical Procedures including:

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

Air ambulance

Durable medical equipment over the purchase price or the per month rental of $500

Home health agency services including nursing, physical therapy, occupational therapy, speech therapy, home IV therapy and home uterine monitoring

Hospice care

Orthognathic procedures (surgery performed to correct or straighten jaw and/or other facial bone misalignment to improve function)

Prosthetics and orthotics over $500

Outpatient diagnostic procedures:

- MRI (magnetic resonance imaging)
- MUGA (multiple gated acquisition)– cardiac scan
- PET (positron-emission tomography)
- SPECT (single photon emission computed tomography)

Tocolytic services (intravenous drugs used to decrease or stop uterine contraction in premature labor)

Transplant related services

- Evaluation of transplant candidacy
- Treatment while awaiting transplant
- Transplant procedures
- Post transplant care

[1]Certification is not required for the length of a hospital stay for reconstructive surgery incident to a mastectomy. Certification is also not required for the length of stay for the first 48 hours following a normal delivery or 96 hours following cesarean delivery.

Pre-existing conditions

Health Net Life imposes pre-existing exclusions on medical conditions for which you havebeen treated during the six-month period prior to enrollment. A pre-existing condition is a medical condition, illness or injury for which you received care or advice within six months prior to enrolling in our plan. A pre-existing condition generally applies to all employees and their dependents, whether or not they are a late enrollee.

This exclusion is automatically waived for newborns and adopted children who are enrolled within 30 days of becoming eligible, and for maternity conditions. This exclusion can be waived for initial enrollees (those enrolled with a group on the group's initial effective date), with Underwriting approval.

Creditable coverage

In accordance with state and federal law, you are entitled to credit for creditable coverage, which may reduce or offset the pre-existing condition exclusion applicable under this PPO plan. Creditable coverage* includes any individual, group or government plan medical insurance coverage that you had from another carrier immediately prior to enrolling in this PPO plan. Health Net Life will give you credit for any creditable health coverage, and will assist you in obtaining this information if you are unable to do so.

Creditable coverage will not be granted if you were without health coverage for more than 63 days prior to enrolling in this PPO plan, Net, unless your previous health coverage was discontinued because you lost your job. In such an event, you are entitled to qualifying creditable coverage credit as long as you enroll within 180 days of the end of your previous coverage.

**Coverage under the following types of policies does not qualify for creditable coverage: accident only, automobile or no-fault insurance, dental, disability income, long-term care vision and workers' compensation. For a more complete list of policies that do not qualify for creditable coverage please refer to the Certificate.*

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 for all medical care provided after the 30th day of your baby's life.

Emergencies

Health Net Life 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.

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).

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

Medically necessary care

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

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 your treating Physician and authorized by Health Net Life. The physician must determine that participation has a meaningful potential to benefit you and the trial has therapeutic intent. For further information, please refer to your *Certificate*.

Continuity of care

If our contract with a PPO health care provider is terminated, you may be able to elect continued care by that provider if you are receiving care for an acute condition, serious chronic condition, pregnancy, new-born, terminal illness or scheduled surgery. If you would like more information on how to request continued care, please contact the Member Services Department at **1-800-361-3366**.

Extension of benefits

If you are totally disabled when your employer ends its agreement with Health Net Life, 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
- You become 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 Life within 90 days after your employer ends its agreement with us. We will require medical proof of the total disability at specified intervals.

Out-of-State Providers

Health Net PPO has created a program which allows Covered Persons access to participating providers outside their state of residence. This program is through the out-of-state provider network shown on your HNL ID card and is limited to Covered Persons traveling outside their state of residence for a period not exceeding six months. The program is not intended for Covered Persons traveling outside their state of residence solely to receive medical care.

If you are traveling outside your state of residence, require medical care or treatment, and use a provider from the out-of-state provider network, your out-of-pocket expenses may be lower than those incurred when you use an Out-of-Network Provider.

When you obtain services outside your state of residence through the out-of-state provider network, you will be subject to the same Copayments, Coinsurances, deductibles, maximums and limitations as you would be if you obtained services from a Preferred Provider in your state of residence. There is the following exception: Covered Expenses will be calculated based on the lower of (i) the actual billed charges or (ii) the charge that the out-of-state provider network is allowed to charge, based on the contract between HNL and the network. In a small number of states, local statutes may dictate a different basis for calculating your Covered Expenses.

Confidentiality and release of your information

Health Net Life knows that personal information in your medical records is private. Therefore, we protect your personal health information in all setting (including oral, written and electronic information). The only time we would release your confidential information without your authorization is for payment, treatment, health care operations (including but not limited to utilization management, quality improvement, disease or case management programs) or when permitted or required to do so by law for things such as a court order or subpoena. We will not release your confidential claims details to your employer or their agent. Often, Health Net Life 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 enrollees.

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 Certificate. The notice of privacy practices is also available on the HNL website at **www.health.net** under "Privacy Information" or you may contact the Member Services Department at **1-800-361-3366** to obtain a copy.

Technology assessment

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

Health Net Life 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 Life 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 Life 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 prior certification, 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 Life's high quality medical management standards.

Prior certification

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 prior certification 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 Life utilization management process, please call the Member Services Department at **1-800-361-3366**.

Payment of fees and charges

Your coinsurance, copayment and deductibles

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

Prepayment of fees

Your employer will pay Health Net Life 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, coinsurance or deductibles, which are described in the "Schedule of benefits and coverage" section of this SB/DF. Beyond these charges the remainder of the cost of covered services will be paid by Health Net Life.

When the total amount of copayments and coinsurance you pay equals the annual out-of-pocket maximum amount shown in the "Schedule of benefits and coverage" section, you will not have to pay additional copayments or coinsurance for the rest of the year for most services provided, unless your doctor charges an amount that Health Net Life considers to be in excess of covered expenses. Additionally, deductibles, coinsurance and copayments for any covered supplemental benefits purchased by your employer, such as prescription drugs (with the exception of copayments for diabetic supplies) or eyewear will also not be applied to the limit, as well as:

- Charges applied to the deductibles, except the calendar year deductible;
- Charges in excess of covered expenses;
- Charges for services or supplies not covered by this plan;
- Services for which the Member is required to pay a 50 percent coinsurance; and
- Services for which certification was required but not obtained.

For further information please refer to the *Certificate*. Covered expenses for Out-of-Network providers are based on cutomary and reasonable charges.

Coordination of benefits

When you are covered by another group health plan, Health Net Life 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 Life will coordinate payment with Medicare. If you have questions about Medicare eligibility rules, contact your local Social Security office.

Liability of enrollee for payment

If you receive health care services from doctors outside our network, covered services will be paid at the Out-of-Network benefit level. You are responsible for any copayments, coinsurance amounts and amounts in excess of C&R.

Third-party liability

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

Reimbursement provisions

If you have out-of-pocket expenses for covered services, call the Member Services Department for a claim form and instructions. You will be reimbursed for these expenses less any required copayment, coinsurance or deductible.

Please contact the Member Services Department at **1-800-361-3366** to obtain claim forms, and to find out whether you should send the completed form to your doctor, hospital or to Health Net Life. Claims must be received by Health Net Life within one year of the date of service to be eligible for reimbursement.

Renewing, continuing or ending coverage

Renewal provisions

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

Small employer Cal-COBRA coverage

State law provides that members who enroll in this plan and later lose eligibility may be entitled to continuation of group coverage. More information regarding eligibility for this coverage is provided in your *Certificate*.

Individual continuation of benefits

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

- COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside of California. Please check with your group to determine if you are eligible.
- Additional COBRA-like Coverage (Cal-COBRA): California law provides that an employee and his or her spouse who elected COBRA coverage following termination of employment may be entitled to additional COBRA-like coverage.

  If the Subscriber was 60 years of age or older on the date of his or her termination of employment and had worked for the employer for the previous five years, the Subscriber and his or her spouse may be eligible for additional coverage when federal COBRA coverage expires. You may request additional information from Health Net Life. If you wish to purchase this additional COBRA-like coverage, you must notify Health Net Life of your wish to do so within 30 calendar days prior to the date continuation coverage under COBRA is scheduled to end.

  NOTE: If you have exhausted federal COBRA coverage and have less than 36 months of COBRA coverage, you have the opportunity to continue coverage through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.
- **HIPAA:** 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 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 indivi dual:

  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 cove rage 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 coverage was available, it must have been elected and such coverage must have been exhausted. This would include the new Cal-COBRA for employers with 2 to 20 employees.

For more information regarding guarantee issue coverage through HNL, please call Our Individual Sales Department at **1-800-909-3447**. If You believe Your rights under HIPAA have been violated, please contact the Department of Insurance at **1-888-927-HELP**.

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 31 days of the date group coverage ends. Please contact the 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 Life. Please refer to the “Extension of benefits” section of this SB/DF for more information.

Termination of benefits

Health Net Life can terminate your coverage when:

- The agreement between the employer covered under this plan and Health Net Life ends;
- The employer covered under this plan fails to pay premium charges; or
- You no longer work for the employer covered under this plan.

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 premium charges, benefits will end on the last day for which premium charges have been made, unless:

- You apply for conversion coverage within 31 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 Insurance (DOI) is responsible for regulating disability insurance carriers (Health Net Life is a disability insurance carrier). The DOI has a toll-free telephone number

(**1-800-927-HELP**) to receive complaints about carriers.

Member grievance and appeals process

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

To file a grievance or appeal you may call **1-800-361-3366** submit the member grievance form through **www.health.net**.

You may also write to:

Health Net Life Insurance Company
P.O. Box 10348
Van Nuys, CA 91410-0348

Please include all the information from your Health Net Life identification card as well as the details of your concern or problem. Health Net Life 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 Life will notify you of the status of your grievance no later than three days from the receipt of all the required information.

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

Also, if Health Net Life 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 Life's decision from the Department of Insurance if you meet the eligibility criteria set out in the *Certificate*.

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 Life uses binding arbitration to settle disputes, including medical malpractice. When you enroll in Health Net Life, 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 *Certificate*.

Prescription drug program

Health Net Life is contracted with many major pharmacy chains, supermarket based pharmacies and privately owned neighborhood pharmacies. For a complete and up-to-date list of participating pharmacies, please visit our website at **www.health.net** under the pharmacy information or call the Member Services Department at **1-800-361-3366**.

Prescriptions By Mail Drug Program

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

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

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 Life members while attempting to maintain affordable pharmacy benefits.

We specifically suggest to all Health Net Life contracted Participating Providers and specialists that they refer to this List when choosing drugs for patients who are Health Net Life 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 participating 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 Life most current Recommended Drug List, please visit our web site at **www.health.net** under the pharmacy information or call the Member Services Department at

1-800-361-3366.

What is “prior authorization?”

Some prescription medications require prior authorization. This means that your doctor must contact Health Net Life in advance to provide the medical reason for prescribing the medication. (Health Net Life will handle urgent requests within 72 hours of receiving all necessary information.) Upon receiving your physician’s request for prior authorization, Health Net Life 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 Life to obtain the usage guidelines for specific medications.

If authorization is denied by Health Net Life, 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 *Certificate* for details regarding your right to appeal.

To submit an appeal:

- Call Member Services Department at **1-800-361-3366**
- Visit **www.health.net** for information on e-mailing Member Services Department; or
- Write to: Member Services Department
  Health Net Life Member Services
  P.O. Box 10196
  Van Nuys, CA 91410-0348

What’s covered

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

Outpatient prescription medication:

- Level I drugs listed on the Recommended Drug List (primarily generic); and
- Level II drugs listed on the Recommended Drug List (primarily brand name) and diabetic supplies (including insulin).

Note:

- Prescription drug covered expenses are the lesser of Health Net Life’s contracted pharmacy rate or the pharmacy’s usual and customary charges for covered prescription drugs;
- If a pharmacy calendar year deductible (per covered person) applies, you must pay this amount for prescription drug covered expenses before Health Net Life begins to pay. Diabetic supplies are not subject to the deductible. After the deductible is met the copayments or coinsurance amounts apply;
- Prescription drug refills are covered, up to a 30-consecutive-day supply per prescription at a Health Net Life 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 Life as the retail pharmacy copayment;

- Oral contraceptives and emergency contraceptives are covered. Vaginal contraceptives are limited to diaphragms and cervical caps and are only covered when a physician performs a fitting examination and prescribes the device. Such devices are only available through a prescription from a pharmacy and are limited to one fitting and prescription per calendar year, unless additional fittings or devices are medically necessary. Injectable contraceptives are covered when administered by a physician. If your Physician determines that the covered methods are not appropriate, then another FDA approved contraceptive method will be provided. Refer to your plan's *Certificate* for more information on contraceptives covered under the medical benefit;
- Diabetic supplies (blood glucose testing strips, lancets, needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (that is, opened in order to dispense the product in quantities other than those packaged). When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times your Physician has prescribed for a 30-day period.

What's not covered (exclusions and limitations)

Services or supplies excluded under pharmacy services may be covered under the medical benefits portion of your plan. Consult your plan's *Certificate* 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;
- Coverage for devices is limited to vaginal contraceptive devices and diabetic supplies. No other devices are covered;
- Drugs that are appetite suppressants or are indicated for and prescribed for body weight reduction, except when prescribed for the treatment of obesity are not covered, except when medically necessary for the treatment of morbid obesity. In such cases the drugs will be subject to prior authorization from Health Net Life;
- Drug products that help you reduce or quit smoking or for nicotine addiction (for example, nicotine patches);
- Drugs or medicines administered by a physician or physician's staff member;
- Drugs prescribed to shorten the duration of the common cold;
- Drugs (including injectable medications) prescribed for the treatment of sexual dysfunction are not covered;
- 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, 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 Life;
- 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 Life;

- Prescription drugs prescribed by an unlicensed physician;
- Replacement of lost, stolen or damaged medications;
- Services or supplies which are covered in full or for which you are not legally required to pay;
- Supply amounts for prescriptions that exceed the FDA's or Health Net Life's indicated usage recommendation are not covered unless Medically Necessary and prior authorization is obtained from Health Net Life;
- Supply amounts (for any number of days) which exceed the Food and Drug Administration's or Health Net Life's indicated usage guidelines;
- 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 *Certificate* to determine the exact terms and conditions of your coverage.

For more information, please contact us at:

Health Net PPO
Post Office Box 10348
Van Nuys, California 91410-0348

Member Services
1·800·361·3366
Spanish
1·800·331·1777
Mandarin
1·877·891·9053
Cantonese
1·877·891·9050
Korean
1·877·339·8596
Tagalog
1·877·891·9051
Vietnamese
1·877·339·8621

Telecommunications Device for the Hearing Impaired
1·800·995·0852

www.health.net