Health Net of California

www.healthnet.com/fehb

800-522-0088

health net

2026

A Health Maintenance Organization (High, Standard and Basic Options)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details. This plan is accredited. See page 13.

Serving: Southern California Service Areas

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 14 for requirements.

Postal Employees and Annuitants are no longer eligible for this plan (unless currently under Temporary Continuation of Coverage)

IMPORTANT
- Rates: Back Cover
- Changes for 2026: Page 16
- Summary of Benefits: Page 96

Enrollment codes for this Plan:

LP1 Southern CA High Option - Self Only
LP3 Southern CA High Option - Self Plus One
LP2 Southern CA High Option - Self and Family

P64 Southern CA Standard Option - Self Only
P66 Southern CA Standard Option - Self Plus One
P65 Southern CA Standard Option - Self and Family

P61 Southern CA Basic Option - Self Only
P63 Southern CA Basic Option - Self Plus One
P62 Southern CA Basic Option - Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from Health Net of California About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Health Net of California prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least one percent per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19**%** higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213, (TTY: 800-325-0778).

Additional Premium for Medicare's High Income Members
Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return**. You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, TTY 877-486-2048

Table of Contents

Cover Page 1
Important Notice 1
Table of Contents 2
Introduction 4
Plain Language 4
Stop HealthCare Fraud! 4
Discrimination is Against the Law 5
Preventing Medical Mistakes 6
FEHB Facts 8
- Coverage information 8
- No pre-existing condition limitation 8
- Minimum essential coverage (MEC) 8
- Minimum value standard 8
- Where you can get information about enrolling in the FEHB Program 8
- Enrollment types available for you and your family 8
- Family member coverage 9
- Children's Equity Act 10
- When benefits and premiums start 11
- When you retire 11
- When you lose benefits 11
- When FEHB coverage ends 11
- Upon divorce 11
- Temporary Continuation of Coverage (TCC) 12
- Converting to individual coverage 12
- Health Insurance Marketplace 12

Section 1. How This Plan Works 13
Section 2. Changes for 2026 16
Section 3. How You Get Care 17
- Identification cards 17
- Where you get covered care 17
  - Balance Billing Protection 17
  - Plan providers 17
  - Plan facilities 17
- What you must do to get covered care 17
  - Primary care 18
  - Specialty care 18
  - Hospital Care 19
- If you are hospitalized when your enrollment begins 20
- You need prior Plan approval for certain services 20
- Inpatient hospital admission 20
- Other services 20
- How to request precertification for an admission or get prior authorization for Other services 20
- Non-urgent care claims 21
- Urgent care claims 21
- Concurrent care claims 21
- Emergency inpatient admission 22

- Maternity care 22
- If your treatment needs to be extended 22
- What happens when you do not follow the precertification rules when using non-network facilities 22
- Circumstances beyond our control 22
- If you disagree with our pre-service claim decision 22
- To reconsider a non-urgent care claim 22
- To reconsider an urgent care claim 23
- To file an appeal with OPM 23

Section 4. Your Cost for Covered Services 24
- Carryover 25
- When Government facilities bill us 25
- Important Notice About Surprise Billing – Know Your Rights 25
- The Federal Flexible Spending Account Program - FSAFEDS 26

Section 5. High, Standard and Basic Option Benefits 27
Section 5. High, Standard and Basic Option Benefits Overview 29
Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals 30
Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals 47
Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services 59
Section 5(d). Emergency Services/Accidents 62
Section 5(e). Mental Health and Substance Use Disorder Benefits 64
Section 5(f). Prescription Drug Benefits 67
Section 5(g). Dental Benefits 73
Section 5(h). Wellness and Other Special Features 74
Non-FEHB Benefits Available to Plan Members 76
Section 6. General Exclusions - Services, Drugs and Supplies We Do Not Cover 77
Section 7. Filing a Claim for Covered Services 78
Section 8. The Disputed Claims Process 80
Section 9. Coordinating Benefits with Medicare and Other Coverage 83
- When you have other health coverage 83
- TRICARE and CHAMPVA 83
- Workers' Compensation 83
- Medicaid 83
- When other Government agencies are responsible for your care 84
- When others are responsible for injuries 84
- When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage 84
- Clinical Trials 84
- When you have Medicare 85
- The Original Medicare Plan (Part A or Part B) 85

Section 10. Definitions of Terms We Use in This Brochure 91
Index 94
Summary of Benefits for the High Option of Health Net of California - 2026 96
Summary of Benefits for the Standard Option of Health Net of California - 2026 97
Summary of Benefits for the Basic Option of Health Net of California - 2026 98
2026 Rate Information for Health Net of California 99

Introduction

This brochure describes the benefits of Health Net of California under contract (CS 2002) between Health Net and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The Customer Contact Center may be reached at 800-522-0088 or through our website: www.healthnet.com/fehb. The address for Health Net of California's administrative offices is:

Health Net of California
P.O. Box 9103
Van Nuys, CA 91409-9103

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2026, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2026, and changes are summarized on page 99. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee and each covered family member, "we" means Health Net of California.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we will tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop HealthCare Fraud!

Fraud increases the cost of healthcare for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud - Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.

- If the provider does not resolve the matter, call us at 800-522-0088 and explain the situation.
- If we do not resolve the issue:

CALL - THE HEALTHCARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26).

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- If you have any questions about the eligibility of a family member, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, sex (pregnancy, or genetic information). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, sex (pregnancy or genetic information).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions, and understand answers.

1. Keep and bring a list of all the medications you take.

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understanding both the generic and brand names for all of your medication(s) is important. This helps to ensure you do not receive double dosing from taking both a generic and brand of the same medication. It also helps you avoid taking a medication to which you are allergic.

2. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal.
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

3. **Talk to your doctor about which hospital or clinic is best for your health needs.**

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

4. **Make sure you understand what will happen if you need surgery.**

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:

- "Exactly what will you be doing?"
- "About how long will it take?"
- "What will happen after surgery?"
- "How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- https://psnet.ahrq.gov/issue/national-patient-safety-foundation. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error. When a Health Net member is admitted, Health Net requests hospitals submit inpatient hospital claims with Present on Admission (POA) indicators. Present on admission is defined as a condition that is present at the time the order for admission occurs. Conditions that develop during an outpatient encounter, including in the emergency department or during observation or outpatient surgery, are included within the definition of present on admission conditions. Each condition reported during the admission must be catalogued according to when it occurred. If a member experiences a Healthcare Acquired Condition (HAC), Health Net requests that the admitting hospital refrain from billing or adjust the billing to Health Net or the member for any charges associated with the HAC if it is determined it was preventable.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-individual-shared-responsibility-provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, disability leave, pensions, etc. you must also contact your employing or retirement office.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse, and your children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2026 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2025 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for all services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 days extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or assistance with enrolling in a conversion policy (non-FEHB individual policy).

- **Upon divorce**

If you are an enrollee, and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices, https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, or if you are a covered child and you turn 26.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-522-0088 or visit our website at www.healthnet.com/fehb.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit **www.HealthCare.gov**. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Health Net holds an accredited status with the National Committee for Quality Assurance (NCQA), for Health Plan, Health Equity, and Health Equity Plus. NCQA is a private, nonprofit organization dedicated to improving healthcare quality. NCQA accredits and certifies a wide range of healthcare organizations. It also recognizes clinicians and practices in key areas of performance. NCQA is committed to providing healthcare quality information for consumers, purchasers, healthcare providers and researchers. To learn more about this plan's accreditation(s), please visit the following websites: National Committee for Quality Assurance (ncqa.org).

Health Net requires you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your healthcare services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General Features of our High, Standard, and Basic Options:

We will continue to offer our High, Standard, and Basic Option HMO plans in Southern CA and in Tijuana and Mexicali, Mexico.

Please make sure to verify if your physician is in the network. The High, Standard and Basic Options utilize the same service area, and the same access to all providers/networks in your FEHB defined Service Area.

To check if your physician is in our network, visit www.healthnet.com/fehb.

Telehealth services with Health Net's preferred vendor is available at $0 cost to our members.

High Option members with Medicare parts A and B can enroll in a Medicare Advantage plan which offers reduced cost shares for most services. In addition, our Basic Option offers members with Medicare parts A and B a plan with reduced or no cost shares for most services.

How we pay providers

We contract with Participating Physician Groups (PPGs), rather than directly with physicians, on a capitated basis for HMO plans. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, and non-covered services and supplies). We will also contract directly with an individual physician in rural areas where PPGs do not exist.

Preventive Care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles, or annual limits when received from a network provider.

Your rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Health Net of California received certification as a Federally Qualified HMO in 1979 and was licensed by the California Department of Corporations in 1991.
- Health Net of California is a for profit, Mixed Model (MMP) HMO.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, Health Net of California at www.healthnet.com/fehb. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 800-522-0088, or write to Health Net of California, P.O. Box 9103, Van Nuys, CA 91409-9103. You may also contact us by visiting our website at www.healthnet.com/fehb.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.healthnet.com/fehb to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is:

Southern California full county: Orange

Partial counties: Los Angeles, Kern, Riverside, San Bernardino and San Diego counties, California. The following ZIP codes are those included in these partial counties:

KERN: 93263,93301,93302,93303,93304,93305,93306,93307,93308,93309,93311,93312,93313,93314

LOS ANGELES:
90001,90002,90003,90004,90005,90006,90007,90008,90009,90010,90011,90012,90013,90014,90015,90016,90017,90018,90019,90020,
90021,90022,90023,90024,90025,90026,90027,90028,90029,90030,90031,90032,90033,90034,90035,90036,90037,90038,90039,90040,
90041,90042,90043,90044,90045,90046,90047,90048,90049,90050,90051,90052,90053,90054,90055,90056,90057,90058,90059,90060,
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90747,90748,90749,90755,90801,90802,90803,90804,90805,90806,90807,90808,90809,90810,90813,90814,90815,90822,90831,90832,
90833,90840,90842,90844,90846,90847,90848,90853,90895,91001,91003,91006,91007,91008,91009,91010,91011,91012,91016,91017,
91020,91021,91023,91024,91025,91030,91031,91040,91041,91042,91043,91046,91066,91077,91101,91102,91103,91104,91105,91106,
91107,91108,91109,91110,91114,91115,91116,91117,91118,91121,91123,91124,91125,91126,91129,91182,91184,91185,91188,91189,
91199,91201,91202,91203,91204,91205,91206,91207,91208,91209,91210,91214,91221,91222,91224,91225,91226,91301,91302,91303,
91304,91305,91306,91307,91308,91309,91311,91313,91316,91324,91325,91326,91327,91328,91329,91330,91331,91333,91334,91335,
91337,91340,91341,91342,91343,91344,91345,91346,91352,91353,91356,91357,91364,91365,91367,91371,91372,91376,91392,91393,
91394,91395,91396,91401,91402,91403,91404,91405,91406,91407,91408,91409,91410,91411,91412,91413,91416,91423,91426,91436,
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SAN BERNARDINO:
91701,91708,91709,91710,91729,91730,91737,91739,91743,91758,91759,91761,91762,91763,91764,91784,91786,92313,-92316,92317,92318,92321,92322,92324,92325,92331,92334,92335,92336,92337,92344,92345,92346,92350,92352,92354,-92357,92358,92359,92369,92373,92374,92375,92376,92377,92378,92382,92385,92391,92399,92401,92402,92403,92404,-92405,92406,92407,92408,92410,92411,92413,92415,92418,92423,92427

SAN DIEGO:
91901,91902,91903,91908,91909,91910,91911,91912,91913,91914,91915,91916,91917,91921,91931,91932,91933,91935,91941,91942,91943,91944,91945,91946,91948,91950,91951,91976,91977,91978,91979,92003,92007,92008,92009,92010,92011,92013,92014,92018,92019,92020,92021,92022,92023,92024,92025,92026,92027,92028,92029,92030,92033,92037,92038,92039,92040,92046,92049,92051,92052,92054,92055,92056,92057,92058,92059,92060,92061,92064,92065,92067,92068,92069,92070,92071,92072,92074,92075,92078,92079,92081,92082,92083,92084,92085,92088,92091,92092,92093,92101,92102,92103,92104,92105,92106,92107,92108,92109,92110,92111,92112,92113,92114,92115,92116,92117,92118,92119,92120,92121,92122,92123,92124,92126,92127,92128,92129,92130,92131,92132,92134,92135,92136,92137,92138,92139,92140,92142,92143,92145,92147,92149,92150,92152,92153,92154,92155,92158,92159,92160,92161,92163,92165,92166,92167,92168,92169,92170,92171,92172,92173,92174,92175,92176,92177,92178,92179,92182,92186,92187,92191,92192,92193,92195,92196,92197,92198,92199

The cities of Tijuana and Mexicali in Mexico

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other healthcare services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your covered family members live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2026

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to High, Standard, and Basic Option Plans:

- Due to the State Mandate 729, the following treatment of infertility and fertility services will be added to your plan:
  - In vitro fertilization (IVF) medical benefits,
  - Embryo transfer and zygote intra- fallopian transfer (ZIFT)
  - Fertility medications cannot have any exclusions, limitations, or other restrictions placed on them that are different from those imposed on other prescription medications.
  - Services and supplies related to ART procedures
  - Cost of donor sperm and ova storage
  - Injectable medications for infertility treatments
  - Donor oocytes
  - Cryopreservation of sperm; storage of sperm, ova, and embryos; follow-up Assisted Reproductive Technologies(ART) to achieve future pregnancy such as artificial insemination, in vitro fertilization, and/or embryo transfer; Medically necessary standard fertility preservation services no longer limited to iatrogenic infertility.
  - Storage of sperm, ova, and embryos is covered when medically necessary for infertility treatment and compliant with ART criteria in our clinical policy. Cryopreservation Short term storage for one year. Additional 90 day increments after one year if medical necessity is met.
- Health Net will no longer cover the cost of any surgical procedures or puberty blockers, hormone therapy or hormonal treatments for the purpose of the treatment of Gender Dysphoria for members of any age.
- Health Net will no longer cover drugs prescribed in connection with Sex-Trait Modification for treatment of gender dysphoria

Changes to High Option Plan:

- Your share of the premium rate will decrease for Self Only, Self Plus One, and Self and Family. See page 99.

Changes to Standard Option Plan:

- Your catastrophic protection out-of-pocket maximum will increase to $1,650 for Self Only, $3,300 for Self Plus One or $4,950 for Self and Family enrollment
- Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. See page 99.

Changes to Basic Option Plan:

- Your catastrophic protection out-of-pocket maximum will increase to $5,500 for Self Only, $11,000 for Self Plus One or $11,000 for Self and Family
- Your share of the premium rate will increase for Self Only, Self Plus One, and Self and Family. See page 99.

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-522-0088 or write to us at Health Net of California, PO Box 9103, Van Nuys, CA 91409-9103. You may also request replacement cards through our Website www.healthnet.com/fehb.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments or coinsurance, and you will not have to file claims.

- **Balance Billing Protection**

FEHB Carriers must have clauses in their in-network (participating) provider agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **Plan providers**

Plan providers are participating physician groups, physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We maintain stringent credentialing and recredentialing criteria for our Plan Providers.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex, pregnancy or genetic information.

This plan provides Care Coordinators for complex conditions and can be reached at 800-522-0088 for assistance.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care provider. This decision is important since your primary care provider provides or arranges for most of your healthcare.

You must select a Participating Physicians Group (PPG) within a 30 mile radius of your home or work-site. Each family member may choose their own PPG and primary care provider.

You may transfer to another PPG by calling us at 800-522-0088. You may change PPG's once a month or upon our approval. The request will be denied if you are more than three months pregnant, confined to a hospital, in a surgery follow-up period (not yet released by the surgeon) or receiving treatment for an illness that is not yet complete.

- **Primary care**

Your primary care provider can be a family practitioner, internist or pediatrician. Your primary care provider will provide most of your healthcare, or give you a referral to see a specialist.

If you want to change primary care provider or if your primary care provider leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care provider will refer you to a specialist for needed care. When you receive a referral from your primary care provider, you must return to the primary care provider after the consultation, unless your primary care provider authorized a certain number of visits without additional referrals. The primary care provider must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care provider gives you a referral.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care provider will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.
- Your primary care provider will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our plan, talk to your primary care provider. If they decide to refer you to a specialist, ask if you can see your current specialist.
- If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- You may continue seeing your specialist for up to 90 days if you are undergoing treatment for a chronic or disabling condition and you lose access to your specialist because:
  - we terminate our contract with your specialist for other than cause;
  - we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
  - we reduce our service area and you enroll in another FEHB plan;

Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

> Note: If you lose access to your specialist because you changed your carrier or plan option enrollment, contact your new plan.

Sex-Trait Modification: If you are mid-treatment under this Plan, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care for that treatment. Our exception process is as follows:

To request an exception to determine if your qualifying medical conditions will meet the criteria for continued care, you must submit an appeal to Health Net. An appeal will be resolved within 30 days. Please provide a brief explanation of your medical condition, including when you started treatment for this condition, and send a copy of the denial notice, if applicable, to Health Net and we will review your request. To request an appeal, do one of the following:

- *Call Health Net Member Services at 800-522-0088 to request an appeal,*
- *Submit online at www.healthnet.com/fehb by logging into your own account and clicking on the GRIEVANCE FORM link*
- *Or write to Health Net Appeals & Grievance, P.O. Box 10348, Van Nuys, CA 91410-0348*

Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.

- If you are a new Health Net of California member and are currently receiving treatment for a qualifying medical condition from a provider who is not in our network, you may be eligible to complete treatment of your condition with the provider. Or, if you are an existing member and are currently receiving treatment for a qualifying medical condition from a provider who is leaving our network, you may be eligible to complete treatment of your condition with the provider. In order to receive more information about continuity of care and qualifying medical conditions and situations, please contact us at 800-522-0088 and we will assist you.

You also have the right to a second opinion when:

- your primary care provider 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 primary care provider or a referral physician is unable to diagnose your condition, or test results are conflicting.

To request an authorization for a second opinion, contact your Primary Care Provider or Health Net of California Member Services at 800-522-0088. Physicians at your Physician Group or Health Net of California will review your request in accordance with Health Net of California's second opinion policy. You may obtain a copy of this policy from Health Net of California's Member Service Department. All second opinions must be provided by a participating network physician who specializes in the illness, disease or condition associated with the request. If there is no appropriately qualified physician in the network, your primary care provider will arrange for an out-of-network second opinion.

If you disagree with our decision on your exception, please see Section 8 of this brochure for the disputed claims process.

- **Hospital Care**

Your Plan primary care provider or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-522-0088. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your primary care provider arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services*. You must get prior approval for those services listed. Failure to do so will result in denied claims and member will be responsible for the full cost.

- **Inpatient hospital admission**

Precertification is the process by which - prior to your inpatient hospital admission - we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care provider has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for some services such as but not limited to:

- Acute rehabilitation and behavioral health facility admissions
- Air ambulance and non-emergent ambulance transportation
- All bariatric-related consultations, services and surgical services
- Clinical trials
- Durable medical equipment
- Home health services, including but not limited to IV infusion, hospice
- Outpatient diagnostic procedures, including but not limited to CT, MRA, MRI, PET and SPECT
- Transplants
- Growth Hormone Treatment (GHT)
- Certain formulary and non-formulary prescription drugs

Services that are not authorized by your primary care provider or Health Net of California will not be covered.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 800-977-7282 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;

- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim, (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow-up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-522-0088. You may also call OPM's FEHB 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-522-0088. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must phone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Prior authorization may be obtained by you or your Provider. Coverage for those services will be provided only if Prior Authorization has been obtained from us. If a Member receives care from a nonparticipating Physician or other healthcare Provider without a required Prior Authorization, the Member shall be responsible for the cost of these services. Failure of the nonparticipating Provider to obtain the Prior Authorization shall in no way relieve the Member of the financial responsibility for services received from that Provider.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call Member Services at 800-522-0088.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date of the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

  In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

  After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Cost for Covered Services

This is what you will pay out-of-pocket for covered care:

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. deductible, coinsurance, and copayments) for the covered care you receive.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

Example: When you see your primary care provider, you pay a copayment of $20 per office visit for the High Option, $30 per office visit for the Standard Option, and $40 per office visit for the Basic Option. When you go in the hospital you pay $150 per day (5 day max copay) per admission on the High Option, $750 copay per admission on the Standard Option, and $500 per day (3 day max copay) per admission on the Basic Option.

Coinsurance

Coinsurance is the percentage of our negotiated fee that you must pay for your care.

Example: In our Plan, you pay 50% of our allowance for infertility services and 20% to a maximum of $200 per day for injectable medications.

Deductible

We do not have a deductible.

Differences between our Plan allowance and the bill

You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum

After your (deductible, copayments and coinsurance) reaches the out-of-pocket maximum you do not have to pay any more for covered services, with the exception of certain cost sharing for the services below which do not count toward your catastrophic protection out-of-pocket maximum.

Your out-of-pocket maximum for services rendered during the 2026 calendar year is:

High Option

(Medical Benefit Plan)	(Prescription Drug Plan)
Self Only $1,500	Self Only $2,900
Self Plus One $3,000	Self Plus One $5,800
Self and Family $4,500	Self and Family 8,700

Standard Option

(Medical Benefit Plan)	(Prescription Drug Plan)
Self Only $1,650	Self Only $2,900
Self Plus One $3,300	Self Plus One $5,800
Self and Family $4,950	Self and Family 8,700

Basic Option

(Medical Benefit Plan)	(Prescription Drug Plan)
Self Only $5,500	Self Only $2,000
Self Plus One $11,000	Self Plus One $4,000
Self and Family $11,000	Self and Family 4,000

Your out-of-pocket maximum may differ if you changed plans at Open Season.

However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Eyeglasses or contact lenses
- Expenses for services and supplies that exceed the stated maximum dollar or day limit
- Expenses from utilizing out-of-network providers

Carryover

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your prior option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

In addition, your health plan adopts and complies with the surprise billing laws of California. For specific information on surprise billing, the rights, and protections you have, and your responsibilities go to https://www.healthnet.com/content/healthnet/en_us/members.html or contact the plan at 800-522-0088.

Per section 2799A-5(c) of the PHS Act, section 9820(c) of the Internal Revenue Code, section 720(c) of the Employee Retirement Income Security Act.

For more information, please visit our website at www.healthnet.com on:

1. the restrictions on balance billing in certain circumstances,
2. any applicable state law protections against balance billing,
3. the requirements described under Code section 9816, ERISA section 716, and PHS Act section 2799A-1, and
4. information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.

The Federal Flexible Spending Account Program - FSAFEDS

- HealthCare FSA (HCFSA) - Reimburses an FSA participant for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, over-the counter drugs and medications, vision and dental expenses, and much more for their tax dependents, and their adult children (through the end of the calendar year in which they can turn 26).
- FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. High, Standard and Basic Option Benefits

See Section 2 for how our benefits changed this year. The Summary of Benefits is the benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High, Standard and Basic Option Benefits Overview....29

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals....30
- Diagnostic and treatment services....30
- Telehealth services....31
- Lab, X-ray and other diagnostic tests....31
- Preventive care, adult....32
- Preventive care, children....33
- Maternity care....35
- Family planning....36
- Infertility services....38
- Allergy care....39
- Treatment therapies....40
- Physical and occupational therapies....41
- Speech therapy....41
- Injectable Medications....41
- Hearing services (testing, treatment, and supplies)....42
- Vision services (testing, treatment, and supplies)....42
- Foot care....42
- Orthopedic and prosthetic devices....43
- Durable medical equipment (DME)....44
- Home health services....45
- Chiropractic....45
- Alternative treatments....46
- Educational classes and programs....46

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals....47
- Surgical procedures....47
- Reconstructive surgery....50
- Oral and maxillofacial surgery....52
- Organ/tissue transplants....53
- Anesthesia....58

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services....59
- Inpatient hospital....59
- Outpatient hospital or ambulatory surgical center....60
- Extended care benefits/Skilled nursing care facility benefits....60
- Hospice care....61
- End of life care....61
- Ambulance....61

Section 5(d). Emergency Services/Accidents....62
- Emergency within our service area....63
- Emergency outside our service area....63
- Ambulance....63

Section 5(e). Mental Health and Substance Use Disorder Benefits....64

- Professional services....64
- Diagnostics....65
- Inpatient hospital or other covered facility....65
- Outpatient hospital or other covered facility....65
- Preauthorization....65

Section 5(f). Prescription Drug Benefits....67
- Covered medications and supplies....68
- Preventive medications....72

Section 5(g). Dental Benefits....73
- Accidental injury benefit....73
- Dental benefits....73

Section 5(h). Wellness and Other Special Features....74
- Centers of Excellence....74
- Flexible benefits option....74
- Health Net's Wellness Programs....74
- Services for deaf and hearing impaired....75

Summary of Benefits for the High Option of Health Net of California - 2026....96

Summary of Benefits for the Standard Option of Health Net of California - 2026....97

Summary of Benefits for the Basic Option of Health Net of California - 2026....98

Section 5. High, Standard and Basic Option Benefits Overview

Health Net of California offers three benefit plans to Federal members; High, Standard and Basic Options. All benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High, Standard, and Basic Options Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High, Standard or Basic Option benefits, contact us at 800-522-0088 or on our website at www.healthnet.com/fehb.

Our plans offer comprehensive coverage which includes preventive and acute care services but have varying copays. All plan options utilize the same service area and providers. Members in our plans must select a primary care provider in a participating medical group. Our members also have an option to access services in Mexico. You can visit www.healthnet.com/fehb to view available providers.

Our High Option benefits include:

- PCP office visit copay - $20; Specialist office visit copay - $30
- Telehealth services (virtual visit) through Health Net preferred vendor is $0; Telehealth services (virtual visit) through the medical group, office/specialist copay applies.
- Inpatient Hospitalization - $150 copay per day up to 5 days
- Prescriptions Drug Copays - $10 generic, $35 brand, $60 non-formulary, 20% to a maximum $200 per prescription for specialty drugs
- Chiropractic and Acupuncture - $10 copay, 20 visits

Our Standard Option benefits include:

- PCP office visit copay - $30; Specialist office visit copay - $50
- Telehealth services (virtual visit) through Health Net preferred vendor is $0; Telehealth services (virtual visit) through the medical group, office/specialist copay applies.
- Inpatient Hospitalization - $750 copay per admission
- Prescriptions Drug Copays - $15 generic, $35 brand, $65 non-formulary, 20% to a maximum $200 per prescription for specialty drugs
- Chiropractic and Acupuncture - $10 copay, 20 visits

Our Basic Option benefits include:

- PCP and Specialist office visit copay - $40
- Telehealth services (virtual visit) through Health Net preferred vendor is $0; Telehealth services through the medical group, office/specialist copay applies.
- Inpatient Hospitalization - $500 copay per day up to 3 days
- Prescriptions Drug Copays Retail- $15 generic, $35 brand, $65 non-formulary, 20% to a maximum $200 per prescription for specialty drugs
- Chiropractic and Acupuncture - $10 copay, 20 visits

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay		
Diagnostic and treatment services	**High Option**	**Standard Option**	**Basic Option**
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion • Initial examination of a newborn child	$20 per PCP visit, $30 per specialist visit	$30 per PCP visit, $50 per specialist visit	$40 per visit
Professional services of healthcare professionals at CVS MinuteClinics	$20 per visit	$30 per visit	$30 per visit
Preventive Care services at CVS Minute Clinics	Nothing	Nothing	Nothing
Professional services of physicians • In an urgent care center	$20 per visit	$30 per visit	$40 per visit
Professional services of physicians • During a hospital stay • In a skilled nursing facility	Nothing	Nothing	Nothing
At home	$20 per visit	$20 per visit	Nothing
Immunizations for occupational and foreign travel	20% of charges	20% of charges	20% of charges
Not covered: • *Treatment that is not authorized by a plan physician* • *Treatment that is not medically necessary*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Telehealth services	**High Option**	**Standard Option**	**Basic Option**
Telehealth consultations (virtual visit) through Health Net's preferred vendor board-certified doctors and pediatricians by secure video, mobile app or phone. Available 24 hours, 7 days a week for non-emergency conditions such as: • Allergies • Cold/flu • Ear problems • Respiratory problems • Sore throats • Urinary problems/UTI Note: Telehealth services (virtual visit) also include access to behavioral therapy services including mental health and substance use disorder treatment. For more information, please visit www.healthnet.com/fehb.	Nothing	Nothing	Nothing
Telehealth consultations (virtual visit) provided by the physicians in your medical group	$20 per PCP visit, $30 specialist copay	$30 per PCP visit, $50 specialist copay	$40 per visit
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**	**Basic Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	Nothing	Nothing	Nothing
CT, MRI, PET, SPECT and other specialized scans	$250 Copay	$250 Copay	Nothing

Benefit Description	You pay		
Preventive care, adult	**High Option**	**Standard Option**	**Basic Option**
Routine physical every year The following preventive services are covered at the time interval recommended at each of the links below: • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women please visit the Health and Human Services (HHS) website at https://www.hrsa.gov/womens-guidelines • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	Nothing	Nothing	Nothing
• Routine mammogram	Nothing	Nothing	Nothing
• Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/imz-schedules/index.html Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay		
Preventive care, adult (cont.)	**High Option**	**Standard Option**	**Basic Option**
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy, • Family centered programs when medically identified to support obesity prevention and management by an in-network provider.	Nothing	Nothing	Nothing
When anti-obesity medication is prescribed. See Section 5(f)	See Section 5(f) for cost share requirements for anti-obesity medications.	See Section 5(f) for cost share requirements for anti-obesity medications.	See Section 5(f) for cost share requirements for anti-obesity medications.
When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.	See Section 5(b) for surgery requirements and cost share.	See Section 5(b) for surgery requirements and cost share.	See Section 5(b) for surgery requirements and cost share.
Not covered: • Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel. • Medications for travel or work-related exposure.	All charges	All charges	All charges
Preventive care, children	**High Option**	**Standard Option**	**Basic Option**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org. • Children's immunizations endorsed by the Centers for Disease Control (CDC) including Dtap/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at https://www.cdc.gov/vaccines/schedules/index.html	Nothing	Nothing	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay		
Preventive care, children (cont.)	**High Option**	**Standard Option**	**Basic Option**
• You can also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing	Nothing	Nothing
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: · Intensive nutrition and behavioral weight-loss counseling therapy, · Family centered programs when medically identified to support obesity prevention and management by an in-network provider.	Nothing	Nothing	Nothing
When anti-obesity medication is prescribed. See Section 5(f)	See Section 5(f) for cost share requirements for anti-obesity medications.	See Section 5(f) for cost share requirements for anti-obesity medications.	See Section 5(f) for cost share requirements for anti-obesity medications.
When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.	See Section 5(b) for surgery requirements and cost share.	See Section 5(b) for surgery requirements and cost share.	See Section 5(b) for surgery requirements and cost share.
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp,* athletic exams, *or for travel.* • Medications for travel or work-related exposure.	*All charges*	All charges	*All charges*

Benefit Description	You pay		
Maternity care	**High Option**	**Standard Option**	**Basic Option**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes • Screening and counseling for prenatal and postpartum depression	$20 per PCP office visit, $30 per specialist visit	$30 per PCP office visit, $50 per specialist visit	$40 per office
Breastfeeding and lactation support, supplies and counseling for each birth	Nothing	Nothing	Nothing
Delivery Note: Here are some things to keep in mind: You do not need to precertify your vaginal delivery; see page 20 for other circumstances, such as extended stays for you or your baby. • As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. This plan also includes a doula program, please see Section 5(a) under Educational Classes and Program, and Section 5(h) under Wellness and Other Special Features. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	Nothing	Nothing	Nothing

Benefit Description	You pay		
Family planning	**High Option**	**Standard Option**	**Basic Option**
Contraceptive counseling on an annual basis	Nothing	Nothing	Nothing
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories in the HRSA supported guidelines. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms Note: See additional Family Planning and Prescription drug coverage Section 5(f) Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. • Use the contraception exception process if the contraception recommended by your provider is not covered or has an out-of-pocket cost. You or your provider may submit an exception request. • Members can call the Customer Contact Center at 1-800-522-0088 to submit an exception request. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	Nothing	Nothing	Nothing
• Voluntary male sterilization	Nothing	Nothing	Nothing
Genetic testing for mother/child is subject to medical necessity and experimental/ investigational review by the Plan.	Nothing	Nothing	Nothing

Family planning - continued on next page

Benefit Description	You pay		
Family planning (cont.)	**High Option**	**Standard Option**	**Basic Option**
Cell-free fetal DNA testing is a screening test of the woman's blood taken after 10 weeks of pregnancy. It measures the relative amount of free fetal DNA and indicates if the fetus is at increased risk of having Down syndrome (trisomy 21), Edwards syndrome (trisomy 18) and Patau syndrome (trisomy 13). One cell-free fetal DNA test per pregnancy is medically necessary for members meeting all of the following criteria: • Underwent pretest counseling, *and* • Current pregnancy not a multiple gestation, *and* • Current pregnancy between 10 and 22 weeks gestation at the time the blood was drawn, *and* • High risk for fetal aneuploidy as evidenced by one of the following: - Maternal age ≥35 years at delivery, *or* - Maternal history of a child affected with trisomy, *or* - Abnormal ultrasound findings, *or* - Positive test result for aneuploidy, including first trimester, sequential, or integrated screen, or quadruple screen, *or* - A parent carrying a balanced Robertsonian translocation with increased risk of trisomy 13 or trisomy 21. Cell-free fetal DNA testing for any indication not listed above is considered not medically necessary. Cell-free fetal DNA testing for additional chromosomal abnormalities other than trisomy 21, 18 or 13 are considered not medically necessary, including, but not limited to, other trisomies, aneuploidies, or microdeletions.	Nothing	Nothing	Nothing
Not covered: • Reversal of voluntary surgical sterilization • Genetic counseling and testing not listed above	All charges	All charges	All charges
Cystic fibrosis and spinal muscular atrophy carrier testings are subject to medical necessity and experimental/investigational review by the Plan.	Nothing	Nothing	Nothing

Family planning - continued on next page

Benefit Description	You pay		
Family planning (cont.)	**High Option**	**Standard Option**	**Basic Option**
Cystic fibrosis and spinal muscular atrophy carrier screenings medically necessary for women who are pregnant and meet the following criteria: • No prior CF or SMA screening results are available, and • Pregnancy 22 weeks gestation, and • Underwent pretest counseling. Cystic fibrosis and spinal muscular atrophy carrier screenings anytime other than during pregnancy are subject to medically necessary review by the Plan when meeting the most current version of the relevant nationally recognized decision support tools.	Nothing	Nothing	Nothing
Infertility services	**High Option**	**Standard Option**	**Basic Option**
Infertility exists when the member is a female or the member has been unable to conceive pregnancy through attempted egg-sperm contact or a licensed physician's determination of infertility. Coverage includes: • Artificial insemination (AI): - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) - Fertility drugs • Embryo transfer and gamete intra-fallopian transfer (GIFT) • In vitro fertilization (IVF) medical benefits • Embryo transfer and zygote intra- fallopian transfer (ZIFT) • Fertility medications cannot have any exclusions, limitations, or other restrictions placed on them that are different from those imposed on other prescription medications. • Services and supplies related to ART procedures • Cost of donor sperm and ova storage • Injectable medications for infertility treatments	$20 per PCP office visit, $30 per specialist visit. For infertility medications, the appropriate pharmacy tier copay will apply	$30 per PCP office visit, $50 per specialist visit. For infertility medications, the appropriate pharmacy tier copay will apply	$40 per PCP office visit, $40 per specialist visit. For infertility medications, the appropriate pharmacy tier copay will apply

Infertility services - continued on next page

Benefit Description	You pay		
Infertility services (cont.)	**High Option**	**Standard Option**	**Basic Option**
• Cryopreservation for embryos, oocytes and sperm • Pre-implantation genetic testing (CPT code 81479 not covered) • Donor oocytes Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit. For further information, please view our clinical policy at https://www.healthnet.com/content/healthnet/en_us/providers/working-with-hn/medical_policies.html#clinical_practice_guidelines Storage of sperm, ova, and embryos is covered when medically necessary for infertility treatment and compliant with ART criteria in our clinical policy. Cryopreservation Short term storage for one year. Additional 90 day increments after one year if medical necessity is met.	$20 per PCP office visit, $30 per specialist visit. For infertility medications, the appropriate pharmacy tier copay will apply	$30 per PCP office visit, $50 per specialist visit. For infertility medications, the appropriate pharmacy tier copay will apply	$40 per PCP office visit, $40 per specialist visit. For infertility medications, the appropriate pharmacy tier copay will apply
In Vitro Fertilization (IVF) Medications (oral and injectables) for up to 3 three cycles of IVF are covered	$20 per PCP office visit, $30 per specialist visit. For infertility medications, the appropriate pharmacy tier copay will apply	$30 per PCP office visit, $50 per specialist visit. For infertility medications, the appropriate pharmacy tier copay will apply	$40 per PCP office visit, $40 per specialist visit. For infertility medications, the appropriate pharmacy tier copay will apply
Not covered: • Pre-implantation genetic diagnosis • Gestational carriers (surrogates) • Donor sperm and ova collection	*All charges*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**	**Basic Option**
• Testing and treatment • Allergy injections • Allergy serum	Nothing	Nothing	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Treatment therapies	**High Option**	**Standard Option**	**Basic Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on page 52. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder	Nothing	Nothing	Nothing
• Intravenous (IV)/Infusion Therapy – Home IV or antibiotic therapy administered at home by home health nurse	$20 copay	$30 copay	$40 copay
• Cardiac rehabilitation following qualifying event/condition is provided in accordance with the treatment plan • Growth hormone therapy (GHT) • Note: – We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See Other services under You need prior Plan approval for certain services on page 20.	Nothing 20% to a maximum of $200 per day	$30 per visit 20% to a maximum of $200 per day	$40 per visit 20% to a maximum of $200 per day
Special food products and formulas Coverage for testing and treatment of phenylketonuria (PKU) or other inborn errors of metabolism includes formulas and special food products that are part of a diet prescribed by a Physician and managed by a licensed health care professional in consultation with a Physician who specializes in the treatment of metabolic disease. The diet must be deemed Medically Necessary to prevent the development of serious physical or mental disabilities or to promote normal development or function. Coverage is provided only for those costs which exceed the cost of a normal diet.	Nothing	Nothing	Nothing

Treatment therapies - continued on next page

Benefit Description	You pay		
Treatment therapies (cont.)	**High Option**	**Standard Option**	**Basic Option**
Not Covered: Other specialized formulas and nutritional supplements are not covered	Nothing	Nothing	Nothing
Physical and occupational therapies	**High Option**	**Standard Option**	**Basic Option**
Services of each of the following: • Qualified physical therapists • Occupational therapists Note: We only cover therapy when a physician: • Orders the care • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed.	Nothing	$30 per visit	$40 per visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *When medical documentation does not support the medical necessity because of the member's inability to progress toward the treatment plan goals or when the member has already met the treatment plan goals.*	*All charges*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**	**Basic Option**
Services for speech therapy are covered	Nothing	$30 per visit	$40 per visit
Injectable Medications	**High Option**	**Standard Option**	**Basic Option**
• Office Based - Therapeutic Injections • Self Administered - acquired through specialty pharmacy with prescription • Growth Hormone Therapy (GHT) Note: Does not apply to: Allergy serum injections (see page 39); Injectable fertility drugs (see page 38); Routine immunizations (see page 32) and Immunizations for occupational and foreign travel (see page 30).	20% to a maximum of $200 per day	20% to a maximum of $200 per day	20% to a maximum of $200 per day

Benefit Description	You pay		
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**	**Basic Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	$20 per PCP office visit, $30 per specialist visit	$30 per PCP office visit, $50 per specialist visit	$40 per visit
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids and cochlear implants Note: For benefits for the devices, See Section 5(a) *Orthopedic and prosthetic devices.*	$20 per PCP office visit, $30 per specialist visit	$30 per PCP office visit, $50 per specialist visit	$40 per office visit
Not covered: • *Hearing services that are not shown as covered*	*All charges*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**	**Basic Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Eye exam to determine the need for vision correction (see preventive care) Annual eye refractions	$20 per PCP office visit, $30 per specialist visit	$30 per PCP office visit, $50 per specialist visit	$40 per office visit
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Eyeglasses or contact lenses after Interocular lens implant*	*All charges*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**	**Basic Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	$20 per PCP office visit, $30 per specialist visit	$30 per PCP office visit, $50 per specialist visit	$40 per office visit
Not covered:	*All charges*	*All charges*	*All charges*

Foot care - continued on next page

Benefit Description	You pay		
Foot care (cont.)	**High Option**	**Standard Option**	**Basic Option**
• *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (except for surgical treatment)*	*All charges*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**	**Basic Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy.	Nothing	Nothing	Nothing
• External hearing aids for children (under 18 years of age) with hearing loss - $1,500 maximum benefit every 36 months • External hearing aids for adults - 2 hearing aids every 36 months with a maximum benefit of $1,500 every 36 months • Implanted hearing-related devices, such as bone anchored hearing aids and cochlear implants Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	Nothing	Nothing	Nothing
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, except when they have been incorporated into a cast, splint, brace or strapping of the foot, or except to treat diabetes-related complications when prescribed by your Plan physician, heel pads and heel cups*	*All charges*	*All charges*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay		
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**	**Basic Option**
• *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**	**Basic Option**
We cover rental or purchase of prescribed durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Standard wheelchairs, electric wheelchairs if medically necessary • Crutches • Walkers • Speech generating devices • Blood glucose monitors • Insulin pumps Note: Call us at 800-522-0088 as soon your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	Nothing	Nothing	Nothing
Not covered: • *Exercise equipment* • *Hygienic equipment and supplies (to achieve cleanliness even when related to other covered medical services)* • *Stockings* • *Surgical dressings, except primary dressings that are applied by a Plan physician or a Hospital to lesions of the skin or surgical incisions* • *Jacuzzis and whirlpools* • *Orthotics which are not custom made to fit your body (Orthotics are supports or braces for weak or ineffective joints or muscles)*	*All charges*	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay		
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**	**Basic Option**
• *Foot orthotic, except when they have been incorporated into a cast, splint, brace or strapping of the foot* • *Laptop computers, desktop computers or PDA's that are not dedicated speech generating devices are not covered*	*All charges*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**	**Basic Option**
• Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. *Note: Your Plan physician will review the home health service program for continuing appropriateness.*	Nothing for the first 30 visits, $10 per visit thereafter	Nothing for the first 30 visits, $10 per visit thereafter	$40 per visit 100 visits
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**	**Basic Option**
• Chiropractic and Acupuncture services – by the chiropractors/acupuncturists that participate in the American Specialty Health Plan (ASHP) network. 20 visits per calendar year are covered for these services without a referral from the Plan physician	$10 per office visit	$10 per office visit	$10 per office visit
Chiropractic appliances are covered up to $50 per calendar year	All charges above $50 per calendar year	All charges above $50 per calendar year	All charges above $50 per calendar year

Benefit Description	You pay		
Alternative treatments	**High Option**	**Standard Option**	**Basic Option**
Acupuncture - by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner. Dry Needling - by a licensed or certified practitioner	$20 per PCP office visit, $30 per specialist visit	$30 per PCP office visit, $50 per specialist visit	$40 per office visit
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Massage therapy*	*All charges*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**	**Basic Option**
Coverage is provided for: • Tobacco cessation programs, including individual, group, telephonic counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. • The following Smoking/Tobacco Cessation prescribed medications: Zyban, Chantix, Nicotrol Inhaler, and Nicotrol NS, dosage limits and prior authorization requirements apply • FDA approved over-the-counter Nicotine replacement therapy medications. Written prescription required and dosage limits apply • Diabetes self management	Nothing Nothing for drugs filled at a Plan pharmacy Nothing for drugs filled through mail order program	Nothing Nothing for drugs filled at a Plan pharmacy Nothing for drugs filled through mail order program	Nothing Nothing for drugs filled at a Plan pharmacy Nothing for drugs filled through mail order program
Health Net's Wellness Programs • Weight management • Diabetes self-management • Emotional health • Exercise • Nutrition • Stress management • Prenatal education • Treatment support videos • Diabetic Prevention Program • Health Net Doula Program	Nothing	Nothing	Nothing

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**

Benefit Description	You pay		
Surgical procedures	**High Option**	**Standard Option**	**Basic Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Routine pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of severe obesity (bariatric surgery) Health Net considers the following bariatric surgical procedures medically appropriate when all of the general criteria and all of the criteria specific to the procedures are met. Here is a list of the general criteria: • Patient is an adult greater than 18 and less than 65 years of age unless the patient is greater than 65 and is considered a low-risk candidate; • Morbid obesity has persisted for at least 5 years, especially in the year prior to the scheduled surgery;	$20 per PCP visit, $30 per specialist visit Nothing for surgery $150 copayment per day up to 5 days per inpatient admission or $200 copayment for outpatient surgery	$30 per PCP visit, $50 per specialist visit Nothing for surgery $750 copayment per inpatient admission or $350 copayment for outpatient surgery	$40 per office visit Nothing for surgery $500 copayment per day up to 3 days per inpatient admission or $500 copayment for outpatient surgery when performed at a hospital / $200 copayment for outpatient surgery when performed at an ambulatory surgery center

Surgical procedures - continued on next page

Benefit Description	You pay		
Surgical procedures (cont.)	**High Option**	**Standard Option**	**Basic Option**
• The patient has clinically severe obesity defined by either Body mass index greater than or equal to 40 kg/m2 or a weight of at least two times the ideal weight for frame, age, height, and gender, as specified in the 1983 Metropolitan Life Insurance tables; or BMI of between 35 kg/m2 and 40 kg/m2 with one or more of life-threatening, obesity-related co-morbidities which have not responded to optimal medical management. • In the two years prior to the planned date of surgery, the patient has failed to lose weight or has regained weight despite participation in a six-month dietary program supervised by either a physician or professional. • All patients must undergo a psychological evaluation by a psychiatrist/psychologist familiar with the implications of weight reduction surgery to rule out the presence of major psychological pathology (active substance abuse, schizophrenia, borderline personality disorder, uncontrolled depression) and to determine whether the patient will comply with the strict postoperative diet and lifelong follow-up. • Treatable metabolic causes for obesity, especially hypothyroidism, should be excluded before surgery. Consult with your physician for all specific criteria related to the above procedures. Health Net has a designated network of bariatric surgical centers to perform weight loss surgery. Your Member Physician can provide you with information about these centers. You will be directed to a Health Net designated bariatric surgical center at the time authorizations is obtained. If you live 50 miles or more from the nearest Health Net designated bariatric surgical center, you are eligible to receive travel expense reimbursement. All requests for travel reimbursement must be prior approved by Health Net. • Insertion of internal prosthetic devices . See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Treatment of burns	$20 per PCP visit, $30 per specialist visit Nothing for surgery $150 copayment per day up to 5 days per inpatient admission or $200 copayment for outpatient surgery	$30 per PCP visit, $50 per specialist visit Nothing for surgery $750 copayment per inpatient admission or $350 copayment for outpatient surgery	$40 per office visit Nothing for surgery $500 copayment per day up to 3 days per inpatient admission or $500 copayment for outpatient surgery when performed at a hospital / $200 copayment for outpatient surgery when performed at an ambulatory surgery center

Surgical procedures - continued on next page

Benefit Description	You pay		
Surgical procedures (cont.)	**High Option**	**Standard Option**	**Basic Option**
Note: For female surgical family planning procedures see Family Planning Section 5(a) Note: For male surgical family planning procedures see Family Planning Section 5(a) Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$20 per PCP visit, $30 per specialist visit Nothing for surgery $150 copayment per day up to 5 days per inpatient admission or $200 copayment for outpatient surgery	$30 per PCP visit, $50 per specialist visit Nothing for surgery $750 copayment per inpatient admission or $350 copayment for outpatient surgery	$40 per office visit Nothing for surgery $500 copayment per day up to 3 days per inpatient admission or $500 copayment for outpatient surgery when performed at a hospital / $200 copayment for outpatient surgery when performed at an ambulatory surgery center
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot (see Section 5(a) Foot care)*	*All charges*	*All charges*	*All charges*
Medically necessary standard fertility preservation for iatrogenic infertility for adults and adolescents with a female reproduction system prior to commencing treatment that is likely to cause infertility (excluding voluntary sterilization): 1. Embryo cryopreservation; 2. Cryopreservation of mature oocytes; 3. Ovarian transposition (oophoropexy); 4. Radiation (gonadal) shielding; 5. Conservative gynecologic surgery including but not limited to the following: - Radical trachelectomy in early stage cervical cancer (i.e., stage IA2 to IB cervical cancer with diameter <2 cm and invasion <10 mm); - Ovarian cystectomy for early-stage ovarian cancer. Medically necessary standard fertility preservation for iatrogenic infertility adults and adolescents with a male reproductive system prior to commencing treatment that is likely to cause infertility (excluding voluntary sterilization): 1. Cryopreservation of sperm; 2. Radiation (gonadal) shielding	$150 copayment per day up to 5 days per inpatient admission or $200 copayment for outpatient surgery	$750 copayment per inpatient admission or $350 copayment for outpatient surgery	$500 copayment per day up to 3 days per inpatient admission or $500 copayment for outpatient surgery when performed at a hospital / $200 copayment for outpatient surgery when performed at an ambulatory surgery center

Surgical procedures - continued on next page

Benefit Description	You pay		
Surgical procedures (cont.)	**High Option**	**Standard Option**	**Basic Option**
Note: your pay cost-sharing for other services associated with fertility preservation for iatrogenic infertility, including: • Lab, X-ray and other diagnostic services as described in Section 5(a) • Outpatient hospital and ambulatory surgical centers as described in Section (b) • Prescription drugs as described in Section 5 (f) Storage of sperm, ova, and embryos is covered when medically necessary for infertility treatment and compliant with ART criteria in our clinical policy. Cryopreservation Short term storage for one year. Additional 90 day increments after one year if medical necessity is met.	$150 copayment per day up to 5 days per inpatient admission or $200 copayment for outpatient surgery	$750 copayment per inpatient admission or $350 copayment for outpatient surgery	$500 copayment per day up to 3 days per inpatient admission or $500 copayment for outpatient surgery when performed at a hospital / $200 copayment for outpatient surgery when performed at an ambulatory surgery center
Not covered: Coverage for fertility preservation does not include the following: • Pre-implantation genetic diagnosis • Gestational carriers (surrogates)	All charges	All charges	All charges
Reconstructive surgery	**High Option**	**Standard Option**	**Basic Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas;	Nothing for surgery $150 copayment per day up to 5 days per inpatient admission or $200 copay for outpatient surgery	Nothing for surgery $750 copayment per inpatient admission or $350 copayment for outpatient surgery	Nothing for surgery $500 copayment per day up to 3 days per inpatient admission or $500 copayment for outpatient surgery when performed at a hospital / $200 copayment for outpatient surgery when performed at an ambulatory surgery center

Reconstructive surgery - continued on next page

Benefit Description	You pay		
Reconstructive surgery (cont.)	**High Option**	**Standard Option**	**Basic Option**
- breast prostheses and surgical bras and replacements (see Section 5(a) Prosthetic devices for coverage). Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing for surgery $150 copayment per day up to 5 days per inpatient admission or $200 copay for outpatient surgery	Nothing for surgery $750 copayment per inpatient admission or $350 copayment for outpatient surgery	Nothing for surgery $500 copayment per day up to 3 days per inpatient admission or $500 copayment for outpatient surgery when performed at a hospital / $200 copayment for outpatient surgery when performed at an ambulatory surgery center
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury if repair is initiated within* • *Surgery for Sex-Trait Modification to treat gender dysphoria* *If you are mid-treatment under this Plan, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care for that treatment. Our exception process is as follows:* To request an exception to determine if your qualifying medical conditions will meet the criteria for continued care, you must submit an appeal to Health Net. An appeal will be resolved within 30 days. Please provide a brief explanation of your medical condition, including when you started treatment for this condition, and send a copy of the denial notice, if applicable, to Health Net and we will review your request. To request an appeal, do one of the following:	*All charges*	*All charges*	*All charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay		
Reconstructive surgery (cont.)	**High Option**	**Standard Option**	**Basic Option**
• Call Health Net Member Services at 800-522-0088 to request an appeal, • Submit online at *www.healthnet.com/fehb* by logging into your own account and clicking on the GRIEVANCE FORM link • Or write to Health Net Appeals & Grievance, P.O. Box 10348, Van Nuys, CA 91410-0348 *If you disagree with our decision on your exception, please see Section 8 of this brochure for the disputed claims process.* *Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.*	*All charges*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**	**Basic Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing for surgery $150 copayment per day up to 5 days per inpatient admission or $200 copayment for outpatient surgery	Nothing for surgery $750 copayment per inpatient admission or $350 copayment for outpatient surgery	Nothing for surgery $500 copayment per day up to 3 days per inpatient admission or $500 copayment for outpatient surgery when performed at a hospital / $200 copayment for outpatient surgery when performed at an ambulatory surgery center
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival, and alveolar bone)*	All charges	All charges	All charges

Benefit Description	You pay		
Organ/tissue transplants	**High Option**	**Standard Option**	**Basic Option**
These **solid organ and tissue transplants** are subject to medical necessity and experimental/ investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal Transplant -Isolated small intestine -Small intestine with the liver -Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas These **tandem blood or marrow cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Nothing for surgery $150 copayment per day up to 5 days for inpatient admission	Nothing for surgery $750 copayment for inpatient admission	Nothing for surgery $500 copayment per day up to 3 days for inpatient admission
Blood or marrow stem cell transplants The plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Acute myeloid leukemia	Nothing for surgery $150 copayment per day up to 5 days for inpatient admission	Nothing for surgery $750 copayment for inpatient admission	Nothing for surgery $500 copayment per day up to 3 days for inpatient admission

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Basic Option**
- Advanced Hodgkins lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkins lymphoma with recurrence (relapsed) - Aggressive non-Hodgkin lymphomas - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteoporosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e. Fanconi's Paroxysmal Nocturnal Hemoglobiuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g. Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g. Hurler's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodyplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g. Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome - Hematopoietic stem cell transplant • Autologous transplants for - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis	Nothing for surgery $150 copayment per day up to 5 days for inpatient admission	Nothing for surgery $750 copayment for inpatient admission	Nothing for surgery $500 copayment per day up to 3 days for inpatient admission

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Basic Option**
- Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Advanced Ewing's sarcoma (pediatric only) - Medulloblastoma - Multiple myeloma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Refroperitoneal, and Ovarian germ cell tumors - Hematopoietic stem cell transplant	Nothing for surgery $150 copayment per day up to 5 days for inpatient admission	Nothing for surgery $750 copayment for inpatient admission	Nothing for surgery $500 copayment per day up to 3 days for inpatient admission
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute Lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia (when criteria is met) - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs)(when criteria is met) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e. Fanconi's PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia			

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Basic Option**
• Autologous transplants for - Acute lymphocytic or nonlymphocytic (i. e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	Nothing for surgery $150 copayment per day up to 5 days for inpatient admission	Nothing for surgery $750 copayment for inpatient admission	Nothing for surgery $500 copayment per day up to 3 days for inpatient admission
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Sickle Cell anemia • Mini-transplants (non-myeloblative allogeneic, reduced instensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i. e. myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia	Nothing for surgery $150 copayment per day up to 5 days for inpatient admission	Nothing for surgery $750 copayment for inpatient admission	Nothing for surgery $500 copayment per day up to 3 days for inpatient admission

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Basic Option**
- Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodyplastic syndromes - Myeloproliferative disorders (MPDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinomas - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma (pediatric only) - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphoma - Breast cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) (adults only) - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	Nothing for surgery $150 copayment per day up to 5 days for inpatient admission	Nothing for surgery $750 copayment for inpatient admission	Nothing for surgery $500 copayment per day up to 3 days for inpatient admission

Organ/tissue transplants - continued on next page

Benefit Description	You pay		
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**	**Basic Option**
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/ stem cell transplant donors in addition to the testing of family members.	Nothing for surgery $150 copayment per day up to 5 days for inpatient admission	Nothing for surgery $750 copayment for inpatient admission	Nothing for surgery $500 copayment per day up to 3 days for inpatient admission
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**	**Basic Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing after $150 copayment per day up to 5 days for inpatient admission or after $200 copayment for outpatient surgery	Nothing after $750 copayment for inpatient admission or $350 copayment for outpatient surgery	Nothing after $500 copayment per day up to 3 days for inpatient admission or after $500 copayment for outpatient surgery when performed at a hospital / $200 copayment for outpatient surgery when performed at an ambulatory surgery center

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).

Benefit Description	You pay		
Inpatient hospital	**High Option**	**Standard Option**	**Basic Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$150 copayment per day up to 5 days per inpatient admission	$750 per admission	$500 copayment per day up to 3 days per inpatient admission
General nursing care Meals and special diets	Nothing	Nothing	Nothing
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing	Nothing	Nothing
Not covered: • Custodial care	*All charges*	*All charges*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay		
Inpatient hospital (cont.)	**High Option**	**Standard Option**	**Basic Option**
• Non-covered facilities, such as nursing homes, schools • *Personal comfort items, such as phone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**	**Basic Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing	Nothing	Nothing
Not covered: Blood and blood derivatives not replaced by the member	*All charges*	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**	**Basic Option**
Extended care/Skilled nursing facility (SNF): Up to 100 days per calendar year for services such as: • Bed, board and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan physician	Nothing	Nothing	Days 1-10: Nothing Days 11-100 - $25 per day
Not covered: Custodial care and personal comfort items such as phone and television	*All charges*	*All charges*	*All charges*

Benefit Description	You pay		
Hospice care	**High Option**	**Standard Option**	**Basic Option**
Hospice care: Up to 210 days for services such as: • Inpatient and outpatient care • Family counseling Note: Hospice care services are provided under the direction of a Plan physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less	Nothing	Nothing	Nothing
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*	*All charges*
End of life care	**High Option**	**Standard Option**	**Basic Option**
The Plan has a comprehensive program for end of life care. the program makes available • Durable Power of Attorney for healthcare • Addresses financial counseling • Includes legal counseling • Addresses caregiver needs • Includes bereavement counseling for many members Note: This program is based on Medicare guidelines for hospice coverage, and the Plan contracts with open access hospice programs that allow medical services not limited to palliative care.	Nothing	Nothing	Nothing
Ambulance	**High Option**	**Standard Option**	**Basic Option**
Local professional ambulance service when medically appropriate	Nothing	$100 per trip	$100 per trip

Section 5(d). Emergency Services/Accidents

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Out of service area emergency is defined as an emergency service rendered outside of your participating provider group network or out of state or out of the country emergency.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. An emergency will also include screening, examination and evaluation by a physician (or other healthcare professional acting within the scope of their license) to determine if a psychiatric medical emergency condition exists and the treatment necessary to relieve or eliminate such condition, is within the capability of the facility. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, contact the local emergency system (i.e., the 911 phone system) or go to the nearest hospital emergency room. Please call your Participating Physician Group. In extreme emergencies, if you are unable to contact your medical group be sure to tell the emergency room personnel that you are a Health Net of California member so they can notify us at 800-522-0088. You or a family member should notify us within 48 hours, unless it was not reasonably possible to do so. It is your responsibility to ensure that we have been notified in a timely manner.

If you need to be hospitalized, we must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify us within that time. If you are hospitalized in a non- Health Net of California facility and Health Net of California doctors believe care can be better provided in a participating hospital, you will be transferred when medically feasible with any ambulance charges covered in full. Benefits are available for care from non-Health Net of California providers in a medical emergency only if delay in reaching a participating provider would result in death, disability or significant jeopardy to your condition.

Any follow-up care recommended by non-Health Net of California providers must be approved by us or provided by our participating providers.

Emergencies outside our service area: Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness. If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the plan within that time. If a Health Net doctor believes care can be better provided by a participating hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Any follow-up care recommended by non-Health Net of California providers must be approved by us or provided by our participating providers.

Benefit Description	You pay		
Emergency within our service area	**High Option**	**Standard Option**	**Basic Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$20 per visit	$30 per visit	$40 per visit
• Emergency care at an emergency room • Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: If the emergency results in admission to a hospital, the copay is waived	$100 per visit	$150 per visit	$100 per visit
Not covered: Elective care or non-emergency care	*All charges*	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**	**Basic Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$20 per visit	$30 per visit	$40 per visit
• Emergency care at an emergency room • Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: If the emergency results in admission to a hospital, the copay is waived	$100 per visit	$150 per visit	$100 per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Follow-up care not authorized by your participating physician group*	*All charges*	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**	**Basic Option**
Professional ground and air ambulance service when medically appropriate.	Nothing	$100 copay per trip	$100 copay per trip

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things to keep in mind about these benefits:

• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

• We do not have a calendar year deductible.

• Be sure to read Section 4, Your costs for covered services, for valuable information about how cost - sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

• All services must be Medically Necessary. We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.

• OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay		
Professional services	**High Option**	**Standard Option**	**Basic Option**
If we approve part or all of a treatment plan, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners as long as they act within the scope of their license. This includes psychiatrists, psychologists, clinical social workers, licensed professional counselors, and marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions	Your cost-sharing responsibilities are no greater than for other illnesses or conditions	Your cost-sharing responsibilities are no greater than for other illnesses or conditions
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management • Psychological and neuropsychological testing when necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits). • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling by licensed practitioners. • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$20 per visit	$30 per visit	$40 per visit
Applied Behavioral Analysis (ABA) therapy for autism spectrum disorder	Nothing	Nothing	Nothing

Benefit Description	You pay		
Diagnostics	**High Option**	**Standard Option**	**Basic Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner	$20 per visit	$30 per visit	$40 per visit
• Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	No charge for laboratory, X-ray and other diagnostic tests. See Section 5(c) for facility charges	No charge for laboratory, X-ray and other diagnostic tests. See Section 5(c) for facility charges	No charge for laboratory, X-ray and other diagnostic tests. See Section 5(c) for facility charges
• Inpatient diagnostic tests provided and billed by a hospital or other covered facility	$150 per day up to 5 days per admission	$750 per admission	$500 per day up to 3 days per admission
Inpatient hospital or other covered facility	**High Option**	**Standard Option**	**Basic Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$150 per day up to 5 days per admission	$750 per admission	$500 per day up to 3 days per admission
Outpatient hospital or other covered facility	**High Option**	**Standard Option**	**Basic Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	Nothing	Nothing	Nothing

Preauthorization

The Mental Health and Substance Use Disorder benefits are administered by Health Net Behavioral Health. When you need to see a Participating Mental Health Professional, contact the Behavioral Health Administrator by calling the Health Net Customer Contact Center at the phone number on your Health Net I.D. card.

Certain services and supplies for Mental Health and Substance Use Disorder require prior authorization by the Behavioral Health Administrator to be covered. The services and supplies that require prior authorization are:

- Outpatient procedures that are not part of an office visit (for example: psychological and neuropsychological testing, outpatient electroconvulsive therapy (ECT) and transcranial magnetic stimulation (TMS), outpatient detoxification, partial hospitalization, day treatment, half-day partial hospitalization and 23-hour outpatient observation; and
- Inpatient, residential, partial hospitalization, inpatient ECT, Inpatient psychological and neuropsychological testing; and
- Behavioral health treatment for Autism (see below under “Outpatient Services”).

No prior authorization is required for outpatient office visits.

We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.

OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Section 5(f). Prescription Drug Benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 69.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- We do not have a calendar year deductible.
- Some preferred and non-preferred drugs require prior authorization from us. Contact us at 800-522-0088 to find out if your medication requires it and for information on what your physician must do to obtain prior authorization.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Covered preventive drugs including statin (low to moderate-dose) when prescribed to adults aged 40-75 years who meet all 3 of the following criteria:
  -Do not have a history of cardiovascular disease (e.g., symptomatic CVD or ischemic stroke)
  -Have one or more CVD risk factors (e.g., dyslipidemia, diabetes, hypertension or smoking)
  -Have a calculated 10-year risk of a cardiovascular event of 10% or greater
- The exclusion for hormone treatments for Sex-Trait Modification for gender dysphoria only pertains to chemical and surgical modification of an individual's sex traits. We do not exclude coverage for entire classes of pharmaceuticals, e.g., GnRH agonists may be prescribed during IVF, for reduction of endometriosis or fibroids, and for cancer treatment or prostate cancer/tumor growth prevention.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/ certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail if a maintenance medication. It may be required to obtain Specialty Drugs from a Specialty Pharmacy.
- **We use a preferred list.** A preferred is the approved list of drugs that are covered. It identifies whether a generic version of a brand name drug exists, and if prior authorization is required. Drugs that are not excluded or limited from coverage are also covered and are considered non-preferred drugs. Non-preferred drugs require a higher copayment.

You can get a copy of the preferred list by calling us at 800-522-0088 or visit our web site at www.healthnet.com/fehb.

- **We have a managed formulary**. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name drug from a preferred list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. Please see our online formulary and drug pricing search tools at the following www.healthnet.com/fehb or call Member Services at 800-522-0088.
- These are the dispensing limitations.
- When the prescription drug is filled at a Plan pharmacy: The pharmacy may dispense up to a 30-day supply for each drug or for each refill at the appropriate time interval.
- When the prescription drug is filled through the mail order program, the mail order pharmacy may dispense up to a 90-day supply for each medication drug or refill allowed by the prescription at the appropriate time interval.

If you send in an order too soon after the last one was filled, you will get a notice from the pharmacy indicating that it is too early to fill the prescription and when the next fill is available.

- If a member requires an interim supply of medication due to an active military duty assignment or if there is a national emergency, call us at 800-522-0088 for immediate assistance

Mail order is for the dispensing of chronic medications that your physician has already approved for long-term use. Not all drugs are available via mail order, such as

- Drugs requiring immediate use that the delay in obtaining such drugs would interfere with the physician's treatment plan

Drugs requiring detailed instruction which cannot be provided by the mail order pharmacy compared to a retail pharmacist at the time the prescription is filled.

- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a FDA approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

The prescribed supply may not always be an appropriate drug treatment plan, according to the FDA or our usage guidelines. If this is the case, the amount of medication dispensed may be reduced.

If there is no generic equivalent available, you will still have to pay the brand name copayment.

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

Some preferred, non-preferred and specialty drugs may require prior authorization from us to be covered. If a drug does require a prior authorization, it is noted on the Drug List with a PA. You can ask your doctor to contact Health Net to request coverage for the prescribed medication. Compounded drugs (that use FDA approved drugs for an FDA approved indication) and that are not commercially available are covered. Coverage for compounded drugs is subject to prior authorization and medical necessity.

When you do have to file a claim. In most cases you do not have to file a claim when purchasing drugs at the Plan pharmacy. However, you must pay for the drug when it is dispensed, and file a claim for reimbursement when the following occurs:

- Your Plan ID card is not available.
- Eligibility cannot be determined.
- The prescription drug is dispensed outside of California for a medical emergency.

For claims questions and assistance, or to request a prescription drug claim form or mail order request form, call us at 800-522-0088.

Benefit Description	You pay		
Covered medications and supplies	**High Option**	**Standard Option**	**Basic Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Diabetic supplies limited to (specific brands apply):	For drugs filled at a Plan pharmacy: $10 for generic drugs; $35 for brand drugs; $60 for non-preferred drugs 20% to a maximum of $200 per prescription for specialty drugs	For drugs filled at a Plan pharmacy: $15 for generic drugs $35 for brand drugs $65 for non-preferred drugs 20% to a maximum of $200 per prescription for specialty drugs	For drugs filled at a Plan pharmacy: $15 for generic drugs; $35 for brand drugs; $65 for non-preferred drugs 20% to a maximum of $200 per prescription for specialty drugs

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Basic Option**
- blood glucose monitoring strips, Ketone test strips and lancet - Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see limits listed in the Drug List)	For drugs filled at a Plan pharmacy: $10 for generic drugs; $35 for brand drugs; $60 for non-preferred drugs 20% to a maximum of $200 per prescription for specialty drugs For drugs filled through the mail order program: $20 for generic drugs; $70 for brand drugs; $120 for non-preferred drugs Note: If there is no generic equivalent available, you will still have to pay the brand name copay	For drugs filled at a Plan pharmacy: $15 for generic drugs $35 for brand drugs $65 for non-preferred drugs 20% to a maximum of $200 per prescription for specialty drugs For drugs filled through the mail order program: $30 for generic drugs $70 for brand drugs $130 for non-preferred drugs Note: If there is no generic equivalent available, you will still have to pay the brand name copay	For drugs filled at a Plan pharmacy: $15 for generic drugs; $35 for brand drugs; $65 for non-preferred drugs 20% to a maximum of $200 per prescription for specialty drugs For drugs filled through the mail order program: $30 for generic drugs; $70 for brand drugs; $130 for non-preferred drugs Note: If there is no generic equivalent available, you will still have to pay the brand name copay
Medications prescribed to treat obesity Appetite suppressants and drugs for body weight reduction require a prescription in order to be dispensed for the treatment of obesity are covered when Medically Necessary for the treatment of morbid obesity or when you meet Health Net Prior Authorization coverage requirements. The prescribing Physician must request and obtain Prior Authorization for coverage. Saxenda (self-injectable) is covered with prior authorization approval. Wegovy (self-injectable) is with prior authorization approval. Oral anti-obesity medications that are in the Health Net Preferred Drug list include Qsymia, Contrave, Orlistat, Phentemine are covered with prior authorization.	50% of charges	50% of charges	50% of charges

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Basic Option**
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. • Note: The "morning after pill" is an over-the-counter emergency contraceptive drug. It is considered a preventive service under contraceptives, with no cost to the member if prescribed by a physician and purchased at a network pharmacy. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. - Use the contraception exception process if the contraception recommended by your provider is not covered or has an out-of-pocket cost. You or your provider may submit an exception request. - Members can call the Customer Contact Center at 1-800-522-0088 to submit an exception request • Reimbursement for over-the-counter contraceptives can be submitted in accordance with Section 7. Note: For additional Family Planning benefits see Section 5(a)	Nothing	Nothing	Nothing
Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a)	See section 5(a)	See section 5(a)	See section 5(a)
Not covered • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies*	All charges	All charges	All charges

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Basic Option**
• *Non-prescription medications unless specifically indicated elsewhere* • *Drugs prescribed in connection with Sex-Trait Modification for treatment of gender dysphoria* If you are mid-treatment under this Plan, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care for that treatment. Our exception process is as follows: To request an exception to determine if your qualifying medical conditions will meet the criteria for continued care, you must submit an appeal to Health Net. An appeal will be resolved within 30 days. Please provide a brief explanation of your medical condition, including when you started treatment for this condition, and send a copy of the denial notice, if applicable, to Health Net and we will review your request. To request an appeal, do one of the following: • Call Health Net Member Services at 800-522-0088 to request an appeal, • Submit online at www.healthnet.com/fehb by logging into your own account and clicking on the GRIEVANCE FORM link • Or write to Health Net Appeals & Grievance, P.O. Box 10348, Van Nuys, CA 91410-0348 If you disagree with our decision on your exception, please see Section 8 of this brochure for the disputed claims process. *Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.*	All charges	All charges	All charges
Opioid rescue agents are covered under this Plan with no cost sharing when obtained with a prescription from a network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose	Nothing	Nothing	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay		
Covered medications and supplies (cont.)	**High Option**	**Standard Option**	**Basic Option**
Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/	Nothing	Nothing	Nothing
Limited benefits: • Drugs for sexual dysfunction are limited to 2 doses per week or 8 tablets per month Fertility drugs associated with covered services under the diagnosis and treatment of infertility are covered services under the diagnosis and treatment of infertility are covered under the Medical Services and Supplies Benefits (see page 38).	50% of charges	50% of charges	50% of charges
Preventive medications	**High Option**	**Standard Option**	**Basic Option**
The following are covered: Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing	Nothing	Nothing
Not covered: • Drugs and supplies for cosmetic purposes • Drugs to enhance athletic performance • Fertility drugs • Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies • Nonprescription medications	All charges	All charges	All charges

Section 5(g). Dental Benefits

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay		
Accidental injury benefit	**High Option**	**Standard Option**	**Basic Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	$20 copay at the PCP's office, $30 at the specialist's office and a $100 copayment at the emergency room	$30 copay at the PCP's office, $50 at the specialist's office and a $150 copayment at the emergency room	$40 per office visit and a $100 copayment at the emergency room
Dental benefits	**High Option**	**Standard Option**	**Basic Option**
Dental examinations and treatment of the gingival tissues (gums) when performed for the diagnosis or treatment of a tumor.	$20 per PCP office visit, $30 per specialist visit	$30 per PCP visit, $50 per specialist visit	$40 per office visit
Not covered: *Other dental services not shown as covered*	*All charges*	*All charges*	*All charges*

Section 5(h). Wellness and Other Special Features

Feature	Description
Centers of Excellence	For organ and tissue transplants, we contract with premier transplant centers of excellence in Northern, Southern and Central California that have established their superior ability to perform certain transplant procedures. Your participating physician group will work with you to find the best center for your condition.
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (See Section 8).
Health Net's Wellness Programs	Health Net's Wellness Programs address the health needs of the whole person from wellness health coaching to chronic condition management. • Members can take a RealAge Test which provides a personalized report of the individual's behavioral and medical health risks. • Receive timely access through the Nurse Advice Line for help with everyday health questions 24/7. • Craving to Quit is our tobacco cessation program that allows members to talk with a quit coach for encouragement and support and offers a personalized plan to quit. • Start Smart for Your Baby (SSFB) is a program for pregnant and new parents, providing custom support and care for a healthy pregnancy and baby. For more information on our Wellness Programs, members can call the Customer Service number found on the back of the member ID card or go towww.healthnet.com/fehb and click on "Health and Wellness."
Health Net's Doula Program – Personal Care and Support During Pregnancy	The Program provides: • One visit with a doula to get to know each other. • Up to eight visits that can happen during the pregnancy and postpartum.

	• Support during labor and birth* • Up to two-three-hour postpartum visits after the end of a pregnancy. *This would also apply to stillbirth, miscarriage, or abortion. For more information on our Wellness Programs, members can call the Customer Service number found on the back of the member ID card or go towww.healthnet.com/fehb and click on "Health and Wellness."
Active & Fit Direct Program	Active and Fit Direct program offers fitness center membership to 12,700+ fitness centers nationwide for just $28 a month (plus a one-time $28 enrollment fee). For more information, please visit our website at www.healthnet.com/fehb or contact us at 800-522-0088.
Services for deaf and hearing impaired	Please contact our Telecommunications Device for the Deaf at 800-995-0852.

Non-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 800-522-0088 or visit the website at www.healthnet.com/fehb.

Medicare Prepaid Plan Enrollment	This Plan offers Medicare recipients the opportunity to enroll in the Plan (Health Net Seniority Plus program) through Medicare. Annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join Health Net Seniority Plus but will have to pay for Medicare Part A in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 800-596-6565 for information on the Health Net Seniority Plus Medicare prepaid plan and the cost of that enrollment. If you are eligible for Medicare and are interested in enrolling in a Medicare HMO sponsored by Health Net of California without dropping your enrollment in Health Net's FEHB plan, call 800-596-6565 for information on the benefits available under the Medicare HMO.
Individual Plans for Domestic Partners	Health Net has affordable healthcare plans members can depend on. We offer a wide range of competitively-priced plans with the benefits your dependents are looking for. Members can also take advantage of our Wellness Center® a free series of tools and services to help you manage and support your well-being. For more information on Health Net Individual and Family plans go to www.healthnet.com and click on Shoppers or call Health Net at 800-909-3447.

Section 6. General Exclusions - Services, Drugs and Supplies We Do Not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Extra care costs associated with clinical trials.
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services or supplies we are prohibited from covering under the Federal law.
- Any benefits or services required solely for your employment are not covered by this plan.
- Chemical or surgical modification of an individual's sex traits through medical interventions (to include treatment of gender dysphoria), other than mid-treatment exceptions, see Section 3. How You Get Care.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Providers must file HIPAA compliant electronic on the form CMS-1500, Health Insurance Claim Form. In cases where a paper claim must be used, the facility will file on the UB-04 form. For claims questions and assistance, contact us at 800-522-0088, or at our Website www.healthnet.com/fehb.

When you must file a claim – such as for services you receive outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the provider or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

Health Net of California, Commercial Claims, P.O. Box 9040, Farmington, MO 63640-9040

Prescription drugs

When you purchase a prescription drug, and your Plan ID card is not available, eligibility cannot be determined, or the prescription is for a medical emergency outside of California, you must pay for the drug when it is dispensed, and file a claim for reimbursement. For claims questions and assistance, or to request a prescription drug claim form call us at 800-522-0088.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the following year after you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claim procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims processed in Section 8 of this brochure.

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a limitation on the re-issuance of uncashed checks often indicated on the check.

Overseas claims

In order to enroll in any Health Net plan, members must reside or work in an approved service area in California from which a member has reasonable access to our network providers (see Section 1. How This Plan Works for the list of service area). Coverage of care received outside the Service Area will be limited to services provided in connection with Emergency Care or Urgently Needed Care. If you need to submit a claim related to emergency or urgently needed care, visit our website at www.healthnet.com/fehb or call Member Services at 800-522-0088. Completed claim forms and itemized bill must be sent to Health Net of California, Commercial Claims, P.O. Box 9040, Farmington, MO 63640-9040

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow the required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure or plan website.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient admissions.

To help you prepare your appeal, you may contact us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Appeals and Grievance Department by writing to P.O. Box 10348, Van Nuys, CA 91410-0348 or calling 800-522-0088.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: 1. Write to us within 6 months from the date of our decision; and 2. Send your request to us at: Health Net of California, P.O. Box 10348, Van Nuys, CA 91410-0348; and 3. Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and 4. Include a copy of your insurance ID card, copies of documents that support your claim, such as a copy of your plans first appeal denial letter, physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. 5. Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in a sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: 1. Pay the claim or 2. Write to you and maintain our denial or

3. Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3

If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employees Insurance Operations, FEHB 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM's review within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 800-522-0088. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 3 at 202-606-0737 between 8 am and 5 pm Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.healthnet.com/fehb.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

TRICARE and CHAMPVA

TRICARE is the healthcare program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these state programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on www.BENEFEDS.gov or by phone at 877-888-3337, (TTY 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.

- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan physician.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 800-522-0088 or see our website at www.healthnet.com/fehb.

We do not waive any costs on the High Option if the Original Medicare Plan is your primary payor:

Deductible
You pay without Medicare – (High Option): N/A – No deductible
You pay with Medicare Part B - (High Option): N/A – No deductible

Out-of-Pocket Maximum
You pay without Medicare – (High Option): $1,500 Self Only/$3,000 Self Plus One/ $4,500 Self and Family
You pay with Medicare Part B - (High Option): $1,500 Self Only/$3,000 Self Plus One/$4,500 Self and Family

Part B Premium Reimbursement Offered
You pay without Medicare – (High Option): N/A
You pay with Medicare Part B - (High Option): N/A

Primary Care Provider
You pay without Medicare – (High Option): $20 copay
You pay with Medicare Part B - (High Option): $20 copay

Specialist
You pay without Medicare – (High Option): $30 copay
You pay with Medicare Part B - (High Option): $30 copay

Inpatient Hospital
You pay without Medicare – (High Option): $150/per day (5 day max copay)
You pay with Medicare Part B - (High Option): $150/per day (5 day max copay)

Outpatient Surgery - Hospital
You pay without Medicare – (High Option): $200 copay
You pay with Medicare Part B - (High Option): $200 copay

Incentives Offered
You pay without Medicare – (High Option): N/A
You pay with Medicare Part B - (High Option): N/A

We do not waive any costs on the Standard Option if the Original Medicare Plan is your primary payor:

Deductible
You pay without Medicare – (Standard Option): N/A – No deductible
You pay with Medicare Part B - (Standard Option): N/A – No deductible

Out-of-Pocket Maximum
You pay without Medicare – (Standard Option): $1,650 Self Only/$3,300 Self Plus One/$4,950 Self and Family
You pay with Medicare Part B - (Standard Option): $1,650 Self Only/$3,300 Self Plus One/$4,950 Self and Family

Part B Premium Reimbursement Offered
You pay without Medicare – (Standard Option): N/A
You pay with Medicare Part B - (Standard Option): N/A

Primary Care Provider
You pay without Medicare – (Standard Option): $30 copay
You pay with Medicare Part B - (Standard Option): $30 copay

Specialist
You pay without Medicare – (Standard Option): $50 copay
You pay with Medicare Part B - (Standard Option): $50 copay

Inpatient Hospital
You pay without Medicare – (Standard Option): $750 per admission
You pay with Medicare Part B - (Standard Option): $750 per admission

Outpatient Surgery - Hospital
You pay without Medicare – (Standard Option): $350 copay
You pay with Medicare Part B - (Standard Option): $350 copay

Incentives Offered
You pay without Medicare – (Standard Option): N/A
You pay with Medicare Part B - (Standard Option): N/A

We waive some costs on the Basic Option Plan if the Original Medicare Plan is your primary Payor and you are a U.S. resident - We will waive some out-of-pocket costs as follows:

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. **If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.**

Deductible
You pay without Medicare – (Basic Option): N/A – No deductible
You pay with Medicare Part B - (Basic Option): N/A – No deductible

Out-of-Pocket Maximum
You pay without Medicare – (Basic Option): $5,500 Self Only/$11,000 Self Plus One/ $11,000 Self and Family
You pay with Medicare Part B (Basic Option): $5,500 Self Only/$11,000 Self Plus One/$11,000 Self and Family

Part B Premium Reimbursement Offered
You pay without Medicare – (Basic Option): N/A
You pay with Medicare Part B - (Basic Option): N/A

Primary Care Provider
You pay without Medicare – (Basic Option): $40 copay
You pay with Medicare Part B - (Basic Option): $0 copay

Specialist
You pay without Medicare – (Basic Option): $40 copay
You pay with Medicare Part B - (Basic Option): $0 copay

Inpatient Hospital
You pay without Medicare – (Basic Option): $500/ per day (3 day max copay)
You pay with Medicare Part B - (Basic Option): $0 copay

Outpatient Surgery - Hospital
You pay without Medicare – (Basic Option): $500 copay when performed at a hospital/ $200 copay when performed at an ambulatory surgery center
You pay with Medicare Part B - (Basic Option): $0 copay

Incentives Offered
You pay without Medicare – (Basic Option): N/A
You pay with Medicare Part B - (Basic Option): N/A

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefit from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan the following options are available to you:

This Plan and our Medicare Advantage plan:

We offer a plan that will offer lower office visit copayments, urgent care and emergency care, plus additional coverage for additional benefits such as dental and the Silver and Fit Fitness program. You may enroll in the plan if:

- You enroll in the Plan's High Option

- You enroll in Seniority Plus for Federal Members
- The FEHB subscriber completes an additional application for enrollment in Seniority Plus.

For more information on our Medicare Advantage Seniority Plus, please contact us at 800-275-4737.

Deductible
You pay without Medicare- (High Option): N/A - No deductible
You pay with Health Net Medicare Advantage Seniority Plus: N/A - No deductible

Out-of-Pocket Maximum
You pay without Medicare- (High Option): $1,500 Self Only/$3,000 Self Plus One/ $4,500 Self and Family
You pay with Health Net Medicare Advantage Seniority Plus: $3,400 for Self Only

Part B Premium Reimbursement Offered
You pay without Medicare- (High Option): N/A
You pay with Health Net Medicare Advantage Seniority Plus: No

Primary Care Provider
You pay without Medicare- (High Option): $20 copay
You pay with Health Net Medicare Advantage Seniority Plus: $5 copay

Specialist
You pay without Medicare- (High Option): $30 copay
You pay with Health Net Medicare Advantage Seniority Plus: $5 copay

Inpatient Hospital
You pay without Medicare- (High Option): $150/per day (5 day max copay)
You pay with Health Net Medicare Advantage Seniority Plus: $0 copay

Outpatient Surgery - Hospital
You pay without Medicare- (High Option): $200 copay
You pay with Health Net Medicare Advantage Seniority Plus: $0 copay

Incentives Offered
You pay without Medicare- (High Option): N/A
You pay with Health Net Medicare Advantage Seniority Plus: This plan includes Dental and Vision benefits. It also offers Silver and Fit Fitness program at no cost to you.

This Plan and another Plan's Medicare Advantage plan:
You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments or coinsurance. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan:
If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For more information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to reenroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB Plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation		✓*
9) Are a Federal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical Trials Cost Categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs - costs for routine services such as doctor visits, lab tests, X-rays and scans, hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

See Section 4, page 24

Copayment

See Section 4, page 24

Cost-sharing

See Section 4, page 24

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Custodial care is care provided to assist in meeting the activities of daily living such as help in walking, getting in and out of bed, bathing, feeding, and supervision of medications which are ordinarily self-administered. Custodial care that lasts 90 days or more is sometimes known as Long term care.

Deductible

See Section 4, page 24

Experimental or investigational service	Experimental or investigational services are services that are not widely accepted or recognized within the organized medical community as standards of care. Our Medical Policy Committee determines what procedures and services are experimental/ investigational using published peer review medical and surgical literature. The procedure or service will be evaluated based on its health effects, safety, quality and cost effectiveness. In some cases, we use an independent medical review for expert evaluation and determination of coverage.
Group health coverage	Health coverage provided through a group policy, such as the FEHB program.
Healthcare professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.
Infertility	Infertility exists when any of the following apply to a Member: • The Member is a female (or individual with female reproductive organs) that has been unable to conceive pregnancy after 1 year of regular unprotected sex when under 35 years of age, or 6 months when age 35 and older, or when a pregnancy did occur, a live birth was not achieved; OR • The Member has been unable to conceive pregnancy through attempted egg-sperm contact via artificial insemination; OR • A licensed physician's determination of infertility, based on the Member's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.
Medical necessity	Medical necessity is the criteria used by us and the participating physician group to provide covered services in the prevention, diagnosis, and treatment of your illness or condition. Determination of whether services or supplies are medically necessary will be made according to procedures we and the participating physician group have established. Medically necessary services are determined to be: • Not experimental or investigational • Appropriate and necessary for the symptoms, diagnosis, or treatment of a condition, illness or injury • Provided for the diagnosis or care and treatment of the condition, illness or injury • Not primarily for the convenience of the member, member's physician, or anyone else • The most appropriate supply or level that can safely be provided. For example, outpatient rather than inpatient surgery may be authorized when the setting is safe and adequate.
PCP office visit	Primary care provider office visit
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Surprise bill

An unexpected bill you receive for

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Urgent care claims

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service and not Post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 800-522-0088. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refer to Health Net of California.

You

You refers to the enrollee and each covered family member.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Accidental Injury.....50-52, 73, 96
Allergy tests.....30-46
Allogeneic (donor).....47-58
Alternative treatments.....30-46
Ambulance.....17-23, 25-26, 59-61, 63, 93
Anesthesia.....6-7, 58, 60
Autologous bone marrow transplant...30-46
Biopsy.....47-58
Blood and blood plasma.....59-61
Casts.....59-61
Catastrophic protection out-of-pocket maximum.....16, 24-25, 76
Changes for 2026.....16
Chemotherapy.....30-46
Claims...13-15, 20-26, 29, 50-52, 67-72, 74, 78-82, 85-87, 91-93
Coinsurance.....13-15, 24-26, 91
Colorectal cancer screening.....30-46
Congenital anomalies.....47-58
Contraceptive drugs and devices.....67-72
Cost-sharing.....11, 13-15, 24, 47-50, 64, 73
Crutches.....30-46
Cryopreservation.....16, 30-58
Deductible...12-15, 17, 24, 26, 30, 59, 67, 79, 85-87
Definitions.....30, 59, 64, 91-93
Dental care.....96-98
Diagnostic services.....47-58
Disputed claims review...18-19, 22-23, 78-82
Donor expenses.....16, 38-39, 53-58
Dressings.....59-60
Durable medical equipment.....20, 44-45
Effective date of enrollment.....17-23
Emergency...6-7, 13-15, 22, 25-26, 62-63, 67-72
Experimental or investigational.....77, 92
Eyeglasses.....24-26, 42
Family planning.....36-38, 47-50, 68-72
Fraud.....4-5, 8-12
gender.....16-23, 47-58, 67-72, 77
Hearing services.....30-46
Hospital.....6-7, 11, 13-15, 30-61
Iatrogenic infertility.....16, 47-50
Immunizations.....13-15, 30, 41
Infertility.....16, 38-39, 47-50, 92
Inpatient hospital benefits.....73
Insulin.....30-46, 68-72
Licensed Practical Nurse (LPN).....30-46
Magnetic Resonance Imagings (MRIs).....20, 31
Mammograms.....30-46
Maternity benefits.....22, 35
Medicaid.....83-90
Medically necessary...5, 16-17, 35, 38-39, 47-50, 62, 67, 92
Mental Health/Substance Use Disorder Benefits.....31, 64-66
No Surprises Act (NSA).....24-26
Non-FEHB benefits.....76
Occupational therapy.....30, 41
Ocular injury.....30-46
Office visits.....13-15, 64-66, 97
Oral and maxillofacial surgery.....47-58
Out-of-pocket expenses.....25-26
Outpatient.....6-7, 20, 59-61, 65-66, 92
Oxygen.....44-45, 59-60
Pap test.....30-46
Physician.....13-15, 17, 20, 30-46, 59-61
Prescription drugs.....20, 67-72, 78, 98
Preventive Care, adult.....30-46
Preventive services.....32-34
Prior approval.....20, 22-23, 67, 81-82, 92
Prosthetic devices.....30-50, 83
Psychologist.....47-50, 64
Radiation therapy.....30-46
Reconstructive surgery.....47-52
Room and board.....59-60, 65
Skilled nursing facility care...19, 30, 58, 60
Smoking cessation.....46, 68-72, 74
Speech therapy.....30-46
Splints.....59-61
Subrogation.....84, 93
Surgery.....6-7, 17-18, 47-61
Syringes.....67-72
Temporary Continuation of Coverage (TCC).....4-5, 11-12
Transplants.....20, 40-41, 52-58
Treatment therapies.....30-46
Vision services.....42, 84
X-rays.....31, 53-58, 91

Notes

Summary of Benefits for the High Option of Health Net of California - 2026

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.healthnet.com/fehb.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	$20 per office visit; $30 specialist	29
Services provided by a hospital: Inpatient	$150 per day up to 5 days per admission copay	59
Services provided by a hospital: Outpatient Surgery at a Hospital or Ambulatory Surgical Center	$200 copay	60
Emergency benefits: In-area	$100 per visit (waived if admitted to hospital)	63
Emergency benefits: Out-of-area	$100 per visit (waived if admitted to hospital)	63
Mental health and substance use disorder treatment:	Regular cost-sharing	64
Prescription drugs:	$10 copay for a 30-day supply of formulary generic drugs - $20 for a 90-day supply through mail order. $35 copay for a 30-day supply of formulary brand name drugs - $70 for a 90-day supply through mail order. $60 copay for a 30-day supply of non-formulary drugs - $120 for a 90-day supply through mail order. 20% to a maximum of $200 per prescription for specialty drugs - not available through mail order.	69
Dental care - Accidental Injury:	$20 PCP office visit; $30 specialist visit; $100 Emergency Room	72
Vision care:	$20 PCP office visit, $30 specialist visit	42
Special features:	Services for the deaf and hearing impaired, Centers of Excellence, Decision Power, Active & Fit Direct program	73
Protection against catastrophic costs (your catastrophic out-of-pocket maximum)**:**	Nothing after $1,500/Self Only, $3,000/Self Plus One or $4,500/Self and Family enrollment per year. For prescriptions Nothing after $2,900/Self Only, $5,800/Self Plus One or $8,700/Family enrollment per year.	24

Summary of Benefits for the Standard Option of Health Net of California - 2026

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.healthnet.com/fehb.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	$30 per office visits; $50 specialist	29
Services provided by a hospital: Inpatient	$750 copay per admission	59
Services provided by a hospital: Outpatient Surgery at a Hospital or Ambulatory Surgical Center	$350 copay	60
Emergency benefits: In-area	$150 per visit (waived if admitted to Hospital)	63
Emergency benefits: Out-of-area	$150 per visit (waived if admitted to Hospital)	63
Mental health and substance use disorder treatment:	Regular cost-sharing	64
Prescription drugs:	$15 copay for a 30-day supply of preferred generic drugs - $30 for a 90-day supply through mail order $35 copay for a 30-day supply of preferred generic drugs - $70 for a 90-day supply through mail order $65 copay for a 30-day supply of preferred generic drugs - $130 for a 90-day supply through mail order	69
Dental care - Accidental injury:	$30 PCP office visit; $50 specialist visit; 150 Emergency Room	72
Vision care:	$30 PCP office visit; $50 specialist visit	42
Special features:	Services for the deaf and hearing impaired, Centers of Excellence, Decision Power, Active & Fit Direct program	73
Protection against catastrophic costs (your catastrophic out-of-pocket maximum):	Nothing after $1,650/Self Only, $3,300/Self Plus One, $4,950/Self and Family enrollment per year. For prescriptions Nothing after $2,900/Self Only, $5,800/Self Plus One or $8,700/Family enrollment per year.	24

Summary of Benefits for the Basic Option of Health Net of California - 2026

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.healthnet.com/fehb.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Basic Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	$40 per office visit	29
Services provided by a hospital: Inpatient	$500 copayment per day up to 3 days for inpatient admission	59
Services provided by a hospital: Outpatient surgery at a hospital or ambulatory surgical center	$500 copayment when performed at a hospital / $200 copayment when performed at an ambulatory surgery center	60
Emergency benefits: In-area	$100 per visit (waived if admitted to hospital)	63
Emergency benefits: Out-of-area	$100 per visit (waived if admitted to hospital)	63
Mental health and substance use disorder treatment:	Regular cost-sharing	64
Prescription drugs:	$15 copay for a 30-day supply of formulary generic drugs - $30 for a 90-day supply through mail order. $35 copay for a 30-day supply of formulary brand name drugs - $70 for a 90-day supply through mail order. $65 copay for a 30-day supply of non-formulary drugs - $130 for a 90-day supply through mail order. 20% to a maximum of $200 per prescription for specialty drugs - not available through mail order.	69
Dental care - accidental injury	$40 per office visit and $100 Emergency Room	72
Vision care:	$40 per office visit	42
Special features:	Services for the deaf and hearing impaired; Centers of Excellence, Decision Power, Active & Fit Direct program	73
Protection against catastrophic costs (your catastrophic out-of-pocket maximum):	Nothing after $5,500/Self Only, $11,000/Self Plus One or $11,000/Self and Family enrollment per year. For prescriptions Nothing after $2,000/Self Only, $4,000/Self Plus One or $4,000/Family enrollment per year.	24

2026 Rate Information for Health Net of California

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options, please go to www.opm.gov/FEHBpremiumsor www.opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the monthly non-Postal column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
California					
Standard Option Self Only	P64	$324.76	$192.11	$703.65	$416.24
Standard Option Self Plus One	P66	$711.17	$425.95	$1,540.87	$922.89
Standard Option Self and Family	P65	$778.03	$462.46	$1,685.73	$1,002.00
Basic Option Self Only	P61	$239.14	$79.71	$518.13	$172.71
Basic Option Self Plus One	P63	$526.10	$175.37	$1,139.89	$379.96
Basic Option Self and Family	P62	$573.92	$191.31	$1,243.50	$414.50
California					
High Option Self Only	LP1	$324.76	$368.72	$703.65	$798.89
High Option Self Plus One	LP3	$711.17	$814.50	$1,540.87	$1,764.75
High Option Self and Family	LP2	$778.03	$886.33	$1,685.73	$1,920.38

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