# SAVE FOR A HEALTHY FUTURE

Effective October 1, 2005

**SIMPLECHOICE HSA**
**Health coverage made easy.**

Health Net®
A Better Decision

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# WHAT IS AN HSA?

HSA stands for Health Savings Account. It is an individually owned savings account you can open at a bank or financial institution and use for current and future health care expenses. You decide when and how much to contribute, and make withdrawals each time you incur a qualified medical expense[1].

The benefits of an HSA are:

- Individual contributions are pre-tax.
- HSA funds can be invested and investment earnings are non-taxable.
- Withdrawals are non-taxable when used for qualified medical or pharmacy expenses.
- There is no time limit for using the funds; they roll over from year to year.
- The HSA belongs to you; you keep it even if you change jobs or retire.

## HEALTH NET SIMPLECHOICE HSA

Health Net SimpleChoice HSA gives you all the tax-friendly advantages of a health savings account combined with the advantages of a PPO medical plan. You can save and spend your health care dollars tax-free and see any licensed health care professional without a referral. Other SimpleChoice HSA benefits include:

- Comprehensive plan coverage.
- Wide range of specialists.
- Network of more than 50,000 physicians and 300 hospitals in California.
- Low $40 copayments for in-network preventative-care visits without having to meet a deductible.
- No coinsurance on in-network benefits which means once you pay your deductible you are covered in full.
- Care when traveling out-of-state.

Maximum SimpleChoice HSA contributions for 2005 are $2,650 for an individual and $5,250 for a family. Medical and pharmacy deductibles are combined, which means you pay for the entire cost of medical services and prescriptions until you have paid the deductible amount.

[1]Qualified medical expenses include but are not limited to the following: medical deductibles, copayments, eye exams, eyeglasses, contact lenses and corrective LASIK eye surgery; hearing aids; orthodontia and prescription drugs. A complete list of qualified expenses can be found in IRS Publication 502 – Medical and Dental Expenses at www.irs.gov. Simply enter “502” in the Search Forms and Publications field.

**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 | SimpleChoice HSA | |
|---|---|---|
| | In-network[1] | Out-of-network[2] |
| **Lifetime Maximum** | $6 million | |
| **Annual deductible**<br>For contracts of 2 or more members, there are no benefits until the family deductible is met | $4,000 single/$8,000 family<br>(Outpatient Prescription Drugs subject to the deductible) | |
| **Annual out-of-pocket maximum**<br>Preferred providers | $4,000 single/$8,000 family<br>(includes deductible) | |
| **Non-preferred providers** | $5,000 single/$10,000 family<br>(includes deductible) | |
| **Visit to physician** | Covered in full after deductible is met | 50% |
| **X-ray and laboratory procedures**[3] | Covered in full after deductible is met | 50% |
| **Annual Routine Physical Exams** | Covered in full after deductible is met | Not Covered |
| **Adult preventive care (age 19 and older)**<br>Yearly OB/GYN exam[4] (breast and pelvic exams, Pap smears and mammography) / Yearly Prostate cancer screening and exam | $40 (Deductible waived) | Not Covered |
| **Child preventive care (newborns to age 18)**<br>Checkups, immunizations, vision and hearing exams | $40 (Deductible waived) | Not Covered |
| **Maternity and pregnancy**<br>Prenatal and postnatal office visits | Not Covered | |
| Maternity care in hospital | Not Covered | |
| **Emergency and urgent care**<br>Emergency room (professional and facility charges) | Covered in full after deductible is met | |
| Urgent care center (facility charges) | Covered in full after deductible is met | |
| Ambulance[3] | Covered in full after deductible is met | |
| **Outpatient Services**[3]<br>Outpatient Surgery (hospital or outpatient surgery center charges only) | Covered in full after deductible is met | 50%[6] |
| Outpatient facility services | Covered in full after deductible is met | 50%[6] |
| **Hospitalization Services**[3]<br>Inpatient, semiprivate hospital room or intensive care unit with ancillary services (unlimited, except for non-severe mental health and substance abuse treatment) | Covered in full after deductible is met | 50%[6] |
| Surgeon or assistant surgeon and anesthetic service (inpatient hospital setting) | Covered in full after deductible is met | 50% |
| **Reproductive health**<br>Sterilization | Covered in full after deductible is met | Not Covered |
| **Other services**<br>Rehabilitative therapy includes physical, speech, occupational, respiratory and cardiac therapy[3] | Covered in full after deductible is met | Not Covered |
| **Chiropractic care/acupuncture**<br>(12-visit calendar year maximum/$20 maximum payable per visit) | Covered in full after deductible is met | Not Covered |
| **Mental health for non-severe conditions**[3,5] | Covered in full after deductible is met | 50% |
| **Durable medical equipment (including foot orthotics)**[3] | Covered in full after deductible is met | Not Covered |
| **Outpatient prescription drugs**[7]<br>Filled at participating pharmacy (up to a 30-day supply); not covered at non-participating pharmacies | Covered in full after deductible is met | Not Covered |
| **Optional Dental and Vision Coverage**[9,10] | Included with purchase of SimpleChoice HSA Plus, additional premium required, refer to page 6. For coverage details, refer to page 15. | |

[1] **Member pays the negotiated rate, which is the rate the Participating or Preferred Provider has agreed to accept for providing a covered service.**

[2] Percentage 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.

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

[4] Mammograms 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.

[5] Non-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.

[6] Maximum Allowable charges are $600 per day.

[7] Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's usual and customary charge for covered 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 the Customer Contact Center at the number listed on your ID card or visit our web site at www.healthnet.com.

[8] A Health Net "Plus" plan is Health Net medical coverage plan with Health Net Dental & Vision coverage included. The "Plus" indicates the addition of the optional coverage.

[9] Dental benefits underwritten by Health Net Life Insurance Company and administered by SafeGuard Health Plans, Inc.

[10] Vision benefits underwritten by Health Net Life Insurance Company and administered by EyeMed Vision Plan, LLC.

# SIMPLECHOICE HSA RATES

## MONTHLY PREMIUM RATES

Finding the rate that applies to you is easy:

1. Find your region on the rate chart below.
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.
4. Applications must include the first month's premium.

### Administrative fee

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

## MEDICAL REGIONS

The premium is calculated based on the subscriber's home address. Please refer to the regions below to determine the rating region. The areas are determined by ZIP codes/county. Please refer to www.healthnet.com and search our doctor network for the PPO preferred providers within the network. If there is a question regarding area availability, please contact your Health Net Regional Sales Manager or call **1-800-909-3447**.

## HEALTH NET PPO REGIONS

Region 1 Los Angeles County

Region 2 Merced, Napa, Sacramento, San Joaquin, Sonoma, Stanislaus, Tulare, Western El Dorado, and Western Placer Counties

Region 3 Riverside, San Bernardino, Santa Barbara, and Ventura Counties

Region 4 Alameda, Contra Costa, Marin, San Fransico, San Mateo, Santa Clara, Santa Cruz, and Solano Counties

Region 5 Orange and San Diego Counties

Region 6 Fresno, Kern, and Kings Counties

Region 7 Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Eastern El Dorado, Eastern Placer, Glenn, Humboldt, Inyo, Lake, Lassen, Madera, Mariposa, Mendocino, Modoc, Mono, Monterey, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba Counties

Region 8 Imperial and San Luis Obispo Counties

## MODIFIED ISSUE EXPLAINED (PPO PLANS ONLY)

### What is a Modified issue?

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

### How does Health Net calculate Modified issue premiums?

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.

| | AGE | SUBSCRIBER | SUBSCRIBER & SPOUSE/ DOMESTIC PARTNER | SUBSCRIBER & CHILD | SUBSCRIBER & CHILDREN | FAMILY |
|---|---|---|---|---|---|---|
| **REGION 1** | **1 - 18** | 35 | N/A | N/A | N/A | N/A |
| | **19 - 24** | 35 | 70 | 112 | 158 | 193 |
| | **25 - 29** | 35 | 70 | 112 | 158 | 193 |
| | **30 - 34** | 50 | 100 | 117 | 152 | 202 |
| | **35 - 39** | 66 | 132 | 122 | 157 | 223 |
| | **40 - 44** | 92 | 184 | 130 | 165 | 257 |
| | **45 - 49** | 130 | 260 | 165 | 200 | 330 |
| | **50 - 54** | 170 | 340 | 205 | 240 | 410 |
| | **55 - 59** | 215 | 430 | 250 | 285 | 500 |
| | **60 - 64** | 268 | 536 | 303 | 338 | 606 |
| **REGION 2** | **1 - 18** | 36 | N/A | N/A | N/A | N/A |
| | **19 - 24** | 35 | 70 | 121 | 169 | 204 |
| | **25 - 29** | 35 | 70 | 121 | 169 | 204 |
| | **30 - 34** | 51 | 102 | 124 | 160 | 211 |
| | **35 - 39** | 67 | 134 | 128 | 164 | 231 |
| | **40 - 44** | 94 | 188 | 133 | 169 | 263 |
| | **45 - 49** | 126 | 252 | 162 | 198 | 324 |
| | **50 - 54** | 165 | 330 | 201 | 237 | 402 |
| | **55 - 59** | 212 | 424 | 248 | 284 | 496 |
| | **60 - 64** | 274 | 548 | 310 | 346 | 620 |

| | AGE | SUBSCRIBER | SUBSCRIBER & SPOUSE/ DOMESTIC PARTNER | SUBSCRIBER & CHILD | SUBSCRIBER & CHILDREN | FAMILY |
|---|---|---|---|---|---|---|
| **REGION 3** | **1 - 18** | 33 | N/A | N/A | N/A | N/A |
| | **19 - 24** | 35 | 70 | 108 | 151 | 186 |
| | **25 - 29** | 35 | 70 | 108 | 151 | 186 |
| | **30 - 34** | 49 | 98 | 112 | 145 | 194 |
| | **35 - 39** | 64 | 128 | 117 | 150 | 214 |
| | **40 - 44** | 90 | 180 | 126 | 159 | 249 |
| | **45 - 49** | 122 | 244 | 155 | 188 | 310 |
| | **50 - 54** | 159 | 318 | 192 | 225 | 384 |
| | **55 - 59** | 204 | 408 | 237 | 270 | 474 |
| | **60 - 64** | 263 | 526 | 296 | 329 | 592 |
| **REGION 4** | **1 - 18** | 36 | N/A | N/A | N/A | N/A |
| | **19 - 24** | 36 | 72 | 122 | 171 | 207 |
| | **25 - 29** | 36 | 72 | 122 | 171 | 207 |
| | **30 - 34** | 51 | 102 | 125 | 161 | 212 |
| | **35 - 39** | 68 | 136 | 129 | 165 | 233 |
| | **40 - 44** | 95 | 190 | 134 | 170 | 265 |
| | **45 - 49** | 127 | 254 | 163 | 199 | 326 |
| | **50 - 54** | 169 | 338 | 205 | 241 | 410 |
| | **55 - 59** | 214 | 428 | 250 | 286 | 500 |
| | **60 - 64** | 279 | 558 | 315 | 351 | 630 |
| **REGION 5** | **1 - 18** | 35 | N/A | N/A | N/A | N/A |
| | **19 - 24** | 35 | 70 | 112 | 158 | 193 |
| | **25 - 29** | 35 | 70 | 112 | 158 | 193 |
| | **30 - 34** | 50 | 100 | 117 | 152 | 202 |
| | **35 - 39** | 66 | 132 | 122 | 157 | 223 |
| | **40 - 44** | 92 | 184 | 130 | 165 | 257 |
| | **45 - 49** | 130 | 260 | 165 | 200 | 330 |
| | **50 - 54** | 170 | 340 | 205 | 240 | 410 |
| | **55 - 59** | 215 | 430 | 250 | 285 | 500 |
| | **60 - 64** | 268 | 536 | 303 | 338 | 606 |
| **REGION 6** | **1 - 18** | 38 | N/A | N/A | N/A | N/A |
| | **19 - 24** | 37 | 74 | 128 | 179 | 216 |
| | **25 - 29** | 37 | 74 | 128 | 179 | 216 |
| | **30 - 34** | 53 | 106 | 131 | 169 | 222 |
| | **35 - 39** | 72 | 144 | 136 | 174 | 246 |
| | **40 - 44** | 99 | 198 | 140 | 178 | 277 |
| | **45 - 49** | 133 | 266 | 171 | 209 | 342 |
| | **50 - 54** | 174 | 348 | 212 | 250 | 424 |
| | **55 - 59** | 223 | 446 | 261 | 299 | 522 |
| | **60 - 64** | 291 | 582 | 329 | 367 | 658 |
| **REGION 7** | **1 - 18** | 50 | N/A | N/A | N/A | N/A |
| | **19 - 24** | 50 | 100 | 160 | 225 | 275 |
| | **25 - 29** | 50 | 100 | 160 | 225 | 275 |
| | **30 - 34** | 71 | 142 | 166 | 216 | 287 |
| | **35 - 39** | 94 | 188 | 174 | 224 | 318 |
| | **40 - 44** | 131 | 262 | 185 | 235 | 366 |
| | **45 - 49** | 185 | 370 | 235 | 285 | 470 |
| | **50 - 54** | 242 | 484 | 292 | 342 | 584 |
| | **55 - 59** | 306 | 612 | 356 | 406 | 712 |
| | **60 - 64** | 382 | 764 | 432 | 482 | 864 |
| **REGION 8** | **1 - 18** | 50 | N/A | N/A | N/A | N/A |
| | **19 - 24** | 50 | 100 | 160 | 225 | 275 |
| | **25 - 29** | 50 | 100 | 160 | 225 | 275 |
| | **30 - 34** | 71 | 142 | 166 | 216 | 287 |
| | **35 - 39** | 94 | 188 | 174 | 224 | 318 |
| | **40 - 44** | 131 | 262 | 185 | 235 | 366 |
| | **45 - 49** | 185 | 370 | 235 | 285 | 470 |
| | **50 - 54** | 242 | 484 | 292 | 342 | 584 |
| | **55 - 59** | 306 | 612 | 356 | 406 | 712 |
| | **60 - 64** | 382 | 764 | 432 | 482 | 864 |

# SUPPLEMENTAL DENTAL AND VISION PPO[1] PLUS COVERAGE

Augment your HSA plan with Health Net's dental and vision benefits administered through SafeGuard Health Plans, Inc. and Eyemed Vision Care, LLC.

**Dental benefits include:**

- Choose your own dental providers
- Available fee schedule shows the maximum allowable amount so you know costs up front
- $50 deductible waived for diagnostic and preventive services

**Vision benefits include:**

- 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 a vision PPO provider

| MONTHLY PREMIUMS AS LOW AS $25 | |
|---|---|
| Subscriber | **$25** |
| Subscriber & spouse | **$50** |
| Subscriber & child | **$50** |
| Subscriber & children | **$75** |
| Family | **$100** |

[1]A Health Net "PPO Plus" plan is a Health Net PPO plan with Health Net Dental and Vision coverage included. The "Plus" indicates the addition of the optional coverage. Health Net Dental and Vision plans are underwritten by Health Net Life Insurance Company.

# SUPPLEMENTAL LIFE INSURANCE COVERAGE

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.

Health Net Life Insurance Company offers affordable Individual Term Life Insurance in the following amounts: $15,000, $30,000 and $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 | $68.10 |
| 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 to purchase Individual Term Life Insurance.
- Only available for primary subscriber.
- Not available with modified issue PPO plans, HIPAA guaranteed issue and Quick Net plans.

# HOW DO I APPLY?

To enroll in the Health Net SimpleChoice HSA plan:

- Call 1-800-909-3447
- Visit our website at www.healthnet.com and select *Individual & Family Plans*
- Contact your Health Net authorized agent

If you are signing a paper application:

1. Sign and date the application
2. Include a check payable to Health Net for the applicable premium payment
3. Mail the completed application and check (within 30 days of signature date) to your authorized agent or to:

   Health Net
   Individual and Family Coverage
   P.O. Box 1150
   Rancho Cordova, CA 95741-1150

**ONCE ENROLLED IN THE SIMPLECHOICE HSA PLAN:**

1. Open an HSA at a bank or other qualified financial institution.
2. Decide how much to contribute based on your yearly health care needs. You can use your HSA to pay for your qualified medical expenses while the plan deductible is in effect.
3. Withdraw funds for your portion of any qualified medical expenses.
4. 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.

# IMPORTANT THINGS TO KNOW ABOUT YOUR MEDICAL COVERAGE OPTIONS

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

**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. 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;
- have had your most recent coverage under a group health plan (COBRA and Cal-COBRA coverage are considered group coverage);
- not be eligible for coverage under any group health plan, Medicare or Medicaid, and must not have other health insurance coverage;
- not have had your most recent coverage terminated due to fraud or nonpayment of premiums; and
- 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 on 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 Customer Contact Center 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**

**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.**

### 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 Customer Contact Center at 1-800-839-2172.

### What are Health Net's premium ratios?

Health Net Life's 2003 ratio of premium costs to health services paid for the Individual & Family PPO insurance plans was 68 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, not to exceed twelve months from the contract termination date.
- A pregnancy (including the duration of the pregnancy and immediate postpartum care)
- A newborn up to age 36 months, not to exceed 12 months from the contract expiration date.
- A terminal illness (for the duration of the 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. The member must request continued care within 30 days upon receiving notification of the provider's date of 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 Customer Contact Center 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 (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 Customer Contact Center at 1-800-839-2172 to ensure that you can obtain the health care services that you need.**

**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.

## 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.

## CERTIFICATION 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.

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.

## EXCLUSIONS AND LIMITATIONS

No payment will be made under 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 Life PPO Policy.

- Services and supplies that 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 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 appearance[1]
- 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 eyeglasses[2]
- 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

[1] 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.

[2] The SimpleChoice HSA Plus plan includes 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 Policy.

- 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
- 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
- Care for conditions of pregnancy, including hospital and professional services. This includes prenatal and postnatal care and delivery
- Physician's visit to a members home

# DENTAL AND VISION BENEFITS AND COVERAGES

## DENTAL

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 Customer Service at 1-800-880-8113. Representatives will be happy to assist you.

## VISION

Vision coverage for PPO Plus Plans is underwritten by Health Net Life Insurance Company and administered by EyeMed Vision Care, Inc. 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.

### 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."

### 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.

## 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.**

| COVERED BENEFITS | | MAXIMUM ALLOWABLE 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 |

| COVERED BENEFITS | | MAXIMUM ALLOWABLE FEE |
|---|---|---|
| | **Restorative procedures (continued)** | |
| 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 |
| D2710 | Crown – resin-based composite (indirect)[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 |
| | **Diagnostic procedures** | |
| 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 |
| D2794 | Crown – titanium | $154 |
| D2910 | Recement inlay, onlay or partial coverage restoration | $11 |
| D2915 | Recement cast or prefabricated post and core | $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 |

[1]Subject to six-month waiting period
[2]Subject to three-month waiting period

| COVERED BENEFITS | | MAXIMUM ALLOWABLE FEE |
|---|---|---|
| | **Endodontic procedures (continued)** | |
| 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 – one to three contiguous teeth or bounded teeth spaces – per quadrant | $44 |
| D4260 | Osseous surgery *(including flap entry and closure)* – four or more contiguous teeth or bounded teeth spaces, per quadrant[2] | $176 |
| D4261 | Osseous surgery *(including flap entry and closure)* – one to three contiguous teeth or bounded teeth spaces – per quadrant[2] | $44 |
| D4341 | Periodontal scaling and root planing – four or more teeth – per quadrant[2] | $44 |
| D4342 | Periodontal scaling and root planning – 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[v] | $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 |

| COVERED BENEFITS | | MAXIMUM ALLOWABLE FEE |
|---|---|---|
| | **Prosthodontics – removable (continued)** | |
| 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)*[1] | $50 |
| D5821 | Interim partial denture, anterior stayplate *(lower)*[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 |
| D6214 | Pontic – titanium | $77 |
| D6240 | Pontic, porcelain fused to high noble metal[1] | $138 |
| 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 *(bridge)* | $17 |
| | **Oral surgery** | |
| D7111 | Extraction, coronal remnants – deciduous tooth[2] | $22 |
| D7140 | Extraction, erupted tooth or exposed root *(elevation and/or forceps removal)*[2] | $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[2] | $17 |
| D7210 | Surgical removal of erupted tooth[2] | $33 |
| D7220 | Removal of impacted tooth, soft tissue[2] | $44 |

[1]Subject to six-month waiting period
[2]Subject to three-month waiting period

Summary of dental benefits (continued)

| COVERED BENEFITS | | MAXIMUM ALLOWABLE FEE |
|---|---|---|
| **Oral surgery (continued)** | | |
| 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 |
| D7311 | Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant | $11 |
| D7320 | Alveoloplasty not in conjunction with extractions, per quadrant[2] | $44 |
| D7321 | Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant[2] | $22 |
| D7471 | Removal of lateral exostosis *(maxilla or mandible)*, per site[2] | $61 |

| COVERED BENEFITS | | MAXIMUM ALLOWABLE FEE |
|---|---|---|
| | **Oral surgery (continued)** | |
| 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[2] | $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 |

[1]Subject to six-month waiting period
[2]Subject to three-month waiting period

## 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 BENEFITS | 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**<br>One complete visual examination every 12 consecutive months | 100% of negotiated rate *(includes dilation)* | Plan pays up to $45 *(dilation not included)* |
| **Frames**<br>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**<br>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:<br>Single vision – up to $43,<br>Bifocal – up to $58,<br>Trifocal – up to $70,<br>Lenticular:<br>Single vision – $125<br>Multifocal – $125 |
| **Medically necessary contact lenses**<br>One pair or single lenses every 24 months in lieu of all other vision materials<br>(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**<br>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 |

# EXCLUSIONS AND LIMITATIONS

## DENTAL

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.

## DENTAL 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 EXCLUSIONS

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.

**For more information, please contact:**

Health Net
Post Office Box 1150
Rancho Cordova, California 95741-1150

Individual & Family Plans:
**1-800-909-3447**

1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

Telecommunications Device
for the Hearing and Speech Impaired:
**1-800-995-0852**

**www.healthnet.com**

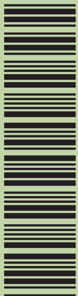
**Other options:**

Coverage for family members over 65 years of age:
**1-800-944-7287**

Coverage for children in a low-income household:
**1-800-765-8378**

Coverage for businesses with fewer than 50 employees:
**1-800-447-8812**

Coverage for businesses with 50+ employees:
**1-800-448-4411, option 4**



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