Summary *of* Benefits

Small Business Group
Bronze PPO • Insurance Plan BG9

Health Net®
LIFE INSURANCE COMPANY

DELIVERING CHOICES

When you need health care, it's nice to have options. That's why Health Net Life* offers a Preferred Provider Organization (PPO) insurance plan (called "Health Net PPO") — an insurance plan that offers you flexibility and choice. This SB answers basic questions about Health Net PPO. Please contact the Customer Contact Center at the telephone number listed on the back cover and talk to one of our friendly, knowledgeable representatives if you have additional questions.

The coverage described in this SB/DF shall be consistent with the Essential Health Benefits coverage requirements in accordance with the Affordable Care Act (ACA). The Essential Health Benefits are not subject to any annual dollar limits.

The benefits described under this SB/DF do not discriminate on the basis of race, ethnicity, color, nationality, ancestry, gender, gender identity, gender expression, age, disability, sexual orientation, genetic information, marital status, domestic partner status or religion, and are not subject to any pre-existing condition or exclusion period.

If you have further questions, contact us:

By phone at 1-800-361-3366,

Or write to: Health Net Life Insurance Company
P.O. Box 10196
Van Nuys, CA 91410-0196

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

This *Summary of benefits* (SB) is only a summary of your health insurance plan. The plan's *Certificate of Insurance (Certificate)*, which you will receive after you enroll, contains the exact terms and conditions of your Health Net Life coverage. You have the right to view the *Certificate* prior to enrollment. To obtain a copy of *Certificate*, contact the Customer Contact Center at 1-888-926-5133. You should also consult the *Health Net PPO Group Insurance Policy (Policy)* (issued to your employer) to determine governing contractual provisions. It is important for you to carefully read this SB and the plan's *Certificate* thoroughly once received, especially those sections that apply to those with special health care needs. This SB includes a matrix of benefits in the section titled "Schedule of benefits and coverage." In case of conflict, the *Certificate* will control. State mandated benefits may apply depending upon your state of residence.

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How the insurance plan works

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

SELECTION OF PHYSICIANS

This insurance plan allows you to:

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

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

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

Your choice of doctors and hospitals may determine which services will be covered, as well as how much you will pay. In many instances, certification is required for full benefits (see "Schedule of benefits and coverage" section of this brochure). Preferred providers are listed on the HNL website at www.healthnet.com or you can contact the Customer Contact Center at the telephone number listed on the back cover to obtain a copy of the Preferred Provider Directory.

WHEN YOU USE AN OUT-OF-NETWORK PROVIDER, BENEFITS ARE SUBSTANTIALLY REDUCED AND YOU WILL INCUR A SIGNIFICANTLY HIGHER OUT-OF-POCKET EXPENSE. TO MAXIMIZE THE BENEFITS RECEIVED UNDER THIS HEALTH NET PPO INSURANCE PLAN, YOU MUST USE PREFERRED PROVIDERS.

HOW TO ENROLL

Complete the enrollment form found in the enrollment packet and return the form to your employer. If a form is not included, your employer may require you to use an electronic enrollment form or an interactive voice response enrollment system. Please contact your employer for more information

Some hospitals and other providers do not provide one or more of the following services that may be covered under the plan's *Certificate* and that you or your dependents might need:

- **Family planning;**
- **Contraceptive services; including emergency contraception;**
- **Sterilization, including tubal ligation at the time of labor;**
- **Infertility treatments; or**
- **Abortion.**

You should obtain more information before you enroll. Call your prospective doctor, participating or preferred provider or clinic, or call the Customer Contact Center at the telephone number listed on the back cover to ensure that you can obtain the health care services that you need.

Schedule of benefits and coverage

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

Principal benefits and coverage matrix

Benefit levels	PPO	OON (out-of network)
Features	**(Preferred providers)** Care provided by doctors and hospitals contracted with our PPO	**(All other providers)** Care provided by licensed doctors and hospitals not contracted with our PPO
	• Lower out-of-pocket costs • Great freedom of choice • Certification from Health Net Life required for certain services • Claim forms usually not required for reimbursement • Must meet annual deductible (and coinsurance, if applicable to this insurance plan) • Coverage for preventive care services available	• Higher out-of-pocket costs • Greatest freedom of choice • Certification from Health Net Life required for certain services • Claim forms required for reimbursement • Must meet annual deductible and coinsurance

+ *For the PPO level of benefits, the percentages that appear in this chart are based on contracted rates with providers. See the "Payment of premiums and charges" section, under "Contracted Rate" for additional details.*

For the out-of-network level of benefits, the percentages that appear in this chart are based on the Resource Based Relative Value Schedule (RBRVS). The covered person is responsible for charges in excess of RBRVS fees in addition to the coinsurance shown.

Deductibles	PPO	OON (out-of network)

You must pay this amount for covered services before HNL begins to pay. However, PPO services to which a copayment applies are not subject to the calendar year deductible.

Calendar year deductible *The medical and the prescription drug benefits are subject to the calendar year deductible (unless otherwise noted). Your payment of the medical and prescription drug covered expenses (combined for PPO and out-of-network) will be applied to the calendar year deductible.*

For each covered person	$5,000	$10,000
For a family	$10,000	$20,000

Insurance Plan maximums	PPO	OON (out-of network)

Yearly Out-of-pocket maximum (OOPM)

Once your payment of deductibles, copayments and coinsurance (combined for PPO and out-of-network) for the medical and prescription drug benefits equals the amount shown below in any one calendar year, no further copayment, coinsurance or additional deductibles for covered services, supplies or prescription drugs are required for the remainder of that year. Payments for services not covered by this insurance plan or for certain services as specified in the "Payment of premiums and charges" section of this SB, will not be applied to this yearly out-of-pocket maximum.

For each covered person	$6,250	$12,500
For each family	$12,500	$25,000

Type of services, benefit maximums & what you pay

Professional services	PPO	OON
Visit to physician	$60♦	50%
Specialist consultations	$70	50%
Prenatal office visits*	$0±	50%
Postnatal office visits	$60♦	50%
Normal delivery, cesarean section, newborn inpatient professional care✱	30%	50%
Treatment of complications of pregnancy✱	See note below**	See note below**
Physician visit to hospital or skilled nursing facility	30%	50%
Surgeon or assistant surgeon services▲, *,□	30%	50%

Administration of anesthetics	30%	50%
Rehabilitative therapy (including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)*	$60∞	Not covered
Habilitative therapy (including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)*	$60∞	Not covered
Organ and stem cell transplants (non-experimental and non-investigational)*	30%	Not covered
Chemotherapy	$60	50%
Radiation therapy	$60	50%
Vision and hearing examinations (for diagnosis or treatment, including refractive eye examinations)	$70	Not covered

♦ *Deductible applies after 1st 3 non-preventive visits.*

∞ *Deductible applies.*

± *Deductible waived.*

* *Prenatal, and newborn care office visits for preventive care are covered in full for preferred providers. If the primary purpose of the office visit is unrelated to a preventive service or if other non-preventive services are received during the same office visit, the above copayment or coinsurance will apply for the non-preventive services.*

** *Applicable deductible, copayment or coinsurance requirements apply to any services and supplies required for the treatment of an illness or condition, including but not limited to, complications of pregnancy. For example, if the complication requires an office visit, then the office visit copayment or coinsurance will apply.*

* *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $250 penalty will be charged.*

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

▫ *The coverage described above in relation to medically necessary rehabilitative services for post-mastectomy lymphedema syndrome complies with requirements under the Women's Health and Cancer Rights Act of 1998. In compliance with the Women's Health Cancer Rights Act of 1998, this Plan provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.*

Allergy treatment and other injections (except for infertility injections)	PPO	OON
Allergy testing	$70	50%
Allergy serum	$70	50%
Allergy injection services	$70	50%
Injections (except for infertility)		
Injectable drugs administered by a physician	$70	50%

Note:

Certain injectable drugs which are considered self-administered are covered on the specialty drug tier under the pharmacy benefit. Specialty drugs are not covered under the medical benefits even if they are administered in a physician's office. If you need to have the provider administer the specialty drug, you will need to obtain the specialty drug through the Specialty Pharmacy Vendor and bring it with you to the provider office. Alternatively, you can coordinate delivery of the specialty drug directly to the provider office through the Specialty Pharmacy Vendor. Please refer to the "Specialty Pharmacy Vendor" portion of this "Schedule of benefits and coverage" section for the applicable copayment or coinsurance.

Injections for the treatment of infertility are described below in the "Infertility services" section.

Outpatient services	PPO	OON
Outpatient facility services (other than surgery, except for infertility services)*	30%	50%
Outpatient surgery (hospital or outpatient surgery center charges only, except for infertility services)*	30%	50%

* *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $250 penalty will be charged.*

Outpatient care for infertility is described below in the "Infertility services" section.

Hospital services	PPO	OON
Semi-private hospital room or special care unit with ancillary services, including delivery and maternity care (unlimited days)	30%	50%
Skilled nursing facility stay	30%	50%

Confinement for bariatric (weight loss) surgery ..... 30% ..... Not covered

These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $250 penalty will be charged.

The above coinsurance for inpatient hospital or special care unit services is applicable for each admission for the hospitalization of an adult, pediatric or newborn patient. If a newborn patient requires admission to a special care unit, a separate coinsurance for inpatient hospital services will apply.

Inpatient care for infertility is described below in the "Infertility services" section.

Radiological services	**PPO**	**OON**
Laboratory procedures	30%	50%
X-ray and diagnostic imaging	30%	50%
Imaging (CT/PET scans, MRIs)	30%	50%

These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $250 penalty will be charged.

Preventive Care	**PPO**	**OON**
Preventive care services	$0±	Not covered

± *Deductible waived.*

Preventive care services are covered for children and adults, as directed by your physician, based on the guidelines from the U.S. Preventive Services Task Force Grade A&B recommendations, the Advisory Committee on Immunization Practices that have been adopted by the Center for Disease Control and Prevention, the guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA).

Preventive care services are not subject to the calendar year deductible and include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA.

One breast pump and the necessary supplies to operate it will be covered for each pregnancy at no cost to the covered person. We will determine the type of equipment, whether to rent or pur-

chase the equipment and the vendor who provides it. Breast pumps can be obtained by calling the Customer Contact Center at the phone number listed on the back cover of this booklet.

Emergency health coverage	PPO	OON
Emergency room (facility and professional services)[£]	$300	$300
Urgent care services	$120[♦]	50%

[♦] *Deductible applies after 1st 3 non-preventive visits.*

[£] *Waived if admitted.*

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

Ambulance services	PPO	OON
Ground ambulance	$300	$300
Air ambulance	$300	$300

These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $250 penalty will be charged.

Outpatient prescription drug plan

Prescription drugs	Participating pharmacy	Nonparticipating pharmacy

+ The prescription drug benefit is subject to the calendar year deductible and the OOPM as described at the beginning of this section. Please also refer to the "Prescription drug program" section of this SB for definitions, benefits and limitations.

Retail pharmacy (up to a 30-day supply)

Tier I drugs listed on the Essential Rx Drug List (primarily generic)	$15	Not covered
Tier II drugs listed on the Essential Rx rug List (primarily preferred brand name) and diabetic supplies (including insulin)[♦]	$50	Not covered
Tier III drugs listed on the Essential Rx Drug List (or non-preferred drugs not listed on the Essential Rx Drug List)[♦]	$75	Not covered

Preventive drugs, including smoking cessation drugs, and women's contraceptives * ..... $0± ..... Not covered

Specialty Pharmacy Vendor

	Specialty Pharmacy
Specialty Drugs when listed in the Essential Rx Drug List	30%

Mail-order program (up to a 90-day supply of maintenance drugs)

Tier I drugs listed on the Essential Rx Drug List (primarily generic)..... $30..... Not covered

Tier II drugs listed on the Essential Rx Drug List (primarily preferred brand name) and diabetic supplies (including insulin)◆..... $100..... Not covered

Tier III drugs listed on the Essential Rx Drug List (or non-preferred drugs not listed on the Essential Rx Drug List)◆..... $150..... Not covered

Preventive drugs, including smoking cessation drugs, and women's contraceptives* ..... $0± ..... Not covered

± *Deductible waived.*

Orally administered anti-cancer drugs will have a deductible, copayment and coinsurance maximum of $200 for an individual prescription of up to a 30-day supply.

◆ *Generic drugs will be dispensed when a generic drug equivalent is commercially available. When a brand name drug is dispensed and a generic equivalent is commercially available, the covered person must pay the Tier III drug copayment or specialty drug coinsurance, as applicable, when Medically Necessary.*

** Preventive drugs, including smoking cessation drugs, and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the covered person and are not subject to the deductible. Preventive drugs are prescribed over-the-counter drugs or Prescription Drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations.*

If a brand name drug is dispensed, and there is a generic equivalent commercially available, you will be required to pay the Tier III drug copayment or specialty drug coinsurance, as applicable.

Medical supplies	PPO	OON
Durable medical equipment *	30%	Not covered
Diabetes education	$60◆	50%

Orthotics (such as bracing, supports and casts)*	30%	Not covered
Corrective footwear*	30%	Not covered
Diabetic equipment (See the "Prescription Drug Program" section of this SB for diabetic supplies benefit information)	30%	50%
Diabetic footwear	30%	50%
Prostheses*	30%	50%

♦ *Deductible applies after 1st 3 non-preventive visits.*

Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under "Preventive care" in this section.

Durable medical equipment is covered when medically necessary and acquired or supplied by an HNL designated contracted vendor for durable medical equipment. Preferred providers that are not designated by HNL as a contracted vendor for durable medical equipment are considered out-of-network providers for purposes of determining coverage and benefits. Durable medical equipment is not covered if provided by an out-of-network provider. For information about HNL's designated contracted vendors for durable medical equipment, please contact the Customer Contact Center at the telephone number on the back cover.

Diabetic equipment covered under the medical benefit (through "Diabetic equipment") includes blood glucose monitors designed for the visually impaired, insulin pumps and related supplies, and corrective footwear. Diabetic equipment and supplies covered under the prescription drug benefit include insulin, specific brands of blood glucose monitors and testing strips, Ketone urine testing strips, lancets and lancet puncture devices, specific brands of pen delivery systems for the administration of insulin (including pen needles) and insulin syringes.

In addition, the following supplies are covered under the medical benefit as specified: visual aids (excluding eyewear) to assist the visually impaired with the proper dosing of insulin are provided through the prosthesis benefit; Glucagon is provided through the self-injectable benefit. Self-management training, education and medical nutrition therapy will be covered only when provided by licensed health care professionals with expertise in the management or treatment of diabetes (provided through the patient education benefit).

* *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $250 penalty will be charged.*

Mental disorders and chemical dependency benefits	PPO	OON

+ Severe mental illness includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition the Diagnostic and Statistical Manual for Mental Disorders), autism, anorexia nervosa and bulimia nervosa.

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

Severe Mental Illness and Serious Emotional Disturbances of a Child

Outpatient office visits (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring) *	$60♦	50%
Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care program, day treatment, partial hospitalization and other outpatient procedures including behavioral health treatment for pervasive developmental disorder or autism)*	0%±	50%
Inpatient facility*	30%	50%

Other Mental Disorders

Outpatient office visits (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring) *	$60♦	50%
Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care program, day treatment, partial hospitalization and other outpatient services)*	0%±	50%
Inpatient facility*	30%	50%

Chemical Dependency

Outpatient office visits (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring) *	$60♦	50%
Outpatient services other than office visits (psychological and neuropsychological testing, intensive outpatient care program, day treatment, partial hospitalization and other outpatient services)*	0%±	50%
Inpatient facility *	30%	50%
Inpatient detoxification*	30%	50%

♦ *Deductible applies after 1st 3 non-preventive visits.*

± *Deductible waived.*

**Each group therapy session requires only one half of a private office visit copayment. If two or more covered persons in the same family attend the same outpatient treatment session, only one copayment will be applied.*

**These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $250 penalty will be charged.*

Home Health Services	PPO	OON
Home health visits*	30%	50%
*Maximum visits per calendar year*ᵃ	*100*	*100*

ᵃ *Combined for PPO and out-of-network.*

***** *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $250 penalty will be charged.*

Other services	PPO	OON
Sterilization - Vasectomy	30%	50%
Sterilization - Tubal ligation	$0±	Not covered
Blood, blood plasma, blood derivatives and blood factors (except for drugs used to treat hemophilia, including blood factors)**	30%	50%
Drugs used to treat hemophilia, including blood factors**	30%	Not covered
Renal dialysis	$60	50%
Hospice services*	$0	50%
Infusion therapy (home or physician's office)*	$60	50%

± *Deductible waived.*

***** *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, a $250 penalty will be charged.*

*** Drugs used to treat hemophilia, including blood factors, are covered on the specialty drug tier under the pharmacy benefit. Specialty drugs are not covered under the medical benefit even if they are administered in a physician's office. If you need to have the provider administer the specialty drug, you will need to obtain the specialty drug through the Specialty Pharmacy Vendor and bring it with you to the provider's office. Alternatively, you may be able to coordinate delivery of the specialty drug directly to the provider's office through the Specialty Pharmacy Vendor.*

Infertility services and supplies are described below in the "Infertility services" section.

Sterilization of females and women's contraception methods and counseling, as supported by HRSA guidelines, are covered under "Preventive Care Services" in this section.

Infertility services	PPO	OON
Infertility services and supplies (all covered services that diagnose, evaluate or treat infertility)	Not covered	Not covered

Notes:

Infertility services include prescription drugs, professional services, inpatient and outpatient care and treatment by injections.

Acupuncture care	**PPO**	**OON**
Office visits*	$60♦	Not covered

♦ *Deductible applies after 1st 3 non-preventive visits.*

* *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB.*

Pediatric Vision care (birth through age 18)

+ *Pediatric vision benefits are administered by EyeMed Vision Care, LLC, a contracted vision services provider panel. Refer to the "Pediatric Vision Care Program" section later in this SB/DF for the benefit information which includes the Eyewear Schedule.*

Pediatric dental (birth through age 18) (in California only)

+ *Pediatric dental benefits are underwrietten by Unimerica Life Insurance Company and administered by Dental Benefit Administrative Services. Unimerica Life Insurance Company and Dental Benefit Adminstrative Services are not affliliated with Health Net Life. Refer to the "Pediatric dental program" section later in this SB/DF for the benefit information which includes the Dental Schedule See the Certificate for additional details.*

Limits of coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- Air or ground ambulance and paramedic services that are not emergency care or which do not result in a patient's transportation will not be covered unless certification is obtained and services are medically necessary.
- Artificial insemination;
- Care for mental health care as a condition of parole or probation, or court-ordered treatment and testing for mental disorders, except when such services are medically necessary;
- Charges in excess of rate negotiated between any organization and the physician, hospital or other provider;
- Conception by medical procedures (IVF, GIFT and ZIFT);
- Conditions resulting from the release of nuclear energy when government funds are available;
- Corrective footwear is not covered unless medically necessary and custom made for the covered person or is a podiatric device to prevent or treat diabetes-related complications;
- Cosmetic services or supplies;
- Custodial or live-in care;
- For Covered Persons age 19 and over, dental services. However, medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures are covered. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate;
- Disposable supplies for home use;
- Experimental or investigational procedures, except as set out under the "Clinical trials" and "If you have a disagreement with our insurance plan" sections of this SB;
- Prenatal genetic testing is not covered except when determined by Health Net Life to be medically necessary. The prescribing physician must request prior authorization for coverage;
- Hearing aids;
- Hypnosis;
- Immunizations and injections for foreign travel or occupational purposes;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder;
- Non-eligible institutions. This insurance plan only covers services or supplies provided by a legally operated hospital, Medicare-approved skilled nursing facility or other properly licensed facility as specified in the *Certificate*. Any institution, regardless of how it is designated, is not an eligible institution. Services or supplies provided by such institutions are not covered;
- Nontreatable disorders;
- Outpatient prescriptions drugs or medications (except as noted under "Prescription drug program");
- Orthotics (such as bracing, supports and casts) that are not custom made to fit the covered person's body. Refer to the "corrective footwear" bullet above for additional foot orthotic limitations;
- Personal or comfort items;
- Physician self-treatment;
- Physician treating immediate family members;
- Private rooms when hospitalized, unless medically necessary;
- Private-duty nursing;

- Refractive eye surgery unless medically necessary, recommended by the covered person's treating physician and authorized by Health Net Life;
- Reversal of surgical sterilization;
- Routine foot care for treatment of corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes, except when medically necessary;
- Routine physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp or other nonpreventive purposes;
- Services and supplies determined not to be medically necessary as defined in the *Certificate*;
- Services and supplies not specifically listed in the plan's *Certificate* as covered expenses;
- Services and supplies that do not require payment in the absence of insurance;
- Services for an injury incurred in the commission (or attempted commission) of a crime unless the condition was an injury resulting from an act of domestic violence or an injury resulting from a medical condition;
- Services for conditions of pregnancy for a surrogate pregnancy are covered when the surrogate parent is the covered person under this HNL plan. However, when compensation is obtained for the surrogacy, Health Net Life shall have a lien on such compensation to recover its medical expense. A surrogate parent is a woman who agrees to become pregnant with the intent of surrendering custody of the child to another person;
- Services not related to a covered illness or injury, except as provided under preventive care and annual routine exams;
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the plan's *Certificate*;
- Sex change services unless the health care services involved are otherwise available under the plan's *Certificate*;
- Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary;
- Treatment of obesity, weight reduction or weight management, except for treatment of morbid obesity;
- Services related to educational and professional purposes, except for behavioral health treatment for pervasive developmental disorder or autism;
- Stress, except when rendered in connection with services provided for a treatable mental disorder;

The above is a partial list of the principal exclusions and limitations applicable to the medical portion of your Health Net PPO insurance plan. The *Certificate*, which you will receive if you enroll in this insurance plan, will contain the full list.

Benefits and coverage

WHAT YOU PAY FOR SERVICES

The "Schedule of benefits and coverage" section explains your coverage and payment for services. Please take a moment to look it over.

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

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

SPECIAL ENROLLMENT RIGHTS UNDER CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

The Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) creates a special enrollment period in which individuals and their dependent(s) are eligible to request enrollment in this plan within 60 days of becoming ineligible and losing coverage from the Access for Infants and Mothers Program (AIM) or a Medi-Cal plan.

NOTICE OF REQUIRED COVERAGE

Benefits of this insurance plan provide coverage required by the Federal Newborns' and Mothers' Health Protection Act of 1996 and Women's Health and Cancer Right Act of 1998.

The Newborns' and Mothers' Health Protection Act of 1996 sets requirements for a minimum Hospital length of stay following delivery. Specifically, Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Women's Health and Cancer Right Act of 1998 applies to medically necessary mastectomies and requires coverage for prosthetic devices and reconstructive surgery on either breast provided to restore and achieve symmetry.

SERVICES REQUIRING CERTIFICATION[1]

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

Services that require certification include:

All inpatient admissions, any facility:
- Acute rehabilitation center
- Chemical dependency care facility, except in an emergency
- Hospice
- Hospital, except in an emergency
- Mental health facility, except in an emergency
- Skilled nursing facility

Ambulance: Non-emergency, air or ground ambulance services

Behavioral health treatment for pervasive developmental disorder or autism beyond the initial 6 months of treatment

Chondrocyte implants

Cochlear implants

Clinical trials.

Custom orthotics

Dermatology in a Physician's office

- Skin injections and implants
- Dermabrasions and chemical peels
- Laser treatment
- Chemical exfoliation and electrolysis

Durable medical equipment:
- Bone growth stimulator
- Continuous positive airway pressure (CPAP)
- Custom-made items
- Hospital beds
- Power wheelchairs
- Scooters

Elective caesarean section

Experimental/investigational services and new technologies.

Genetic testing

Home Health Care Services including home uterine monitoring, hospice, nursing, occupational therapy, physical therapy, speech therapy, and tocolytic services.

Medically Necessary orthodontic treatment (for covered persons under 19 years of age)

Neuro or spinal cord stimulator

Occupational and speech therapy.

Organ, tissue and stem cell transplant services, including pre-evaluation and pre-treatment services and the transplant procedure.

Outpatient Diagnostic Procedures:
- CT (Computerized Tomography)
- MRA (Magnetic Resonance Angiography)
- MRI (Magnetic Resonance Imaging)
- PET (Positron Emission Tomography)
- Nuclear cardiology procedures, including SPECT (Single Photon Emission Computed Tomography)
- Sleep studies

Outpatient pharmaceuticals:
- Self-injectables
- Hemophilia factors and intravenous immunoglobulin (IVIG)
- IV and infusion medications
- Certain physician-administered drugs, whether administered in a physician office, free-standing infusion center, home infusion, outpatient surgery center, outpatient dialysis center, or outpatient hospital. Refer to the Health Net Life website, www.healthnet.com, for a list of physician-administered drugs that require Certification.

Outpatient physical therapy and acupuncture (exceeding 12 visits)

Outpatient surgical procedures:
- Bariatric procedures
- Blepharoplasty
- Breast reductions and augmentations
- Mastectomy for gynecomastia
- Orthognathic procedures (includes TMJ treatment)
- Rhinoplasty
- Septoplasty
- Treatment of varicose veins
- Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
- Medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

Prosthesis and orthotics over $2,500 in billed charges.

Radiation therapy

- Intensity modulated radiation therapy (IMRT)
- Proton beam therapy
- Stereotactic radiosurgery and stereotactic body radiotherapy (SBRT)

X-Stop

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

COVERAGE FOR NEWBORNS

Children born after your date of enrollment are automatically covered at birth. To continue coverage, the child must be enrolled through your employer before the 30th day of the child's life. If the child is not enrolled within 30 days of the child's birth:

- Coverage will end the 31st day after birth; **and**
- You will have to pay for all medical care provided after the 30th day of your baby's life.

EMERGENCIES

Health Net Life covers emergency and urgently needed care throughout the world. If you need emergency or urgently needed care, seek care where it is immediately available.

You are encouraged to use appropriately the **911** emergency response system, in areas where the system is established and operating, when you have an emergency medical condition (including severe mental illness and serious emotional disturbances of a child) that requires an emergency response. All ambulance and ambulance transport services provided as a result of a **911** call will be covered, if the request is made for an emergency medical condition (including severe mental illness and serious emotional disturbances of a child).

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

Emergency care *means any otherwise covered service for an acute illness, a new injury or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or, if a minor, to the minor's parent or guardian that a reasonable person with an average knowledge of health and medicine (a prudent layperson) would believe requires immediate treatment (including severe mental illness and serious emotional disturbances of a child), and without immediate treatment, any of the following would occur: (a) his or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger); (b) his or her bodily functions, organs or parts would become seriously damaged; or (c) his or her bodily organs or parts would seriously malfunction. Emergency care also includes treatment of severe pain or active labor. Active labor means labor at the time that either of the following would occur: (a) there is inadequate time to effect safe transfer to another hospital prior to delivery; or (b) a transfer poses a threat to the health and safety of the covered person or her unborn child.*

Urgently Needed Care means any otherwise covered medical service that a reasonable person with an average knowledge of health and medicine would seek for treatment of an injury, unexpected illness or complication of an existing condition, including pregnancy, to prevent the serious deterioration of his or her health, but which does not qualify as Emergency Care, as defined in this section. This may include services for which a person should reasonably have known an emergency did not exist.

MEDICALLY NECESSARY CARE

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

CLINICAL TRIALS

Routine patient care costs for patients diagnosed with cancer or other life-threatening disease or condition who are accepted into phase I, II, III, or IV clinical trials are covered when medically necessary, recommended by the covered person's treating physician and authorized by Health Net Life. The physician must determine that participation has a meaningful potential to benefit the covered person and the trial has therapeutic intent. For further information, please refer to the plan's *Certificate*.

CONTINUITY OF CARE

If our contract with a PPO health care provider is terminated, you may be able to elect continued care by that provider if you are receiving care for an acute condition, serious chronic condition, pregnancy, new born, terminal illness or scheduled surgery. If you would like more information on how to request continued care, please call the Customer Contact Center at the telephone number listed on the back cover.

EXTENSION OF BENEFITS

If you or a covered dependent is totally disabled when your employer ends its agreement with Health Net Life, we will cover the treatment for the disability until one of the following occurs:

- A maximum of 12 consecutive months elapses from the termination date;
- Available benefits are exhausted;
- The disability ends; or
- You become enrolled in another insurance plan that covers the disability.

Your application for an extension of benefits for disability must be made to Health Net Life within 90 days after your employer ends its agreement with us. We will require medical proof of the total disability at specified intervals.

OUT-OF-STATE PROVIDERS

Health Net PPO has created a program, which allows covered persons access to participating providers outside their state of residence. These providers participate in a network, other than the HNL PPO network, that agrees to provide discounted health care services to HNL covered persons. This program is through the out-of-state provider network shown on your HNL ID card and is limited to covered persons traveling outside their state of residence.

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

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

CONFIDENTIALITY AND RELEASE OF COVERED PERSON INFORMATION

Health Net Life knows that personal information in your medical records is private. Therefore, we protect your personal health information in all setting (including oral, written and electronic information). The only time we would release your confidential information without your authorization is for payment, treatment, health care operations (including but not limited to utilization management, quality improvement, disease or case management programs) or when permitted or required to do so by law, such as for court order or subpoena. We will not release your confidential claims details to your employer or their agent. Often, Health Net Life is required to comply with aggregated measurement and data reporting requirements. In those cases, we protect your privacy by not releasing any information that identifies our covered persons.

PRIVACY PRACTICES

Once you become a Health Net Life covered person, Health Net Life uses and discloses a covered person's protected health information and nonpublic personal financial information* for purposes of treatment, payment, health care operations, and where permitted or required by law. Health Net Life provides covered persons with a Notice of Privacy Practices that describes how it uses and discloses protected health information; the individual's rights to access, to request amendments, restrictions, and an accounting of disclosures of protected health information; and the procedures for filing complaints. Health Net Life will provide you the opportunity to approve or refuse the release of your information for non-routine releases such as marketing. Health Net Life provides access to covered persons to inspect or obtain a copy of the covered person's protected health information in designated record sets maintained by Health Net Life. Health Net Life protects oral, written and electronic information across the organization by using reasonable and appropriate security safeguards. These safeguards include limiting access to an individual's protected health information to only those who have a need to know in order to perform payment, treatment, health care operations or where permitted or required by law. Health Net Life releases protected health information to insurance plan sponsors for administration of self-funded plans but does not release protected health information to plan sponsors/employers for insured products unless the plan sponsor is performing a payment or health care operation function for the plan. Health Net Life's entire Notice of Privacy Practices can be found in the plan's *Certificate*, at www.healthnet.com under "Privacy" or you may call the Customer Contact Center at the telephone number listed on the back cover to obtain a copy.

** Nonpublic personal financial information includes personally identifiable financial information that you provided to us to obtain health plan coverage or we obtained in providing benefits to you. Examples include Social Security numbers, account balances and payment history. We do not disclose any nonpublic personal information about you to anyone, except as permitted by law.*

TECHNOLOGY ASSESSMENT

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

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

The expert medical reviewer also advises Health Net Life when patients require quick determinations of coverage, when there is no guiding principle for certain technologies, or when the complexity of a patient's medical condition requires expert evaluation. If Health Net Life denies, modifies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational, you may request an independent medical review (IMR) of Health Net Life's decision from the Department of Insurance. Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" in the Certificate for additional details.

Utilization management

Utilization management is an important component of health care management. Through the processes of prior certification, concurrent and retrospective review and care management, we evaluate the services provided to our covered persons to be sure they are medically necessary and appropriate for the setting and time. These processes help to maintain Health Net Life's high quality medical management standards.

PRIOR CERTIFICATION

Certain proposed services may require an assessment prior to approval. Evidence-based criteria are used to evaluate whether or not the procedure is medically necessary and planned for the appropriate setting (that is, inpatient, outpatient surgery, etc.).

CONCURRENT REVIEW

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

DISCHARGE PLANNING

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

RETROSPECTIVE REVIEW

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

CARE OR CASE MANAGEMENT

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

If you would like additional information regarding Health Net Life utilization management process, please call the Customer Contact Center at the telephone number listed on the back cover.

Payment of premiums and charges

YOUR COINSURANCE, COPAYMENT AND DEDUCTIBLES

The "Schedule of benefits and coverage" section explains your coverage and payment for services. Please take a moment to look it over.

PREPAYMENT OF PREMIUMS

Your employer will pay Health Net Life your monthly premiums for you and all enrolled dependents. Check with your employer regarding any share that you may be required to pay. If your share ever increases, your employer will inform you in advance.

OTHER CHARGES

You are responsible for payment of your share of the cost of services covered by this insurance plan. Amounts paid by you are called copayments, coinsurance or deductibles, which are described in the "Schedule of benefits and coverage" section of this SB. Beyond these charges the remainder of the cost of covered services will be paid by Health Net Life.

When the total amount of deductibles, copayments and coinsurance you pay equals the annual out-of-pocket maximum amount shown in the "Schedule of benefits and coverage" section, you will not have to pay additional copayments or coinsurance for the rest of the year for most services provided, unless your doctor charges an amount that Health Net Life considers to be in excess of covered expenses. Additionally, the following expenses will not be applied to the limit:

- Charges in excess of covered expenses;
- Charges for services or supplies not covered by this insurance plan;
- Penalties for services for which certification was required but not obtained.

For further information please refer to the *Certificate*. Covered expenses for out-of-network providers are limited to the amount shown on the Resource Based Relative Value Schedule (RBRVS) established by the federal government for Medicare and then adjusted by 75%. For those services that do not have a RBRVS amount, Health Net Life has developed a limited fee schedule shown in the *Certificate*.

CONTRACTED RATE

The contracted rate is the rate that preferred providers are allowed to charge you, based on a contract between Health Net Life and such provider. Covered Expenses for services provided by a preferred provider will be based on the contracted rate.

MAXIMUM ALLOWABLE AMOUNT

The maximum allowable amount is the amount on which HNL bases its reimbursement for covered services and supplies received from an inpatient hospital, skilled nursing facility, home health care agency, for outpatient surgery or for emergency care received during foreign travel or work assignment, provided by an out-of-network provider, which may be less than the amount billed for those services and supplies. Health Net Life calculates maximum allowable amount as the lesser of the amount billed by the out-of-network provider or the amount determined as set forth herein. Maximum allowable amount is not the amount that Health Net Life pays for a covered service; the actual payment will be reduced by applicable coinsurance, copayments, deductibles and other applicable amounts. Please refer to the insurance plan's *Certificate* for additional information.

- The maximum allowable amount for out-of-network emergency care will be the greatest of: (1) the amount negotiated with preferred providers for the emergency service provided, excluding any in-network copayment or coinsurance; (2) the amount calculated using the same method HNL generally uses to determine payments for out-of-network providers, excluding any in-network copayment or coinsurance; or (3) the amount paid under Medicare Part A or B, excluding any in-network copayment or coinsurance.
- For all services received from an inpatient hospital, skilled nursing facility, home health care agency, for outpatient surgery or for emergency care received during foreign travel or work assignment, maximum allowable amount is determined by applying a percentage of what Medicare would allow (known as the Medicare allowable amount). The maximum allowable amount for such services is 190% of the Medicare allowable amount.
- In the event the applicable service or database does not include an amount for the service or supply provided, maximum allowable amount shall be deemed to be 75% of the covered charges billed by the provider. The maximum allowable amount determined under the databases described above may be more or less than 75% of the amount normally charged by the provider for the same services or supplies.
- The maximum allowable amount may also be subject to other limitations on covered expenses See the insurance plan's *Certificate* under "Schedule of Benefits," "Plan Benefits" and "General Limitations and Exclusions" sections for specific benefit limitations, maximums, pre-certification requirements and payment policies that limit the amount HNL pays for certain covered services and supplies. HNL uses available guidelines of Medicare and its contractors, other governmental regulatory bodies and nationally recognized medical societies and organizations to assist in its determination as to which services and procedures are eligible for reimbursement.

In addition to the above, from time to time, HNL also contracts with vendors that have contracted fee arrangements with providers ("Third Party Networks"). In the event HNL contracts with a Third

Party Network that has a contract with the out-of-network provider, HNL may, at its option, use the rate agreed to by the Third Party Network as the maximum allowable amount, in which case you will not be responsible for the difference between the maximum allowable amount and the billed charges. You will be responsible for any applicable deductible, copayment and/or coinsurance at the out-of-network level.

In addition, HNL may, at its option, refer a claim for out-of-network services to a fee negotiation service to negotiate the maximum allowable amount for the service or supply provided directly with the out-of-network provider. In that situation, if the out-of-network provider agrees to a negotiated maximum allowable amount, you will not be responsible for the difference between the maximum allowable amount and the billed charges. You will be responsible for any applicable deductible, copayment and/or coinsurance at the out-of-network level.

In the event that the billed charges for the out-of-network provider are more than the maximum allowable amount, you are responsible for any amounts charged in excess of the maximum allowable amount, except where the out-of-network provider's fee is determined by reference to a Third Party Network agreement or the out-of-network provider agrees to a negotiated maximum allowable amount.

Please note that whenever you obtain covered services and supplies from an out-of-network provider, you are responsible for applicable deductibles, copayments and coinsurance.

For more information on the determination of maximum allowable amount, or for information, services and tools to help you further understand your potential financial responsibilities for covered out-of-network services and supplies please log on to www.healthnet.com or contact HNL's Customer Contact Center at the number on your identification card.

LIABILITY OF ENROLLEE FOR PAYMENT

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

REIMBURSEMENT PROVISIONS

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

Please call the Customer Contact Center at the telephone number listed on the back cover to obtain claim forms, and to find out whether you should send the completed form to your doctor, hospital or to Health Net Life. Claims must be received by Health Net Life within one year of the date of service to be eligible for reimbursement.

+ ***How to file a claim:***

For medical services*, please send a completed claim form to:*

Health Net Commercial Claims
P.O. Box 14702
Lexington, KY 40512

For outpatient prescription drugs *please send a completed prescription drug claim form to:*

Health Net
C/O Caremark
P.O. Box 52136
Phoenix, AZ 85072

Please call the Customer Contact Center at the telephone number listed on the back cover or visit our website at ***www.healthnet.com*** *to obtain a prescription drug claim form.*


Claims for covered expenses filed more than 20 days from the date of service will not be paid unless you can show that it was not reasonably possible to file your claim within that time limit and that you have filed as soon as was reasonably possible.

Renewing, continuing or ending coverage

RENEWAL PROVISIONS

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

SMALL EMPLOYER CAL-COBRA COVERAGE

When the group is a small employer (as defined in the Certificate), state law provides that members who enroll in this plan and later lose eligibility may be entitled to continuation of group coverage. More information regarding eligibility for this coverage is provided in your Certificate.

INDIVIDUAL CONTINUATION OF BENEFITS


Please examine your options carefully before declining coverage.

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

- **COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985):** For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside of California. Please check with your group to determine if you and your covered dependents are eligible.

- **Small Employer Cal-COBRA Continuation Coverage:** For employers with fewer than 20 employees who were eligible to enroll in the employer's health plan on 50% of the employer's business days in the preceding year, Health Net Life is required by state law to offer continuation coverage.

- **Cal-COBRA Continuation Coverage:** If you have exhausted COBRA and you live in the United States, you may be eligible for additional continuation coverage under state Cal-COBRA law. This coverage may be available if you have exhausted federal COBRA coverage, have had less than 36 months of COBRA coverage and you are not entitled to Medicare. If you are eligible, you have the opportunity to continue group coverage under the *Certificate* through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.

- **USERRA Coverage:** Under a federal law known as the Uniformed Services Employment and Reemployment Rights Act (USERRA), employers are required to provide employees who are absent from employment to serve in the uniformed services and their dependents who would lose their group health coverage the opportunity to elect continuation coverage for a period of up to 24 months. Please check with your group to determine if you are eligible.

Also, you may be eligible for continued coverage for a disabling condition (for up to 12 months) if your employer terminates its agreement with Health Net Life. Please refer to the "Extension of benefits" section of this SB for more information.

TERMINATION OF BENEFITS

Your coverage under this insurance plan ends when:

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

If the employer covered under this insurance plan does not pay appropriate premium charges, benefits will end on the last day for which premium charges have been made, unless:

- You apply for conversion coverage within 31 days of that date; or
- You are totally disabled and apply for an extension of benefits for the disabling condition within 90 days.

If the person involved in any of the above activities is the enrolled employee, coverage under this insurance plan will end as well for any covered dependents.

If you have a disagreement with our insurance plan

The California Department of Insurance (CDI) is responsible for regulating disability insurance carriers (Health Net Life is a disability insurance carrier). The CDI has a toll-free telephone number (**1-800-927-HELP**) to receive complaints about carriers.

If you have been unable to resolve a problem concerning your insurance coverage, after discussions with Health Net Life Insurance Company, or its agent or other representative, you may contact:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
South Tower
Los Angeles, CA 90013
1-800-927-HELP or 1-800-927-4357
www.insurance.ca.gov

GRIEVANCE AND APPEALS PROCESS

If you are dissatisfied with the quality of care that you have received or feel that you have been incorrectly denied a service or claim, you may file a grievance or appeal. You must file your grievance or appeal with HNL within 365 calendar days following the date of the incident or action that caused your grievance.

+ How to file a grievance or appeal:

You may call the telephone number listed on the back cover or submit the covered person grievance form through the HNL website at ***www.healthnet.com****.*

You may also write to:

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

Please include all the information from your Health Net Life identification card as well as the details of your concern or problem. Health Net Life will acknowledge your grievance or appeal within five calendar days, review the information and tell you of our decision in writing within 15 days of receiving the grievance if the grievance pertains to a claims dispute or within 30 days of receiving the grievance for all other grievances. For conditions where there is an immediate and serious threat to your health, including severe pain or the potential loss of life, limb or major bodily function, Health Net Life will notify you of the status of your grievance no later than three days from receipt of all the required information.

In addition, you can request an independent medical review of disputed health care services from the Department of Insurance, if you believe that health care services eligible for coverage and

payment under the insurance plan was improperly denied, modified or delayed by Health Net Life or one of its participating providers.

Also, if Health Net Life denies your appeal of a denial for lack of medical necessity, or denies or delays coverage for requested treatment involving experimental or investigational drugs, devices, procedures or therapies, you can request an independent medical review of Health Net Life's decision from the Department of Insurance if you meet the eligibility criteria set out in the Certificate.

ARBITRATION

If you are not satisfied with the result of the grievance hearing and appeals process, you may submit the problem to binding arbitration. Health Net Life uses binding arbitration to settle disputes, including medical malpractice. When you enroll in Health Net Life, you agree to submit any disputes to arbitration, in lieu of a jury or court trial.

Additional insurance plan benefit information

The following insurance plan benefits show benefits available with your insurance plan. For a more complete description of copayments, and exclusions and limitations of service, please see your insurance plan's *Certificate*.

Prescription drug program

Health Net Life contracts with many major pharmacy chains, supermarket based pharmacies and privately owned neighborhood pharmacies. For a complete and up-to-date list of participating pharmacies, please visit our website at www.healthnet.com or call the Customer Contact Center at the telephone number listed on the back cover.

PRESCRIPTIONS BY MAIL DRUG PROGRAM

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period), you have the option of filling it through our convenient Prescriptions by Mail Drug Program. This program allows you to receive up to a 90-consecutive-calendar-day supply of maintenance medications. For complete information, call the Customer Contact Center at the telephone number listed on the back cover.

Schedule II narcotic drugs (which are drugs that have a high abuse risk as classified by the Federal Drug Enforcement Administration) are *not covered through mail order. For further information, please refer to the Certificate.*

THE HEALTH NET ESSENTIAL RX DRUG LIST

This insurance plan uses the Essential Rx Drug List. The Health Net Essential Rx Drug List (or the List) is the approved list of medications covered for illnesses and conditions. It was developed to identify the safest and most effective medications for Health Net Life covered persons while attempting to maintain affordable pharmacy benefits.

We specifically suggest to all Health Net Life contracted participating providers and specialists that they refer to this List when choosing drugs for patients who are Health Net Life covered persons. When your physician prescribes medications listed in the Essential Rx Drug List, it ensures that you are receiving a high quality prescription medication that is also of high value.

The Essential Rx Drug List is updated regularly, based on input from the Health Net Pharmacy and Therapeutics (P&T) Committee. The committee members are actively practicing physicians of various medical specialties and clinical pharmacists. Voting members are recruited from participating physician groups throughout California based on their experience, knowledge and expertise. In addition, the P&T Committee frequently consults with other medical experts to provide additional input to the Committee. Updates to the Essential Rx Drug List and drug usage guidelines are made as new clinical information and new drugs become available. In order to keep the List current, the P&T Committee evaluates clinical effectiveness, safety and overall value through:

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

To obtain a copy of Health Net Life most current Essential Rx Drug List, please visit our web site at www.healthnet.com under the pharmacy information, or call the Customer Contact Center at the telephone number listed on the back cover.

WHAT IS "PRIOR AUTHORIZATION?"

Some drugs require prior authorization. This means that your doctor must contact Health Net Life in advance to provide the medical reason for prescribing the medication.

+ How to request prior authorization:

Requests for prior authorization may be submitted electronically or by telephone or facsimile. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 2 business days or 72 hours, whichever is less, after Health Net Life's receipt of the request and any additional information requested by Health Net Life that is reasonably necessary to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 2 business days, as appropriate and medically necessary, for the nature of the covered person's condition after Health Net Life's receipt of the information reasonably necessary and requested by Health Net Life to make the determination. Upon receiving your physician's request for prior authorization, Health Net Life will evaluate the information submitted and make a determination based on established clinical criteria for the particular medication.

If a drug is not on the Essential Rx Drug List, and is not specifically excluded from coverage, your physician can ask for an exception. To request an exception, your Physician can submit a prior authorization request along with a statement supporting the request. Requests for prior authorization may be submitted electronically or by telephone or facsimile. If we approve an exception for a drug that is not on the Essential Rx Drug List, the non-preferred brand name drug tier (Tier III) or specialty copayment applies. If you are suffering from a condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug that is not on the Essential Rx Drug List, then You, Your designee or your physician can request an expedited review. Expedited requests for prior authorization will be processed within 24 hours after HNL's receipt of the request and any additional information requested by HNL that is reasonably necessary to make a determination.

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

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

The appeal may be submitted in writing, by telephone or through e-mail. We must receive the appeal within 60 days of the date of the denial notice. Please refer to the plan's *Certificate* for details regarding your right to appeal.

To submit an appeal:

- Call the Customer Contact Center at the telephone number listed on the back cover
- Visit www.healthnet.com for information on e-mailing the Customer Contact Center; or
- Write to:

  Health Net Life
  Customer Contact Center
  P.O. Box 10196
  Van Nuys, CA 91410-0348

WHAT'S COVERED

+ *Please refer to the "Schedule of benefits and coverage" section of this SB for the deductibles and copayments.*

This insurance plan covers the following:

- Tier I drugs – Drugs listed as Tier I on the Essential Rx Drug List that are not excluded from coverage (primarily generic);
- Tier II drugs – Drugs listed as Tier II on the Essential Rx Drug List that are not excluded from coverage (primarily brand name and diabetic supplies, including insulin); and
- Tier III drugs – Drugs listed on the Essential Rx Drug List as Tier III or drugs that are not listed on the Essential Rx Drug List.
- Preventive drugs and women's contraceptives
- Specialty Drugs
  Specialty Drugs listed in the Health Net Essential Rx Drug List are covered when prior authorization is obtained from HNL and the drugs are dispensed through HNL's Specialty Pharmacy Vendor. These drugs include self-administered injectable and other drugs that have significantly higher cost than traditional pharmacy benefit drugs. Please note that needles and syringes required to administer the self-injected medications are covered only when obtained through the Specialty Pharmacy Vendor.

  Self-administered injectable medications are defined as drugs that are:

  1. Medically necessary
  2. Administered by the patient or family member; either subcutaneously or intramuscularly
  3. Deemed safe for self-administration as determined by Health Net's Pharmacy and Therapeutics Committee
  4. Included in the Health Net Essential Rx Drug List

5. Shown on the Essential Rx Drug List as requiring prior authorization.

MORE INFORMATION ABOUT DRUGS THAT WE COVER

- Prescription drug covered expenses are the lesser of Health Net Life's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs;
- If a prescription drug deductible (per covered person each calendar year) applies, you must pay this amount for prescription drug covered expenses before Health Net Life begins to pay. Diabetic supplies, preventive drugs and women's contraceptives are not subject to the deductible. After the deductible is met the copayments or coinsurance amounts apply;
- Prescription drug refills are covered, up to a 30-consecutive-day supply per prescription at a Health Net Life contracted pharmacy for one copayment;
- If the pharmacy's retail price is less than the applicable copayment, the covered person will only pay the pharmacy's retail price;
- Mail order drugs are covered up to a 90-consecutive-calendar-day supply. When the retail pharmacy copayment is a percentage, the mail order copayment is the same percentage of the cost to Health Net Life as the retail pharmacy copayment;
- Preventive drugs, including smoking cessation drugs, are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations. Covered contraceptives are FDA-approved contraceptives for women that are either available over-the-counter or are only available with a prescription. Vaginal, oral, transdermal and emergency contraceptives are covered under this pharmacy benefit. IUD, implantable and injectable contraceptives are covered (when administered by a physician) under the medical benefit. Refer to the plan's *Certificate* for more information.
- Diabetic supplies (blood glucose testing strips, lancets, needles and syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (that is, opened in order to dispense the product in quantities other than those packaged). When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times your physician has prescribed for a 30-day period. For more information about diabetic equipment and supplies, please see "Endnotes" in the "Schedule of benefits and coverage" section of this SB.
- Sexual dysfunction drugs which are drugs that establish, maintain or enhance sexual functioning are covered for sexual dysfunction when medically necessary. Sexual dysfunction drugs are covered when prior authorization is obtained from HNL. Injectable sexual dysfunction drugs must be dispensed through HNL's Specialty Pharmacy Vendor. These prescription drugs are covered for up to the number of doses or tablets specified in HNL's Essential Rx Drug List. For information about HNL's Essential Rx Drug List, please call the Customer Contact Center at the telephone number on your ID card.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

+ *Services or supplies excluded under pharmacy services may be covered under the medical benefits portion of your insurance plan. In addition to the exclusion and limitations listed below, prescription drug benefits are subject to the insurance plan's general exclusions and limitations. Consult your insurance plan's Certificate for more information.*

- Allergy serum;
- Coverage for devices is limited to FDA approved vaginal contraceptive devices and diabetic supplies. No other devices are covered;
- Drugs that are appetite suppressants or are indicated for and prescribed for body weight reduction;
- Drugs or medicines administered by a physician or physician's staff member;
- Drugs prescribed to shorten the duration of the common cold;
- Drugs prescribed for routine dental treatment;
- Drugs used for diagnostic purposes;
- Experimental drugs (those that are labeled "Caution - Limited by Federal Law to investigational use only"). If you are denied coverage of a drug because the drug is investigational or experimental you will have a right to independent medical review. See "If you have a disagreement with our insurance plan" section of this SB for additional information;
- Hypodermic needles or syringes, except for specific brands of disposable insulin needles and syringes and specific brands of pen devices. Needles and syringes required to administer self-injected medications (other than insulin) will be provided through Our Specialty Pharmacy Vendor. All other devices, syringes and needles are not covered;
- Immunizing agents, injections (except for insulin and self-administered injectable drugs as described in the Essential Rx Drug List), agents for surgical implantation, biological sera, blood, blood derivatives or blood plasma obtained through a prescription;
- Individual doses of medication dispensed in plastic, unit dose or foil packages unless medically necessary or only available in that form;
- Irrigation solutions and saline solutions;
- Limits on quantity, dosage and treatment duration may apply to some drugs. Medications taken on an "as-needed" basis may have a copayment based on a standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If medically necessary, your physician may request a larger quantity from Health Net Life;
- Medical equipment and supplies (including insulin), that are available without a prescription are covered when prescribed by a physician for the management and treatment of diabetes or for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations or for female contraception as approved by the FDA. Any other nonprescription drug, medical equipment or supply that can be purchased without a prescription drug order is not covered even if a physician writes a prescription drug order for such drug, equipment or supply. However, if a higher dosage form of a prescription drug or over-the counter (OTC) drug is only available by prescription, that higher dosage drug will be covered. If a drug that was previously available by prescription becomes available in an OTC form in the same prescription strength, then any prescription drugs that are similar agents and have comparable clinical effect(s) will only be covered when medically necessary and prior authorization is obtained from Health Net Life;
- Prescription drugs prescribed by an unlicensed physician;
- Replacement of lost, stolen or damaged medications;
- Services or supplies which are covered in full or for which you are not legally required to pay;
- Supply amounts for prescriptions that exceed the FDA's or Health Net Life's indicated usage recommendation are not covered unless medically necessary and prior authorization is obtained from Health Net Life;
- Drugs prescribed for a condition or treatment not covered by this insurance plan are not covered. However, the insurance plan does cover drugs for medical conditions that result from nonroutine complications of a noncovered service.

This is only a summary. Consult your insurance plan's *Certificate* to determine the exact terms and conditions of your coverage.

Pediatric vision care program

The pediatric vision services benefits are provided by Health Net Life. Health Net Life contracts with EyeMed Vision Care, LLC, a vision services provider panel, to administer the pediatric vision services benefits.

Professional Services	*Copayment*
Routine eye examination with dilation, as Medically Necessary	$0±

Limitation:

In accordance with professionally recognized standards of practice, this Plan covers one complete vision examination once every calendar year. .

Materials (including frames and lenses)	*Copayment*
Provider selected Frames (one every calendar year)	$0±
Standard Plastic Eyeglass Lenses (one pair every calendar year)	$0±

- Single vision, bifocal, trifocal, lenticular
- Glass or plastic
- Oversized and glass-grey #3 prescription sunglass lenses

Optional Lenses and Treatments including: ..... $0±

- UV Treatment
- Tint (Fashion & Gradient & Glass-Grey)
- Standard Plastic Scratch Coating
- Standard Polycarbonate –
- Photocromatic / Transitions Plastic
- Standard , Premium and Ultra Anti-Reflective Coating
- Polarized
- Standard, Premium, Select, and Ultra Progressive Lens
- Hi-Index Lenses
- Blended segment Lenses
- Intermediate vision Lenses
- Select or ultra progressive lenses

Premium Progressive Lenses ..... $0±

Provider selected Contact Lenses, a one year supply every calendar year (In lieu of eyeglass lenses) ..... $0±

- Disposable
- Conventional
- Medically Necessary*

Subnormal or Low Vision Services and Aids - one comprehensive low vision evaluation every 5 years; low vision aids, including high-power spectacles, magnifiers or telescopes (limited to one aid per year) and follow-up care (limited to 4 visits every 5 years) ..... $0±

± *Deductible waived.*

* Contact Lenses may be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, Contact Lenses may be Medically Necessary and appropriate when the use of Contact Lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

Contact Lenses may be Medically Necessary for the treatment of conditions, including, but not limited to: keratoconus, pathological myopia, aphakia, anisometropia, aniridia, corneal disorders, post-traumatic disorders and irregular astigmatism.

Medically Necessary Contact Lenses are dispensed in lieu of other eyewear. Participating providers will obtain the necessary pre-authorization for these services.

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

+ Services or supplies excluded under the vision care program may be covered under the medical benefits portion of your plan. Consult the plan's Certificate for more information.

In addition to the limitations described above, the plan does not cover the following:

- Eye examinations required for work or school;
- Medical or surgical treatment of the eyes;
- Nonprescription eyewear, vision devices or nonprescription sunglasses; and
- Replacement of lost, stolen or broken frames or lenses, unless benefits are otherwise available.
- Orthoptics (eye exercises);

LIABILITY FOR PAYMENT

If you go to a care provider not affiliated with Health Net Life, you will be responsible for payment of your eye exam, glasses or contact lenses.

You may also have to pay additional fees when you use an affiliated provider if you choose lenses, frames or contact lenses that cost more than the covered expense. Health Net Life will seek reimbursement for vision and eyewear services that are covered under Workers' Compensation or required by occupational disease law.

This is only a summary. Consult the plan's* Certificate *to determine the exact terms and conditions of your coverage.

Pediatric dental program

Benefits

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Calendar Year basis unless otherwise specifically stated.

Benefit Description	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic and Preventive Benefits	$0	$0
Restorative Benefits	20%	20%
Oral Surgery	50%	50%
Endodontics	50%	50%
Periodontics	50%	50%
Crown and Fixed Bridge	50%	50%
Removable Prosthetics	50%	50%
Medically Necessary Orthodontics	50%	50%
Other benefits	50%	50%

Diagnostic and Preventive Benefits

Benefit includes:

- Initial and periodic oral examinations
- Consultations, including specialist consultations
- Topical fluoride treatment
- Preventive dental education and oral hygiene instruction
- Roentgenology (x-rays)
- Prophylaxis services (cleanings)
- Dental sealant treatments
- Space Maintainers, including removable acrylic and fixed band type
- Preventive dental education and oral hygiene instruction

Diagnostic & Preventive Limitations:

- Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.

- Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months.
- Panoramic film x-rays are limited to once every 24 consecutive months.
- Prophylaxis services (cleanings) are limited to two in a 12-month period.
- Dental sealant treatments are limited to permanent first and second molars only.

Restorative Benefits

Restorations include:

- Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries
- Micro filled resin restorations which are noncosmetic
- Replacement of restoration
- Use of pins and pin build-up in conjunction with a restoration
- Sedative base and sedative fillings

Basic Restorative Limitations:

- For the treatment of caries, if the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations. Any other restoration such as a crown or jacket is considered an upgrade and the Covered Person will pay the difference in cost.
- Composite resin or acrylic restorations in posterior teeth are considered an upgrade and the Covered Person will pay the difference in cost. Amalgam, synthetic and plastics fillings are the Plan benefit. Plan will pay as amalgam, synthetic or plastic.
- Replacement of a restoration is covered only when it is defective, as evidence by conditions such a recurrent caries or fracture, and replacement is dentally necessary.

Oral Surgery

Oral surgery includes:

- Extractions, including surgical extractions
- Removal of impacted teeth
- Biopsy of oral tissues
- Alveolectomies
- Excision of cysts and neoplasms
- Treatment of palatal torus
- Treatment of mandibular torus
- Frenectomy
- Incision and drainage of abscesses

- Post-operative services, including exams, suture removal and treatment of complications
- Root recovery (separate procedure)

Oral Surgery Limitation

- The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

Endodontic

Endodontics benefits include:

- Direct pulp capping
- Pulpotomy and vital pulpotomy
- Apexification filling with calcium hydroxide
- Root amputation
- Root canal therapy, including culture canal limited retreatment of previous root canal therapy as specified below
- Apicoectomy
- Vitality tests

Endodontics Limitations

- Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing systems.
- Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

Periodontics

Periodontics benefits include:

- Emergency treatment, including treatment for periodontal abscess and acute periodontitis
- Periodontal scaling and root planing, and subgingival curettage
- Gingivectomy
- Osseous or muco-gingival surgery

Periodontics Limitation

- Periodontal scaling and root planing, and subgingival curettage are limited to five (5) quadrant treatments in any 12 consecutive months.

Crown and Fixed Bridge

Crown and fixed bridge benefits include:

- Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel
- Related dowel pins and pin build-up
- Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold
- Recementation of crowns, bridges, inlays and onlays
- Cast post and core, including cast retention under crowns
- Repair or replacement of crowns, abutments or pontics

Crown Limitations

- Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional.
- Only acrylic crowns and stainless crowns are a benefit for children under 12 years of age. If other types of crowns are chosen the Covered Person will pay the difference in cost for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.
- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filing. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filing.
- Veneers posterior to the second bicuspid are considered an upgrade and the member will pay the difference in cost. An allowance will be made for a cast full crown.

Bridge Work Limitations

- Fixed bridges will be used only when a partial cannot satisfactorily restore the case. •
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person under the age of 16. If performed on a Member under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.
- Fixed bridges used to replace missing posterior teeth are considered an upgrade and the Covered Person will pay the difference in cost when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
- Fixed bridges are an upgrade and the Covered Person will pay the difference in cost when provided in connection with a partial denture on the same arch.
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.
- The benefit allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is considered an upgrade and the Covered Person will pay the difference in cost.

Removable Prosthetics

Removable prosthetics include:

- Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers

- Office or laboratory relines or rebases
- Denture repair
- Denture adjustment
- Tissue conditioning
- Denture duplication
- Space maintainer
- Stayplate

Removable Prosthetics Limitations

- Partial dentures will not be replaced within 36 months, unless 1) It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or 2) The denture is unsatisfactory and cannot be made satisfactory.
- The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.
- A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered an upgrade and the Covered Person will pay the difference in cost.
- Full upper and/or lower denture are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.
- The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. It a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.
- Office or laboratory relines or rebases are limited to one (1) per arch in any 12 consecutive months.
- Tissue conditioning is limited to two per denture.
- Implants are considered an upgrade and the Covered Person will pay the difference in cost.
- Stayplates (interim partial dentures) are a benefit only when used as anterior space maintainers for children.

Other Benefits

Other dental benefits include:

- Local anesthetics
- Deep sedation/general anesthesia and intravenous conscious sedation/analgesia are covered only in conjunction with covered oral surgery procedures when dispensed in a dental office by a practitioner acting within the scope of their licensure. (Patient apprehension and/or nervousness are not of themselves sufficient justification.)

- Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Emergency treatment, palliative treatment
- Coordination of benefits with Member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services

Medically Necessary Orthodontia:

- Orthodontic care is covered when Medically Necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

Medically Necessary Orthodontic Limitation

- All orthodontic treatment must be prior authorized, refer to the "Certification Requirements" section for additional details.

Pediatric Dental Exclusions

1. Services which, in the opinion of the attending dentist, are not necessary to the covered person's dental health.
2. Cosmetic dental care.
3. Experimental procedures or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or devices usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficiency have not been determined for use in the treatment for which the item in service in question is recommended or prescribed. Denial of Experimental procedures or Investigational services is subject to Independent Medical Review (please refer to the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "Specific Provisions" section of the *Certificate* for more information).
4. Services that were provided without cost to the covered person by State government or an agency thereof, or any municipality, county or other subdivisions.
5. Hospital charges of any kind.
6. Loss or theft of dentures or bridgework.
7. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the covered person become eligible for such services.
8. Dispensing of drugs not normally supplied in a dental office.
9. The cost of precious metals used in any form of dental benefits.
10. The surgical removal of implants.

Notice of language services

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or call 1-800-522-0088. For more help: If you are enrolled in a PPO or EPO insurance policy underwritten by Health Net Life Insurance Company, call the CA Dept. of Insurance at 1-800-927-4357. If you are enrolled in a HMO or HSP plan provided by Health Net of California, Inc., call the DMHC Helpline at 1-888-HMO-2219. Your ID card indicates whether your plan was issued by Health Net Life Insurance Company or Health Net of California, Inc.

English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o llame al 800-522-0088. Para obtener más ayuda: Si está inscrito en una póliza de seguro PPO o EPO asegurada por Health Net Life Insurance Company, llame al Departamento de Seguros de CA al 1-800-927-4357. Si está inscrito en un plan HMO o HSP proporcionado por Health Net of California, Inc., llame a la Línea de Ayuda del Departamento de Cuidado Médico (por sus siglas en inglés, DMHC) al 1-888-HMO-2219. Su tarjeta de identificación indica si su plan fue emitido por Health Net Life Insurance Company o Health Net of California, Inc.

Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，也可以把部分翻譯成您語言的文件寄送給您。如需協助，請撥您會員卡上所列的電話號碼與我們聯絡，或撥 1-800-522-0088。如需其他協助：如果您投保的是 Health Net Life Insurance Company 核保的 PPO 或 EPO 保險保單，請撥 California Department of Insurance 電話 1-800-927-4357。如果您投保的是 Health Net of California, Inc. 提供的 HMO 或 HSP 計畫，請撥 DMHC 協助專線 1-888-HMO-2219。您的會員卡會註明您的計畫是由 Health Net Life Insurance Company 或 Health Net of California, Inc. 核發

Chinese

Dịch vụ ngôn ngữ miễn phí. Quý vị có thể được cấp thông dịch viên và người đọc giúp các tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, vui lòng gọi cho chúng tôi theo số điện thoại ghi trên thẻ hội viên của quý vị hoặc gọi Trung tâm Liên lạc Hội viên của Health Net theo số 1-800-522-0088. Để được trợ giúp bổ túc: Nếu quý vị ghi danh trong các hợp đồng bảo hiểm PPO hoặc EPO do Health Net Life Insurance Company cam kết tài trợ, vui lòng gọi Bộ Bảo hiểm của California theo số 1-800-927-4357. Nếu quý vị ghi danh trong chương trình bảo hiểm HMO hoặc HSP do Health Net of California, Inc. cung cấp, xin gọi Đường dây trợ giúp của DMHC theo số 1-888-HMO-2219. Trên thẻ hội viên của quý vị có ghi rõ chương trình bảo hiểm của quý vị là do Health Net Life Insurance Company hay Health Net of California, Inc. cung cấp.

Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상의 안내번호로 전화해 주시거나 Health Net의 고객 서비스 센터, 안내번호 1-800-522-0088번으로 전화해 주십시오. 더 많은 도움이 필요하시면: 만일 귀하가 Health Net Life Insurance Company가 인수한 PPO 또는 EPO 보험 폴리시에 가입하신 경우, 캘리포니아 보험국 (CA Dept. of Insurance), 안내번호 1-800-927-4357번으로 문의해 주십시오. 만일 귀하가 Health Net of California, Inc.에서 제공하는 HMO 또는 HSP 플랜에 가입하신 경우, 보건관리부 (DMHC) 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오. 귀하의 ID상에 귀하의 플랜이 Health Net Life Insurance Company에서 제공되는지 또는 Health Net of California, Inc.에서 제공되는지 명시되어 있습니다.

Korean

Walang Gastusin na Mga Serbisyo sa Wika. Maaari kang kumuha ng interpreter at basahin sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa nakalistang numero sa iyong ID card o sa Customer Contact Center ng Health Net sa 1-800-522-0088. Para sa karagdagang tulong: Kung naka-enroll ka sa isang insurance policy ng PPO o EPO na napapailalim sa Health Net Life Insurance Company, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Kung naka-enroll ka sa isang plano ng HMO o HSP na ipinagkakaloob ng Health Net of California, Inc., tumawag sa DMHC Helpline sa 1-888-HMO-2219. Isinasaad ng iyong ID card kung ang iyong plano ay ibinigay ng Health Net Life Insurance Company o Health Net of California, Inc.

Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք բանավոր թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ Ձեր լեզվով: Օգնության համար մեզ զանգահարեք Ձեր ինքնության (ID) տոմսի վրա նշված համարով, կամ եթե գործատիրոջ խմբի դիմորդ եք, խնդրում ենք 1-800-522-0088 համարով զանգահարել Health Net-ի Հաճախորդի Կապի Կենտրոն: Հավելյալ օգնության համար՝ եթե գրանցվել եք PPO կամ EPO ապահովագրական ծրագրում, որի մատակարարն է Health Net Life Insurance Company-ն, 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք (CA Dept. of Insurance): եթե գրանցվել եք HMO կամ HSP ծրագրում, որի մատակարարն է Health Net of California, Inc.-ը, 1-888-HMO-2219 համարով զանգահարեք DMHC-ի Օգնության Գծին: Ձեր ինքնության տոմսը նշում է, թե ով է թողարկել Ձեր ծրագիրը՝ Health Net Life Insurance Company-ն, թե՞ Health Net of California, Inc.-ը:

Armenian

無料の言語サービス。日本語の通訳が書類をお読みします。サービスをご希望の方は、IDカード記載の番号まで、またはHealth Netの顧客コンタクト・センター、1-800-522-0088までお電話ください。さらに援助が必要な場合、Health Net Life Insurance Companyが保険引受会社となるPPOまたはEPO保険ポリシーにご加入の方は、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Health Net of California, Inc.が提供するHMOまたはHSPプランにご加入の方は、DMHCヘルプライン、1-888-HMO-2219までご連絡ください。お客様のプランの発行者がHealth Net Life Insurance CompanyまたはHealth Net of California, Inc.のどちらであるかは、IDカードに記載されています。

Japanese

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочитать документы на вашем языке. Если вам требуется помощь, звоните нам по номеру телефона, указанному на вашей идентификационной карте или в Контактный центр для клиентов компании Health Net (Customer Contact Center) по телефону 1-800-522-0088. Для получения дополнительной помощи: если у вас страховой полис Организации с предпочтительными поставщиками услуг (Preferred Provider Organization, PPO) или Организации с обязательными поставщиками услуг (Exclusive Provider Organization, EPO), который предоставляется компанией Health Net Life Insurance Company, обращайтесь в Департамент страхования штата Калифорния (CA Dept. of Insurance) по номеру 1-800-927-4357. Если вы зарегистрированы в плане HMO или HSP, который предоставлен компанией Health Net of California, Inc., звоните на телефон Горячей линии Департамента организованного медицинского обслуживания (DMHC Helpline) по номеру 1-888-HMO-2219. На вашей идентификационной карте указано, был ли ваш план оформлен компанией Health Net Life Insurance Company или компанией Health Net of California, Inc.

Russian

خدمات بی هزینه مربوط به زبان. می توانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید تا نوشته ها به زبان خودتان برایتان خوانده شوند. برای دریافت کردن کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا مرکز تماس مشتریان Health Net به شماره 1-800-522-0088 تماس بگیرید.
برای دریافت کمک بیشتر: اگر برای یک بیمه نامه PPO یا EPO که توسط Health Net Life Insurance Company تضمین شده است ثبت نام کرده اید، به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید. اگر در یک طرح HMO یا HSP که توسط Health Net of California, Inc. فراهم شده است ثبت نام میکنید، به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید. کارت شناسائی تان نشان میدهد که آیا طرح شما توسط Health Net Life Insurance Company صادر شده است یا Health Net of California, Inc.

Farsi

ਭਾਸ਼ਾ ਦੀਆਂ ਮੁਫਤ ਸੇਵਾਵਾਂ। ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਆ ਮਿਲ ਸਕਦਾ ਹੈ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ, ਜਾਂ Health Net ਦੇ ਗਾਹਕ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ 1-800-522-0088 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕਿਸੇ PPO ਜਾਂ EPO ਬੀਮਾ ਪਾਲਿਸੀ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ ਕੈਲੀਫੋਰਨਿਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ Health Net of California, Inc. ਵਲੋਂ ਮੁਹੱਈਆ ਕੀਤੀ ਗਈ ਕਿਸੇ HMO ਜਾਂ HSP ਯੋਜਨਾ ਲਈ ਨਾਂ ਲਿਖਵਾਇਆ ਹੈ ਤਾਂ DMHC ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਤੁਹਾਡੇ ਆਈ ਡੀ ਕਾਰਡ ਤੇ ਇਹ ਦਿਖਾਇਆ ਗਿਆ ਹੈ ਕਿ ਤੁਹਾਡੀ ਯੋਜਨਾ Health Net Life Insurance Company ਵਲੋਂ ਜਾਰੀ ਕੀਤੀ ਗਈ ਸੀ ਜਾਂ Health Net of California, Inc. ਵਲੋਂ।

Punjabi

សេវាបកប្រែភាសាឥតអស់ថ្លៃ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងថ្លែងអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខមានកត់នៅលើប័ណ្ណ ID របស់អ្នក ឬមជ្ឈមណ្ឌលទំនាក់ទំនងអតិថិជនរបស់ Health Net តាមលេខ 1-800-522-0088។ សំរាប់ជំនួយបន្ថែម : បើអ្នកបានចុះឈ្មោះក្នុងផ្សាប់សន្យាធានារ៉ាប់រង PPO ឬ EPO បានធានារ៉ាប់រងដោយ Health Net Life Insurance Company ទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357។ បើអ្នកបានចុះឈ្មោះក្នុងគំរោង HMO ឬ HSP ដែលបានផ្តល់ដោយ Health Net of California, Inc. ទូរស័ព្ទទៅខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219។ ប័ណ្ណ ID របស់អ្នក បង្ហាញថាតើគំរោងរបស់អ្នកបានចេញដោយ Health Net Life Insurance Company ឬ Health Net of California, Inc.។

Khmer

Kev Pab Lus Tsis Muaj Nqi Them. Koj txais tau tus neeg txhais lus thiab muab tau cov ntawv los nyeem rau koj ua koj hom lus. Kom tau kev pab, hu tuaj rau peb ntawm tus xovtooj uas nyob ntawm koj daim npav ID lossis Health Net Lub Chaw Pab Cov Tib Neeg Siv Cov Kev Pab (Customer Contact Center) ntawm 1-800-522-0088. Yog xav tau kev pab ntxiv: Yog koj muaj npe nkag nrog PPO lossis EPO cov kev tuav pov hwm los ntawm Health Net Life Insurance Company, hu rau CA Qhov Chaw Saib Xyuas Txog Kev Tuav Pov Hwm (Dept. of Insurance) ntawm 1-800-927-4357. Yog koj muaj npe nkag nrog ib qho kev npaj pab HMO lossis HSP uas los ntawm Health Net of California, Inc., hu rau DMHC Tus Xovtooj Muab Kev Pab ntawm 1-888-HMO-2219. Koj daim npav ID yuav qhia tau tias koj qhov kev npaj pab yog los ntawm Health Net Life Insurance Company lossis Health Net of California, Inc.

Hmong

Doo Bąąh 'Alínígóó Saad Bee 'áka'anída'awo'ígíí. 'Ata' halne'í dóó naaltsoos bee 'éédahozinígíí t'áá ni nizaad bee hadadilyaago nich'į' yídóoltah. 'Áka'a'eyeed biniiyégo, ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' béésh bee haneí biká'ígíí bee nich'į' hodíilnih, doodago ninaalishí bił hada'dil'ínígíí t'áá shǫǫdí Health Net Na'iilniihí Hane' 'ÍłtʻįĥBiłHaz'ánijį' 1-800-522-0088 hodíilnih.T'áá náásgóó 'áka'a'eyeed biniiyégo: PPO doodago EPO béeso 'ách'ąąh naa'nil bibee haz'áanii Health Net Life Insurance Company bich'į' haidiilaaígíí bił ha'dít'éhígíí bił ha'diléehgo, CA Dept. béeso 'áchąąh naa'nil bił haz'ánígíí bich'į' kohjį' ąǫįóóǫįąíǫęąęį hodíilnih. Health Net of California, Inc. biyaadóó HMO doodago HSP bił ha'dít'éhígíí bił ha'diléehgo, DMHC 'Áka'aná'awo' Bił Haz'ánígíí kohjį'1-888-HMO-2219 hodíilnih. Health Net Life Insurance Company doodago Health Net of California, Inc. bił naaltsoos bił náha'dít'éhígíí ninaaltsoos nitł'izí bine'dęę' bikáá'.

Navajo

الخدمات اللغوية المجانية. يمكنك الحصول على مترجم فوري للمساعدة في قراءة مستنداتك باللغة التي تتحدث بها. للحصول على المساعدة، يُرجى الاتصال بنا على الرقم الموضح على بطاقة التعريف الخاصة بك أو الاتصال بمركز التواصل مع العملاء لدى Health Net على الرقم 1-800-522-0088. للحصول على المزيد من المساعدة:
إذا كنت مسجلاً في سياسة التأمين بخطة PPO أو EPO التي تضمنها شركة التأمين على الحياة Health Net Life Insurance Company، يُرجى الاتصال بـ CA Dept. of Insurance (وزارة التأمين بولاية كاليفورنيا) على الرقم 1-800-927-4357. إذا كنت مسجلاً في خطة HMO أو HSP التي توفرها شركة Health Net of California, Inc.، يُرجى الاتصال بخط المساعدة لدى DMHC على الرقم 1-888-HMO-2219. توضح بطاقة التعريف الخاصة بك ما إذا كان تم إصدار خطتك عبر شركة التأمين على الحياة Health Net Life Insurance Company أو شركة Health Net of California, Inc.

Arabic

CONTACT US

For more information, please contact us at:

Health Net PPO
Post Office Box 10196
Van Nuys, California 91410-0196

Customer Contact Center

1-800-361-3366 – California PPO Covered Person
1-800-861-7214 – Out-of-State (non-California) PPO Covered Persons

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

1/2015 SBID: 81604