HEALTH NET INDIVIDUAL & FAMILY COVERAGE

THE GUIDE TO PERSONALIZED HEALTH COVERAGE CHOICES

Summary of HMO and PPO benefits and provisions for coverage

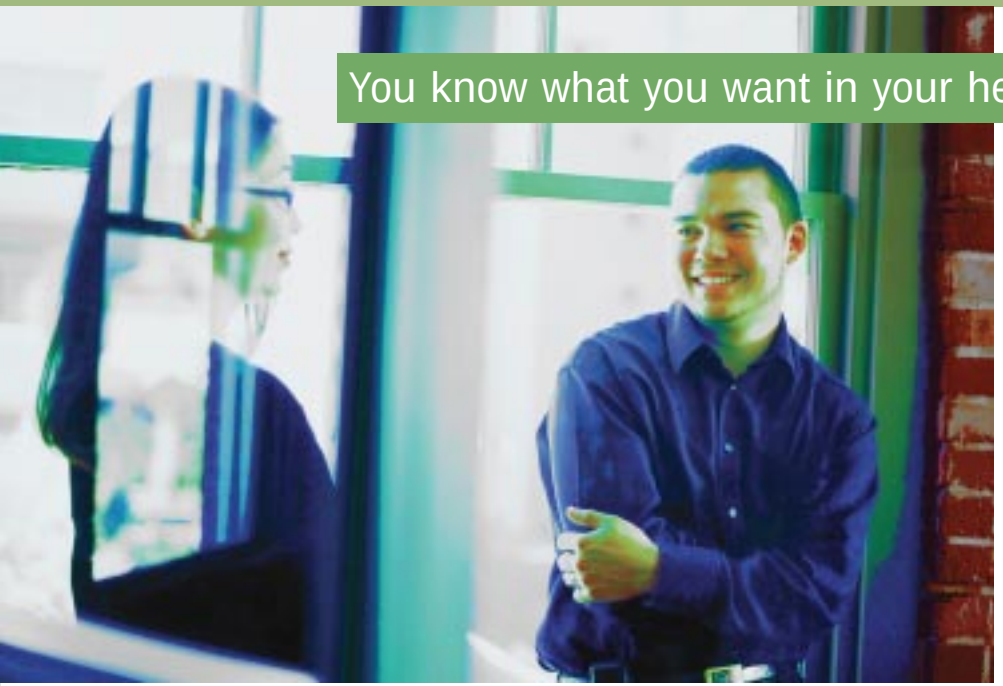
Effective February 1, 2004

Health Net®
A Better Decision

This document is only a summary of your health coverage. You have the right to view the Plan Contract and Evidence of Coverage (EOC) for HMO and EOA plans and the Policy for PPO coverage prior to enrollment. To obtain a copy of these documents, contact your authorized Health Net Agent, or your Health Net Sales Representative at 1-800-909-3447. Your Plan Contract and EOC or Policy, which you will receive after you enroll, contain the terms and conditions, as well as the governing and exact contractual provisions, of your Health Net coverage. It is important for you to carefully read this document and your Plan Contract and EOC or Policy thoroughly once you receive them, especially all sections that apply to those with special health care needs. Health benefits and coverage comparison matrices on the insert following page 8 are included to help you compare coverage benefits.

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

HEALTH COVERAGE THAT PUTS YOU FIRST



You know what you want in your health coverage.

Health Net gives you all this and more, by offering health coverage designed to suit your needs and help your family take more control over their health care.*

Health Net offers you:

- Nearly 25-year history of health coverage
- Tens of thousands of contracted physicians
- A plan to fit a variety of health care needs and budgets

Health Net's commercial plans have been awarded "Excellent" accreditation status from the NCQA, an independent, not-for-profit agency that evaluates health plans for quality.

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*HMO and ELECT Open Access plans are offered by Health Net of California, Inc. PPO plans are underwritten by Health Net Life Insurance Company.

CONTENTS

UNDERSTANDING YOUR COVERAGE CHOICES

WHAT IS AN HMO?

With an HMO, you select your Primary Care Physician from our Individual & Family Plan HMO network. Your Primary Care Physician oversees all your health care and provides the referral/authorization if specialty care is needed. Primary Care Physicians include general and family practitioners, internists, pediatricians and OB/GYNs. A Primary Care Physician's office is just like any other private doctor's office. When you need to see your doctor, just call for an appointment. To obtain health care, simply present your ID card and pay the appropriate copayment.

Your Primary Care Physician must first be contacted for initial treatment and consultation before you receive any care or treatment through a hospital, specialist or other health care provider, except for OB/GYN visits, as set out later in this guide. All treatments recommended by such providers must be authorized by your Primary Care Physician.

HMO advantages include

- No paperwork or claim forms
- Emergency care coverage worldwide
- Set copayments for office visits and prenatal, postnatal and newborn care
- Hospital coverage
- No charge for X-ray and laboratory services
- Prescription coverage

WHAT IS A PPO?

Health Net's Preferred Provider Organization (PPO) is a network of more than 45,000 physicians statewide. You may select any physician at any time from the network, or you can see physicians outside the PPO network (for a higher cost).

PPO advantages include

- Freedom to see any physician at any time
- No referral or authorization needed to see specialists
- Lower copayments and coinsurance when you see in-network physicians
- Hospital coverage
- Preventive care services
- Prescription coverage

PPO VALUE BASIC 1000 / 4000 / 2500 / 500

	Value Basic 1000	Value Basic 4000	Value Basic 2500	Value Basic 500
Deductible	$1,000 / 2 per family	$4,000 / 2 per family	$2,500 / 2 per family	$500 / 2 per family
Out-of-pocket maximum	$3,000 single (includes deductible) 2 per family	$4,000 calendar deductible only 2 per family	$2,500 calendar deductible only 2 per family	$3,500 single (includes deductible) 2 per family
Office visits	Negotiated fee until out-of-pocket maximum is met, then covered in full	$40 (medical calendar year deductible waived)	Negotiated fee until deductible is met then covered in full	$30 (medical calendar year deductible waived) office visit maximum of 2 per year for adults and 4 per year for children
Inpatient hospital care	25% (calendar year deductible also applies)	Negotiated fee until deductible is met then covered in full	Negotiated fee until deductible is met then covered in full	20% / $250 per admission copay / calendar year deductible also applies
Chiropractic (maximum 12 visits per calendar year)	50% ($20 maximum payable per visit)	50% ($20 maximum payable per visit)	50% ($20 maximum payable per visit)	50% ($20 maximum payable per visit)
Prescriptions	$500 calendar year maximum $100 deductible, then $15 Level I (generic) / $35 Level II (brand) / $50 Level III (non-formulary)	$1,000 calendar year maximum $100 deductible, then $15 Level I (generic) / $35 Level II (brand) / $50 Level III (non-formulary)	no calendar year maximum $100 deductible, then $15 Level I (generic) / $35 Level II (brand) / $50 Level III (non-formulary)	$1,000 calendar year maximum $100 deductible, then $15 Level I (generic) / $35 Level II (brand) / $50 Level III (non-formulary)
Dental[1]	Optional, included with purchase of Value Basic 1000 Plus	Optional, included with purchase of Value Basic 4000 Plus	Optional, included with purchase of Value Basic 2500 Plus	Optional, included with purchase of Value Basic 500 Plus
Vision[2]	Optional, included with purchase of Value Basic 1000 Plus	Optional, included with purchase of Value Basic 4000 Plus	Optional, included with purchase of Value Basic 2500 Plus	Optional, included with purchase of Value Basic 500 Plus

[1]Underwritten by Health Net Life and administered through SafeGuard Health Plans, Inc.

[2]Underwritten by Health Net Life and administered through EyeMed Vision Care.

Medical benefits based on use of contracted providers and facilities. Refer to the insert following page 8 for detailed benefit description.

Optional dental and vision coverage with PPO Plus options

Your dental coverage includes:

- Freedom to see any dentist of your choice
- $50 deductible, waived for diagnostic and preventive services
- All covered services are reimbursed up to a maximum allowed fee as shown in the Schedule of Benefits

Your vision coverage includes:

- Lower out-of-pocket payments when members see a Preferred Vision Provider
- One vision examination every 12 months
- 20% discount on second pair of frames and lenses (including prescription sunglasses)

For more details on vision and dental coverage, see pages 10–13 and 18–19.

CONTACT YOUR AUTHORIZED HEALTH NET AGENT OR CALL 1-800-909-3447
VISIT OUR WEBSITE TO LEARN MORE: WWW.HEALTH.NET

PPO VALUE BASIC PLANS

- **Our lowest premium PPOs**
- **Protection against major health expenses**

ALL THIS, AND...

Prescription coverage
Emergency care
Inpatient hospital coverage
Optional dental and vision coverage

Q & A

What is an annual deductible?
The annual deductible is the set amount you pay each calendar year before Health Net pays any benefits. For example, if your plan has a $1,000 annual deductible, you would need to pay $1,000 in out-of-pocket health care fees for covered services before Health Net pays for any benefits.

What is the annual out-of-pocket maximum?
The out-of-pocket maximum (OOPM) is the maximum dollar amount of copayments and coinsurance you must pay during a calendar year. Once you have paid the calendar year deductible copayments and coinsurance equal to the OOPM, you will not be required to pay further copayments and coinsurance for covered expenses incurred during the remainder of the calendar year. You will, however, continue to pay any charges billed in excess of covered amounts for the services of out-of-network providers.

PPO VALUE PLANS

- **Affordable coverage**
- **A balance between coverage and cost**

ALL THIS, AND...

Prescription coverage
24-hour emergency care
Inpatient hospital coverage
Optional dental and vision coverage

Q & A

What is coinsurance?
Coinsurance is the percentage of covered expenses for which you are responsible. If your coinsurance amount is 20 percent, you would pay 20 percent of the contracted fee for that expense with an in-network physician or other provider. If you use an out-of-network physician or provider, you pay 50 percent of the allowed charges, plus any amount charged by the physician or provider in excess of the allowed amount.

How do I know if my family has met its annual out-of-pocket maximum?
In most cases, two family members must satisfy their individual out-of-pocket maximums in full for the out-of-pocket maximum to be satisfied for the entire family. Please see your policy for plan specifics.

PPO VALUE 30 / 400 / 25 / 750

	Value 30	Value 400	Value 25	Value 750
Deductible	$2,500 / 2 per family	$400 / 2 per family	$1,000 / 2 per family	$750 / 2 per family
Out-of-pocket maximum	$4,500 single (includes deductible) 2 per family	$4,500 single (includes deductible) 2 per family	$4,000 single (includes deductible) 2 per family	$3,500 single (includes deductible) 2 per family
Office visits (medical calendar year deductible waived)	$30	$40	$25	$20
Inpatient hospital care (calendar year deductible also applies)	30% / $250 per-admission copay	40% / $400 per-admission copay	25% / $250 per-admission copay	20% / $250 per-admission copay
Prescription coverage	$100 deductible, then $15 Level I (generic) / $35 Level II (brand) / $50 Level III (non-formulary)	$100 deductible, then $15 Level I (generic) / $35 Level II (brand) / $50 Level III (non-formulary)	$100 deductible, then $15 Level I (generic) / $35 Level II (brand) / $50 Level III (non-formulary)	$100 deductible, then $15 Level I (generic) / $35 Level II (brand) / $50 Level III (non-formulary)
Dental[1]	Optional, included with purchase of Value 30 Plus	Optional, included with purchase of Value 400 Plus	Optional, included with purchase of Value 25 Plus	Optional, included with purchase of Value 750 Plus
Vision[2]	Optional, included with purchase of Value 30 Plus	Optional, included with purchase of Value 400 Plus	Optional, included with purchase of Value 25 Plus	Optional, included with purchase of Value 750 Plus

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[2]Underwritten by Health Net Life and administered through EyeMed Vision Care.

Medical benefits based on use of contracted providers and facilities. Refer to the insert following page 8 for detailed benefit description.

Optional dental and vision coverage with PPO Plus options

Your dental coverage includes:

- Freedom to see any dentist of your choice
- $50 deductible, waived for diagnostic and preventive services
- All covered services are reimbursed up to a maximum allowed fee as shown in the Schedule of Benefits

Your vision coverage includes:

- Lower out-of-pocket payments when members see a Preferred Vision Provider
- One vision examination every 12 months
- 20% discount on second pair of frames and lenses (including prescription sunglasses)

For more details on vision and dental coverage, see pages 10–13 and 18–19.

ELECT OPEN ACCESS 15

	ELECT Open Access 15
Deductible	$0 (Inpatient and prescription deductibles apply)
Office visits	$15 (Open Access benefit available for $35)
Inpatient hospital care	$1,000 deductible applies
Maternity care	Covered in full after inpatient hospital care deductible has been met
Out-of-pocket maximum	$3,000 / single (includes deductible) $6,000 / family (includes deductible)
Prescription coverage	$100 calendar year deductible per member applies; $15 Level I (primarily generic); $25 Level II (primarily brand); $50 Level III (drugs not on the Recommended Drug List)
Dental*	Optional, included with purchase of EOA Plus
Vision*	Optional, included with purchase of EOA Plus

*Underwritten by Health Net of California and administered through SafeGuard Health Plans, Inc.

Optional dental and vision coverage with EOA Plus – available to you with no deductibles!

Your dental coverage includes:

- Established network of credentialed dentists
- Preventive dental care provided at set copayments or at no charge
- Orthodontic benefits

Your vision coverage includes:

- Thousands of credentialed optometrists, ophthalmologists and opticians
- Vision exams for a $10 copayment
- Frame and lens allowances
- 20% discount on second pair of frames and lenses (including prescription sunglasses)

For more details on vision and dental coverage, see pages 14–17 and 20–21.

CONTACT YOUR AUTHORIZED HEALTH NET AGENT OR CALL 1-800-909-3447
VISIT OUR WEBSITE TO LEARN MORE: WWW.HEALTH.NET

ELECT OPEN ACCESS

- **A balance of security and choice**
- **The advantages of an HMO plan with an option to self-refer to specialists in Health Net's PPO network**

LOOK AT WHAT ELSE YOU GET...

Prescription coverage
Emergency care
Inpatient hospital coverage
Maternity care
Optional dental and vision coverage
Set office visit copayments
Option of self-referral for a specialist office visit for $35

Q & A

What is the annual out-of-pocket maximum?
Copayments and the inpatient hospital services deductible that you or your family members pay for covered services apply toward the individual or family out-of-pocket maximum (OOPM). After you or your family members meet your OOPM, you pay no additional amounts for covered services for the balance of the calendar year (except as otherwise noted). Once an individual member in a family satisfies the individual OOPM, the remaining enrolled family members must continue to pay copayments and the inpatient hospital services deductible until either: (a) the aggregate of such copayments and deductibles paid by the family reaches the family OOPM; or (b) each enrolled family member individually satisfies the individual OOPM. You are responsible for all charges related to services not covered by the health plan. Amounts paid toward certain covered services are not applicable to a member's OOPM. These exceptions are specified in the principal benefits section later in this guide. In order for the family OOPM to apply, you and your family must be enrolled as a family.

HMO PLANS

- **Health care made easy and affordable**
- **Set copayments and no paperwork**

ALL THIS, PLUS...

Prescription coverage

Emergency care

Inpatient hospital coverage

Maternity care

Optional dental and vision coverage

Q & A

What's the best way to find a Health Net contracted doctor close to my home or work?
To find the most up-to-date physician list, simply visit DocSearch at our web site, www.health.net – you'll find a complete listing of our HMO and PPO network physicians. Search by specialty, city, county or doctor's name to find the physician most convenient for you. To request provider information you may also call 1-800-909-3447 or contact your Health Net authorized broker.

What is a copayment?
A copayment is a fixed dollar amount due and payable to your physician or other care provider at the time services are rendered.

HMO 15 / 40

	HMO 15	HMO 40
Deductible	$0 (Inpatient and prescription deductibles apply)	$0 (Inpatient and prescription deductibles apply)
Office visits	$15	$40
Inpatient hospital care	$1,000 deductible applies	$1,500 deductible applies
Maternity care	Covered in full after inpatient hospital care deductible has been met	
Out-of-pocket maximum	$3,000 / single; $6,000 / family (includes deductible)	$3,000 / single; $6,000 / family (includes deductible)
Prescription coverage	$100 calendar year deductible per member applies; $15 Level I (primarily generic); $25 Level II (primarily brand); $50 Level III (drugs not on the Recommended Drug List)	$100 calendar year deductible per member applies; $15 Level I (primarily generic); $25 Level II (primarily brand); $50 Level III (drugs not on the Recommended Drug List)
Dental*	Optional, included with purchase of HMO 15 Plus	Optional, included with purchase HMO 40 Plus
Vision*	Optional, included with purchase of HMO 15 Plus	Optional, included with purchase HMO 40 Plus

*Underwritten by Health Net of California and administered through SafeGuard Health Plans, Inc.

Optional dental and vision coverage with HMO Plus – available to you with no deductibles!

Your dental coverage includes:

- Established network of credentialed dentists
- Preventive dental care provided at set copayments or at no charge
- Orthodontic benefits

Your vision coverage includes:

- Thousands of credentialed optometrists, ophthalmologists and opticians
- Vision exams for a $10 copayment
- Frame and lens allowances
- 20% discount on second pair of frames and lenses (including prescription sunglasses)

For more details on vision and dental coverage, see pages 14–17 and 20–21.

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DENTAL AND VISION COVERAGE FROM HEALTH NET

DENTAL AND VISION FOR PPO PLUS PLANS

Dental

- Choose your own dental providers
- Available fee schedule shows the maximum allowable amount
- $50 deductible waived for diagnostic and preventive services

Vision

- The flexibility of an out-of-network provider option (PPO)
- Single, bifocal and lenticular lenses covered at 100% in-network
- Freedom to take your prescription to any Vision PPO provider

DENTAL AND VISION FOR HMO PLUS PLANS

Dental

- Most dental procedures covered at listed copayments
- Additional cleanings in the same calendar year
- Extensive network of more than 2,500 providers
- Less restrictive benefit limitations
- Posterior (back teeth) resin fillings

Vision

- A network-based provider selection at time of service
- Thousands of credentialed optometrists, ophthalmologists and opticians
- Vision exams for a $10 copayment
- 20% discount on second pair of frame and lenses (including prescription sunglasses)

Health Net offers a full line of dental and vision benefits through its affiliate SafeGuard Health Plans and EyeMed Vision Care. You'll have access to network-based dental and vision plans that together have nearly 1 million members in California.

HOW TO APPLY

ENJOY THE BENEFITS OF HEALTH COVERAGE. APPLY NOW.

A final reminder

- We also offer PPO coverage effective the 15th of the month
- All applications must be completed by the individual applying for coverage

Questions?

If you have questions choosing a coverage option, selecting a doctor or completing the application, please contact your Health Net authorized agent, or call 1-800-909-3447 and a Health Net sales representative will be happy to assist you.

Helping you make the best decision

For specific benefit and coverage comparisons, just turn to the handy pullout Individual & Family Plan comparison matrices on the following pages. You'll find all our Individual & Family Plan offerings there, listed in an informative side-by-side matrix formatted to help you make your final plan decision.

It's all there for you!

WE'VE MADE IT EASY.

Simply look on the back cover for the toll-free phone numbers (English and Spanish), visit our website at **www.health.net** and apply online, or contact your Health Net authorized agent.

You may also choose to mail in your application. To apply by mail, simply fill out your application completely. Please remember to:

- Type or print clearly in blue or black ink
- Indicate which coverage option you want
- Choose a Primary Care Physician for each enrolled member applying for the HMO or EOA plan
  - Each family member may select a different Primary Care Physician
  - The physician's office must be within a 30-mile radius of the member's residence or office
  - If you or a covered family member does not select a physician, one will be assigned based on your home ZIP code

After completing the application, make sure:

- You, your spouse (if applicable) and dependents over age 18 (if applicable) sign and date the application
- A check payable to Health Net for the applicable premium payment is included
- Health Net receives your application within 30 days of signature date
- To mail the completed application and check to your authorized Health Net agent or to:

Health Net
Individual & Family Coverage
Post Office Box 1150
Rancho Cordova, California 95741-1150

PROTECT YOUR FAMILY –
NO MATTER WHAT THE FUTURE HOLDS.

LIFE INSURANCE PLANS

You can trust Health Net Life Insurance Company for your Term Life Insurance needs

Health Net Life Insurance Company is pleased to offer affordable Individual Term Life Insurance in the following amounts:

$15,000 • $30,000 • $50,000

Monthly Term Life Insurance Rates

Age of primary insured	Cost per $1,000	Total monthly cost		
		$15,000	$30,000	$50,000
19–29	$0.19	$2.85	$5.70	$9.50
30–39	$0.22	$3.30	$6.60	$11.00
40–49	$0.50	$7.50	$15.00	$25.00
50–59	$1.37	$20.55	$41.10	$68.50
60–64	$2.00	$30.00	$60.00	$100.00

Terms

- If you wish to purchase life insurance, you must purchase a minimum coverage of $15,000.
- The maximum life insurance benefit is $50,000.
- You must be at least 19 years old in order to purchase Individual Term Life Insurance.
- Only available for primary subscriber.

Individual Term Life Insurance is underwritten by Health Net Life Insurance Company.

Since you apply for health insurance with Health Net, there is no additional information required to review your eligibility for Individual Term Life Insurance. Coverage will not become effective until approved in writing by Health Net Life Insurance Company.

You have big dreams for your children. You want to make sure they grow up in a comfortable home and have adequate necessities. But what if death robs your family of your support? All of these dreams can still come true – if you plan now to provide the financial resources your family will need.

CALL 1-800-909-3447 FOR MORE INFORMATION.

IMPORTANT THINGS TO KNOW

Dental coverage included with Health Net Individual & Family PPO Plus options

Principal benefits and coverages of the Dental Plan provided with PPO Plus plans

Dental coverage for PPO Plus plans is underwritten by Health Net Life Insurance Company and administered by SafeGuard Health Plans, Inc. This benefit is included with Health Net PPO Plus plans only.

Dental benefits are for individuals and families who want quality, yet affordable, dental coverage with the freedom to go to any licensed dentist or dental specialist.

Dental benefits are not subject to health plan deductible requirements, and do not accumulate toward the out-of-pocket maximum responsibility.

A choice of providers

Under the Dental Plan, covered services can be obtained from any licensed dentist of your choice to receive your dental care. No referral is necessary to see a specialist. All covered services are reimbursed up to a maximum allowed fee as shown in the Schedule of Benefits.

Deductibles

At the time you receive services, you will be required to satisfy the calendar year deductible. Deductibles are paid to your dentist at the time care is rendered. The Dental Plan has a deductible of $50. The deductible amount will apply separately to you and each of your dependents. This deductible is waived for diagnostic and preventive services.

Maximum allowed fee

The maximum allowed fee is the maximum amount Health Net Life will pay for covered services (please refer to the Schedule of Benefits). You will be responsible for your deductible and the dentist's normal charges in excess of the maximum allowed fee.

Maximum benefit limit

The calendar year maximum benefit for the Dental Plan is $1,000. The calendar year maximum benefit will apply separately to you and each of your dependents. This is the maximum amount Health Net Life will pay for covered services per calendar year.

Dental Member Services

If you have a question about the benefits of the Dental Plan, just call Health Net Dental's Customer Service at 1-800-880-8113. Representatives will be happy to assist you.

SCHEDULE OF BENEFITS FOR DENTAL CARE PROVIDED WITH PPO PLUS PLANS

THIS MATRIX IS INTENDED AS A SUMMARY ONLY. THE POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Summary of dental benefits

	COVERED PROCEDURES	MAX. ALLOW. FEE
	Diagnostic procedures	
D0120	Periodic oral examination	$13
D0140	Limited oral evaluation, problem focused	$17
D0150	Comprehensive oral examination	$17
D0210	Intraoral – complete series including bitewings (FMX)	$40
D0220	Intraoral – periapical, first film	$10
D0230	Intraoral – periapical, each additional film	$7
D0240	Intraoral – occlusal film	$11
D0250	Extraoral – first film	$13
D0260	Extraoral – each additional film	$10
D0270	Bitewing – single film	$10
D0272	Bitewings – two films	$15
D0274	Bitewings – four films	$21
D0330	Panoramic film	$31
	Preventive procedures	
D1110	Dental prophylaxis – adult	$32
D1120	Dental prophylaxis – children to age 14	$25
D1201	Topical application of fluoride (including prophylaxis – child)	$25
D1203	Topical application of fluoride (excluding prophylaxis – child)	$17
D1351	Sealant, per tooth	$4
D1510	Space maintainer – fixed, unilateral	$61
D1515	Space maintainer – fixed, bilateral	$61
D1520	Space maintainer – removable, unilateral	$72
D1525	Space maintainer – removable, bilateral	$72
	Restorative procedures	
D2140	Amalgam – one surface, primary	$19
D2150	Amalgam – two surfaces, primary	$24
D2160	Amalgam – three surfaces, primary	$29
D2161	Amalgam – four or more surfaces, primary	$35
D2140	Amalgam – one surface, permanent	$22
D2150	Amalgam – two surfaces, permanent	$28
D2160	Amalgam – three surfaces, permanent	$33
D2161	Amalgam – four or more surfaces, permanent	$39
D2330	Resin – one surface, anterior	$19
D2331	Resin – two surfaces, anterior	$24
D2332	Resin – three surfaces, anterior	$29
D2335	Resin – four or more surfaces or involving incisal angle, anterior	$35
D2390	Resin-based composite crown – anterior, (primary teeth)	$31
D2510	Inlay metallic, one surface*	$66
D2520	Inlay metallic, two surfaces*	$72
D2530	Inlay metallic, three or more surfaces*	$83
D2542	Onlay – metallic, two surfaces*	$110
D2543	Onlay – metallic – three surfaces*	$110
D2544	Onlay – metallic – four or more surfaces*	$110
D2710	Crown resin, laboratory*	$127
D2720	Crown resin with high noble metal*	$154
D2721	Crown resin with predominantly base metal*	$154
D2722	Crown resin with noble metal*	$154
D2740	Crown porcelain/ceramic substrate*	$248
D2750	Crown porcelain fused to high noble metal*	$248
D2751	Crown porcelain fused to predominantly base metal*	$248
D2752	Crown porcelain fused to noble metal*	$248
D2790	Crown full cast high noble metal*	$154
D2791	Crown full cast predominantly base metal*	$154
D2792	Crown full cast noble metal*	$154
D2910	Recement inlay	$11
D2920	Recement crown	$11
D2930	Prefabricated stainless steel crown, primary tooth	$31
D2931	Prefabricated stainless steel crown, permanent tooth	$31
D2950	Core buildup, including any pins*	$22
D2952	Cast post and core in addition to crown*	$28
D2953	Each additional cast post – same tooth*	$28
D2954	Prefabricated post and core in addition to crown*	$28
D2957	Each additional prefabricated post – same tooth*	$28
	Endodontic procedures	
D3110	Pulp cap – direct, excluding final restoration	$10
D3120	Pulp cap – indirect, excluding final restoration	$17

COVERED PROCEDURES		MAX. ALLOW. FEE
D3220	Therapeutic pulpotomy, excluding final restoration – removal of pulp coronal to the dentinoenamel junction and application of medicament, primary teeth only	$13
D3310	Root canal anterior, excluding final restoration**	$121
D3320	Root canal bicuspid, excluding final restoration**	$143
D3330	Root canal molar, excluding final restoration**	$193
D3346	Retreatment of previous root canal therapy – anterior**	$121
D3347	Retreatment of previous root canal therapy – bicuspid**	$143
D3348	Retreatment of previous root canal therapy – molar**	$193
D3410	Apicoectomy/periradicular surgery, anterior**	$66
D3421	Apicoectomy/periradicular surgery, bicuspid (first root) **	$88
D3425	Apicoectomy/periradicular surgery, molar (first root) **	$88
D3426	Apicoectomy/periradicular surgery (each additional root) **	$28
D3430	Retrograde filling, per root**	$17

*Subject to 6-month waiting period
**Subject to 3-month waiting period

	Periodontic procedures	
D4210	Gingivectomy or gingivoplasty, per quadrant**	$99
D4211	Gingivectomy or gingivoplasty, per tooth, if not done in conjunction with a crown-lengthening procedure**	$28
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces, per quadrant**	$176
D4261	Osseous surgery (including flap entry and closure) – one to three teeth per quadrant**	$176
D4341	Periodontal scaling and root planing – four or more contiguous teeth or bounded teeth spaces per quadrant**	$23
D4342	Periodontal scaling and root planning – one to three teeth, per quadrant**	$23

	Prosthodontics (removable)	
D5110	Complete upper denture*	$264
D5120	Complete lower denture*	$264
D5130	Immediate upper denture*	$264
D5140	Immediate lower denture*	$264
D5211	Upper partial – resin base*	$132
D5212	Lower partial – resin base*	$132
D5213	Upper partial – cast metal base with resin saddles*	$264
D5214	Lower partial – case metal base with resin saddles*	$264
D5281	Removable unilateral partial denture – one piece cast metal*	$88
D5410	Adjust complete denture, upper	$11
D5411	Adjust complete denture, lower	$11
D5421	Adjust partial denture, upper	$11
D5422	Adjust partial denture, lower	$11
D5510	Repair broken complete denture base	$22
D5520	Replace missing or broken teeth complete denture, each tooth	$8
D5610	Repair resin saddle or base	$22
D5640	Replace tooth on denture, no other repair, each tooth	$8
D5650	Add tooth to partial denture to replace extracted tooth, not involving clasps	$9
D5660	Add clasp or rest to existing partial denture	$9
D5710	Rebase complete upper denture	$28
D5711	Rebase complete lower denture	$28
D5720	Rebase partial upper denture	$28
D5721	Rebase partial lower denture	$28
D5730	Reline upper complete denture, chairside	$28
D5731	Reline lower complete denture, chairside	$28
D5740	Reline upper partial denture, chairside	$28
D5741	Reline lower partial denture, chairside	$28
D5750	Reline upper complete denture, laboratory	$61
D5751	Reline lower complete denture, laboratory	$61
D5760	Reline upper partial denture, laboratory	$61
D5761	Reline lower partial denture, laboratory	$61
D5820	Interim partial denture, anterior stayplate (upper)*	$50
D5821	Interim partial denture, anterior stayplate (lower)*	$50

* Subject to 6-month waiting period
** Subject to 3-month waiting period

	Prosthodontics (fixed)	
D6210	Pontic – cast high noble metal*	$77
D6211	Pontic – cast predominantly base metal*	$77
D6212	Pontic – cast noble metal*	$77
D6240	Pontic, porcelain fused to high noble metal*	$138
D6241	Pontic, porcelain fused to predominantly base metal*	$138
D6242	Pontic, porcelain fused to noble metal*	$138
D6250	Pontic, resin with high noble metal*	$94
D6251	Pontic, resin with predominantly base metal*	$94
D6252	Pontic, resin with noble metal*	$94
D6930	Recement fixed partial (bridge)	$17

	Oral surgery	
D7111	Coronal remnants – deciduous tooth**	$22
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)**	$22
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal), each additional tooth when performed on the same visit as the first extraction**	$17
D7210	Surgical removal of erupted tooth**	$33
D7220	Removal of impacted tooth, soft tissue**	$44
D7230	Removal of impacted tooth, partially bony**	$55
D7240	Removal of impacted tooth, completely bony**	$66
D7241	Removal of impacted tooth, completely bony, complications**	$66
D7310	Alveoloplasty in conjunction with extractions, per quadrant**	$22
D7320	Alveoloplasty not in conjunction with extractions, per quadrant**	$44
D7471	Removal of lateral exostosis (maxilla or mandible), per site**	$61
D7472	Removal of torus palitinus	$61
D7473	Removal of torus mandibularis	$61
D7485	Surgical reduction of osseous tuberosity	$61
D7970	Excision of hyperplastic tissue, per arch**	$55

	Adjunctive general services	
D9220	General anesthesia, first 30 minutes	$28
D9310	Specialist consultation (other than treatment provider)	$20
D9430	Office visit, regular hours, no other service	$20
D9440	Office visit, after hours, no other service	$20

* Subject to 6-month waiting period
** Subject to 3-month waiting period

PRINCIPAL EXCLUSIONS AND LIMITATIONS FOR DENTAL CARE PROVIDED WITH PPO PLUS PLANS

The following are selective listings only. For a comprehensive listing see the Health Net PPO Policy.

Limitations to covered services and supplies

1. Type I: Preventive and diagnostic dental services

Coverage is provided for the following preventive dental services and subject to the following limitations:

a) Initial or periodic oral exams, limited to one per six-month period. Initial exams will be limited to the allowance for a periodic exam.

b) Intraoral complete series X-rays, including 4 bitewings and up to 14 periapical X-rays, or panoramic film with 4 bitewings, either is limited to one per 36-month period and no payment for any combination of films shall exceed the amount determined for a complete series of X-rays.

c) Bitewing X-rays series (two or four films), limited to one per 12-month period.

d) If an intraoral complete or panoramic X-ray with bitewings has not been provided in a 36-month period, then a panoramic film without bitewings is a benefit and is limited to one per 36-month period.

e) Intraoral periapical X-rays, limited to four films per 6-month period when performed as a separate procedure from a complete series of X-rays.

f) Intraoral occlusal X-rays, limited to two films per 12-month period.

g) Extraoral X-rays, limited to two films per 12-month period.

h) Bitewing X-rays are not covered within a 12-month period from the date of an intraoral complete series X-rays.

i) Dental prophylaxis (cleaning and scaling), limited to one per 6-month period.

j) Topical fluoride treatment is limited to one per 12-month period for Dependent children under age 16.

k) Sealants are limited to one application to an unrestored permanent first or second molar tooth per 36-month period for Dependent children under age 14.

l) Space maintainers for primary teeth (limited to initial appliance only), including all adjustments and recementation made within 6 months of installation, limited to dependent children under age 14.

m) Emergency oral exams.

n) Limited oral evaluation, problem focused.

2. Type II: Basic dental services (non-restorative)

Coverage is provided for the following non-restorative basic dental services and subject to the following limitations:

a) Pulpotomy.

b) Root canal therapy, reimbursement includes preoperative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care, limited to one time on the same tooth.

c) Root canal retreatment, reimbursement includes pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care performed not less than 12 months after the initial therapy, limited to one time on the same tooth per 12-month period.

d) Apicoectomy/periradicular surgery (anterior, bicuspid, molar, each additional root), paid as a separate benefit only if services are performed not less than 12 months after the initial root canal therapy is completed. Reimbursement includes pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.

e) Periodontal scaling and root planing (per quadrant), limited to one time per quadrant per 24-month period and only if not performed on the same date of service as a prophylaxis or any other periodontal procedure.

f) For non-surgical periodontal procedures that are quadrant based and when there are less than 5 teeth remaining in the quadrant and the need for treatment is indicated, as determined by Health Net Life, payment will be provided at 50 percent of the full quadrant rate. A maximum of 2 quadrants of periodontal procedures will be paid on the same date of service unless supported with documentation for medical need.

g) For surgical periodontal procedures that are quadrant based and when there are less than 3 teeth requiring treatment, as determined by Health Net Life, payment will be provided at 50 percent of the full quadrant rate. A maximum of 2 quadrants of periodontal procedures will be paid on the same date of service unless supported with documentation for medical need.

h) Periodontal surgery related services as listed below, limited to:

- 1 time per quadrant of the mouth in any 36-month period with charges combined for gingivectomy, gingival curettage, or osseous surgery performed in the same quadrant within the same 36-month period.

i) Oral surgery services as listed below, including an allowance for local anesthesia and routine postoperative care:

- Simple extraction;
- Surgical extractions of erupted or impacted teeth;
- Alveoloplasty; and
- Excision of hyperplastic tissue – per arch.

j) General anesthesia and intravenous sedation is covered only in conjunction with the extraction of impacted teeth, limited as follows:

- Considered for payment as a separate benefit only when medically necessary as determined by Health Net Life.

k) Specialist consultation.

3. Type II: Basic Dental Services (Restorative)

Coverage is provided for the following restorative basic dental services and subject to the following limitations:

a) Amalgam restorations inclusive of any etching and bonding, limited as follows:

- Multiple restorations (surfaces) on a single tooth are combined for coverage purposes.
- Benefits for the replacement of an existing amalgam restoration will only be considered for payment if at least 12 months have passed since the existing amalgam restoration was placed.
- Acid etch is not covered as a separate procedure.

b) Composite restorations inclusive of any etching and bonding, limited as follows:

- Multiple restorations (surfaces) on a single anterior tooth are combined for coverage purposes.
- Acid etch is not covered as a separate procedure.
- Benefits for the replacement of an existing anterior composite restoration will only be considered for payment if at least 12 months have passed since the existing anterior composite restoration was placed.
- Benefits for composite resin restorations on posterior teeth (behind the second bicuspid) will be based on the allowance for the corresponding amalgam restoration.

c) Stainless steel crowns are limited to one per tooth per 36-month period for members age 19 and under for teeth not restorable by an amalgam or composite filling.

4. Type III: Major dental services

Coverage is provided for the following major dental services and subject to the following limitations:

a) Inlays and onlays:

- Are covered only when the tooth cannot be restored by an amalgam filling.
- Are covered only if more than 5 years have elapsed since last placement; and
- Limited to persons age 19 and above.
- Composite or porcelain is not covered on molar teeth.

b) Porcelain substrate or metal crowns;

- Porcelain or porcelain fused to metal crowns are not covered on molar teeth.

c) Crowns:

- Are covered only when the tooth cannot be restored by an amalgam or composite filling.
- Are covered only if more than 5 years have elapsed since last placement; and
- Limited to persons over age 19.

d) Crown build-up, including pins and pre-fabricated posts. (Current periapical X-ray and narrative should indicate insufficient remaining tooth structure. Coverage is subject to determination of dental necessity.)

e) Post and core, covered only for endodontically treated teeth requiring crowns.

f) Full dentures, 1 time per arch, limited as follows:

- Replacement dentures are covered only if:

1) 5 years have elapsed since last placement and the denture cannot be made serviceable; and

2) 2 years have elapsed after the member's effective date of coverage under the Dental Plan.

g) Health Net Life will not pay additional benefits for personalized dentures or overdentures and associated treatment.

h) Partial dentures, including any clasps and rests and all teeth, 1 partial per arch, limited as follows:

- Replacement partial dentures are covered only if:

1) 5 years have elapsed since last placement (please refer to the Denture or Bridge Replacement/Addition provision for exceptions) and the partial denture cannot be made serviceable; and

2) 2 years have elapsed after the member's effective date of coverage under the Dental Plan.

i) There is no benefit for precision or semi-precision attachments.

j) Each additional clasp and rest.

k) Full or partial dentures, adjustments limited to one time per arch in any 12-month period following the initial 6-month denture placement period.

l) One repair per arch to full or partial dentures and bridges limited to repairs performed more than 12 months after the initial insertion; repairs are limited to those resulting from normal wear and to one repair every 12 months.

m) Relining or rebasing dentures, limited to:

- 1 time per arch per 36-month period; and
- For standard dentures, when done within 12 months or the insertion of the denture.
- For immediate dentures, when done within 6 months after the insertion of the denture.

n) Stayplates (temporary partial dentures) are limited to the replacement of anterior teeth and only during the healing phase following extractions.

o) Benefits for the replacement of an existing fixed partial denture are payable only if the existing bridge:

1) Is more than 5 years old (see the Denture or Bridge Replacement/Addition provision for exceptions);

2) Cannot be made serviceable; and

3) 2 years have elapsed after the member's effective date of coverage under the Dental Plan.

- A fixed partial denture is the benefit for the replacement of a missing single tooth only if there are no other missing teeth in the same arch.
- A removable partial denture is the benefit for the replacement of more than 1 missing tooth in the same arch, limited to one per 5 years.

5. Denture or bridge replacement/addition

Health Net Life will not pay for the replacement of a full denture, partial denture, fixed partial denture or for teeth added to a partial denture unless:

a) 5 years have elapsed since last replacement of the denture or bridge;

b) The denture or bridge cannot be made serviceable;

c) The denture or bridge was damaged while in the member's mouth when an injury was suffered while insured under the Policy, and it cannot be made serviceable; and

d) 2 years have elapsed after the member's effective date of coverage under the Dental Plan. However, the following exceptions will apply:

e) Benefits for the replacement of an existing partial denture that is less than 5 years old will be covered if there is a dentally necessary extraction of an additional functioning natural tooth and the partial denture cannot be made serviceable.

f) For an existing fixed partial denture that is less than 5 years old, and an existing abutment or a functioning natural tooth within the same arch is extracted, the covered benefit will be a partial denture.

6. Missing teeth limitation

Health Net Life will not pay benefits for replacement of teeth missing on you or your dependents' effective date of coverage for the purpose of the initial placement of a full denture, partial denture or fixed partial denture (bridge), except as follows:

a) The initial placement of full or partial dentures will be considered a covered dental charge if the placement includes the initial replacement of a functioning natural tooth extracted while the member is insured under the Policy.

b) The initial placement of a fixed partial denture will be considered a covered dental charge if the placement includes the initial replacement of a functioning natural tooth extracted while the member is insured under the Policy. However, the following restrictions will apply:

- Benefits will only be covered for the replacement of the teeth extracted while the member is covered under the Policy and the replacement is furnished within 12 months of the date the tooth was first extracted.
- Benefits will not be covered for the replacement of other teeth that were missing on the member's effective date. Please refer to the Type III: Major Dental Services section of the Policy for further information.

General exclusions

Health Net Life will not pay expenses incurred for any of the following:

1. Treatment that is: a) not included in the Dental Plan Schedule of Benefits; b) not dentally necessary; or c) Experimental in nature.

2. Services and supplies related to the change of vertical dimension, restoration or maintenance of occlusion, re-implantation, splinting and stabilizing teeth, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for myofascial pain disorders (MPD) or temporomandibular joint dysfunction (TMJ).

3. Services and supplies provided primarily for cosmetic purposes.

4. Crowns, inlays, cast restorations or other laboratory prepared restorations on teeth that may be restored with an amalgam or composite resin filling.

5. Athletic mouthguards; denture duplication; infection control; separate charges for acid etch; treatment of jaw fractures; orthognathic surgery; exams required by a third party; travel time; transportation costs; professional advice given on the phone.

6. Implants, related procedures or services involving root form implants.

7. Grafting (bone or tissue) and guided tissue regeneration.

8. Prescription drugs or any medications are not covered.

9. Services, procedures or supplies for which a charge would not have been made in the absence of insurance.

10. Procedures, services or supplies for which the member does not have to pay, except when payment of such benefits is required by law and then only to the extent required by law.

11. Treatment will be considered a covered service and supply only when the member is eligible for services on the date treatment is started. Payment is based on the start date.

12. Services and supplies obtained while outside the United States, except for emergency dental care.

Dental coverage included with Health Net HMO and EOA Plus plan options

Principal benefits and coverages for dental care with HMO Plus and EOA Plus plans

Dental coverage for HMO Plus and EOA Plus plans is underwritten by Health Net of California and administered by SafeGuard Health Plans, Inc. This benefit is included with HMO 15 Plus, HMO 40 Plus and EOA 15 Plus only.

Selecting a dentist

Our dental plan makes it easy for you to choose a personal dental provider. When you enroll, you must select a dentist for your entire family from our list of Primary Dentists for your area. You may change your Primary Dentist up to three times per year. Primary Dentist changes made prior to the 20th of the month are effective the first of the following month. Simply select a new dentist from the listing of Primary Dentists and call Health Net Dental's Member Services department at 1-800-880-8113 with your change. We also offer orthodontic coverage for adults and children. Simply select your orthodontist from the directory at any time during the year.

Copayments

Copayments are your share of costs for covered services and are paid to the dentist at the time of care. Your dental benefits do not have deductibles or any annual maximum dollar benefit limitations. Simply present your Health Net Dental membership ID card to the participating Primary Dentist you selected. It's that simple!

Please note: The HMO 15 Plus, HMO 40 Plus and EOA 15 Plus Plans are not available in all counties. Please see the Individual & Family Rate Guide for details.

Benefits and coverage matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Summary of benefits

	Deductibles	none
	Lifetime maximums	none
	Professional services – Diagnostic	
D0120	Periodic oral evaluation	no charge
D0140	Limited oral evaluation – problem focused	no charge
D0150	Comprehensive oral evaluation – new or established patient	no charge
D0210	Intraoral – complete series (including bitewings)	no charge
D0220	Intraoral – periapical first film	no charge
D0230	Intraoral – periapical each additional film	no charge
D0240	Intraoral – occlusal film	no charge
D0270	Bitewing – single film	no charge
D0272	Bitewings – two films	no charge
D0274	Bitewings – four films	no charge
	Bitewing X-rays are limited to one series of four films in any 12-month period	
D0330	Panoramic film	no charge
D0460	Pulp vitality tests	no charge
D0470	Diagnostic casts	no charge
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	no charge
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	no charge
	Preventive	
D1110	Prophylaxis – adult (initial)	$8
D1110	Prophylaxis - adult (second in same calendar year) *Prophylaxis is limited to: (a) one initial treatment every 12 months, and (b) one "second" treatment every 12 months. An additional prophylaxis will be covered if determined to be dentally necessary consistent with professional practice. For example, for high-risk patients, such as women who are pregnant, enrollees undergoing cancer chemotherapy, or enrollees with compromising systemic diseases such as diabetes.*	$23
D1120	Prophylaxis – child (initial)	$8
D1120	Prophylaxis – child (second in same calendar year)	$23
D1201	Topical application of fluoride (including prophylaxis) – child (initial)	$13
D1201	Topical application of fluoride (including prophylaxis) – child (second in same year)	$28
D1203	Topical application of fluoride (prophylaxis not included) – child	$3
D1203	Topical application of fluoride (prophylaxis not included) – adult	$3
D1310	Nutritional counseling for control of dental disease	no charge
D1330	Oral hygiene instructions	no charge
D1351	Sealant – per tooth	$5
D1510	Space maintainer – fixed – unilateral	$75
D1515	Space maintainer – fixed – bilateral	$155
D1520	Space maintainer – removable – unilateral	$100
D1525	Space maintainer – removable – bilateral	$170
D1550	Re-cementation of space maintainer	$15
	Restorative	
D2140	Amalgam – one surface, primary	$20
D2150	Amalgam – two surfaces, primary	$25
D2160	Amalgam – three surfaces, primary	$37
D2161	Amalgam – four or more surfaces, primary	$37
D2140	Amalgam – one surface, permanent	$25
D2150	Amalgam – two surfaces, permanent	$32
D2160	Amalgam – three surfaces, permanent	$41
D2161	Amalgam – four or more surfaces, permanent	$49
D2330	Resin-based composite – one surface, anterior	$35
D2331	Resin-based composite – two surfaces, anterior	$45
D2332	Resin-based composite – three surfaces, anterior	$55
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$65
D2391	Resin-based composite – one surface, posterior (permanent tooth)	$55
D2392	Resin-based composite – two surfaces, posterior (permanent tooth)	$70
D2393	Resin-based composite – three surfaces, posterior (permanent tooth)	$85
D2394	Resin-based composite – four or more surfaces, posterior (permanent tooth)	$85
D2391	Resin-based composite – one surface, posterior (primary tooth)	$40
D2392	Resin-based composite – two surfaces, posterior (primary tooth)	$55
D2393	Resin-based composite – three surfaces, posterior (primary tooth)	$70
D2394	Resin-based composite – four or more surfaces, posterior (primary tooth)	$70
	Crowns – Single restorations only	
D2710	Crown – resin (indirect) (excluding molars)	$240 plus actual lab cost of noble or high noble metal

COVERED SERVICES		MEMBER PAYS
D2720	Crown – resin with high noble metal (excluding molars)	$240 plus actual lab cost of noble or high noble metal
D2721	Crown – resin with predominantly base metal (excluding molars)	$240 plus actual lab cost of noble or high noble metal
D2722	Crown – resin with noble metal (excluding molars)	$240 plus actual lab cost of noble or high noble metal
D2750	Crown – porcelain fused to high noble metal (excluding molars)	$305 plus actual lab cost of noble or high noble metal
D2751	Crown – porcelain fused to predominantly base metal (excluding molars)	$305 plus actual lab cost of noble or high noble metal
D2752	Crown – porcelain fused to noble metal (excluding molars)	$305 plus actual lab cost of noble or high noble metal
D2780	Crown – 3/4 cast high noble metal	$280 plus actual lab cost of noble or high noble metal
D2781	Crown – 3/4 cast predominantly base metal	$280 plus actual lab cost of noble or high noble metal
D2782	Crown – 3/4 cast noble metal	$280 plus actual lab cost of noble or high noble metal
D2790	Crown – full cast high noble metal	$280 plus actual lab cost of noble or high noble metal
D2791	Crown – full cast predominantly base metal	$280 plus actual lab cost of noble or high noble metal
D2792	Crown – full cast noble metal	$280 plus actual lab cost of noble or high noble metal
D2910	Recement inlay	$15
D2920	Recement crown	$21
D2930	Prefabricated stainless steel crown – primary tooth	$55
D2931	Prefabricated stainless steel crown – permanent tooth	$65
D2940	Sedative filling	$20
D2950	Core buildup, including any pins	$23 plus actual lab cost of noble or high noble metal
D2951	Pin retention – per tooth, in addition to restoration	$20 plus actual lab cost of noble or high noble metal
D2952	Cast post and core in addition to crown	$100 plus actual lab cost of noble or high noble metal
D2953	Each additional cast post – same tooth	$100 plus actual lab cost of noble or high noble metal
D2954	Prefabricated post and core in addition to crown	$60
D2957	Each additional prefabricated post – same tooth	$60
	Endodontics	
D3110	Pulp cap – direct (excluding final restoration)	$21
D3120	Pulp cap – indirect (excluding final restoration)	$21
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$33
D3310	Anterior (excluding final restoration)	$170
D3320	Bicuspid (excluding final restoration)	$220
D3330	Molar (excluding final restoration)	$290
D3346	Retreatment of previous root canal therapy – anterior	$185
D3347	Retreatment of previous root canal therapy – bicuspid	$240
D3348	Retreatment of previous root canal therapy – molar	$315
D3410	Apicoectomy/periradicular surgery – anterior	$155
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	$155
D3425	Apicoectomy/periradicular surgery – molar (first root)	$155
D3426	Apicoectomy/periradicular surgery – (each additional root)	$75
D3430	Retrograde filling – per root	$48
D3450	Root amputation – per root	$85
D3920	Hemisection (including any root removal), not including root canal therapy	$85
	Periodontics	
D4210	Gingivectomy or gingivoplasty, four or more contiguous teeth or bounded teeth spaces per quadrant	$230
D4211	Gingivectomy or gingivoplasty, one to three teeth, per quadrant	$33
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces, per quadrant	$30
D4241	Gingival flap procedure, including root planing – one to three teeth, per quadrant	$30
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces, per quadrant	$290
D4261	Osseous surgery (including flap entry and closure) – one to three teeth, per quadrant	$290
D4341	Periodontal scaling and root planing – four or more contiguous teeth or bounded teeth spaces, per quadrant	$30
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant	$30
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$20
	Prosthodontics (Removable)	
D5110	Complete denture – maxillary	$405
D5120	Complete denture – mandibular	$405
D5130	Immediate denture – maxillary	$420
D5140	Immediate denture – mandibular	$420
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests, and teeth)	$290
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)	$290
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$385
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$385
D5410	Adjust complete denture – maxillary	$15
D5411	Adjust complete denture – mandibular	$15
D5421	Adjust partial denture – maxillary	$15
D5422	Adjust partial denture – mandibular	$15
D5510	Repair broken complete denture base	$45

COVERED SERVICES		MEMBER PAYS
D5520	Replace missing or broken tooth – complete denture (each tooth)	$53
D5610	Repair resin denture base	$45
D5620	Repair cast framework	$58
D5630	Repair or replace broken clasp	$63
D5640	Replace broken teeth – per tooth	$53
D5650	Add tooth to existing partial denture	$58
D5660	Add clasp to existing partial denture	$63
D5710	Rebase complete maxillary denture	$185
D5711	Rebase complete mandibular denture	$185
D5720	Rebase maxillary partial denture	$185
D5721	Rebase mandibular partial denture	$185
D5730	Reline complete maxillary denture (chairside)	$70
D5731	Reline complete mandibular denture (chairside)	$70
D5740	Reline maxillary partial denture (chairside)	$70
D5741	Reline mandibular partial denture (chairside)	$70
D5750	Reline complete maxillary denture (laboratory)	$120
D5751	Reline complete mandibular denture (laboratory)	$120
D5760	Reline maxillary partial denture (laboratory)	$120
D5761	Reline mandibular partial denture (laboratory)	
D5820	Interim partial denture (maxillary)	$135
D5821	Interim partial denture (mandibular)	$135
D5850	Tissue conditioning, maxillary	$40
D5851	Tissue conditioning, mandibular	$40
	Prosthodontics (fixed)	
D6210	Pontic – cast high noble metal	$280 plus acutal lab cost of noble or high noble metal
D6211	Pontic – cast predominantly base metal	$280
D6212	Pontic – cast noble metal	$280 plus acutal lab cost of noble or high noble metal
D6240	Pontic – porcelain fused to high noble metal (excluding molars)	$305 plus acutal lab cost of noble or high noble metal
D6241	Pontic – porcelain fused to predominantly base metal (excluding molars)	$305 plus acutal lab cost of noble or high noble metal
D6242	Pontic – porcelain fused to noble metal (excluding molars)	$305 plus acutal lab cost of noble or high noble metal

COVERED SERVICES		MEMBER PAYS
D6750	Crown – porcelain fused to high noble metal (excluding molars)	$305 plus acutal lab cost of noble or high noble metal
D6751	Crown – porcelain fused to predominantly base metal (excluding molars)	$305 plus acutal lab cost of noble or high noble metal
D6752	Crown – porcelain fused to noble metal (excluding molars)	$305 plus acutal lab cost of noble or high noble metal
D6780	Crown – 3/4 cast high noble metal	$280 plus acutal lab cost of noble or high noble metal
D6781	Crown – 3/4 cast predominantly base metal	$280 plus acutal lab cost of noble or high noble metal
D6782	Crown – 3/4 cast noble metal	$280 plus actual lab cost of noble or high noble metal
D6790	Crown – full cast high noble metal	$280 plus actual lab cost of noble or high noble metal
D6791	Crown – full cast predominantly base metal	$280 plus actual lab cost of noble or high noble metal
D6792	Crown – full cast noble metal	$280 plus actual lab cost of noble or high noble metal
D6930	Recement fixed partial denture *Fixed bridgework will be covered only when a removable partial denture cannot satisfactorily restore the case*	$23
D6970	Cast post and core addition to fixed partial denture retainer	$100 plus actual lab cost of noble or high noble metal
D6971	Cast post as part of fixed partial denture retainer	$100 plus actual lab cost of noble or high noble metal
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$60
D6973	Core build up for retainer, including any pins	$23 plus actual lab cost of noble or high noble metal
D6976	Each additional cast post – same tooth	$100 plus actual lab cost of noble or high noble metal
D6977	Each additional prefabricated post – same tooth	$60

COVERED SERVICES		MEMBER PAYS
	Oral and maxillofacial surgery	
D7111	Coronal remnants – deciduous tooth	$35
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$35
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) – each additional tooth	$27
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (root removal – exposed roots)	$43
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$50
D7220	Removal of impacted tooth – soft tissue	$70
D7230	Removal of impacted tooth – partially bony	$105
D7240	Removal of impacted tooth – completely bony	$135
D7250	Surgical removal of residual tooth roots (cutting procedure)	$50
	Orthodontics	
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,800
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,800
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,000
D8210	Removable appliance therapy	$115
D8220	Fixed appliance therapy	$220
D8670	Routine orthodontic visits	$17
	Adjunctive general services	
D9110	Emergency visits – during regular dental office hours *Note: this copay is in addition to specific services copays*	$14
	Professional visits	
D9440	Emergency visits – after regular dental office hours *Note: this copay is in addition to specific services copays*	$55
	Ambulance services	Not covered
	Prescription drug coverage	Not covered
	Durable medical equipment	Not covered

	COVERED SERVICES	MEMBER PAYS
	Mental health services	Not covered
	Chemical dependency services	Not covered
	Home health services	Not covered
	Other services	
	Miscellaneous services	
D9930	Treatment of complications (post-surgical) – unusual circumstances, by report	$11
D9951	Occlusal adjustment – limited (per quadrant)	$27
D9952	Occlusal adjustment – complete (per quadrant)	$27
D9999	Missed appointments without 24-hour prior notice *Note: The copayment for missed appointments may not apply if: (a) the member canceled at least 24 hours in advance, or (b) the member missed the appointment because of an emergency or circumstances beyond the control of the member*	$20
D9999	Transfer of all materials with less than a full mouth x-ray	no charge
D9999	Transfer of all materials with a full mouth x-ray	no charge
D9999	Operatory preparation fee (payable per visit in addition to any applicable copayments for covered services rendered)	no charge

Occasionally an instance arises where the general dentist deems that the services of a specialist are required. Health Net of California can assist the member with a referral to a specialist. However, there is no coverage under the plan for services rendered by a specialist except for orthodontic care.

PRINCIPAL EXCLUSIONS AND LIMITATIONS FOR DENTAL CARE WITH HMO AND EOA PLUS PLANS PROVIDED BY HEALTH NET OF CALIFORNIA.

All necessary dental services are covered if performed by the member's Primary Dentist. If services of a dental specialist are required, the member will be responsible for the specialist's fees.

- Prophylaxis is limited to: (a) one initial treatment every 12 months, and (b) one subsequent treatment every 12 months
- Fluoride treatment is covered twice in any 12-month period
- Bitewing X-rays are limited to one series of four films in any 12-month period
- Full-mouth X-rays are limited to once every 36 months or as needed consistent with professional practice guidelines
- Periodontal treatments (subgingival curettage and root planing) are limited to five in any 12-month period
- Replacement of a restoration is covered only when it is dentally necessary
- Fixed bridgework will be covered only when partial bridgework cannot satisfactorily restore the case
- Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair
- Partial dentures will be replaced as dentally necessary consistent with professional standards of practice
- Full upper and/or lower dentures will be replaced as dentally necessary consistent with professional standards of practice
- Services that, in the opinion of the attending dentist or Health Net of California, are not dentally necessary
- Any experimental procedure. Experimental treatment if denied may be appealed through the Independent Medical Review process and that service shall be covered and provided if required under the Independent Medical Review process
- Any procedure of implantation
- Any procedure performed for the purpose of correcting contour, contact or occlusion
- Any procedure that is not specifically listed as a covered service
- Elective dentistry and cosmetic dentistry
- Fees incurred for broken or missed appointments (without 24 hours' notice) are the member's responsibility. However, the copayment for missed appointments may not apply if: (a) the member canceled at least 24 hours in advance; or (b) the member missed the appointment because of an emergency or circumstances beyond the control of the member
- General anesthesia or intravenous/conscious sedation. However, such services may be covered under the medical services portion of this Plan. See the Plan Contract and EOC for details
- Hospital charges of any kind
- Loss or theft of full or partial dentures
- Oral surgery requiring the setting of fractures or dislocations, orthognathic surgery and extraction solely for orthodontic purposes (does not apply to fractured or dislocated (knocked out) teeth)
- Prescription medications
- Services that cannot be performed because of the physical or behavioral limitations of the patient
- Temporomandibular joint treatment (TMJ)
- Treatment of malignancies, cysts, neoplasms or congenital malformations

DENTAL PLAN GENERAL PROVISIONS

An additional charge will be required for missed appointments. Missed appointments without 24 hours' notice will be charged an additional charge. However, the copayment for missed appointments may not apply if: (1) the member canceled at least 24 hours in advance; or (2) the member missed the appointment because of an emergency or circumstances beyond the control of the member.

GRIEVANCE PROCEDURES AND MANDATORY ARBITRATION

A member must submit all grievances concerning this dental plan through Health Net of California's internal grievance procedures before a member may file for arbitration for final and binding resolution of the grievance. Arbitration is the final process for the resolution of any dispute arising out of or relating to this dental plan, whether involving a claim in tort, contract or otherwise.

SERVICES TO WHICH THE MEMBER IS ENTITLED UNDER ANY WORKERS' COMPENSATION LAW OR ACT

This dental plan shall provide coverage for services at the time of need. Where other coverage exists, the Plan may coordinate the benefits and/or assert a lien. It is the responsibility of the member to execute and deliver relevant documents and/or take such action as may be necessary to assure that the plan is reimbursed for benefits provided by Workers' Compensation. This section does not apply to Medi-Cal beneficiaries.

ORTHODONTIC BENEFITS

The orthodontic copayment charged by Health Net of California participating orthodontists for children through age 19 will be $1,800 per case. Adults aged 20 or older will be charged an orthodontic copayment of $2,000 per case. This benefit is limited to 24 months of usual and customary orthodontic banding.

PRINCIPAL ORTHODONTIC EXCLUSIONS AND LIMITATIONS

Health Net of California reserves the right to limit coverage to its choice of participating dentists.

Vision coverage included with Health Net Individual & Family PPO Plus option

IMAGE VISION BENEFITS

Principal benefits and coverages of the Image Health Net Vision plan for vision care provided with PPO Plus plans
Underwritten by Health Net Life Insurance Company and administered by EyeMed Vision Care, Inc.

This benefit is included with Health Net PPO Plus plans.

Image Vision benefits are for individuals and families who want quality, yet affordable, vision coverage.

Vision benefits are not subject to health plan deductible requirements, and do not accumulate toward the maximum calendar year copayment responsibility.

Copayments
At the time you receive services, you will be required to pay the copayment amounts listed in the Schedule of Benefits. The copayment amounts will apply separately to you and each of your dependents.

Maximum Benefit Retail Allowances
After the copayment amounts are satisfied each calendar year, Health Net Life will pay for benefits for covered charges up to the maximum benefit retail allowance, as shown in the Schedule of Benefits. You will be responsible for any charges in excess of the maximum benefit allowance.

A choice of providers
Under the Image Vision Plan, covered services can be obtained from Preferred or Non-preferred Vision Providers. However, if you receive vision services or materials from a Preferred Vision Provider, covered expenses will be paid at a higher level. Certain services or materials may be payable only if obtained from a Preferred Vision Provider, as indicated in the Schedule of Benefits. Preferred Vision Providers have agreed to accept Health Net Life's determination and payment of negotiated rates for covered charges. You will be required to pay applicable copayments and coinsurance amounts and all charges in excess of the maximum benefit retail allowance.

If services or materials are received from Non-preferred Vision Providers, Health Net Life will reimburse covered charges at the maximum benefit retail allowance for covered services, as indicated in the Schedule of Benefits.

Obtaining vision benefits
At the time of your visit, you will be required to pay applicable copayments and coinsurance amounts and all charges in excess of the maximum benefit retail allowances as shown in the Schedule of Benefits.

Preferred vision providers
To get a list of Preferred Providers in your area simply log on to www.health.net and click on DocSearch. Health Net Life will pay the Preferred Vision Provider any covered charges without you having to submit a claim. See the Policy for details.

Non-preferred vision providers
If you receive benefits from a Non-preferred Vision Provider, you will be responsible for the difference in the maximum benefit retail allowance and the provider's normal fee. You will be required to pay the full cost for the covered service, then submit a claim for reimbursement. See the Policy for details.

Vision Member Services
If you have a question about the benefits of the Image Vision Plan, or need assistance in selecting a Preferred Vision Provider, just call Health Net Vision's Member Services at 1-866-392-6058. Representatives will be happy to assist you.

Image Vision Schedule of Benefits

THIS SCHEDULE OF BENEFITS IS INTENDED AS A SUMMARY ONLY. THE POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Covered Vision Charges	Preferred Provider In-Network	Non-preferred Provider Out-of-Network
	Percentage of covered charges or the maximum benefit retail allowance when received from a Preferred Provider.	The maximum benefit retail allowances the plan pays when received from a Non-Preferred Provider.
	You pay the remaining coinsurance or amounts in excess of the maximum benefit retail allowances shown below.	You pay the difference in the maximum benefit retail allowance shown below and the provider's normal fee.
Examination copayment (per member)	$10	$10
Materials copayment (per member)	$25	$25
Vision examination One complete visual examination every 12 consecutive months	100% of negotiated rate (includes dilation)	Plan pays up to $45 (dilation not included)
Frames One frame every 24 months	Plan allows up to a maximum $85 retail benefit allowance	Plan allows up to a maximum $45 retail benefit allowance
Standard corrective lenses Once every 24 consecutive months	100% of negotiated rate for standard single vision, bifocal, trifocal, lenticular single vision and multifocal lenses	Plan pays by lens type for two standard lenses: Single vision – up to $43, Bifocal – up to $58, Trifocal – up to $70, Lenticular – Single vision – $125, Multifocal – $125
Medically necessary contact lenses* One pair or single lenses every 24 months in lieu of all other vision materials *Medically necessary contact lenses must be prior authorized.	Plan pays up to $250 ($125 per lens)	Plan pays up to $250 ($125 per lens)
Non-medically necessary contact lenses One pair every 24 months in lieu of all other vision materials	Plan allows up to $120 in lieu of all other vision materials	Plan pays up to $105 in lieu of all other vision materials

Second pair
We recognize that many members prefer to have a second pair of frames and lenses as a convenience. The first pair of frames and corrective lenses are covered by the plan; however, we have negotiated with Preferred Vision Providers to extend a 20 percent discount from their reasonable and customary fees for a second pair of frames and corrective lenses (including, but not limited to, prescription sunglasses, VDT prescription in lieu of bifocals, safety glasses, occupational or recreational glasses) at the same time as the first pair of frames and corrective lenses. Of the two pairs of frames and corrective lenses, the more expensive pair will be defined as the "first pair" while the less expensive pair will be considered the "second pair."

Principal exclusions and limitations for Image Vision benefits

The following is a selective listing only. For a comprehensive listing see the Health Net PPO policy

1. Charges for procedures, services or materials that are not included as covered charges.

2. Any portion of a charge in excess of the maximum benefit allowance.

3. Expenses for any non-standard corrective lens materials, including but not limited to the following: coated, dyed, glass lens tints or laminated lenses, blended, or oversize lenses, occupational or recreational lenses, polycarbonate, safety glasses, scratch resistant, UV protection, anti-reflective, or photochromatic/ photosensitive lenses.

4. Non-prescription lenses.

5. Orthoptics, vision training and low vision aids and any associated supplemental testing.

6. Medical or surgical treatment of the eye including, but not limited to, Laser In Situ Keratomileusis (LASIK) and Photorefractive Keratectomy (PRK).

7. Prescription or non-prescription medications.

8. Any eye examination or any corrective eyewear required as a condition of employment.

9. Services or materials which the company determines to be experimental, cosmetic or not medically necessary.

10. Any service or material not prescribed by an ophthalmologist, optometrist or registered dispensing optician.

11. Services and materials furnished in conjunction with excluded services and materials.

12. Services and materials for repair or replacement of broken, lost or stolen lenses, contact lenses or frames.

13. Services and materials that a covered person received during a service interval under any other plan offered by the company or one of the company's affiliates.

14. Charges incurred before a covered person's effective date of coverage under the policy or after such coverage terminates.

15. Services or materials received as a result of disease, defect or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.

16. Services and materials obtained while outside the United States, except for emergency vision care.

17. Services or materials resulting from or in the course of your or a dependent's regular occupation for pay or profit for which you or your dependent is entitled to benefits under any worker's compensation law, employer's liability law or similar law. You must promptly claim and notify the company of all such benefits.

18. As follows:

- Charges payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, Health Net Life will always reimburse any state or local medical assistance (Medicaid) agency for covered services and materials;
- Charges not imposed against the person or for which the person is not liable;
- Charges reimbursable by Medicare Part A and Part B. If a person at any time was entitled to enroll in the Medicare program (including part B) but did not do so, his or her benefits under this policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for persons insured under employers who notify the company that they employ 20 or more employees during the previous business year, this exclusion will not apply to an actively working employee and/or his or her spouse who is age 65 or older if the employee elects coverage under this policy instead of coverage under Medicare;

19. Services, procedures or materials for which a charge would not have been made in the absence of insurance.

Prior authorization
Certain vision services require prior authorization by Health Net Life in order to be covered. This means that the vision provider must contact Health Net Life to request that the service be approved before it is provided. Requests for prior authorization will be denied if the requested service is not medically necessary. See the Policy for details.

Vision coverage included with Health Net Individual & Family HMO and EOA Plus Plans

Principal benefits and coverages for vision care provided with HMO and EOA Plus plans
Underwritten by Health Net of California and administered by SafeGuard Health Plans, Inc. This benefit is included with HMO 15 Plus, HMO 40 Plus and EOA 15 Plus

We make it easy for you to choose a personal vision care provider. You can select from a large network of providers, including optometrists, ophthalmologists and dispensing opticians. For names, addresses and phone numbers of participating vision providers log on to www.health.net and click on docsearch. If you need help in selecting a provider, call the Health Net Vision Member Services department at 1-800-880-8113.

Grievance procedures and mandatory arbitration
Members are required to submit all grievances concerning this vision plan through the Health Net of California internal grievance procedures before a member may file for arbitration for final and binding resolution of the grievance. Arbitration is the final process for the resolution of any dispute arising out of or relating to this vision plan, whether involving a claim in tort, contract or otherwise.

Reimbursement provisions for emergency vision care
If you receive emergency vision care from a provider other than a Health Net of California participating provider, you may be asked to make immediate payment for their services and supplies. Coverage for services of a provider other than a Health Net of California participating provider is limited to emergency care when a participating provider is not available. Under these circumstances, Health Net of California will reimburse you up to $40 for an eye examination and up to $50 for frames, corrective lenses and lens options, if you submit a copy of the paid bill to Health Net of California within 60 days of the date of services.

Benefits and coverage matrix for vision care provided with HMO and EOA Plus plans
THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Summary of vision benefits

Deductibles	None
Lifetime maximums	None

Professional services

Vision exam (once every 12 months)	$10 copayment

An additional examination may be provided consistent with professionally recognized standards of practice within 12 months if medically necessary.

Corrective lenses and spectacle frames or contact lenses (once every 12 months)*	$40 copayment
Outpatient services	Not covered
Hospitalization services	Not covered
Emergency services	Any amount charged by a provider in excess of Health Net of California's maximum reimbursement of $40 for an eye examination and $50 for frames, corrective lenses and lens options
Ambulance services	Not covered
Prescription drug coverage	Not covered
Durable medical equipment	Not covered
Mental health services	Not covered
Chemical dependency services	Not covered
Home health services	Not covered
Other services	Not covered

**Frames are covered up to a maximum wholesale allowance of $32, medically necessary contact lenses are covered up to a maximum allowance of $250, non-medically necessary contact lenses are covered up to a maximum retail allowance of $80.*

Vision examination
In accordance with professionally recognized standards of practice, this exam will include an analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities.

Frames
If the exam indicates the necessity of spectacles, this vision plan will cover a frame at the service interval and up to the maximum frame allowance indicated above. If the member selects frames that are more expensive than this allowance, the member will be charged the difference between the allowance and the wholesale cost of the more expensive frames, plus an additional service fee. This total cost represents a savings to the member off retail prices.

Lenses
If the exam results in corrective lenses being prescribed for the first time, or if a current wearer of corrective lenses needs new lenses, this vision plan will cover a pair of lenses at the service level indicated above. Coverage is limited to basic lenses that are medically necessary to correct vision. If the member selects lenses with non-basic features, the member will be responsible for the provider's charges for the extra features.

Medically necessary contact lenses
Coverage for prescriptions for contact lenses is subject to medical necessity, prior authorization by Health Net of California and all applicable exclusions and limitations. Medically necessary contact lenses are covered at the service interval and up to maximum allowance indicated above.

Non-medically necessary contact lenses
Prescriptions for contact lenses that are not medically necessary are covered at the service interval and up to the maximum retail contact lens allowance indicated above.

Second pair
Participating vision providers will provide a 20 percent discount off usual and customary fees for a second pair of frames and spectacle lenses (including prescription sunglasses) for members at the same interval as the first pair of frames and spectacle lenses.

Principal exclusions and limitations for vision provided with Health Net HMO and EOA Plus Plans
The following vision services and expenses are not covered under the HMO 15 Plus, HMO 40 Plus and EOA 15 Plus plans:

- Coverage limited to care rendered by participating providers.
- Extras and non-medically necessary services and materials. This vision plan is designed to cover medically necessary visual needs rather than cosmetic desires. Charges for services and materials are excluded if Health Net of California determines them to be: (1) not medically necessary in which case the member pays the difference between the allowance and the cost of the not-medically necessary lens. Not-medically necessary lens features include special lens fabrication, coated lenses, tinted lenses, dyed lenses, laminated lenses, progressive lenses, blended lenses, oversize lenses, occupational lenses, and any other types of lenses or features that Health Net of California determines to be non-basic or not medically necessary; (2) beyond the allowances for frames and contact lenses indicated in the Summary of Vision Care Benefits; or
- Medically necessary contact lenses. Coverage for prescriptions for contact lenses is subject to medical necessity, prior authorization by Health Net of California and all applicable exclusions and limitations. Coverage (exclusive of the indicated copayment) for contact lenses will only be authorized: (1) for contact lenses to correct extreme visual acuity problems that cannot be corrected to 20/70 in the better eye with spectacle lenses; (2) following cataract surgery resulting in aphakia; (3) for anisometropia of 4.0 diopters or greater; or (4) for keratoconus or other corneal irregularities. When covered, contact lenses are furnished at the same interval as spectacle lenses are covered under this vision plan. This coverage is in lieu of all other material benefits of this vision plan. For medically necessary contact lenses, participating vision providers have agreed to limit their charges to a reduced amount that is 80 percent of their usual retail fees. Health Net of California will pay an allowance up to $250 of that reduced amount minus any applicable copayments. The $250 allowance applies to all costs associated with obtaining contact lenses, including the examination, fitting fees and materials. Members are responsible for any reduced amount charged by participating vision providers in excess of the $250 allowance, plus any applicable copayments.

- Non-medically necessary contact lenses. Prescriptions for contact lenses that are not medically necessary are covered up to the maximum retail contact lens benefit allowance indicated above. This coverage is in lieu of all other material benefits of this vision plan. The allowance applies to all costs associated with obtaining contact lenses, including fitting fees and materials. Members are responsible for additional charges in excess of the allowance. If the member selects contact lenses that are more expensive than this allowance, the member will be responsible for the provider's charges in excess of the allowance.
- Medical or hospital. Hospital and medical charges of any kind, vision services rendered in a hospital, and medical or surgical treatment of eyes, are excluded.
- Loss or theft.
- Orthoptics, vision training, subnormal vision aids, plano (non-prescription) lenses and any associated testing.
- Lenses secured when there is no prescription change are excluded.
- A second pair of glasses in lieu of bifocals is excluded.
- Experimental services and supplies are excluded. Experimental treatment if denied may be appealed through the Independent Medical Review process. Services shall be covered and provided if required under the Independent Medical Review process.

Please refer to the Plan Contract and Evidence of Coverage for a complete listing of exclusions and limitations.

Important things to know about all your medical coverage options

Who is eligible?
To be eligible for Health Net Individual & Family HMO, EOA or PPO, you must: be under the age of 65, not be eligible for Medicare, reside continuously in our service area, and meet our application and underwriting requirements for coverage. In addition, your spouse, if under age 65, and all your unmarried dependent children under 19 years of age also are eligible (subject to underwriting requirements). Unmarried dependent children enrolled in an accredited school as full-time students and under 24 years of age are also eligible, if proof of full-time student status is provided.

Am I eligible for guaranteed issue coverage, without the need for medical underwriting?
Under the Health Insurance Portability and Accountability Act (HIPAA) Health Net and other individual health care companies by law must provide coverage to anyone who qualifies for certain coverage regardless of health.

To qualify for a HIPAA plan, you must:

- have completed a total of 18 months of coverage without a significant break (excluding any employer-imposed waiting period) under a group health plan
- the most recent coverage must have been under a group health plan.
- the applicant must not be eligible for coverage under any group health plan, Medicare or Medicaid, and must not have other health insurance coverage.
- the individual's most recent coverage could not have been terminated due to fraud or nonpayment of premiums.
- if COBRA coverage was available, it must have been elected and such coverage must have been exhausted. This would include Cal-COBRA for employers with 2 to 20 employees.

If you want to find out if you qualify, contact us so that we can determine your eligibility and tell you about the available HIPAA plans.

How does the monthly billing work?
Your premium must be received by Health Net by the first day of the coverage month. If there are premium increases after the enrollment effective date, you will be notified at least 30 days in advance.

If you choose Health Net's Simple Pay option, credit card billing or quarterly billing, you will be exempt from any administrative billing fees. If you do not choose Health Net's Simple Pay option, credit card billing or quarterly billing, a $5 per month administrative fee will be charged each month to cover the expense of issuing a monthly bill. If there are changes to the Health Net Individual & Family HMO or EOA Plan Contract and EOC or PPO Policy, including changes in benefits, you will be notified at least 30 days in advance.

Can benefits be terminated?
You may cancel your coverage at any time by giving Health Net written notice. In such event, termination will be effective on the first of the month following our receipt of your written notice to cancel. Health Net has the right to terminate your coverage for any of the following reasons:

- You do not pay your premium on time
- You and/or your family member(s) cease being eligible
- You make false statements about your own or your family's health status
- You and/or your family member(s) repeatedly or materially disrupt the operations of the Physician Group or Health Net to the extent that your behavior substantially impairs Health Net's ability to furnish or arrange services for you or other Health Net members, or the physician's office or Contracting Physician Group's ability to provide services to other patients.
- You and/or your family member(s) threaten the safety of the health care provider, his or her office staff, the contracting Physician Group or Health Net personnel if such behavior does not arise from a diagnosed illness or condition.

Health Net can terminate your coverage, together with all like policies, by giving 90 days' written notice. Members are responsible for payment of any services received after termination of coverage at the provider's prevailing non-member rates. This is also applicable to members who are hospitalized or undergoing treatment for an ongoing condition on the termination date of coverage. If you terminate coverage for yourself or any of your family members, you may apply for re-enrollment, but Health Net may decline enrollment at its discretion.

Are there any renewal provisions?
Subject to the termination provisions discussed, coverage will remain in effect for each month prepayment fees are received and accepted by Health Net. You will be notified 30 days in advance of any changes in fees, benefits or contract provisions.

Does Health Net coordinate benefits?
There are no Coordination of Benefit provisions for individual plans in the State of California.

What is utilization review?
Health Net makes medical care covered under our Individual & Family HMO, EOA or PPO insurance plans subject to policies and procedures that lead to efficient and prudent use of resources and, ultimately, to continuous improvement of quality of care. Health Net bases the approval or denial of services on the following main procedures:

- Evaluation of medical services to assess medical necessity and appropriate level of care
- Implementation of case management for long-term or chronic conditions
- Review and authorization of inpatient admission and referrals to non-contracting providers
- Review of scope of benefits to determine coverage

If you would like additional information regarding Health Net's Utilization Review System, please call the Member Services department at 1-800-839-2172.

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

What if I have a disagreement with Health Net?
Members dissatisfied with the quality of care received, or who believe they were denied service or a claim in error, may file a grievance or appeal. In addition, plan members can request an independent medical review of disputed health care services from the Department of Managed Health Care if they believe that health care services eligible for coverage and payment under their Health Net plan was improperly denied, modified or delayed by Health Net or one of its contracting providers.

Also, if Health Net denies a member's appeal of a denial for lack of medical necessity, or denies or delays coverage for requested treatment involving experimental or investigational drugs, devices, procedures or therapies, members can request an independent medical review of Health Net's decision from the Department of Managed Health Care if they meet eligibility criteria set out in the Plan Contract and Evidence of Coverage or Policy.

Members not satisfied with the results of the grievance and appeals process may submit the problem to binding arbitration. Health Net uses binding arbitration to settle disputes, including medical malpractice. As a condition of enrollment, members give up their right to a jury or trial before a judge for the resolution of such disputes.

Health Net

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

If you have a grievance against Health Net, you should first telephone Health Net at **1-800-839-2172** and use our grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by Health Net, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

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

Important Notice to California Policyholders
In the event that a member needs to contact someone about his or her insurance coverage for any reason, please contact:

Health Net Life Insurance Company
Individual & Family Plans
Post Office Box 1150
Rancho Cordova, California 95741-1150
1-800-909-3447

If a member has been unable to resolve a problem concerning his or her insurance coverage, after discussions with Health Net Life Insurance Company, or its agent or other representative, her or she may contact:

California Department of Insurance, Consumer Services Division
300 South Spring Street
South Tower
Los Angeles, CA 90013
1-800-927-HELP

What if I need a second opinion?

Health Net members have the right to request a second opinion when:

- The member's Primary Care Physician or a referral physician gives a diagnosis or recommends a treatment plan with which the member is not satisfied;
- The member is not satisfied with the result of treatment received;
- The member is 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
- The member's Primary Care Physician or a referral physician is unable to diagnose the member's condition, or test results are conflicting.

To obtain a copy of Health Net's second opinion policy, contact the Member Services Department at 1-800-839-2172.

What are Health Net's premium ratios?

Health Net's 2002 ratio of premium costs to health services paid for Individual & Family HMO plans was 63.3 percent. Health Net Life's 2002 ratio for the Individual & Family PPO insurance plans was 81.7 percent.

What is the relationship of the involved parties?

Physician groups, contracting physicians, hospitals and other health care providers are not agents or employees of Health Net or Health Net Life. Health Net or Health Net Life and each of their employees are not the agents or employees of any physician group, contract physician, hospital or other health care provider. All of the parties are independent contractors and contract with each other to provide you the covered services or supplies of your coverage option. Members are not liable for any acts or omissions of Health Net or Health Net Life, their agents or employees, or of physician groups, any physician or hospital, or any other person or organization with which Health Net or Health Net Life has arranged or will arrange to provide the covered services and supplies of your plan.

What about termination of a provider contract?

If Health Net's contract with a physician group or other provider is terminated, Health Net will transfer any affected members to another contracting physician group or provider to ensure that care continues. In addition, the member may elect continued care if at the time of termination the member was receiving care for:

- An acute or serious chronic condition
- A high-risk pregnancy
- A pregnancy which has reached the second trimester

If you would like more information on how to request continued care please contact the Member Services department at 1-800-839-2172.

What are severe mental illness and serious emotional disturbances of a child?

Severe mental illness includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder, autism, anorexia nervosa, and bulimia nervosa.

Serious emotional disturbances of a child is when a child under the age of 18 has one or more mental disorders identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance abuse disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following: (a) as a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home, or (ii) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year; (b) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to mental disorder; and/or (c) the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Do providers limit services for reproductive care?

Some hospitals and other providers do not provide one or more of the following services that may be covered under your Plan Contract and Evidence of Coverage or Policy and that you or your family member might need: family planning; contraceptive services, including emergency contraception, sterilization, including tubal ligation at the time of labor and delivery, infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic, or call Health Net Member Services at **1-800-839-2172** to ensure that you can obtain the health care services that you need.

ADDITIONAL ITEMS FOR HMO AND EOA COVERAGE ONLY

What is the method of provider reimbursement?

Health Net uses financial incentives and various risk-sharing arrangements when paying providers. Members may request more information about our payment methods by contacting Member Services at the telephone number on their Health Net ID card.

When and how does Health Net pay my medical bills?

We will coordinate the payment for covered services when you receive care from your Primary Care Physician or when your Primary Care Physician refers you to a specialist. We have agreements with these physicians that eliminate the need for claim forms. Simply present your member identification card.

Am I required to see my Primary Care Physician if I have an emergency?

When your situation is life-threatening, call 911. If your situation is not so severe and you cannot call your Primary Care Physician or physician group (medical) or the administrator (mental illness or chemical dependency), or you need medical care right away, go to the nearest medical center or hospital.

An emergency is defined as any otherwise covered service that a reasonable person with an average knowledge of health and medicine would seek if he or she was having serious symptoms (including severe mental illness and serious emotional disturbances of a child), and believed that without immediate treatment, any of the following would occur: (a) his or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger); (b) his or her bodily functions, organs or parts would become seriously damaged; or (c) his or her bodily organs or parts would seriously malfunction.

Emergency care includes ambulance and ambulance transport services provided through the "911" emergency response system, if the request is made for emergency care, as well as additional screening, examination and evaluation by a physician (or other health care provider acting within the scope of his or her license) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate such condition within the capacity of the facility.

Am I liable for payment of certain services?

We are responsible for paying participating providers for covered services. Except for copayments and deductibles, participating providers may not bill you for charges in excess of our payment. You are financially responsible for: (a) services beyond the benefit limitations stated in the Plan Contract and EOC; and (b) services not covered by the Individual & Family HMO and EOA Plans.

The Individual & Family HMO and the EOA Plans do not cover: prepayment fees, copayments, deductibles, services and supplies not covered by the Individual & Family HMO and EOA Plans, or non-emergency care rendered by a nonparticipating provider.

Under the HMO and EOA plans, can I be reimbursed for out-of-network claims?

Some nonparticipating providers will ask you to pay a bill at the time of service. If you have to pay a bill for covered services, submit a copy of the bill, evidence of its payment and the emergency room report to us for reimbursement within 90 days of the date the service was rendered. Coverage for services rendered by nonparticipating providers is limited to emergency care when a participating provider is not available.

How does Health Net handle confidentiality and release of member information?
Health Net knows that personal information in your medical records is private. Therefore, we protect your personal health information in all settings. As part of the application or enrollment form, Health Net members sign a routine consent to obtain or release their medical information. This consent is used by Health Net to ensure notification to and consent from members for present and future routine needs for the use of personal health information.

This consent includes the obtaining or release of all records pertaining to medical history, services rendered or treatment given to all subscribers and members under the plan for the purpose of review, investigation or evaluation of an application, claim, appeals (including the release to an independent reviewer organization) or grievance, or for preventive health or health management purposes.

We will not release your medical records or other confidential information to anyone, such as an employer or insurance broker, who is not authorized to have that information. We will only release information if you give us special consent in writing. The only time we would release such information without your special consent is when we have to comply with a law, court order or subpoena. Often, Health Net is required to comply with aggregated measurement and data reporting requirements. In those cases, we protect your privacy by not releasing any information that identifies our members.

Privacy practices: For a description of how protected information about you may be used and disclosed and how you can get access to this information, please see the Notice of Privacy in your plan contract.

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

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

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

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

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

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

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

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

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

ADDITIONAL ITEMS FOR PPO COVERAGE ONLY

Health Net Individual & Family PPO plans are underwritten by Health Net Life Insurance Company.

Are there any pre-existing conditions?
Until the policy has been in effect for six consecutive months, covered services will not include any care required in connection with the treatment of any condition, disease or injury for which medical advice, diagnosis, care or treatment, including the use of prescription medications, was recommended by or received from a licensed health care practitioner during the six months immediately preceding the effective date of coverage under the policy.

Credit will be given toward the pre-existing condition waiting period for membership with another creditable health care plan if you apply for coverage under Health Net's PPO insurance plan within 62 days of termination with the previous plan.

When do I submit claims?
Some providers will ask you to pay a bill at the time of service. If you have to pay a bill for covered services, submit a copy of the bill and evidence of its payment to Health Net for reimbursement within 60 days of the date the service was rendered. See the Policy for details.

What are customary and reasonable charges?
Customary and reasonable charges, as determined by Health Net Life, are charges that fall within the common range of fees billed by a majority of physicians for a procedure in a given geographic region, or which are justified based on the complexity or the severity of treatment for a specific case.

If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by Health Net or a grievance that has remained unresolved for more than 30 days, you may call the Department of Insurance for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services.

EXCLUSIONS AND LIMITATIONS

Exclusions and limitations common to all Individual & Family coverage options
No payment will be made under the Health Net Individual & Family HMO and EOA plans or the Health Net Individual & Family PPO for expenses incurred for, or which are follow-up care to, any of the items below. The following are selective listings only. For comprehensive listings see the Health Net Individual & Family Plan Contract and Evidence of Coverages (EOC) for the HMO and the EOA plans and the Health Net Life Policy for Individual & Family PPO for the PPO coverages.

- Services and supplies that Health Net or Health Net Life determine are not medically necessary except as set out under "Does Health Net cover the cost of participation in clinical trials" and "What if I have a disagreement with Health Net?"
- Custodial care. Custodial care is not rehabilitative care and is primarily provided to assist a patient in meeting the activities of daily living, such as: help in walking, getting in and out of bed, bathing, dressing, feeding and preparation of special diets, and supervision of medications that are ordinarily self-administered, but not care that requires skilled nursing services on a continuing basis
- Procedures that Health Net or Health Net Life determines to be experimental or investigational except as set out under "Does Health Net cover the cost of participation in clinical trials" and "What if I have a disagreement with Health Net?"

- Services or supplies provided before the effective date of coverage, and services or supplies provided after coverage through this plan has ended, are not covered
- Services for which the member is not legally obligated to pay, or for which no charge is made to the member
- Any service or supplies not specifically listed as covered expenses
- Services or supplies that are intended to impregnate a woman are not covered
- Oral contraceptives and emergency contraceptives are covered. Vaginal contraceptives are limited to diaphragms, cervical caps and IUDs, and are only covered when a contracted physician performs a fitting examination and in the case of diaphragms and cervical caps, prescribes the device. IUDs are only available through the contracted physician's office, are covered as a medical benefit, and are limited to one fitting and device per year, unless additional fittings or devices are medically necessary. Diaphragms and cervical caps are only available through a prescription from a pharmacy and are limited to one prescription per year unless additional fittings or devices are medically necessary. Injectable contraceptives are covered as a medical benefit when administered by a physician.
- Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance*
- Dental care**
- Treatment and services for temporomandibular joint (TMJ) disorders are covered when determined to be medically necessary, excluding crowns, inlays, bridgework and appliances
- Any services or supplies furnished by a non-eligible institution that is other than a legally operated hospital or Medicare-approved skilled nursing facility, or that is primarily a place for the aged, a nursing home or any similar institution, regardless of how designated
- Surgery and related services for the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw, except when such surgery is required due to recent trauma or the existence of tumors or neoplasms, or when otherwise medically necessary
- Hearing aids
- Treatment for mental disorders as a condition of parole or probation and court-ordered testing
- Private duty nursing
- Any eye surgery for the purpose of correcting refractive defects of the eye, unless medically necessary, recommended by the Member's treating physician and authorized by Health Net
- Home birth, unless the criteria for emergency care have been met
- Physician self-treatment
- Physician treating immediate family members
- Contact or corrective lenses (except an implanted lens that replaces the organic eye lens), vision therapy and eyeglasses**
- Treatment for alcoholism or drug addiction, except detoxification
- Services to reverse voluntary surgically induced infertility
- Sex change procedures or treatment
- Physical exams for insurance, licensing, employment, school or camp. Any physical, vision or hearing exams that are not related to diagnosis or treatment of illness or injury, except as specifically stated in the Health Net Life Policy or Health Net HMO or EOA Plan Contract and EOC
- Any outpatient drugs, medications or other substances dispensed or administered in any setting, except as specifically stated in the Health Net Life Policy or Health Net HMO or EOA Plan Contract and EOC
- Services for a surrogate pregnancy are covered. However, when compensation is obtained for the surrogacy, the plan shall have a lien on such compensation to recover its medical expense.
- Although this Plan covers Durable Medical Equipment, it does not cover the following items: (a) exercise equipment; (b) hygienic equipment, jacuzzis and spas; (c) surgical dressings other than primary dressings that are applied by your Physician Group or a Hospital to lesions of the skin or surgical incisions; and (d) stockings, corrective shoes and arch supports
- Personal or comfort items
- Disposable supplies for home use
- Home birth, unless the criteria for emergency care have been met

**When a medically necessary mastectomy has been performed, breast reconstruction surgery and surgery performed on either breast to restore or achieve symmetry (balanced proportions) in the breast are covered. In addition, when surgery is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease, to do either of the following: improve function or create a normal appearance to the extent possible, unless the surgery offers a minimal improvement in the appearance of the member.*

***The HMO 15 Plus, HMO 40 Plus, EOA 15 Plus, PPO Value Basic Plus and PPO Value Plus plans include certain dental and vision services as described in this guide. For dental and vision benefit information for these plans, refer to the benefits sections later in this guide, or the Plan Contract and EOC for HMO Plus plans and the Policy for PPO Value Plus plans.*

Additional exclusions and limitations for HMO and EOA plans only

- Chiropractic services
- Home health care (limited to 100 combined visits per calendar year; maximum three visits per day and two hours per visit)
- Medical services or supplies that are not authorized by Health Net or the physician group according to Health Net's procedures
- Services and supplies rendered by a nonparticipating physician without authorization from Health Net or the Physician Group
- Services and supplies rendered by a nonparticipating physician
- Diagnostic procedures or testing for genetic disorders, except for prenatal diagnosis of fetal genetic disorders in cases of high-risk pregnancy
- Diagnostic procedures or testing for genetic disorders, except for prenatal diagnosis of fetal genetic disorders in cases of high-risk pregnancy
- Nonprescription drug, medical equipment or supply that can be purchased without a prescription (except when prescribed by a physician for management and treatment of diabetes). If a drug that was previously available by prescription becomes available in an over-the-counter (OTC) form in the same prescription strength, then any prescription drugs that are similar agents and have comparable clinical effect(s), will only be covered when Prior Authorization is obtained from Health Net.
- Routine foot care, unless medically necessary for a diabetic condition
- Treatment of obesity when obtained through group programs or organized clinics
- Acupuncture
- Services to diagnose, evaluate or treat infertility are not covered
- Services related to educational and professional services
- Treatment, testing or screening of learning disabilities, except for some conditions when the level of severity meets the criteria of severe mental illness or serious emotional disturbances of a child

Additional exclusions and limitations for ELECT Open Access Plans, Open Access benefit only

- Blood transfusions, including blood processing, the cost of blood, unreplaced blood and blood products
- Any expenses for sterilization
- Visits by a physician to a member's home
- Ground or air ambulance or other medical transportation services
- Renal dialysis
- Home health care visits
- Hospice care
- All services and supplies related to pregnancy
- Any expense related to inpatient hospital or skilled nursing care
- Outpatient hospital services, including outpatient surgery
- Durable medical equipment
- Wellness and other patient educational programs

Additional exclusions and limitations for all PPO plans

- Conditions caused by the member's commission (or attempted commission) of a felony
- Conditions caused by release of nuclear energy, when government funds are available
- Outpatient speech therapy which is not provided in relation to surgery, injury or disease
- Amounts charged by Out-of-Network providers for covered medical services and treatment that Health Net Life determines to be in excess of the covered expense

- Optometric services, eye exercises including orthoptics, except as specifically stated elsewhere in the Policy
- Services or supplies received for the treatment of a pre-existing condition during the first six consecutive months during which the member is covered
- Immunizations or inoculations for adults or children, except as described in the Policy
- Any services not related to the diagnosis or treatment of a covered illness or injury
- Inpatient room and board charges incurred in connection with an admission to a hospital or other inpatient treatment facility primarily for diagnostic tests that could have been performed safely on an outpatient basis
- Inpatient room and board charges in connection with a hospital stay primarily for environmental change, physical therapy or treatment of chronic pain
- Expenses in excess of a hospital's (or other inpatient facility's) most common semiprivate room rate
- Any expenses related to the following items, whether authorized by a physician or not: (a) alteration of the member's residence to accommodate the member's physical or medical condition, including the installation of elevators; (b) corrective appliances, except prosthetics, casts and splints; (c) air purifiers, air conditioners and humidifiers; and (d) educational services or nutritional counseling, except as specifically provided in the Policy
- Treatment or surgery for obesity, weight reduction or weight control, except when provided for morbid obesity, as determined by Health Net Life
- All benefits provided under the Policy shall be reduced by any amounts to which a member is entitled under the program commonly referred to as Medicare when federal law permits Medicare to pay before an individual health plan
- Services performed by a person who lives in the member's home or who is related to the member by blood or marriage
- Any services provided by, or for which payment is made by, a local, state or federal government agency. This limitation does not apply to Medi-Cal, Medicaid or Medicare
- If the member receives services or obtains supplies in a foreign country, benefits will be payable for emergency care only
- Hyperkinetic syndromes, learning disabilities, behavior problems or mental retardation, regardless of the type of service. Certain conditions are covered if their level of severity meets the criteria of serious emotional disturbances of a child or severe mental illness
- Services to diagnose, evaluate or treat infertility

Additional exclusions and limitations for:

Value PPO 25, Value PPO 400, Value PPO 750 and Value Basic 500
- Care for conditions of pregnancy, including hospital and professional services. This includes prenatal and postnatal care, and delivery.

Value Basic 500 and Value Basic 1000
- Immunizations or inoculations for foreign travel or occupational purposes.
- Allergy serum

Value Basic 500, Value Basic 1000, Value Basic 2500 and Value Basic 4000
- Acupuncture
- Routine physical examinations

Value Basic 500
- Rehabilitative services

ADDITIONAL HMO AND EOA PRODUCT INFORMATION

Mental health and chemical dependency services
Health Net has contracted exclusively with Managed Health Network (MHN) specializing in mental health and chemical dependency services.

Members can call 1-888-426-0030 without need for an authorization from their Health Net contracting physician group. The direct access to confidential assessment ensures that any enrolled member who calls will receive timely care specific to their individual needs.

- When Health Net members need mental health or chemical dependency care, simply call the toll-free line. For a referral, intake specialists and clinicians are on duty to take calls 24 hours a day, seven days a week. This 24-hour availability enhances your access, and reduces the possibility of going to a nonparticipating provider for care
- Members who call for non-emergency care will always be referred for an initial evaluation. You will be given the name of a qualified mental health professional from a comprehensive specialty network. There are no additional requirements, and all evaluations are scheduled within ten days from the time of your call or at your convenience. This kind of prompt response to non-emergency situations minimizes your overall costs
- In an emergency, call 911, or you may call the administrator at 1-888-426-0030
- Every member who calls for services is guaranteed an initial evaluation

Prescription drug program
Health Net is contracted with many major pharmacies including Longs, Rite Aid, Sav-on/Osco, Walgreens, Kmart, Costco, Target, Eckerts, Brooks/Maxi Drugs, CVS, Giant Eagle Drugs, Drug Barn/Big A, Drug Emporium, Genovese Drug, Sam's Club, Thrift Drugs, Sav-Mart Drugs, Wal-Mart and those located in the Albertsons, BelAir, Raley's, Ralphs, Safeway, Save Mart, Tom Thumb, Quick Check, Weis, Hy-Vee and Vons/Pavilions supermarket chains in California. There are many other neighborhood pharmacies that are also part of our network. For a complete and up-to-date list of participating pharmacies, call Health Net Member Services or visit our website at www.health.net.

Specific exclusions and limitations apply to the Prescription Drug Program. See the Health Net Individual and Family Plan Contract and Evidence of Coverage for complete details. Remember, limits on quantity, dosage and treatment duration may apply to some drugs.

Prescriptions By Mail Drug Program
If your prescription is for a maintenance medication (a drug that you will be taking for an extended period), you have the option of filling it through our convenient Mail Order Program. This program allows you to receive up to a 90-consecutive-calendar-day supply of maintenance medications. For complete information, call Health Net Member Services at 1-800-839-2172.

Note:
Schedule II drugs are not covered through mail order. See the Health Net Individual & Family Plan Contract and EOC for additional information.

The Health Net Recommended Drug List: Level I drugs (primarily generic) and Level II drugs (primarily brand name)
The Health Net Recommended Drug List (or the List) is the approved list of medications covered for illnesses and conditions. It was developed to identify the safest and most effective medications for Health Net members while attempting to maintain affordable pharmacy benefits.

We specifically suggest to all Health Net contracting Primary Care Physicians and specialists that they refer to this list when choosing drugs for patients who are Health Net members. When your physician prescribes medications listed on the Recommended Drug List, it ensures that you are receiving a high quality prescription medication that is also of high value.

The Recommended Drug List is updated regularly, based on input from the Health Net Pharmacy and Therapeutics (P&T) Committee. The committee's members are actively practicing physicians of various medical specialties and clinical pharmacists. Voting members are recruited from Contracting Physician Groups throughout California based on their experience, knowledge and expertise. In addition, the P&T Committee frequently consults with other medical experts to provide additional input to the Committee. Updates to the Recommended Drug List and usage guidelines are made as new clinical information and new drugs become available.

In order to keep the List current, the P&T Committee evaluates clinical effectiveness, safety and overall value through:

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

To obtain a copy of Health Net's most current Recommended Drug List, please visit our website at www.healthnet.com, under "Pharmacy information," ***or*** call Health Net Member Services at 1-800-839-2172.

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

What is "prior authorization"?
Some prescription medications require prior authorization. This means that your doctor must contact Health Net in advance to provide the medical reason for prescribing the medication. Upon receiving your physician's request for prior authorization, Health Net will evaluate the information submitted and make a determination based on established clinical criteria for the particular medication.

The criteria used for prior authorization are developed and based on input from the Health Net P&T Committee as well as physician specialist experts. Your physician may contact Health Net to obtain the usage guidelines for specific medications.

If authorization is denied by Health Net, you will receive written communication including the specific reason for denial. If you disagree with the decision, you may appeal the decision.

The appeal may be submitted in writing, by telephone or through email. We must receive the appeal within 60 days of the date of the denial notice. Please refer to your Health Net Evidence of Coverage for details regarding your right to appeal.

To submit an appeal:

- Call Health Net Member Services at 1-800-839-2172
- Visit www.health.net for information on emailing Health Net Member Services
- Write to:
  Health Net Member Services
  P.O. Box 10348
  Van Nuys, CA 91410-0348

PPO COVERAGE CERTIFICATION REQUIREMENTS

We work with you and your doctor to determine the most effective course of treatment covered under your policy. Through our Certification Program, you get approval for coverage before obtaining certain types of services. This helps protect you from undergoing unnecessary medical procedures – and from having to pay a medical bill because a service isn't covered.

When you receive certification for coverage, it means we've determined that the procedure your doctor has recommended is medically necessary and is appropriate treatment for your health problem. Certification also confirms that we'll extend coverage for the procedure, according to the terms of your policy. If you don't obtain certification when it is required, any benefits payable will be reduced by 50 percent. The reduction in benefits by 50 percent will apply to the following procedures:

1. Inpatient admissions. Any type of facility, including but not limited to:

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

2. Surgical procedures including:

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

3. Organ and tissue transplant services including pre-evaluation and pre-treatment services, and the trans-plant procedure

4. Home health care agency services including nursing, physical therapy, occupational therapy, speech therapy, home I.V. therapy and home uterine monitoring

5. Hospice care

6. Pregnancy: Upon confirmation of pregnancy and for admission to the hospital, only if your Plan includes coverage for condition of pregnancy.

7. Outpatient diagnostic imaging:

- MRI (Magnetic Resonance Imaging)
- MUGA (Multiple Gated Acquisition) cardiac scan
- PET (Positron-Emission Tomography)
- SPECT (Single Photon Emission Computed Tomography)

8. Durable medical equipment

9. Prosthesis and orthotics

10. Air ambulance

11. Tocolytic services (intravenous drugs used to decrease or stop uterine contractions in premature labor.)

12. Orthognatic procedures (surgery performed to correct or straighten jaw and/or other facial bone mis-alignments to improve function.)

We will consider the medical necessity for the proposed treatment, the proposed level of care (inpatient or outpatient) and the duration of the proposed treatment, with the exception of reconstructive surgery incident to a mastectomy.

You must request certification five or more days before the proposed admission date or commencement of treatment, except when due to an emergency. In the event of an emergency, you or your doctor must contact us within 48 hours or as soon as reasonably possible. Services provided as a result of an emergency will not require certification.

Note: The reduction in benefits by 50 percent that is payable under Individual & Family PPO will continue to apply to benefits payable after you have met your maximum out-of-pocket limit.

PREGNANCY

When a member gives birth to a child in a hospital, she is entitled to benefits for 48 hours of inpatient care following a vaginal delivery or 96 hours following a cesarean section delivery. Certification penalties will not be applied for that period of time. However, certification must be obtained for a cesarean section if the physician determines that a longer stay is medically necessary.

NOW THAT YOU'VE SEEN
WHAT HEALTH NET CAN OFFER YOU…

- **Affordable coverage**
- **A variety of plan types and options**
- **Security and choice**
- **Protection against major health expenses**

…IT'S YOUR MOVE. AND YOUR LIFE. HOW DO YOU WANT TO LIVE IT?

Having health insurance can take the pain out of rising health care costs. With Health Net, you get a choice of affordable health insurance plans for every lifestyle.

Benefits include that occasional trip to the ER, preventive care, doctor visits, hospitalization and more. Health Net Individual & Family Plans feature:

- Prescription coverage with every plan.
- Monthly rates based on the age of the younger spouse, making family coverage more affordable.

CONTACT YOUR AUTHORIZED HEALTH NET AGENT OR CALL 1-800-909-3447
VISIT OUR WEBSITE TO LEARN MORE: WWW.HEALTH.NET

ADDITIONAL OPTIONS

Today's families have many health coverage needs. To help meet those needs, in addition to our Individual & Family Plans we offer other coverage options.

Are you the owner of a small business?

Today, nearly 95 percent of companies in California employ fewer than 50 people. Health Net offers health plans designed to meet the needs of a small business. No matter what a company's size, employers and employees will be sure to find the health coverage they need.

Call your authorized Health Net agent to learn more.

Do you need coverage for your children – but are on a limited income?

The Healthy Families Program can help. It provides children of low-income families with access to coverage they might not otherwise get, for a low monthly premium.

Call 1-888-231-9473 to learn more.

Are you or a family member 65 years of age or older?

If so, take advantage of our Senior Health Plans.

Call 1-800-935-6565 to learn more.

Health Net Individual & Family Plans
Post Office Box 1150
Rancho Cordova, California 95741-1150

For more information, please contact your Health Net authorized agent.

Call toll-free: **1-800-909-3447** or
1-800-331-1777 para los que hablan español

Or visit us online: **www.health.net**

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A Better Decision

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