

A BETTER DECISIONSM
IS LETTING YOUR MONEY
WORK FOR YOU.



Individual & Family Plans
SmartChoice HSA



Health Net[®]
A Better Decision

PUT YOUR MONEY WHERE YOUR HEALTH IS.

SmartChoice HSA offers A Better Decision.SM It allows you to participate in a *tax-friendly HSA*, and take greater control over your medical expenses. You also get the *freedom and security* of PPO plan coverage, with *negotiated discounts* from doctors and hospitals within the Health Net PPO network.

First, you need to enroll in an “HSA-compatible” health plan. Like the SmartChoice HSA.

SMARTCHOICE HSA KEY PLAN BENEFITS

- The PPO plan allows you to visit *any licensed provider* and be eligible for plan coverage. No referrals required.

- You get *in-network savings* when visiting one of more than 48,000 physicians and more than 300 hospitals in California, or more than 340,000 professionals nationwide in the First Health network.
- The PPO plan has a *combined medical and pharmacy deductible*, which means you pay for the entire cost of medical services and prescriptions until you have paid the deductible amount.
- Once your deductible is met, you pay either a copayment (fixed dollar amount) or coinsurance (percentage of cost) for covered medical services and prescriptions.

WHAT IS AN HSA?

An HSA is an individually owned savings account, similar to an IRA, except that you use it for current and future health care costs.

Key HSA features:

- HSA funds can be used without penalty for “qualified medical expenses,” which include medical care and prescriptions, as well as plan deductibles, copayments and coinsurance amounts.¹
- Your contributions are *tax-deductible*.
- The funds can be *invested*, and earnings are *tax-free*.
- There is no time limit for using the funds, they *roll over* from year-to-year.
- Maximum contributions for 2004 are either your health plan deductible or \$2,600/\$5,150 (*individual/family*), whichever is less.

HOW TO TAKE ADVANTAGE OF AN HSA

1. Enroll in an HSA-compatible health plan, like the SmartChoice HSA.
2. Open your HSA at a bank or other qualified financial institution.
3. Decide how much to contribute, based on your expected yearly health care needs. *Remember: You can use your HSA to pay for your qualified medical expenses while the plan deductible is in effect.*
4. Withdraw funds for your portion of any qualified medical expenses.
5. Remember that HSA contributions are tax-deductible. Contributions made through April 15 can be deducted from last year’s gross income when preparing taxes. Consult a professional tax advisor if you have questions.

¹A full list of “qualified expenses” is outlined in IRS Publication 502 – *Qualified Medical and Dental Expenses*, which you can find at www.irs.gov. Simply enter “502” in the “Search Forms and Publications” field.

The above is for general information only. For more specific HSA and tax information, please contact a professional tax advisor.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The Policy should be consulted for a detailed description of coverage benefits and limitations.

Benefit description

Lifetime maximum

Annual deductible

For contracts of 2 or more members, there are no benefits until the family deductible is met

Maximum annual out-of-pocket costs

Office visit

X-ray and laboratory procedures⁴

Annual routine physical exams⁵

Preventive care

Age 19 and older (includes annual OB/GYN exam⁷ and annual prostate cancer screening and exam)

Newborn to age 18 (includes checkups, immunizations, vision and hearing exams)

Maternity and pregnancy (including prenatal and postnatal office visits and maternity care in hospital)

Emergency room (professional and facility)⁹

Urgent care center (facility)⁹

Ambulance⁴

Outpatient services⁶

Outpatient surgery

Outpatient facility services

Hospitalization services⁴

Inpatient, semiprivate hospital room or intensive care unit with ancillary services (unlimited, except for substance abuse treatment)

Surgeon or assistant surgeon and anesthetic service (inpatient hospital setting)

Reproductive health (sterilization)

Other services

Rehabilitative therapy (includes physical, speech, occupational, respiratory and cardiac therapy)⁴

Chiropractic care

Mental health services for severe conditions^{4,11}

Mental health services for non-severe conditions^{4,12,13}

Durable medical equipment (including foot orthotics)⁴

Outpatient prescription drugs (filled at participating pharmacy – up to a 30-day supply; not covered at non-participating pharmacies)¹⁴

Dental and vision benefits

SmartChoice HSA

IN-NETWORK ²	OUT-OF-NETWORK ³
	\$6,000,000
	\$2,500 single / \$5,000 family All benefits including pharmacy are subject to the deductible except preventive care (combined in/out-of-network)
	\$4,000 single / \$10,000 family includes deductible (combined in/out-of-network)
30%	50%
30%	50%
\$70 ⁶	Not covered
\$35 ⁶	Not covered
\$35 ⁶	Not covered
Not covered	Not covered
\$70 copay plus 30%	\$70 copay plus 30%
\$50 copay plus 30%	\$50 copay plus 30%
30%	30%
30%	50% ⁸ \$250 copay ¹⁰
30%	50% ⁸
30%	50% ⁸ \$250 per admission copay ¹⁰
30%	50%
30%	Not covered
30%	50% (\$25 max. payable per visit) 20 visit maximum per calendar year
50%	Not covered (12-visit calendar year maximum / \$20 maximum payable per visit)
\$250 copay ¹⁰ plus 30% inpatient / 30% outpatient	\$250 copay ¹⁰ plus 50% inpatient ⁸ / 50% outpatient
\$250 copay plus 30% inpatient / 30% outpatient	\$250 copay plus 50% inpatient / not covered outpatient
50% (\$2,000 calendar year max.)	Not covered
30%	Not covered

Included with SmartChoice HSA Plus, additional premium required, refer to page 3. For coverage details, refer to pages 3–9.

²Of negotiated rate, the rate the Participating or Preferred Provider has agreed to accept for providing a covered service.

³Percentage is a portion of the covered expense based on (C & R) Customary & Reasonable. You are also responsible for any charges in excess of the covered expense.

⁴Certain services require prior certification from Health Net. Without prior certification, benefit reduced by 50%.

⁵X-ray and laboratory procedures are not subject to the calendar year deductible when provided in relation to an annual physical exam and billed on the same claim. The member is responsible for the copayment and any charges in excess of the \$200 maximum payable per calendar year.

⁶Medical calendar year deductible waived.

⁷Mammograms are covered at the following intervals: One for ages 35-39, one every 24 months for ages 40–49, and one every year for age 50 and older.

⁸Maximum Allowable charges are \$600 per day.

⁹The emergency room and urgent care copay are waived if admitted to the hospital for an emergency. The emergency room and urgent care copay are per visit, apply to the out-of-pocket maximum and continue to apply once the out-of-pocket maximum is met. The calendar year deductible applies to emergency room visits.

(footnotes continued on next page)

INDIVIDUAL TERM LIFE INSURANCE

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.

Individual Term Life Insurance plans 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.

(footnotes continued from previous page)

¹⁰The inpatient/outpatient copay applies to the OOP accumulation and continues to apply once the out-of-pocket maximum is met.

¹¹The following are considered severe mental illness: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia nervosa, serious emotional disturbances in children under age 18.

¹²Covered expenses incurred for non-severe mental illness and chemical dependency do not apply to the out-of-pocket maximum.

¹³Non-severe mental illness inpatient maximum payable per day is \$300, benefit maximum is 30 days; if covered by the plan, outpatient non-severe mental illness is \$30 maximum payable per visit, 20 visits maximum per year.

¹⁴Calendar year deductible applies to prescription drugs. The Recommended Drug List is a list of the prescription drugs that are covered by this plan. It is prepared by Health Net and given to member physicians and participating pharmacies. Some drugs require prior authorization from Health Net. Also, if your condition requires the use of a drug that is not in the Recommended Drug List, your physician may require the drug through the prior authorization process. Urgent prior authorization requests are handled within 72 hours. For a copy of the Recommended Drug List, call Member Services at the number listed on your ID card or visit our web site at www.healthnet.com. Prescription drug charges do apply to your maximum out-of-pocket limit.

IMPORTANT THINGS TO KNOW

MONTHLY PREMIUM RATES

Finding the rate that applies to you is easy:

1. Find the chart for your region on the rate chart inserted in this brochure.
2. Determine your family category.
3. Select your age group. If you are applying as a married couple, domestic partner relationship or a family, use the age category of the younger spouse/ domestic partner and make that person the primary applicant on the application.

Administrative fee

- Simple pay (automatic bank draft) option – no charge
- Credit card billing – no charge
- Monthly billing – \$5 monthly charge

MODIFIED ISSUE EXPLAINED (PPO PLANS ONLY)

Q: What is a Modified Issue?

A: Modified Issue helps certain applicants who might normally not be able to obtain coverage, attain it for a higher premium.

Q: How does Health Net calculate Modified Issue premiums?

A: Modified Issue premiums are calculated by multiplying the preferred premium shown in the rate guide by the rate adjustment factor (RAF) of 1.20 or 1.50.

DENTAL AND VISION WITH PPO PLUS PLANS

Subscriber	\$25
Subscriber & spouse	\$50
Subscriber & child	\$50
Subscriber & children	\$75
Family	\$100

Health Net Dental and Vision plans underwritten by Health Net Life Insurance Company.

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.

COVERED PROCEDURES	MAX. ALLOW. FEE
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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

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 ¹	\$66
D2520	Inlay metallic, two surfaces ¹	\$72
D2530	Inlay metallic, three or more surfaces ¹	\$83
D2542	Onlay – metallic, two surfaces ¹	\$110
D2543	Onlay – metallic – three surfaces ¹	\$110
D2544	Onlay – metallic – four or more surfaces ¹	\$110

COVERED PROCEDURES	MAX. ALLOW. FEE
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D2710	Crown resin, laboratory ¹	\$127
D2720	Crown resin with high noble metal ¹	\$154
D2721	Crown resin with predominantly base metal ¹	\$154
D2722	Crown resin with noble metal ¹	\$154
D2740	Crown porcelain/ceramic substrate ¹	\$248
D2750	Crown porcelain fused to high noble metal ¹	\$248
D2751	Crown porcelain fused to predominantly base metal ¹	\$248
D2752	Crown porcelain fused to noble metal ¹	\$248
D2790	Crown full cast high noble metal ¹	\$154
D2791	Crown full cast predominantly base metal ¹	\$154
D2792	Crown full cast noble metal ¹	\$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 ¹	\$22
D2952	Cast post and core in addition to crown ¹	\$28
D2953	Each additional cast post – same tooth ¹	\$28
D2954	Prefabricated post and core in addition to crown ¹	\$28
D2957	Each additional prefabricated post – same tooth ¹	\$28
Endodontic procedures		
D3110	Pulp cap – direct, excluding final restoration	\$10
D3120	Pulp cap – indirect, excluding final restoration	\$17
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 ²	\$121
D3320	Root canal bicuspid, excluding final restoration ²	\$143
D3330	Root canal molar, excluding final restoration ²	\$193
D3346	Retreatment of previous root canal therapy – anterior ²	\$121
D3347	Retreatment of previous root canal therapy – bicuspid ²	\$143
D3348	Retreatment of previous root canal therapy – molar ²	\$193
D3410	Apicoectomy/periradicular surgery, anterior ²	\$66
D3421	Apicoectomy/periradicular surgery, bicuspid (first root) ²	\$88
D3425	Apicoectomy/periradicular surgery, molar (first root) ²	\$88
D3426	Apicoectomy/periradicular surgery (each additional root) ²	\$28
D3430	Retrograde filling, per root ²	\$17
Periodontic procedures		
D4210	Gingivectomy or gingivoplasty, per quadrant ²	\$99
D4211	Gingivectomy or gingivoplasty, per tooth, if not done in conjunction with a crown-lengthening procedure ²	\$28

¹Subject to 6-month waiting period

²Subject to 3-month waiting period

COVERED PROCEDURES		MAX. ALLOW. FEE
D4260	Osseous surgery (<i>including flap entry and closure</i>) – four or more contiguous teeth or bounded teeth spaces, per quadrant ²	\$176
D4261	Osseous surgery (<i>including flap entry and closure</i>) – one to three teeth per quadrant ²	\$176
D4341	Periodontal scaling and root planing – four or more contiguous teeth or bounded teeth spaces per quadrant ²	\$23
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant ²	\$23
Prosthodontics (removable)		
D5110	Complete upper denture ¹	\$264
D5120	Complete lower denture ¹	\$264
D5130	Immediate upper denture ¹	\$264
D5140	Immediate lower denture ¹	\$264
D5211	Upper partial – resin base ¹	\$132
D5212	Lower partial – resin base ¹	\$132
D5213	Upper partial – cast metal base with resin saddles ¹	\$264
D5214	Lower partial – case metal base with resin saddles ¹	\$264
D5281	Removable unilateral partial denture – one piece cast metal ¹	\$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 (<i>upper</i>) ¹	\$50
D5821	Interim partial denture, anterior stayplate (<i>lower</i>) ¹	\$50
Prosthodontics (fixed)		
D6210	Pontic – cast high noble metal ¹	\$77
D6211	Pontic – cast predominantly base metal ¹	\$77
D6212	Pontic – cast noble metal ¹	\$77
D6240	Pontic, porcelain fused to high noble metal ¹	\$138

COVERED PROCEDURES		MAX. ALLOW. FEE
D6241	Pontic, porcelain fused to predominantly base metal ¹	\$138
D6242	Pontic, porcelain fused to noble metal ¹	\$138
D6250	Pontic, resin with high noble metal ¹	\$94
D6251	Pontic, resin with predominantly base metal ¹	\$94
D6252	Pontic, resin with noble metal ¹	\$94
D6930	Recement fixed partial (<i>bridge</i>)	\$17
Oral surgery		
D7111	Coronal remnants – deciduous tooth ²	\$22
D7140	Extraction, erupted tooth or exposed root (<i>elevation and/or forceps removal</i>) ²	\$22
D7140	Extraction, erupted tooth or exposed root (<i>elevation and/or forceps removal</i>), each additional tooth when performed on the same visit as the first extraction ²	\$17
D7210	Surgical removal of erupted tooth ²	\$33
D7220	Removal of impacted tooth, soft tissue ²	\$44
D7230	Removal of impacted tooth, partially bony ²	\$55
D7240	Removal of impacted tooth, completely bony ²	\$66
D7241	Removal of impacted tooth, completely bony, complications ²	\$66
D7310	Alveoloplasty in conjunction with extractions, per quadrant ²	\$22
D7320	Alveoloplasty not in conjunction with extractions, per quadrant ²	\$44
D7471	Removal of lateral exostosis (<i>maxilla or mandible</i>), per site ²	\$61
D7472	Removal of torus palatinus	\$61
D7473	Removal of torus mandibularis	\$61
D7485	Surgical reduction of osseous tuberosity	\$61
D7970	Excision of hyperplastic tissue, per arch ²	\$55
Adjunctive general services		
D9220	General anesthesia, first 30 minutes	\$28
D9310	Specialist consultation (<i>other than treatment provider</i>)	\$20
D9430	Office visit, regular hours, no other service	\$20
D9440	Office visit, after hours, no other service	\$20

¹Subject to 6-month waiting period

²Subject 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.

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.healthnet.com and click on Search our Doctor Network. 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.

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).

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 (<i>per member</i>)	\$10	\$10
Materials copayment (<i>per member</i>)	\$25	\$25
Vision examination One complete visual examination every 12 consecutive months	100% of negotiated rate (<i>includes dilation</i>)	Plan pays up to \$45 (<i>dilation not included</i>)
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 <small>(Medically necessary contact lenses must be prior authorized)</small>	Plan pays up to \$250 (<i>\$125 per lens</i>)	Plan pays up to \$250 (<i>\$125 per lens</i>)
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

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.

IMPORTANT THINGS TO KNOW ABOUT ALL YOUR MEDICAL COVERAGE OPTIONS

Who is eligible?

To be eligible for Health Net Life Individual & Family 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 or domestic partner, 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.

A Domestic Partner is defined as two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. A registered domestic partnership is established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State and at the time of the filing all of the following are true:

- Both person have a common residence
- Neither person is married to someone else or is a member of another domestic partnership that has not been terminated, dissolved, or adjudged a nullity
- The two persons are not related by blood in a way that would prevent them from being married in California
- Both persons are at least 18 years old
- Both persons are members of the same sex, or opposite sex couples if one or both persons is over age 62 and is eligible for old age insurance benefits under the Social Security Act
- Both persons are capable of consenting to the domestic partnership

Am I eligible for guaranteed issue coverage, without the need for medical underwriting?

The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people covered under existing group health plans to maintain coverage regardless of pre-existing conditions when they change jobs or are unemployed for brief periods of time. California law provides similar and additional protections. Applicants who meet the following requirements are eligible to enroll in a guaranteed issue individual health plan from any health plan that offers individual coverage, including Health Net's Guaranteed PPO plans, without medical underwriting. A health plan cannot reject your application for guaranteed issue individual health coverage if you meet the following requirements, agree to pay the required premiums and live or work in the plan's service area.

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 (COBRA and Cal-COBRA coverage are considered group coverage).
- 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 or Cal-COBRA coverage was available, it must have been elected and such coverage must have been exhausted.

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. If you believe your rights under HIPAA have been violated, please contact the Department of Managed Health Care at 1-888-HMO-2219 or visit the Department's website at www.hmohelp.ca.gov.

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 or credit card billing, you will be exempt from any administrative billing fees. If you do not choose Health Net's Simple Pay option or credit card billing, a \$5 per month administrative fee will be charged each month to cover the expense of issuing a monthly bill.

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 knowingly submit to Health Net materially incorrect or incomplete information which is reasonably relied upon by Health Net in issuing or renewing individual and family plan coverage

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 premiums.

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 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 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 Insurance 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 Insurance if they meet eligibility criteria set out in the 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.

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 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 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 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 Life. 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 Life, their agents or employees, or of physician groups, any physician or hospital, or any other person or organization with which Health Net Life has arranged or will arrange to provide the covered services and supplies of your plan.

What about continuity of care upon 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 and make every effort to ensure continuity of care. At least 60-days prior to termination of a contract with a Physician Group or acute care hospital, Health Net will provide a written notice to affected Members. In addition, the Member may request continued care from a provider whose contract is terminated if at the time of termination the Member was receiving care from such a provider for:

- An acute condition
- A serious chronic condition
- A pregnancy (including the duration of the pregnancy and immediate postpartum care)
- A newborn (up to age 36 months)
- A terminal illness
- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable Copayments and any other exclusions and limitations of this Plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider's contract termination.

If you would like more information on how to request continued care, or request a copy of our continuity of care policy, please contact the Member Services department at the number on your Health Net ID card.

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 (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition of the *Diagnostic and Statistical Manual for Mental Disorders*), autism, anorexia nervosa, and bulimia nervosa.

Serious emotional disturbances of a child is when a child under the age of 18 has one or more mental disorders identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary 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 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 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

No payment will be made under the Health Net Life 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 Health Net Life Policy for Individual & Family PPO for the PPO coverages.

- Care for conditions of pregnancy, including hospital and professional services. This includes prenatal and postnatal care and delivery.
- 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.
- Reimbursement for services for which the Member is not legally obligated to pay the provider or for which the provider pays no charge.
- Any service or supplies not specifically listed as covered expenses, unless coverage is required by state or federal law.
- Services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include, but are not limited to collection, storage or purchase of sperm or ova.
- 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 appearance¹
- Dental care.²
- Treatment and services for temporomandibular joint (TMJ) disorders are covered when determined to be medically necessary, excluding crowns, inlays, bridgework and appliances.
- This Plan only covers services or supplies provided by a legally operated Hospital, Medicare-approved Skilled Nursing Facility, or other properly licensed facility specified as in the Policy. Any institution that is primarily a place for the aged, a nursing home or a similar institution, regardless of how it is designated, is not an eligible institution. Services or supplies that are provided by such institutions are not covered.

- 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.
- Contact or corrective lenses (except an implanted lens that replaces the organic eye lens), vision therapy and eyeglasses²
- Services to reverse voluntary surgically induced infertility
- Sex change procedures or treatment
- Any services or supplies not related to the diagnosis or treatment of a covered condition, illness or injury. However, the Plan does cover Medically Necessary services and supplies for medical conditions directly related to non-covered services when complications exceed routine Follow-Up Care (such as life-threatening complications of cosmetic surgery).
- 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.
- Any outpatient drugs, medications or other substances dispensed or administered in any setting, except as specifically stated in the Health Net Life Policy.
- 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
- Physician self-treatment
- Physicians treating immediate family members
- Treatment for alcoholism or drug addiction, except detoxification
- 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

¹When 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.

²The SmartChoice HSA Plus plan includes certain dental and vision services as described in this guide. For dental and vision benefit information for this plan, refer to the benefits sections in this guide, or the Policy.

- 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 semi-private 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
- Immunizations or inoculations for foreign travel or occupational purposes
- All other immunizations
- Physician's visit to member's home
- Acupuncture

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. Ambulance
 - Air Ambulance
 - Non-emergent transport

3. Ambulatory services
 - Durable Medical Equipment
 - Home Health Care Agency Services including nursing, physical therapy, occupational therapy, speech therapy, home I.V. therapy, Hospice Care, tocolytic services (intravenous drugs used to decrease or stop uterine contractions in premature labor) and home uterine monitoring
 - Prosthesis for major limbs
4. Experimental services, new technology and evolutionary changes in proven technology
5. Orthognatic procedures (surgery performed to correct or straighten jaw and/or other facial bone misalignments to improve function.)
6. Outpatient Diagnostic Imaging:
 - CT Scans
 - MRA (Magnetic Resonance Angiography)
 - MRI (Magnetic Resonance Imaging)
 - MUGA Cardiac Scan (Multiple Gated Acquisition)
 - PET (Positron Emission Tomography)
 - SPECT (Single Photon Emission Computed Tomography)
7. Surgical procedures including:
 - Abdominal, ventral, umbilical, incisional hernia repair
 - Blepharoplasty
 - Breast reductions and augmentations
 - Mastectomy for gynecomastia
 - Rhinoplasty
 - Sclerotherapy
 - Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
8. Temporomandibular Joint (TMJ) Disorder treatment
9. Transplant-related services including pre-evaluation and pre-treatment services, and the transplant procedure

EXCEPTIONS

HNL does not require Certification for dialysis services or maternity care. However, please notify HNL upon initiation of dialysis services or at the time of the first prenatal visit.

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.

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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.healthnet.com



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