INDIVIDUAL & FAMILY PLANS

HMO AND PPO GUARANTEED ISSUE SUMMARY OF BENEFITS

Health coverage made easy.

Effective May 1, 2010

Health Net®
A BETTER DECISION

HEALTH NET GUARANTEED ISSUE INDIVIDUAL & FAMILY COVERAGE

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) makes it easier for people covered under existing group health plans to maintain coverage, regardless of pre-existing conditions, when they change jobs or are unemployed for brief periods of time. California law provides similar and additional protections. Applicants who meet requirements outlined under the "Important things to know about all your coverage options," "Who is eligible?" section are eligible to enroll in a guaranteed issue individual health plan from any health plan that offers individual coverage, including Health Net's Guaranteed HMO and PPO plans, without medical underwriting. A health plan cannot reject your application for guaranteed issue individual health coverage if you meet the eligibility requirements, agree to pay the required premiums and live or work in the plan's service area. In response, Health Net of California, Inc. offers the HMO 15 and HMO 40 plans, and Health Net Life Insurance Company offers the PPO SimpleChoice HSA and PPO SimpleValue 50 coverage options, to eligible individuals at the Guaranteed Issue Rates listed at the end of this Disclosure Form.

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

This document is only a summary of your health coverage. You have the right to view the Plan Contract and Evidence of Coverage (EOC) for HMO Plans and the Policy for PPO coverage prior to enrollment. To obtain a copy of these documents, contact your authorized Health Net agent or your Health Net Sales Representative at 1-800-909-3447. Your Plan Contract and EOC or Policy, which you will receive after you enroll, contains the terms and conditions, as well as the governing and exact contractual provisions, of your Health Net coverage. It is important for you to carefully read this document and your Plan Contract and EOC or Policy thoroughly once received, especially all sections that apply to those with special health care needs. Health benefits and coverage matrices on pages 4 to 9 are included to help you compare coverage benefits.

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

IMPORTANT NOTICE TO CALIFORNIA PPO POLICYHOLDERS

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

Health Net Life Insurance Company
Individual & Family Plans
P.O. Box 1150
Rancho Cordova, CA 95741-1150

1-800-909-3447

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

California Department of Insurance,
Consumer Services Division
300 South Spring Street
South Tower
Los Angeles, CA 90013

1-800-927-HELP

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

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

IMPORTANT INFORMATION TO KNOW ABOUT ENROLLING IN A PPO PLAN

In-network providers have agreed to provide you covered services and supplies and accept a special contracted rate, called the Contracted Rate, as payment in full. Your share of costs is based on this Contracted Rate. Out-of-network providers have not agreed to participate in the Health Net PPO program. **When you use an out-of-network provider, benefits are substantially reduced and you will incur a significantly higher out-of-pocket expense.** Your out-of-pocket expense is greater because: (i) You are responsible for a higher percentage cost of the benefits in comparison to the cost of benefits when services are provided by in-network providers; (ii) Health Net's benefit for out-of-network providers is based on either a percentage of the Maximum Allowable Amount, or Health Net's "Limited Fee Schedule." Please refer to the "PPO Summary of Benefits" insert for details; and (iii) You are financially responsible for any amounts these providers charge in excess of this amount.

UNDERSTANDING YOUR COVERAGE CHOICES

WHAT IS AN HMO?

With an HMO, you select your Primary Care Physician from our Individual & Family Plan HMO network (for information on available providers, see our Individual & Family Plan HMO provider listing, call us at 1-800-909-3447 or visit our website). Your Primary Care Physician oversees all your health care and provides the referral/authorization if specialty care is needed. Primary Care Physicians include general and family practitioners, internists, pediatricians and OB/GYNs. A Primary Care Physician's office is just like any other private doctor's office. When you need to see your doctor, just call for an appointment. To obtain health care, simply present your ID card and pay the appropriate copayment.

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

HMO advantages include:

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

OUT-OF-POCKET MAXIMUM

See the "Principal Benefits and Coverage Matrix–HMO" section for specific information about the out-of-pocket maximum and deductibles for the Guaranteed Issue HMO Plans. The copayments and the calendar year inpatient hospital services deductible that you or your family members pay for covered services apply toward the individual or family out-of-pocket maximum. After you or your family members meet your individual or family out-of-pocket maximum, you pay no additional amounts for covered services for the balance of the calendar year, except as otherwise noted. Once an individual member in a family satisfies the individual out-of-pocket maximum, the remaining enrolled family members must continue to pay the copayments and the calendar year deductible for inpatient hospital facility services until either (a) the aggregate of such copayments and deductibles paid by the family reaches the family out-of-pocket maximum or (b) each enrolled family member individually satisfies the individual out-of-pocket maximum. You are responsible for all charges related to services not covered by the health plan. Amounts that are paid toward certain covered services, are not applicable to a Member's out-of-pocket maximum. See the "Principal Benefits and Coverage Matrix—HMO" section for specific information about which amounts do not apply toward the out-of-pocket maximum. Payments for services not covered by this plan will not be applied to this yearly out-of-pocket maximum. In order for the family out-of-pocket maximum to apply, you and your family must be enrolled as a family unit.

IS A PPO RIGHT FOR YOU?

PPO plans are designed for people who want to see any licensed physician or health care professional and

are willing to pay a bit more for it. Visits to specialists, hospitals and facilities can be made without a referral from your personal doctor.

ACCESS TO CARE

PPOs offer a choice of where you receive services: in-network and out-of-network. Doctors and facilities that are contracted with Health Net PPO are in-network. When you go out-of-network, you will pay more.

COST

Depending on your PPO plan, you may owe a copayment when you visit your doctor. Your copayment is a fixed dollar amount that you pay when receiving care. In addition, you may pay a deductible, which is the amount you pay for covered services before the plan begins to pay. Once plan coverage kicks in, you may also be responsible for coinsurance. This is a percentage of your doctor's bill that is your responsibility. When your doctor submits a bill, we pay our portion and send you a statement of the amount you owe. This statement is called an Explanation of Benefits. Your doctor should bill you for the amounts on this statement.

HEALTH NET PPO ADVANTAGES INCLUDE:

- Choice of more than 61,000 physicians,
- Reduced costs and no claim form filing when using Health Net PPO network doctors and facilities,
- No referrals or authorizations required to see a physician,
- Wide range of specialists, and
- Care when traveling out of state.

CHOOSING THE RIGHT PPO PLAN

SimpleChoice HSA and SimpleValue 50:
The SimpleChoice HSA-Compatible Plan is a high-deductible PPO plan designed to be used with a Health Savings Account (HSAs). Once you enroll in this plan, you open an HSA at a bank or financial institution. The HSA then allows you to save and spend on qualified medical expenses tax-free (including deductibles and copayments).[1]

The PPO SimpleValue 50 is a zero-deductible, applicant-only plan. You pay copayments for doctor visits and coinsurances only where applicable.

[1]Federal tax information only. State taxes may apply. Qualified medical expenses include plan deductibles and copayments, as well as services such as vision, dental and prescription drugs. A full list of qualified medical expenses is outlined in IRS publication 502 – Medicare and Dental Expenses; which you can find at www.irs.gov. Simply enter "502" in the search field.

PRINCIPAL BENEFITS AND COVERAGE MATRIX – HMO

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

BENEFIT DESCRIPTION	HMO 15	HMO 40
Deductibles	$1,000 per calendar year for inpatient hospital services only (prescription drug coverage deductible also applies[1])	$1,500 per calendar year for inpatient hospital services only (prescription drug coverage deductible also applies[1])
Lifetime maximums	Unlimited	Unlimited
Out-of-pocket maximum (Payments for services not covered by this plan will not be applied to this yearly out-of-pocket maximum)	$3,000 single/ $6,000 family (Includes deductible)	$3,000 single/ $6,000 family (Includes deductible)
PROFESSIONAL SERVICES		
Visit to physician	$15	$40
Specialist consultations	$15	$40
Prenatal and postnatal office visits	$15	$40
PREVENTIVE CARE		
Periodic health evaluations and annual preventive physical examinations [2]	$15	$40
Vision screenings and exams	$15	$40
Hearing screenings and exams	$15	$40
Immunizations – Standard	$15	$40
Immunizations – To meet foreign travel or occupational requirements	20%	20%
Prostate cancer screening and exam	$15	$40
Annual OB/GYN exam (breast and pelvic exams, cervical cancer screening and mammography)[3]	$15	$40
Allergy testing	$15	$40
Allergy injection services	$15	$40
All other injections	Covered in full	Covered in full
Allergy serum	Covered in full	Covered in full
OUTPATIENT SERVICES		
Outpatient services other than surgery	Covered in full	Covered in full
Outpatient surgery	$250	$250
HOSPITALIZATION SERVICES		
Semiprivate hospital room or intensive care unit with ancillary services (unlimited, except for non-severe mental health and chemical dependency treatment)	$1,000 deductible applies per calendar year for inpatient services	$1,500 deductible applies per calendar year for inpatient services
Surgeon or assistant surgeon services	Covered in full	Covered in full
Skilled nursing facility stay (limited to 100 days per calendar year)	$50 per day	$50 per day

For HMO footnotes, see page 6–7.

BENEFIT DESCRIPTION	HMO 15	HMO 40
HOSPITALIZATION SERVICES (continued)		
Maternity care in hospital or skilled nursing facility	$0 after inpatient hospital services deductible is met	$0 after inpatient hospital services deductible is met
Physician visit to hospital or skilled nursing facility (excluding care for chemical dependency and mental disorders)	Covered in full	Covered in full
EMERGENCY HEALTH COVERAGE		
Emergency room (professional and facility charges)	$75 (waived if admitted to hospital)	$100 (waived if admitted to hospital)
Urgent care center (professional and facility charges)	$25	$40
AMBULANCE SERVICES		
Ground ambulance	$50	$80
Air ambulance	$50	$80
PRESCRIPTION DRUG COVERAGE $100 prescription deductible per member, per calendar year applies[1,4,5,6,7]		
Prescription drugs filled at a participating pharmacy (up to a 30-day supply)[1]	$15 Level I (primarily generic); $25 Level II (primarily brand name, peak flow meters, inhaler spacers and diabetic supplies, including insulin); $50 Level III Drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)	$15 Level I (primarily generic); $25 Level II (primarily brand name, peak flow meters, inhaler spacers and diabetic supplies, including insulin); $50 Level III Drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)
Prescription drugs filled through mail order (up to a 90-day supply)[1]	$30 Level I (primarily generic); $50 Level II (primarily brand name and diabetic supplies, including insulin); $100 Level III Drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)	$30 Level I (primarily generic); $50 Level II (primarily brand name and diabetic supplies, including insulin); $100 Level III Drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)
Smoking Cessation Drugs (covered up to a 12-week course of therapy per calendar year if you are concurrently enrolled in a comprehensive smoking cessation behavioral support program. For information regarding smoking cessation behavioral support programs available through Health Net, contact the Customer Contact Center at the telephone number on your Health Net ID Card or visit the Health Net website at www.healthnet.com)[1]	50%	50%
Contraceptive drugs[1]	$15 Level I (primarily generic); $25 Level II (primarily brand name); $50 Level III Drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)	$15 Level I (primarily generic); $25 Level II (primarily brand name); $50 Level III Drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)

BENEFIT DESCRIPTION	HMO 15	HMO 40
DURABLE MEDICAL EQUIPMENT		
Durable medical equipment (including nebulizers, face masks and tubing for the treatment of asthma)	50%	50%
Prosthesis[8]	Covered in full	Covered in full
MENTAL HEALTH SERVICES FOR SEVERE MENTAL ILLNESS AND SERIOUS EMOTIONAL DISTURBANCES OF A CHILD CONDITIONS[9]		
Outpatient	$15	$40
Inpatient	Covered in full	Covered in full
MENTAL HEALTH SERVICES FOR NONSEVERE MENTAL ILLNESS[9]		
Outpatient	$30	$40
Inpatient	Covered in full	Covered in full
CHEMICAL DEPENDENCY SERVICES		
Chemical dependency treatment	Not covered	Not covered
Acute care (detoxification)	$100 per day (unlimited)	$100 per day (unlimited)
HOME HEALTH SERVICES		
Home health services (100 visits per calendar year maximum; limited to three visits per day, four-hour maximum per visit)	$15	$40
OTHER		
Diabetic equipment (includes blood glucose monitors, insulin pumps and corrective footwear)[8]	$25	$25
Laboratory procedures and diagnostic imaging (including X-ray) services	Covered in full	Covered in full
Rehabilitative therapy (includes physical, speech, occupational and respiratory therapy)	$15	$40
Sterilizations – Vasectomy	$150	$150
Sterilizations – Tubal ligation	$150	$150
Organ and bone marrow transplants (non-experimental and non-investigational)	Covered in full	Covered in full
Hospice services	Covered in full	Covered in full
Family planning counseling	$15	$40

HMO FOOTNOTES

[1]Does not apply to the Out-of-Pocket Maximum, except copayments for peak flow meters, inhaler spacers used for the treatment of asthma and diabetic supplies.

[2]For preventive health purposes, a periodic health evaluation and diagnostic preventive procedures are covered, based on recommendations published by the U.S. Preventive Services Task Force. In addition, a covered annual cervical cancer screening test includes a Pap test, a human papillomavirus (HPV) screening test that is approved by the U.S. Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA.

[3]Women may obtain OB/GYN physician services in their Primary Care Physician's Physician Group for OB/GYN preventive care, pregnancy and gynecological ailments without first contacting their Primary Care Physician. Mammograms are covered at the following intervals: One for ages 35–39, one every 24 months for ages 40–49, and one every year for age 50 and older.

[4]The Health Net Recommended Drug List is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. Some drugs on the List may require prior authorization from Health Net. Drugs that are not listed on the List (previously known as non-formulary) that are not excluded or limited from coverage are covered. Some drugs that are not listed on the List do require prior authorization from Health Net. Urgent requests from physicians are handled in a timely fashion, not to exceed 72 hours, as appropriate and Medically Necessary for the nature of the member's condition, after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 5 days, as appropriate and Medically Necessary for the nature of the Member's condition, after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination. For a copy of the Recommended Drug List, call the Customer Contact Center at the number listed on your ID card or visit our website at www.healthnet.com.

[5]If the pharmacy's retail price is less than the applicable copayment, you will only pay the pharmacy's retail price.

[6]The prescription drug deductible (per member per calendar year) must be paid for prescription drug covered services before Health Net begins to pay. The prescription drug calendar year deductible does not apply to peak flow meters, inhaler spacers used for the treatment of asthma and diabetic supplies and equipment dispensed through a Participating Pharmacy. Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.

[7]Percentage copayments will be based on Health Net's contracted pharmacy rate.

[8]Diabetic equipment covered under the medical benefit (through "Diabetic Equipment") includes blood glucose monitors designed to assist 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 glucose monitors and blood glucose testing strips, Ketone urine testing strips, lancets and lancet puncture devices, specific brands of pen delivery systems (including pen needles) for the administration of insulin and specific brands of insulin syringes. Additionally, the following supplies are covered under the medical benefit as specified: visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin are provided through the prostheses benefit; Glucogen, provided through the self-injectables 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).

[9]See page 13 for definitions of severe mental illness or serious emotional disturbances of a child. Treatment of non-severe mental disorders is limited to 20 outpatient visits and 30 inpatient days per calendar year.

PRINCIPAL BENEFITS AND COVERAGE MATRIX – PPO

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

BENEFIT DESCRIPTION	PPO SIMPLECHOICE HSA		PPO SIMPLEVALUE 50	
	IN-NETWORK YOU PAY[1]	OUT-OF-NETWORK YOU PAY[2]	IN-NETWORK YOU PAY[1]	OUT-OF-NETWORK YOU PAY[2]
Annual deductible	$4,000 single/$8,000 family All benefits, including Outpatient Prescription Drugs, are subject to the deductible except Preventive Care. For contracts of two or more insureds, there are no benefits until the family deductible is met.		$0 (available as a subscriber-only contract)	
ANNUAL OUT-OF-POCKET MAXIMUM Preferred providers	$4,000 single/$8,000 family combined in- and out-of-network (includes deductible)		$7,500	
Non-preferred providers	$5,000 single/$10,000 family combined in- and out-of-network (includes deductible)		$10,000	
Lifetime Maximum	$6 million		$6 million	
VISIT TO PHYSICIAN	Covered in full after deductible is met	50%	$50	50%
X-RAY AND LABORATORY PROCEDURES[4]	Covered in full after deductible is met	50%	50%	50%

For PPO footnotes, see page 9.

BENEFIT DESCRIPTION	PPO SIMPLECHOICE HSA		PPO SIMPLEVALUE 50	
	IN-NETWORK[1]	OUT-OF-NETWORK[2]	IN-NETWORK[1]	OUT-OF-NETWORK[2]
PREVENTIVE CARE				
Adult preventive care (age 19 and older)				
Routine physical exams, including routine lab and X-ray services[9]	Covered in full after deductible is met	Not covered	50%	Not covered
Annual OB/GYN exam (breast and pelvic exams, cervical cancer screening and mammography)[5]	$40[3]	Not covered	$50	Not covered
Prostate cancer screening and exam	$40[3]	Not covered	$50	Not covered
Child preventive care (newborns to age 18); checkups, vision and hearing exams	$40[3]	Not covered	$50	Not covered
MATERNITY AND PREGNANCY				
Prenatal and postnatal office visits	Not covered	Not covered	Not covered	Not covered
Maternity care in hospital	Not covered	Not covered	Not covered	Not covered
EMERGENCY AND URGENT CARE				
Emergency room (professional and facility charges)	Covered in full after deductible is met		$50 copay plus 50%	
Urgent care center (facility charges)	Covered in full after deductible is met		50%	
Ambulance[4]	Covered in full after deductible is met		50%	
HOSPITALIZATION SERVICES (NON-EMERGENCY CARE)[4]				
Surgeon and anesthetics services	Covered in full after deductible is met	50%	50%	50%
Inpatient, semiprivate hospital room or intensive care unit with ancillary services (unlimited)	Covered in full after deductible is met	50%[6]	$400 copay per day plus 50% (4-day copay maximum)	$400 copay per day plus 50%[6] (4-day copay maximum)
Outpatient surgery (hospital or outpatient surgery center charges only)	Covered in full after deductible is met	50%[6]	$400 copay plus 50%	$400 copay plus 50%[6]
Outpatient facility services	Covered in full after deductible is met	50%[6]	50%	50%[6]
REPRODUCTIVE HEALTH				
Sterilization	Covered in full after deductible is met	Not covered	50%	Not covered

BENEFIT DESCRIPTION	PPO SIMPLECHOICE HSA		PPO SIMPLEVALUE 50	
	IN-NETWORK[1]	OUT-OF-NETWORK[2]	IN-NETWORK[1]	OUT-OF-NETWORK[2]
OTHER SERVICES				
Rehabilitative therapy includes physical, speech, occupational, respiratory and cardiac therapy (20 visits per calendar year combined in- and out-of-network)[4]	Covered in full after deductible is met	Not covered	50%	50%
Chiropractic care (12-visit calendar year maximum combined in- and out-of-network/$20 maximum payable per visit)	Covered in full after deductible is met	Not covered	50%	Not covered
Mental health services for nonsevere conditions[4,7]	Covered in full after deductible is met	50% inpatient/ not covered outpatient	50% inpatient/ 50% outpatient	50% inpatient/ not covered outpatient
Durable medical equipment (including foot orthotics)[4]	Covered in full after deductible is met	Not covered	50%	Not covered
OUTPATIENT PRESCRIPTION DRUGS[8]				
Filled at participating pharmacy (up to a 30-day supply); not covered at non-participating pharmacies	Covered in full after deductible is met	Not covered	$10 Level I (generic) $750 brand ded. $35 Level II (brand) $50 or 50% Level III (whichever is greater, non-formulary)	Not covered
Filled through mail order (up to a 90-day supply)	Covered in full after deductible is met	Not covered	Twice the level of copayment	Not covered

PPO FOOTNOTES

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

[2]Percentage is a portion of the covered expense based on Maximum Allowable Amount. You are also responsible for any charges in excess of the covered expense.

[3]Calendar year deductible waived.

[4]Certain services require prior certification from Health Net. Without prior certification, benefit reduced by 50%. Refer to page 13.

[5]One mammogram for ages 35–39, one every 24 months for ages 40–49, and one every year for age 50 and older.

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

[7]See page 13 for definitions of severe mental illness or serious emotional disturbances of a child. Treatment of non-severe mental disorders is limited to Participating or Preferred Providers for outpatient services, with the following maximums: 20 outpatient visits, $30 maximum payable per outpatient visit; 30 inpatient days per calendar year; and a maximum allowable limit per day for inpatient services of $300. Covered expenses for non-severe mental illness and chemical dependency do not apply to the out-of-pocket maximum.

[8]The Recommended Drug List is a list of the prescription drugs that are covered by this plan. It is prepared by Health Net and given to Insured physicians and participating pharmacies. Some drugs require prior authorization from Health Net. Also, if your condition requires the use of a drug that is not in the Recommended Drug List, your physician may request the drug through the prior authorization process. Urgent prior authorization requests are handled within 72 hours. For a copy of the Recommended Drug List, call the Customer Contact Center at the number listed on your ID card or visit our website at www.healthnet.com.

[9]For annual routine physical exams, the maximum payable per calendar year is $200.

IMPORTANT THINGS TO KNOW ABOUT ALL OF YOUR COVERAGE OPTIONS

Who is eligible?
Applicants who meet the following requirements are eligible to enroll in Health Net's Guaranteed Issue HMOs and PPOs, without underwriting. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance. To be considered an eligible individual:

- The applicant must be under the age of 65.
- The applicant must not be eligible for Medicare.
- The applicant must reside continuously in our service area.
- The most recent coverage must have been under a group health plan (COBRA and Cal-COBRA coverage are considered group coverage).
- The applicant must have a total of 18 months of coverage (including COBRA, if applicable) without a significant break (excluding any employer-imposed waiting periods) in coverage of more than 63 days.
- If COBRA or Cal-COBRA coverage was available, it must have been elected and such coverage must have been exhausted.
- The applicant must not be eligible for coverage under any group health plan, Medicare or Medicaid, and must not have other health insurance coverage.
- The individual's most recent coverage could not have been terminated due to fraud or nonpayment of premiums.

How does the monthly billing work?
Your premium must be received by Health Net by the first day of the coverage month. If there are premium increases after the enrollment effective date, you will be notified at least 30 days in advance. For your monthly billing, you may choose to enroll in Health Net's Simple Pay option, pay by credit card or receive a monthly billing statement by mail. If there are changes to the Health Net Individual & Family HMO Plan Contract and EOC or PPO Policy, including changes in benefits, you will be notified at least 30 days in advance.

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

- You do not pay your premium on time. (If you do not pay your premium on time, Health Net may terminate your coverage upon 15 days' written notice, retroactive to the day following the last day for which premiums were last paid.)
- You and/or your family member(s) cease being eligible.
- You move out of the plan's service area.
- You knowingly submit to Health Net materially incorrect or incomplete information which is reasonably relied upon by Health Net in issuing or renewing individual and family plan coverage.
- You and/or your family member(s) repeatedly or materially disrupt the operations of the Physician Group or Health Net to the extent that your behavior substantially impairs Health Net's ability to furnish or arrange services for you or other Health Net members, or the physician's office or Contracting Physician Group's ability to provide services to other patients.
- You and/or your family member(s) threaten the safety of the health care provider, his or her office staff, the contracting Physician Group or Health Net personnel if such behavior does not arise from a diagnosed illness or condition.

Health Net can terminate your coverage, together with all like policies, by giving 90 day's written notice. If your coverage is terminated because Health Net ceases to offer all like policies, you may be entitled to Conversion coverage. Should such a termination occur, information on Conversion coverage will be provided in the written termination notice. Members are responsible for payment of any services received after termination of coverage at the provider's prevailing non-Member rates. This is also applicable to Members who are hospitalized or undergoing treatment for an ongoing condition on the termination date of coverage.

If you terminate coverage for yourself or any of your family members, you may apply for re-enrollment, but Health Net may decline enrollment at its discretion.

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

Does Health Net Coordinate Benefits?
There are no Coordination of Benefit provisions for individual plans in the state of California.

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

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

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

Does Health Net cover the cost of participation in clinical trials?
Routine patient care costs for patients diagnosed with cancer who are accepted into phase I, II, III or IV clinical trials are covered when Medically Necessary, recommended by the Member's treating Physician and authorized by Health Net. The Physician must determine that participation has a meaningful potential to benefit the Member and the trial has therapeutic intent. For further information, please refer to the Health Net Individual & Family HMO Plan Contract and Evidence of Coverage (EOC) or PPO Policy.

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

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

Members not satisfied with the results of the grievance and appeals process may submit the problem to binding arbitration. Health Net uses binding arbitration to settle disputes, including medical malpractice.

As a condition of enrollment, Members give up their right to a jury or trial before a judge for the resolution of such disputes.

HEALTH NET OF CALIFORNIA (HMO)

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against Health Net, you should first telephone Health Net at **1-800-839-2172** and use our grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by Health Net, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature, and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's internet website http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

What if I need a second opinion?
Health Net Members have the right to request a second opinion when:

- The Member's Primary Care Physician or a referral Physician gives a diagnosis or recommends a treatment plan with which the Member is not satisfied;
- The Member is not satisfied with the result of treatment received;
- The Member is diagnosed with, or a treatment plan is recommended for, a condition that threatens loss of life, limb or bodily function, or a substantial impairment, including but not limited to a serious chronic condition; or
- The Member's Primary Care Physician or a referral Physician is unable to diagnose the Member's condition, or test results are conflicting.

To obtain a copy of Health Net's second opinion policy, contact the Customer Contact Center at 1-800-839-2172.

What are Health Net's premium ratios?
Health Net's 2008 ratio of premium costs to health services paid for Individual & Family HMO plans was 80.8%. Health Net Life's 2008 ratio for the Individual & Family PPO insurance plans was 86.9%.

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

What about continuity of care upon termination of a provider contract?
If Health Net's contract with a physician group or other provider is terminated, Health Net will transfer any affected Members to another contracting physician group or provider and make every effort to ensure continuity of care. At least 60-days prior to termination of a contract with a Physician Group or acute care hospital to which members are assigned for services, Health Net will provide a written notice to affected Members. For all other hospitals that terminate their contract with Health Net, a written notice will be provided to affected members within five days after the effective date of the contract termination.

In addition, the Member may request continued care from a provider whose contract is terminated if at the time of termination the Member was receiving care from such a provider for:

- An acute condition;
- A serious chronic condition not to exceed twelve months from the contract termination date;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- A newborn up to 36 months of age not to exceed twelve months from the contract termination date;
- A terminal illness (for the duration of the terminal illness); or
- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment.

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable copayments and any other exclusions and limitations of this Plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider's contract termination. You must request continued care within 30 days of the provider's date of termination unless you can show that it was not reasonably possible to make the request within 30 days of the provider's date of termination and you make the request as soon as reasonably possible.

If you would like more information on how to request continued care, or request a copy of our continuity of care policy, please contact the Customer Contact Center at 1-800-839-2172.

What are Severe Mental Illness and Serious Emotional Disturbances of a Child?

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

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

Do providers limit services for reproductive care?

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

What is "prior authorization"?

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

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

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

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

To submit an appeal:

- Call the Customer Contact Center at 1-800-839-2172,
- Visit www.healthnet.com for information on emailing the Customer Contact Center, or
- Write to:

  Health Net Customer Contact Center
  P.O. Box 10348
  Van Nuys, CA 91410-0348

ADDITIONAL ITEMS FOR HMO COVERAGE ONLY

What is the method of provider reimbursement?
Health Net uses financial incentives and various risk-sharing arrangements when paying providers. Members may request more information about our payment methods by contacting the Customer Contact Center at the telephone number on the back of their Health Net ID card.

When and how does Health Net pay my medical bills?
Health Net will coordinate the payment for covered services when you receive care from your Primary Care Physician or when you are referred by your Primary Care Physician to a specialist. We have agreements with these physicians that eliminate the need for claim forms. Simply present your Member identification card.

Am I required to see my primary care physician if I have an emergency?
Health Net covers emergency and urgently needed care throughout the world.

If your situation is life-threatening, immediately call 911 if you are in an area where the system is established and operating. If your situation is not so severe, first call your Primary Care Physician or Physician Group (medical), or the Administrator (mental illness or detoxification). If you are unable to call and you need medical care right away, go to the nearest medical center or Hospital.

An emergency 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, 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 Member or her unborn child. Emergency Care will also include additional screening, examination and evaluation by a Physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, either within the capacity of the facility or by transferring the member to a psychiatric unit within a general acute hospital or to an acute psychiatric hospital, as medically necessary.

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).

All follow-up care (including severe mental illness and serious emotional disturbances of a child) after the emergency or urgency has passed and your condition is stable, must be provided or authorized by your Primary Care Physician or Physician Group (medical), or the Administrator (mental illness and chemical dependency), otherwise, it will not be covered by Health Net.

Am I liable for payment of certain services?
Health Net is responsible for paying participating providers for covered services. Except for copayments and deductibles, participating providers may not bill you for charges in excess of our payment. You are financially responsible for: (a) services beyond the benefit limitations stated in the Plan Contract and EOC; and (b) services not covered by the Individual & Family HMO Plan. The Individual & Family HMO Plans do not cover: prepayment fees, copayments, deductibles, services and supplies not covered by the Individual & Family HMO Plans or non-emergency care rendered by a non-participating provider.

Under the HMO plans, can I be reimbursed for out-of-network claims?
Some non-participating providers will ask you to pay a bill at the time of service. If you have to pay a bill for covered services, submit a copy of the bill, evidence of its payment and the emergency room report to us for reimbursement within one year of the date the service was rendered. Coverage for services rendered by non-participating providers is limited to emergency care when a participating provider is not available.

How does Health Net handle confidentiality and release of member information?
Health Net knows that personal information in your medical records is private. Therefore, we protect your personal health information in all settings. As part of the

application or enrollment form, Health Net members sign a routine consent to obtain or release their medical information. This consent is used by Health Net to ensure notification to and consent from members for present and future routine needs for the use of personal health information.

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

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

Privacy Practices
For a description of how protected health information about you may be used and disclosed and how you can get access to this information, please see the Notice of Privacy Practices in your Plan Contract.

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

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

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

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

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

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

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

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

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

ADDITIONAL ITEMS FOR PPO COVERAGE ONLY

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

What are the maximum allowable amounts?
Maximum Allowable Amount is the amount on which Health Net Life Insurance Company (HNL) bases its reimbursement for covered services and supplies provided by an out-of-network provider. Maximum Allowable Amount is not the amount that HNL pays for a covered service; the actual payment will be reduced by applicable coinsurance, copayments, deductibles and other applicable amounts. Refer to your policy for details.

EXCLUSIONS AND LIMITATIONS

EXCLUSIONS AND LIMITATIONS COMMON TO ALL INDIVIDUAL & FAMILY COVERAGE OPTIONS

No payment will be made under the Health Net Individual & Family HMO Plans, or the Health Net Life Individual & Family PPO for expenses incurred for or which are follow-up care to any of the items below. The following are selective listings only. For a comprehensive listing, see the Health Net Individual & Family Plan Contract and EOC for the HMO plans and the Health Net Life Individual & Family PPO Policy for the PPO coverages.

- Services and Supplies which Health Net or Health Net Life determine are not medically necessary, except as set out under "Does Health Net cover the cost of participation in clinical trials?" and "What if I have a disagreement with Health Net?" on page 11.
- Custodial Care. Custodial Care is not rehabilitative care and is primarily provided to assist a patient in meeting the activities of daily living such as: help in walking, getting in and out of bed, bathing, dressing, feeding and preparation of special diets, and supervision of medications which are ordinarily self-administered, but not care that requires skilled nursing services on a continuing basis.
- Procedures that Health Net or Health Net Life determines to be experimental or investigational, except as set out under "Does Health Net cover the cost of participation in clinical trials?" and "What if I have a disagreement with Health Net?" on page 11.
- Services or supplies provided before the effective date of coverage; services or supplies provided after coverage through this plan has ended are not covered.
- Reimbursement for services for which the Member is not legally obligated to pay the provider or for which the provider pays no charge.
- Any service or supplies not specifically listed as covered expenses, unless coverage is required by state or federal law.
- Services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include, but are not limited to, collection, storage or purchase of sperm or ova.
- Oral contraceptives and emergency contraceptives are covered. Vaginal contraceptives are limited to diaphragms, cervical caps and IUDs, and are only covered when a contracted physician performs a fitting examination and in the case of diaphragms and cervical caps, prescribes the device. IUDs are only available through the Member Physician's office, are covered as a medical benefit, and are limited to one fitting and device per year, unless additional fittings or devices are Medically Necessary. Diaphragms and cervical caps are only available through a prescription from a pharmacy and are limited to one prescription per year unless additional fittings or devices are Medically Necessary. Injectable contraceptives are covered as a medical benefit when administered by a physician.
- Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.[1]

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

- Dental care. However, effective July 1, 2010, this plan does cover 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.
- Treatment and services for Temporomandibular Joint Disorders are covered when determined to be Medically Necessary, excluding crowns, onlays, bridgework and appliances.
- This Plan only covers services or supplies provided by a legally operated hospital, Medicare-approved skilled nursing facility, or other properly licensed facility as specified in the Plan Contract and EOC or Policy. Any institution that is primarily a place for the aged, a nursing home or any similar institution, regardless of how it is designated, is not an eligible institution. Services or supplies that are provided by such institutions are not covered.
- Surgery and related services for the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw, except when such surgery is required due to trauma or the existence of tumors or neoplasms, or when otherwise Medically Necessary.
- Hearing aids.
- Treatment for mental disorders as a condition of parole or probation and court ordered testing.
- Private duty nursing.
- Any eye surgery for the purpose of correcting refractive defects of the eye, unless Medically Necessary, recommended by the Member's treating physician and authorized by Health Net.
- Contact or corrective lenses (except an implanted lens that replaces the organic eye lens), vision therapy and eyeglasses.
- Services to reverse voluntary surgically induced infertility.
- Sex change procedures or treatment.
- Physical exams for insurance, licensing, employment, school or camp. Any physical, vision or hearing exams that are not related to diagnosis or treatment of illness or injury, except as specifically stated in the Health Net HMO Plan Contract and EOC or Health Net Life Policy.
- Any outpatient drugs, medications or other substances dispensed or administered in any setting, except as specifically stated in the Health Net HMO Plan Contract and EOC or Health Net Life Policy.
- Services for a surrogate pregnancy are covered when the surrogate is a Health Net member. However, when compensation is obtained for the surrogacy, the plan shall have a lien on such compensation to recover its medical expense.
- Although this plan does cover Durable Medical Equipment, it does not cover the following items: (a) exercise equipment; (b) hygienic equipment, jacuzzis and spas; (c) surgical dressings other than primary dressings that are applied by your Physician Group or a Hospital to lesions of the skin or surgical incisions; and (d) stockings, corrective shoes and arch supports.
- Personal or comfort items.
- Disposable supplies for home use.
- Home birth, unless the criteria for emergency care have been met.
- Physician self-treatment.
- Physicians treating immediate family members.
- Drugs (including injectable medications) for the treatment of sexual dysfunction when prescribed for the treatment of sexual dysfunction.
- Services to diagnose, evaluate or treat infertility are not covered.
- Bariatric surgery provided for the treatment of morbid obesity is covered when Medically Necessary, authorized by Health Net and performed at a Health Net designated bariatric surgical center. Health Net has a designated network of bariatric surgical centers to perform weight loss surgery. Your Member Physician can provide you with information about these centers. You will be directed to a Health Net designated bariatric surgical center at the time authorization is obtained.

ADDITIONAL EXCLUSIONS AND LIMITATIONS FOR HMO PLANS ONLY

- Treatment for alcoholism or drug addiction, except detoxification.
- Treatments which use umbilical cord blood, cord blood stem cells and adult stem cells (nor their collection, preservation and storage) as such treatments are considered to be Experimental or Investigational in nature. For information regarding requesting an Independent Medical Review of a Plan denial of coverage on the basis that it is considered Experimental or Investigational see "What if I have a disagreement with Health Net?" on page 11.
- Chiropractic services.
- Home health care (limited to 100 combined visits per calendar year; maximum three visits per day and four hours per visit).
- Medical services or supplies that are not authorized by Health Net or the physician group according to Health Net's procedures.
- Services and supplies rendered by a nonparticipating physician without authorization from Health Net or the Physician Group.
- Diagnostic procedures or testing for genetic disorders, except for prenatal diagnosis of fetal genetic disorders in cases of high-risk pregnancy.
- Nonprescription drug, medical equipment or supply that can be purchased without a prescription (except when prescribed by a physician for management and treatment of diabetes). If a drug that was previously available by prescription becomes available in an over-the-counter (OTC) form in the same prescription strength, then any prescription drugs that are similar agents and have comparable clinical effect(s), will only be covered when Prior Authorization is obtained from Health Net. However, if a higher dosage form of a nonprescription drug or over-the-counter drug is only available by prescription, that higher dosage will be covered.
- Routine foot care, unless medically necessary for a diabetic condition.
- Acupuncture.
- Services related to educational and professional purposes.
- Treatment, testing or screening of learning disabilities, except for some conditions when the level of severity meets the criteria of severe mental illness or serious emotional disturbances of a child.
- Any services or supplies not related to the diagnosis or treatment of a covered condition, illness or injury. However, the Plan does cover Medically Necessary services and supplies for medical conditions directly related to non-covered services when complications exceed routine Follow-Up Care (such as life-threatening complications of cosmetic surgery).

ADDITIONAL EXCLUSIONS AND LIMITATIONS FOR ALL PPO PLANS

- Conditions caused by the Member's commission (or attempted commission) of a felony.
- Conditions caused by release of nuclear energy, when government funds are available.
- Amounts charged by out-of-network providers for covered medical services and treatment that Health Net Life determines to be in excess of the covered expense.
- Optometric services, eye exercises including orthoptics, except as specifically stated elsewhere in the Policy.
- Immunizations or inoculations for adults or children, except as described in the Policy.
- Any services not related to the diagnosis or treatment of a covered illness or injury.
- Inpatient room and board charges incurred in connection with an admission to a hospital or other inpatient treatment facility primarily for diagnostic tests that could have been performed safely on an outpatient basis.
- Inpatient room and board charges in connection with a hospital stay primarily for environmental change, physical therapy or treatment of chronic pain.

- Expenses in excess of a hospital's (or other inpatient facility's) most common semiprivate room rate.
- Treatment of chronic alcoholism, drug addiction and other chemical dependency problems, including detoxification services, except as specifically stated in the Policy.
- Any expenses related to the following items, whether authorized by a physician or not: (a) alteration of the Member's residence to accommodate the Member's physical or medical condition, including the installation of elevators; (b) corrective appliances, except prosthetics, casts and splints; (c) air purifiers, air conditioners and humidifiers; and (d) educational services or nutritional counseling, except as specifically provided in the Policy.
- Treatment or surgery for obesity, weight reduction or weight control, except when provided for morbid obesity, as determined by Health Net Life.
- All benefits provided under the Policy shall be reduced by any amounts to which a Member is entitled under the program commonly referred to as Medicare when federal law permits Medicare to pay before an individual health plan.
- Genetic testing is covered when determined by Health Net Life to be medically necessary.
- Services performed by a person who lives in the Member's home or who is related to the Member by blood or marriage.
- Any services provided by, or for which payment is made by, a local, state or federal government agency. This limitation does not apply to Medi-Cal, Medicaid or Medicare.
- If the Member receives services or obtains supplies in a foreign country, benefits will be payable for emergency care only.
- Hyperkinetic syndromes, learning disabilities, behavior problems or mental retardation regardless of the type of service. Certain conditions are covered if their level of severity meets the criteria of Serious Emotional Disturbances of a Child or Severe Mental Illness (see page 13 for definitions).
- Outpatient speech therapy which is not provided in relation to surgery, injury or disease.
- Rehabilitative therapy is limited to services after an acute episode of care for chronic conditions, an acute illness or injury or an acute exacerbation of such an illness or injury.

ADDITIONAL EXCLUSIONS AND LIMITATIONS FOR:

PPO SIMPLECHOICE HSA AND SIMPLEVALUE 50

- Care for conditions of pregnancy, including hospital and professional services. This includes prenatal and postnatal care, and delivery.

PPO SIMPLECHOICE HSA ONLY

- Physician visits to a covered person's home.

ADDITIONAL HMO PRODUCT INFORMATION – MENTAL HEALTH AND DETOXIFICATION SERVICES

The Mental Disorders and Detoxification benefits are administered by MHN Services, an affiliate behavioral health administrative services company (the Administrator) which contracts with Health Net to administer these benefits.

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

- When Health Net Members need mental health or detoxification care, simply call the toll-free line. For a referral, intake specialists and clinicians are on duty to take calls 24 hours a day, seven days a week. This 24-hour availability enhances your access, and reduces the possibility of going to a nonparticipating provider for care.
- Members who call for non-emergency care will always be referred for an initial evaluation. You will be given the name of a qualified mental health professional from a comprehensive specialty network. There are

no additional requirements, and all evaluations are scheduled within ten days from the time of your call or at your convenience. This kind of prompt response to non-emergency situations minimizes your overall costs.

- In an emergency, call 911, or you may call the Administrator at 1-888-426-0030.
- Every Member who calls for services is guaranteed an initial evaluation.

ADDITIONAL HMO PRODUCT INFORMATION – PRESCRIPTION DRUG PROGRAM

Health Net is contracted with many major pharmacies, supermarket-based pharmacies and privately owned pharmacies in California. To find a conveniently located Participating Pharmacy, please visit our website at www.healthnet.com or call the Customer Contact Center.

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

PRESCRIPTIONS BY MAIL DRUG PROGRAM

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

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

THE HEALTH NET RECOMMENDED DRUG LIST: LEVEL I DRUGS (PRIMARILY GENERIC) AND LEVEL II DRUGS (PRIMARILY BRAND)

The Health Net Recommended Drug List (or Formulary or the List) is the approved list of medications covered for illnesses and conditions. It was developed to identify the safest and most effective medications for Health Net Members while attempting to maintain affordable pharmacy benefits.

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

The Recommended Drug List is updated regularly, based on input from the Health Net Pharmacy and Therapeutics (P&T) Committee. This committee's members are actively practicing physicians of various medical specialties and clinical pharmacists. Voting members are recruited from contracting Physician Groups throughout California based on their experience, knowledge and expertise. In addition, the P&T Committee frequently consults with other medical experts to provide additional input to the Committee. Updates to the Recommended Drug List and 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's most current Recommended Drug List, please visit our website at www.healthnet.com or call the Customer Contact Center at 1-800-839-2172.

LEVEL III DRUGS

Level III drugs are prescription drugs that are listed as Level III or not listed on the Recommended Drug List and are not excluded from coverage.

PPO COVERAGE CERTIFICATION REQUIREMENTS

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

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

1. Inpatient admissions

   Any type of facility, including but not limited to:

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

2. Surgical procedures including:

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

3. Organ, tissue and bone marrow transplant services, including pre-evaluation and pre-treatment services and the transplant procedure

4. Home Health Care Services including nursing, physical therapy, occupational therapy, speech therapy, home I.V. therapy and home uterine monitoring

5. Hospice Care

6. Outpatient Diagnostic Imaging:

   - CT (Computerized Tomography)
   - MRA (Magnetic Resonance Angiography)
   - MRI (Magnetic Resonance Imaging)
   - PET (Positron Emission Tomography)
   - SPECT (Single Photon Emission Computed Tomography)

7. Durable Medical Equipment including power wheelchairs, scooters, Hospital beds and custom-made items

8. Prosthesis and orthotics over $2,500

9. Air Ambulance

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

11. Orthognathic procedures (surgery performed to correct or straighten jaw and/or other facial bone misalignments to improve function) including TMJ treatment

12. Self-injectable drugs

13. Clinical trials

14. Bariatric-related services:

    - Non-surgical bariatric-related consultations and services
    - All bariatric-related surgical services

EXCEPTIONS

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

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

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

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

HEALTH NET OF CALIFORNIA, INC.

GUARANTEED ISSUE PLAN RATES EFFECTIVE JULY 1, 2009

Please note: If you have a birthday during the year that moves you into a new age category, please be advised that any required rate change will be effective the first of the month following the month in which your birthday occurs.

Region 1: Los Angeles County

TIER	AGE	HMO 15	HMO 40
SUBSCRIBER	1–4	375	343
	5–18	345	343
	19–24	627	450
	25–29	736	525
	30–34	907	659
	35–39	992	727
	40–44	1,050	759
	45–49	1,152	800
	50–54	1,275	935
	55–59	1,531	1,101
	60–64	1,531	1,101
SUBSCRIBER & SPOUSE	19–24	1,242	882
	25–29	1,460	1,031
	30–34	1,807	1,312
	35–39	1,975	1,441
	40–44	2,089	1,507
	45–49	2,296	1,592
	50–54	2,543	1,856
	55–59	3,051	2,189
	60–64	3,051	2,189
SUBSCRIBER & CHILD	19–24	972	778
	25–29	1,084	851
	30–34	1,251	992
	35–39	1,336	1,059
	40–44	1,392	1,091
	45–49	1,501	1,133
	50–54	1,623	1,261
	55–59	1,878	1,426
	60–64	1,878	1,426
SUBSCRIBER & CHILDREN	19–24	1,312	1,110
	25–29	1,424	1,188
	30–34	1,596	1,324
	35–39	1,677	1,392
	40–44	1,739	1,422
	45–49	1,841	1,467
	50–54	1,961	1,596
	55–59	2,218	1,762
	60–64	2,218	1,762
FAMILY	19–24	1,871	1,489
	25–29	2,091	1,638
	30–34	2,434	1,919
	35–39	2,602	2,048
	40–44	2,714	2,113
	45–49	2,924	2,198
	50–54	3,170	2,458
	55–59	3,682	2,794
	60–64	3,682	2,794

Region 2: Merced, Sacramento, San Joaquin, Sonoma, Stanislaus, Tulare, western El Dorado[1] and western Placer[1] counties

TIER	AGE	HMO 15	HMO 40
SUBSCRIBER	1–4	431	372
	5–18	387	372
	19–24	710	482
	25–29	843	562
	30–34	1,045	717
	35–39	1,139	782
	40–44	1,201	821
	45–49	1,312	865
	50–54	1,450	1,004
	55–59	1,740	1,183
	60–64	1,740	1,183
SUBSCRIBER & SPOUSE	19–24	1,409	946
	25–29	1,674	1,105
	30–34	2,079	1,421
	35–39	2,267	1,547
	40–44	2,393	1,630
	45–49	2,612	1,722
	50–54	2,893	1,990
	55–59	3,473	2,356
	60–64	3,473	2,356
SUBSCRIBER & CHILD	19–24	1,101	838
	25–29	1,230	916
	30–34	1,434	1,071
	35–39	1,530	1,135
	40–44	1,594	1,179
	45–49	1,708	1,220
	50–54	1,839	1,358
	55–59	2,133	1,543
	60–64	2,133	1,543
SUBSCRIBER & CHILDREN	19–24	1,496	1,201
	25–29	1,623	1,278
	30–34	1,825	1,438
	35–39	1,921	1,502
	40–44	1,982	1,543
	45–49	2,091	1,586
	50–54	2,232	1,722
	55–59	2,521	1,900
	60–64	2,521	1,900
FAMILY	19–24	2,125	1,604
	25–29	2,385	1,762
	30–34	2,791	2,075
	35–39	2,978	2,206
	40–44	3,107	2,286
	45–49	3,323	2,376
	50–54	3,604	2,650
	55–59	4,183	3,010
	60–64	4,183	3,010

[1]ZIP codes for western El Dorado include: 95623, 95630 and 95762 only. See Region 7 for additional El Dorado County ZIP codes. ZIP codes for western Placer County include: 95602–04, 95648, 95650, 95658, 95661, 95663, 95677–78, 95746–47 and 95765 only. See Region 7 for additional Placer County ZIP codes.

Region 3: Riverside, San Bernardino and Ventura counties

TIER	AGE	HMO 15	HMO 40
SUBSCRIBER	1–4	406	362
	5–18	374	362
	19–24	678	487
	25–29	800	564
	30–34	987	725
	35–39	1,086	792
	40–44	1,147	834
	45–49	1,251	880
	50–54	1,397	1,021
	55–59	1,684	1,205
	60–64	1,684	1,205
SUBSCRIBER & SPOUSE	19–24	1,343	965
	25–29	1,594	1,115
	30–34	1,970	1,438
	35–39	2,157	1,570
	40–44	2,278	1,647
	45–49	2,495	1,747
	50–54	2,781	2,024
	55–59	3,354	2,400
	60–64	3,354	2,400
SUBSCRIBER & CHILD	19–24	1,050	843
	25–29	1,174	916
	30–34	1,361	1,072
	35–39	1,455	1,150
	40–44	1,518	1,183
	45–49	1,625	1,232
	50–54	1,769	1,373
	55–59	2,053	1,564
	60–64	2,053	1,564
SUBSCRIBER & CHILDREN	19–24	1,422	1,201
	25–29	1,545	1,275
	30–34	1,737	1,438
	35–39	1,830	1,504
	40–44	1,885	1,543
	45–49	1,999	1,592
	50–54	2,142	1,735
	55–59	2,425	1,917
	60–64	2,425	1,917
FAMILY	19–24	2,024	1,616
	25–29	2,271	1,762
	30–34	2,650	2,080
	35–39	2,835	2,223
	40–44	2,954	2,298
	45–49	3,175	2,395
	50–54	3,461	2,675
	55–59	4,035	3,046
	60–64	4,035	3,046

Region 4: Alameda, Contra Costa, San Francisco, San Mateo, Santa Clara, Santa Cruz and Solano counties

TIER	AGE	HMO 15	HMO 40
SUBSCRIBER	1–4	459	418
	5–18	418	418
	19–24	763	549
	25–29	909	646
	30–34	1,125	816
	35–39	1,220	895
	40–44	1,292	935
	45–49	1,402	992
	50–54	1,558	1,139
	55–59	1,881	1,358
	60–64	1,881	1,358
SUBSCRIBER & SPOUSE	19–24	1,513	1,082
	25–29	1,812	1,278
	30–34	2,238	1,620
	35–39	2,437	1,776
	40–44	2,568	1,856
	45–49	2,794	1,968
	50–54	3,107	2,271
	55–59	3,750	2,699
	60–64	3,750	2,699
SUBSCRIBER & CHILD	19–24	1,179	946
	25–29	1,331	1,045
	30–34	1,543	1,218
	35–39	1,645	1,297
	40–44	1,710	1,332
	45–49	1,820	1,392
	50–54	1,977	1,545
	55–59	2,296	1,761
	60–64	2,296	1,761
SUBSCRIBER & CHILDREN	19–24	1,599	1,358
	25–29	1,747	1,451
	30–34	1,960	1,630
	35–39	2,063	1,708
	40–44	2,126	1,740
	45–49	2,238	1,802
	50–54	2,395	1,955
	55–59	2,714	2,169
	60–64	2,714	2,169
FAMILY	19–24	2,276	1,820
	25–29	2,573	2,017
	30–34	3,000	2,363
	35–39	3,202	2,519
	40–44	3,328	2,590
	45–49	3,558	2,706
	50–54	3,870	3,010
	55–59	4,510	3,440
	60–64	4,510	3,440

Region 5: Orange and San Diego counties

TIER	AGE	HMO 15	HMO 40
SUBSCRIBER	1–4	406	362
	5–18	372	362
	19–24	674	487
	25–29	800	564
	30–34	986	717
	35–39	1,082	782
	40–44	1,130	821
	45–49	1,242	867
	50–54	1,388	1,009
	55–59	1,671	1,195
	60–64	1,671	1,195
SUBSCRIBER & SPOUSE	19–24	1,337	962
	25–29	1,596	1,115
	30–34	1,961	1,421
	35–39	2,143	1,548
	40–44	2,255	1,626
	45–49	2,476	1,725
	50–54	2,765	2,011
	55–59	3,332	2,381
	60–64	3,332	2,381
SUBSCRIBER & CHILD	19–24	1,043	838
	25–29	1,174	916
	30–34	1,358	1,069
	35–39	1,448	1,135
	40–44	1,504	1,174
	45–49	1,616	1,218
	50–54	1,761	1,363
	55–59	2,041	1,548
	60–64	2,041	1,548
SUBSCRIBER & CHILDREN	19–24	1,416	1,195
	25–29	1,545	1,275
	30–34	1,730	1,424
	35–39	1,817	1,499
	40–44	1,873	1,531
	45–49	1,982	1,577
	50–54	2,128	1,722
	55–59	2,407	1,915
	60–64	2,407	1,915
FAMILY	19–24	2,016	1,609
	25–29	2,271	1,762
	30–34	2,636	2,068
	35–39	2,820	2,206
	40–44	2,932	2,272
	45–49	3,155	2,374
	50–54	3,442	2,662
	55–59	4,005	3,037
	60–64	4,005	3,037

Region 6: Fresno, Kern and Kings counties

TIER	AGE	HMO 15	HMO 40
SUBSCRIBER	1–4	418	385
	5–18	384	385
	19–24	695	501
	25–29	831	589
	30–34	1,026	751
	35–39	1,122	827
	40–44	1,179	855
	45–49	1,293	909
	50–54	1,424	1,055
	55–59	1,713	1,235
	60–64	1,713	1,235
SUBSCRIBER & SPOUSE	19–24	1,382	992
	25–29	1,650	1,164
	30–34	2,043	1,489
	35–39	2,232	1,638
	40–44	2,351	1,708
	45–49	2,570	1,808
	50–54	2,837	2,091
	55–59	3,415	2,463
	60–64	3,415	2,463
SUBSCRIBER & CHILD	19–24	1,082	877
	25–29	1,215	958
	30–34	1,409	1,123
	35–39	1,504	1,195
	40–44	1,565	1,230
	45–49	1,671	1,281
	50–54	1,807	1,422
	55–59	2,092	1,609
	60–64	2,092	1,609
SUBSCRIBER & CHILDREN	19–24	1,456	1,247
	25–29	1,596	1,332
	30–34	1,791	1,502
	35–39	1,883	1,570
	40–44	1,946	1,604
	45–49	2,053	1,659
	50–54	2,189	1,795
	55–59	2,478	1,983
	60–64	2,478	1,983
FAMILY	19–24	2,075	1,671
	25–29	2,351	1,841
	30–34	2,740	2,170
	35–39	2,925	2,317
	40–44	3,046	2,381
	45–49	3,265	2,490
	50–54	3,536	2,772
	55–59	4,110	3,143
	60–64	4,110	3,143

Region 7: Eastern El Dorado,[1] Marin, eastern Placer[1] and Yolo counties

TIER	AGE	HMO 15	HMO 40
SUBSCRIBER	1–4	440	404
	5–18	401	404
	19–24	734	532
	25–29	894	634
	30–34	1,096	810
	35–39	1,191	880
	40–44	1,247	918
	45–49	1,344	957
	50–54	1,479	1,105
	55–59	1,776	1,305
	60–64	1,776	1,305
SUBSCRIBER & SPOUSE	19–24	1,456	1,057
	25–29	1,776	1,258
	30–34	2,179	1,608
	35–39	2,369	1,749
	40–44	2,482	1,829
	45–49	2,675	1,905
	50–54	2,949	2,196
	55–59	3,539	2,599
	60–64	3,539	2,599
SUBSCRIBER & CHILD	19–24	1,137	928
	25–29	1,295	1,030
	30–34	1,494	1,203
	35–39	1,594	1,275
	40–44	1,647	1,312
	45–49	1,747	1,351
	50–54	1,881	1,492
	55–59	2,179	1,700
	60–64	2,179	1,700
SUBSCRIBER & CHILDREN	19–24	1,535	1,322
	25–29	1,696	1,424
	30–34	1,897	1,599
	35–39	1,997	1,669
	40–44	2,050	1,708
	45–49	2,147	1,747
	50–54	2,286	1,893
	55–59	2,582	2,091
	60–64	2,582	2,091
FAMILY	19–24	2,186	1,776
	25–29	2,507	1,978
	30–34	2,908	2,325
	35–39	3,105	2,465
	40–44	3,216	2,546
	45–49	3,408	2,623
	50–54	3,682	2,910
	55–59	4,272	3,318
	60–64	4,272	3,318

[1]ZIP codes for eastern El Dorado include: 95613–14, 95619, 95629, 95633–36, 95643, 95651, 95656, 95664, 95667, 95672, 95682, 95684, 95709, 95720–21, 95726, 95735, 96150–52 and 96154–58 only. See Region 2 for additional El Dorado County ZIP codes. ZIP codes for eastern Placer County include: 95631, 95681, 95701, 95703, 95713–15, 95717, 95722, 95724, 95736, 96140–43, 96145–46, 96148 and 96162 only.

HEALTH NET LIFE INSURANCE COMPANY

GUARANTEED ISSUE PLAN RATES EFFECTIVE MAY 1, 2010

Please note: If you have a birthday during the year that moves you into a new age category, please be advised that any required rate change will be effective the first of the month following the month in which your birthday occurs.

(1 or +2 refers to the applicant's spouse and/or dependent children as defined in the Health Net Life Insurance Company PPO Policy)

Region 1: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo and Yuba counties

TIER	AGE	PPO SIMPLEVALUE 50-COMBO	PPO SIMPLECHOICE HSA
APPLICANT	under 15	295.50	295.50
	15–29	425.00	425.00
	30–34	525.75	525.75
	35–39	571.00	571.00
	40–44	641.75	641.75
	45–49	679.50	679.50
	50–54	807.75	807.75
	55–59	936.75	936.75
	60–64	936.75	936.75
APPLICANT + 1	under 15		520.50
	15–29		859.50
	30–34		966.00
	35–39		1,036.50
	40–44		1,131.75
	45–49		1,215.00
	50–54		1,448.00
	55–59		1,698.00
	60–64		1,698.00
APPLICANT + 2	under 15		759.00
	15–29		1,239.75
	30–34		1,421.50
	35–39		1,487.50
	40–44		1,526.00
	45–49		1,656.75
	50–54		1,869.00
	55–59		2,061.75
	60–64		2,061.75

Region 2: Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma and Stanislaus counties

TIER	AGE	PPO SIMPLEVALUE 50-COMBO	PPO SIMPLECHOICE HSA
APPLICANT	under 15	268.25	268.25
	15–29	368.25	368.25
	30–34	448.75	448.75
	35–39	485.25	485.25
	40–44	545.25	545.25
	45–49	584.25	584.25
	50–54	688.00	688.00
	55–59	794.50	794.50
	60–64	794.50	794.50
APPLICANT + 1	under 15		500.75
	15–29		756.75
	30–34		857.00
	35–39		928.25
	40–44		1,017.25
	45–49		1,081.50
	50–54		1,291.00
	55–59		1,486.00
	60–64		1,486.00
APPLICANT + 2	under 15		775.75
	15–29		1,142.25
	30–34		1,340.00
	35–39		1,375.00
	40–44		1,404.75
	45–49		1,479.50
	50–54		1,657.25
	55–59		1,767.25
	60–64		1,767.25

Region 3: Alameda, Contra Costa, Marin, San Francisco, San Mateo and Santa Clara counties

TIER	AGE	PPO SIMPLEVALUE 50-COMBO	PPO SIMPLECHOICE HSA
APPLICANT	under 15	277.25	277.25
	15–29	380.25	380.25
	30–34	464.75	464.75
	35–39	502.25	502.25
	40–44	564.50	564.50
	45–49	604.25	604.25
	50–54	712.75	712.75
	55–59	821.25	821.25
	60–64	821.25	821.25
APPLICANT + 1	under 15		500.75
	15–29		751.50
	30–34		850.25
	35–39		919.75
	40–44		1,009.25
	45–49		1,076.00
	50–54		1,280.75
	55–59		1,473.00
	60–64		1,473.00
APPLICANT + 2	under 15		781.00
	15–29		1,163.00
	30–34		1,341.25
	35–39		1,390.75
	40–44		1,455.00
	45–49		1,522.75
	50–54		1,703.25
	55–59		1,828.75
	60–64		1,828.75

Region 4: Orange, Santa Barbara and Ventura counties

TIER	AGE	PPO SIMPLEVALUE 50-COMBO	PPO SIMPLECHOICE HSA
APPLICANT	under 15	250.50	250.50
	15–29	346.75	346.75
	30–34	422.75	422.75
	35–39	457.75	457.75
	40–44	514.50	514.50
	45–49	550.50	550.50
	50–54	648.25	648.25
	55–59	748.75	748.75
	60–64	748.75	748.75
APPLICANT + 1	under 15		461.75
	15–29		712.50
	30–34		817.50
	35–39		883.50
	40–44		965.50
	45–49		1,037.50
	50–54		1,242.00
	55–59		1,429.00
	60–64		1,429.00
APPLICANT + 2	under 15		744.25
	15–29		1,118.25
	30–34		1,259.75
	35–39		1,293.00
	40–44		1,322.25
	45–49		1,393.50
	50–54		1,560.25
	55–59		1,665.50
	60–64		1,665.50

Region 5: Los Angeles County

TIER	AGE	PPO SIMPLEVALUE 50-COMBO	PPO SIMPLECHOICE HSA
APPLICANT	under 15	256.00	256.00
	15–29	353.50	353.50
	30–34	430.50	430.50
	35–39	465.75	465.75
	40–44	523.75	523.75
	45–49	560.75	560.75
	50–54	660.00	660.00
	55–59	762.25	762.25
	60–64	762.25	762.25
APPLICANT + 1	under 15		460.75
	15–29		726.25
	30–34		819.50
	35–39		893.75
	40–44		960.50
	45–49		1,034.50
	50–54		1,221.25
	55–59		1,404.00
	60–64		1,404.00
APPLICANT + 2	under 15		756.50
	15–29		1,140.75
	30–34		1,266.00
	35–39		1,307.75
	40–44		1,352.50
	45–49		1,422.75
	50–54		1,592.25
	55–59		1,696.00
	60–64		1,696.00

Region 6: Riverside, San Bernardino, and San Diego counties

TIER	AGE	PPO SIMPLEVALUE 50-COMBO	PPO SIMPLECHOICE HSA
APPLICANT	under 15	249.75	249.75
	15–29	344.50	344.50
	30–34	419.00	419.00
	35–39	453.75	453.75
	40–44	509.75	509.75
	45–49	546.25	546.25
	50–54	642.75	642.75
	55–59	742.00	742.00
	60–64	742.00	742.00
APPLICANT + 1	under 15		450.50
	15–29		695.75
	30–34		784.50
	35–39		856.75
	40–44		933.75
	45–49		989.50
	50–54		1,173.25
	55–59		1,334.50
	60–64		1,334.50
APPLICANT + 2	under 15		716.75
	15–29		1,110.25
	30–34		1,229.00
	35–39		1,263.50
	40–44		1,320.25
	45–49		1,386.50
	50–54		1,531.50
	55–59		1,643.00
	60–64		1,643.00

HOW TO APPLY FOR A HEALTH NET GUARANTEED ISSUE INDIVIDUAL HMO OR PPO[1] PLAN

1. Take time to review your options and choose the coverage that best suits your health care needs. Our Health Net Individual HMO and PPO provider listings define where in California our coverage is available. If you have questions, need help choosing one of our coverage options, completing the application, or if the application is missing from your enrollment information, please call us toll-free at 1-800-909-3447 or contact your authorized Health Net agent.

2. Complete the Health Net Individual & Family HIPAA Guarantee Issue Enrollment Application.

   - You, the applicant, must accurately complete all applicable portions of the application. Your agent may not complete your application for you. Make sure you answer all questions – incomplete applications will be returned.

   - You must complete Part IV and attach proof of creditable coverage. If you do not have proof of creditable coverage, attach any other evidence of creditable coverage (including pay stubs, papers containing enrollment and disenrollment dates, or COBRA award termination letters).

   - HMO only: Each member of your family may select a different Primary Care Physician. Health Net requires that you and your enrolled family members select a Primary Care Physician whose office is located within a 30-mile radius of your (or your respective family member's) residence or office. If you don't choose a doctor when you complete your enrollment application, we'll assign one to you based on your residential ZIP code. If you need help selecting a doctor, give us a call at 1-800-909-3447 or visit our website at www.healthnet.com.

   - Please type or print clearly in blue or black ink.

   - Make sure you and your spouse or Domestic Partner (if applicable) sign and date the application. Signatures are required for all applicants over age 18, including dependents. NOTE: Domestic Partner is defined as two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. A Domestic Partner is a person eligible for coverage provided that the partnership with the Subscriber meets all domestic partnership requirements under California law or other recognized state or local agency. The Domestic Partner and subscriber must meet the following requirements: (a) Both persons have a common residence; (b) Neither person is married to someone else or is a member of another domestic partnership that has not been terminated, dissolved or adjudged a nullity; (c) The two persons are not related by blood in a way that would prevent them from being married in California; (d) Both persons are at least 18 years old; (e) Both persons are members of the same sex, or opposite sex couples if one or both persons is over age 62 and is eligible for old age insurance benefits under the Social Security Act; and (f) Both persons are capable of consenting to the domestic partnership; and (g) Both file a Declaration of Domestic Partnership with the Secretary of State or an equivalent document from another recognized state or local agency, or both are persons of the same sex who have validly formed a legal union other than marriage in a jurisdiction outside of California which is substantially equivalent to a Domestic Partnership as defined under California law.

   - The application must be received by Health Net within 30 days from the date of signature.

   - Remember, applications received by the 25th of the month will be processed for coverage starting the 1st of the following month. We also offer PPO coverage effective the 15th of the month. See the application for details.

   - If you need help completing the application, please call your Authorized Health Net agent or Health Net.

3. Mail the completed Health Net Individual & Family HIPAA Guarantee Issue Enrollment Application, your certificate(s) of creditable coverage or other evidence of creditable coverage, and your personal check for the applicable first month's premium (made payable to Health Net) to your authorized Health Net agent or Health Net at the address below.

   Health Net
   Individual & Family Plans
   P.O. Box 1150
   Rancho Cordova, CA 95741-1150

[1]Underwritten by Health Net Life Insurance Company.

For more information please contact:

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

Individual & Family Plans
1-800-909-3447

Telecommunications device for the hearing and speech impaired
1-800-995-0852

www.healthnet.com

Other options:

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

Coverage for children in a low-income household:
1-800-327-0502

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

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

CA68189 (5/10)

Health Net®

INDIVIDUAL & FAMILY PLANS
HIPAA GUARANTEED ISSUE ENROLLMENT APPLICATION

PART I

Tell us who you are enrolling and select the product.
Application must be typed or completed in blue or black ink.

Requested Effective Date ☐☐/☐☐/☐☐☐☐

THE APPLICATION MUST BE COMPLETED BY THE APPLICANT. NEITHER BROKER NOR ANY OTHER PERSON MAY SIGN THIS APPLICATION AND AGREEMENT ON BEHALF OF THE APPLICANT.

IMPORTANT: Can you read this form? If not, we can have somebody help you read it. You may also be able to get this form written in your language. For free help, please call right away at 800-909-3447, option 2.

IMPORTANTE: ¿Puede leer este formulario? De no ser así, podemos hacer que alguien le ayude a leerlo. También puede obtener este formulario escrito en su idioma. Para obtener ayuda sin costo, llame inmediatamente al 800-909-3447, opción 2.

重要資訊：您是否能閱讀此文件?如果您無法閱讀，我們將請專人協助您。我們也能以您使用的語言翻譯此份文件。請立即致電 800-909-3447，再按 2，洽詢免費服務。

A. REASON FOR APPLICATION

Family Type

☐ Self
☐ Self & Spouse/Domestic Partner
☐ Self & Child
☐ Self & Children
☐ Self, Spouse/Domestic Partner and Child(ren)
☐ **Please check box for Domestic Partner enrollment**

Enrollment Type

☐ New Enrollment ☐ Add Dependent*

B. BILLING OPTIONS

First Premium Payment (select one)

☐ Automated Bank Draft (Please complete the Simple Pay Option section on the last page of this application.)
☐ Pay by Check (Please include completed check and send with application. Amount must match monthly premium.)
☐ Credit Card (Please complete the credit card section on the last page of this application.)

Monthly Premium Payments (select one)

☐ Automated Bank Draft (Please complete the Simple Pay Option section on the last page of this application.)
☐ Monthly Bill
☐ Credit Card (Please complete the credit card section on the last page of this application.)

C. CHOICE OF COVERAGE

Health Net of California – Only 1st of the month effective date is available.

☐ **HIPAA HMO 15**
☐ **HIPAA HMO 40**

Health Net Life Insurance Company – 1st and 15th of the month effective dates are available.

☐ **HIPAA PPO SimpleChoice HSA**
☐ **HIPPA PPO SimpleValue 50**

PART II – APPLICANT INFORMATION

Primary Applicant's Last Name	First Name	MI	☐ Male ☐ Female
Home Address			
City	State	Zip	County Applicant Resides In
Home Phone Number ( )	Work Phone Number ( )		Email address
Primary Applicant's Birth Date (mo/day/year)	Primary Applicant's Social Security Number		

Primary Care Physician ID # (If applicable)	Current Patient ☐ Yes ☐ No	Physician Group ID #	In the past 6 months, have you been a resident of the United States? ☐ Yes ☐ No If no, where was your last residence? _____

PART III – FAMILY MEMBER(S) TO BE ENROLLED

List all eligible family members to be enrolled other than yourself. If a listed family member's last name is different from yours, please explain on a separate sheet of paper.

For Domestic Partner coverage all requirements for eligibility, as required by the applicable laws of the State of California, must be met and a joint Declaration of Domestic Partnership must be filed with the California Secretary of State. **To be processed under one Subscriber, all family members must reside at the same address.**

Relation	Last Name, First Name, MI	Social Security No.	Date of Birth	Primary Care Physician ID #*	Current Patient	Physician Group ID #*
☐ Husband ☐ Wife	Spouse/Domestic Partner	— —	/ /		☐ Yes ☐ No	

*HMO only: If you are applying for HMO coverage, you must select a Physician Group and Primary Care Physician. You may choose the same or different Physician Group and Primary Care Physician for each family member you are enrolling. If you do not select a Primary Care Physician, one will be selected for you within your regional area.

Primary's Social Security Number

PART III – FAMILY MEMBER(S) TO BE ENROLLED (continued)

Relation	Last Name, First Name, MI		Social Security No.	Date of Birth	Primary Care Physician ID #*	Current Patient	Physician Group ID #*
☐ Son ☐ Daughter	Child 1		— —	/ /		☐ Yes ☐ No	
	Full Time Student? ☐ Yes ☐ No	Units Carried	Name of School				
Relation	Last Name, First Name, MI		Social Security No.	Date of Birth	Primary Care Physician ID #*	Current Patient	Physician Group ID #*
☐ Son ☐ Daughter	Child 2		— —	/ /		☐ Yes ☐ No	
	Full Time Student? ☐ Yes ☐ No	Units Carried	Name of School				
Relation	Last Name, First Name, MI		Social Security No.	Date of Birth	Primary Care Physician ID #*	Current Patient	Physician Group ID #*
☐ Son ☐ Daughter	Child 3		— —	/ /		☐ Yes ☐ No	
	Full Time Student? ☐ Yes ☐ No	Units Carried	Name of School				

For additional dependents please attach another sheet with the requested information.

*HMO only: If you are applying for HMO coverage, you must select a Physician Group and Primary Care Physician. You may choose the same or different Physician Group and Primary Care Physician for each family member you are enrolling. If you do not select a Primary Care Physician, one will be selected for you within your regional area.

PART IV – HIPAA COVERAGE

If you do not qualify for the Individual HMO or PPO plans, you may be considered for coverage under the HIPAA Guaranteed Issue plans. The HIPAA Guaranteed Issue plans do not require medical underwriting and the rates are higher compared to the other Individual Plans. If you qualify for coverage under the HIPAA Guaranteed Issue plans please request the complete benefit details and rates for those plans. To be eligible for HIPAA Guaranteed Issue coverage, you must meet every condition below.

1. Have you had a total of at least 18 months of health care coverage (including COBRA or Cal-COBRA, if applicable) without more than a 63-day break (excluding any employer imposed waiting periods) in coverage? Please note that you must apply for HIPAA coverage within the 63-day break after your group health care coverage (including COBRA or Cal-COBRA, if applicable) ended. ☐ Yes ☐ No
2. Was your most recent coverage through a group health plan (COBRA and Cal-COBRA are considered group coverage)? ☐ Yes ☐ No
3. Currently are you eligible for coverage under a group health plan, Medicare or Medicaid? ☐ Yes ☐ No
   (If yes, you are not eligible for HIPAA coverage.)
4. Was your most recent coverage terminated because of nonpayment or fraud? ☐ Yes ☐ No
5. Were you eligible under COBRA or Cal-COBRA? Yes, start date: _____ end date: _____ ☐ Yes ☐ No
   If Yes, did you accept and use up all benefits that were available? ☐ Yes ☐ No
   If No, please explain: _____

PART V. APPLICANT'S AGENT/BROKER INFORMATION – Complete agent/broker name and address is necessary for correspondence to be sent to the agent/broker.

Health Net Broker ID: _____

Name (Print) _____ Phone number _____ Fax number _____

Address _____ Email address _____

X _____ **X** _____

Applicant's Broker Signature/Number (Required) **Date signed (Required)**

Broker Certification

I _____ (Name of Broker)

(NOTE: You must select the appropriate box. You may only select one box.)

(_____) did not assist the applicant(s) in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advice of any kind from me. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties, including but not limited to a fine of up to $10,000.

OR

(_____) assisted the applicant(s) in submitting this application. All information in the health questionnaire(s) was completed by the applicant(s). I advised the applicant(s) that he or she should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that withholding information could result in rescission or cancellation of coverage in the future. The applicant(s) indicated to me that he or she understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties, including but not limited to a fine of up to $10,000.

Please answer all questions 1 through 4:

1) **Who filled out and completed the application form?** _____

2) Did you personally witness the applicant(s) sign the application? ☐ Yes ☐ No

3) Did you review the application after the applicant(s) signed it? ☐ Yes ☐ No

4) Are you aware of any information, including but not limited to medical history, not disclosed in this application that might have a bearing on the risk? ☐ Yes ☐ No If "Yes," please explain: _____

Primary's Social Security Number

PART VI – INDIVIDUAL & FAMILY PLANS EXCEPTION TO STANDARD ENROLLMENT – STATEMENT OF ACCOUNTABILITY

IMPORTANT: Can you read this form? If not, we can have somebody help you read it. You may also be able to get this form written in your language. For free help, please call right away at 800-909-3447, option 2.

IMPORTANTE: ¿Puede leer este formulario? De no ser así, podemos hacer que alguien le ayude a leerlo. También puede obtener este formulario escrito en su idioma. Para obtener ayuda sin costo, llame inmediatamente al 800-909-3447, opción 2.

重要資訊：您是否能閱讀此文件?如果您無法閱讀，我們將請專人協助您。我們也能以您使用的語言翻譯此份文件。請立即致電 800-909-3447，再按 2，洽詢免費服務。

Instructions for Part VI: The following process is to be used when the Applicant cannot complete the Application because he/she cannot read, write and/or speak the language of the Application. Health Net requires that if you need assistance in completing this Application, you must employ the services of a qualified interpreter. Please contact Health Net at 800-909-3447, option 2 for information about qualified interpreter services and how to obtain them. This form must be submitted with the Individual & Family Enrollment Application when applicable.

I, _____ was assisted in the completion of this Application by a qualified interpreter authorized by Health Net because I:

☐ Do not read the language of this Application ☐ Do not speak the language of this Application ☐ Do not write the language of this Application

☐ Other (explain)_____

A qualified interpreter assisted me with the completion of: ☐ The entire Application ☐ The Statement of Health

☐ Other (explain)_____

A qualified interpreter read this Application to me in the following language: _____

SIGNATURE of APPLICANT	Today's Date
Date Application was interpreted	Time Application was interpreted
Qualified interpreter number	

PART VII – CONDITIONS OF ENROLLMENT

GENERAL CONDITIONS: Health Net reserves the right to reject any application for enrollment if the Applicant is not eligible for HIPAA guaranteed issue coverage. Health Net may selectively reject the Applicant or a dependent who is not eligible for HIPAA guaranteed issue coverage. There is no coverage unless this Application is accepted by Health Net's Underwriting Department and a Notice of Acceptance is issued to the Applicant even though you paid money to Health Net for the first month's premium. Cashing your check does not mean your application is approved. If rejected, your money will be returned to you. No other department, officer, agent or employee of Health Net is authorized to grant enrollment. An insurance agent cannot grant approval, change terms or waive requirements. Health Net may require that you or a dependent take a medical examination and you will be responsible for payment of any related fees in such event. This will only occur for individuals who are not eligible for HIPAA guaranteed issue coverage. This application and all medical information or examination reports shall become a part of the Plan Contract or Insurance Policy.

Any intentional or unintentional nondisclosure or misstatement of fact in application materials is cause for disenrollment and rescission of the Plan Contract or Insurance Policy and Health Net may recoup from the Subscriber (or from You or from the Applicant) any amounts paid for Covered Services obtained as a result of such nondisclosure or misstatement of fact. In addition, if a Subscriber makes a false statement or omission as to the Subscriber's or Family Member's health status or history on application materials, Health Net shall have no liability for the provision of coverage under the Plan Contract or Insurance Policy.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents. Health Net uses and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the Plan Contract and Insurance Policy, and that I may also obtain a copy of this Notice on the website at www.healthnet.com or through the Health Net Customer Contact Center. Authorization for use and disclosure of protected health information shall be valid for a period of 24 months from the date of my signature below.

IF SOLE APPLICANT IS A MINOR: If the sole Applicant under this application is under 18 years of age, the Applicant's parent or legal guardian must sign as such. By signing, he or she does hereby agree to be legally responsible for the accuracy of information in this Application and for payments of premiums. If such responsible party is not the natural parent of the Applicant, copies of the court papers authorizing guardianship must be submitted with this Application.

IF APPLICANT CANNOT READ THE LANGUAGE OF THIS APPLICATION: If an Applicant does not read the language of this Application and an interpreter assisted with the completion of the Application, the Applicant must sign and submit the **Statement of Accountability** (see PART VI of this Application "Individual & Family Plans Exception to Standard Enrollment – Statement of Accountability").

Primary's Social Security Number

PART VIII – IMPORTANT PROVISIONS

NOTICE: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **California law prohibits an HIV test from being required or used by health care services plans or insurance companies as a condition of obtaining coverage.**

ACKNOWLEDGEMENT AND AGREEMENT: I, the applicant, understand and agree that by enrolling with or accepting services from Health Net, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I, the applicant, have read and understand the terms of this Application and my signature below indicates that the information entered in this Application is complete, true and correct, and I accept these terms.

BINDING ARBITRATION: I, the applicant, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of the Health Net Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including Health Net, are giving up their constitutional right to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with Health Net involving claims or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I understand the terms of this Binding Arbitration Clause and agree to submit disputes to binding arbitration.

APPLICANT'S OR PARENT'S OR LEGAL GUARDIAN'S SIGNATURE IF APPLICANT IS UNDER 18 YEARS OLD	Date Signed
SPOUSE/DOMESTIC PARTNER'S SIGNATURE	Date Signed
SIGNATURE OF APPLICANT'S DEPENDENT (age 18 or older)	Date Signed
SIGNATURE OF APPLICANT'S DEPENDENT (age 18 or older)	Date Signed

The Application and this Arbitration Clause must be signed by the Applicant. The applicant must personally sign his/her name in ink and agree to comply with the Arbitration Clause and the terms, conditions and provisions of the Application and the Plan Contract or Insurance Policy in order for this Application to be processed. For this Application to be considered, neither Broker nor any other person may sign this Application and Arbitration Clause.

Make personal check payable to "Health Net"
Return Completed Application to: Health Net Individual and Family Enrollment
Post Office Box 1150, Rancho Cordova, California 95741–1150

You may submit a photocopy or facsimile of the Application and Authorizations. Health Net recommends that you retain a copy of this Application and Authorizations for your records.

All references to "Health Net" herein include the affiliates and subsidiaries of Health Net which underwrite or administer the coverage to which this Enrollment Application applies. "Plan Contract" refers to the Health Net of California, Inc. Combined Contract and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company Explanation of Your Insurance Plan, Health Net PPO Policy.

Health Net®

HEALTH NET'S PAY OPTION – MONTHLY AUTOMATIC PAYMENT FOR INDIVIDUAL & FAMILY PLANS AND CALIFORNIA FARM BUREAU MEMBER'S HEALTH INSURANCE PROGRAM

SIMPLE PAYMENT OPTION (Automatic Bank Draft) ☐ First month's payment ☐ Monthly premium payment

Monthly premium charge can be withdrawn directly from your personal checking or savings account. The premium will be withdrawn from your bank account about ten days in advance of the due date. Please select your account type: ☐ Checking ☐ Savings

Account Holder's Social Security Number	Transit Routing Number (9-digits)	Account Number

Bank Name	State

As a convenience, I request and authorize Health Net to pay and charge to the above account checks drawn on that account by and payable to the order of **"Health Net"** provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the Premium withdrawn from my account will be for the future bill period plus any past due balances and my first month's withdraw maybe for multiple periods if I did not submit a check or due to the timing of the set up. I agree that Health Net's rights in respect to each such check shall be the same as if it were a check written to Health Net and signed personally by me. This authority is to remain in effect until revoked by me in writing and until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such check. ***(Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your bank.)***

Automatic Bank Draft (ABD) transmissions are withdrawn from your bank approximately the 20th of every month, for the following month's premium. It can take upwards of 6 weeks to process an ABD request. Therefore, your premium should be submitted with your request for ABD.

I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, I will be charged a $25 service charge for each occurrence. I understand Health Net shall be under no liability whatsoever even though such dishonor may result in the forfeiture of health coverage.

SIGNATURE of ACCOUNT HOLDER (Required to Process)	Date

CREDIT CARD ☐ First month's payment ☐ Monthly premium payment

Monthly premium charge can be charged directly to your credit card account. The premium will be charged to your credit card account approximately ten days in advance of the due date. Your card will be charged for the first month's premium on the day your Application is approved by underwriting.

First Name (as on card)	Middle (as on card)	Last Name (as on card)	Card Type ☐ Visa ☐ MasterCard

Account Number 16-digits (complete)	Expiration Date (MM/YYYY)	Cardholder's email address

Billing Address	City	State	**ZIP**[1]

As a convenience, I request and authorize Health Net Life Insurance Company ("Health Net") to charge my credit card account identified above for the payment of my initial premium and/or my monthly premium. I understand that the Premium charged to my account will be for the future bill period plus any past due balances and that my first month's withdraw / charge may be for multiple periods depending upon date of approval and the bill period. This authority is to remain in effect until revoked by me in writing and until Health Net actually receives such notice, I agree that Health Net shall be fully protected in honoring any such charge. ***(Note: A 30-day notice is required to discontinue this service due to the time required to initiate this change with your credit card company.)*** I further agree that if my credit card is declined for payment, whether with or without cause and whether intentionally or inadvertently, I will be charged a $25 service charge for each occurrence. Credit card account will be charged approximately the 20th of every month, for the following month's premium.

SIGNATURE of CREDIT CARD ACCOUNT HOLDER (Required to Process)	Date

[1]The ZIP code must match the cardholder's address otherwise the credit card cannot be processed.

Health Net®

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. Individual and Family Plan (IFP) applicants please call 800-909-3447, option 2. For more help call the CA Dept. of Insurance at 1-800-927-4357 if you are enrolling in a PPO plan. If you are enrolling in a HMO plan, call the DMHC Helpline at 1-888-HMO-2219.
English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que una persona le lea los documentos y que algunos se le envíen en su idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación. Los solicitantes de Plan Individual y Familiar (IFP, por sus siglas en inglés), deben llamar al 800-909-3447, opción 2. Para obtener ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357, si desea inscribirse en un plan PPO. Si usted se inscribe en un plan HMO, llame a la Línea de ayuda de DMHC, al 1-888-HMO-2219.
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，部分文件可將您的語言版本寄送給您。如需協助，請撥打您會員卡上所列的電話號碼。個人和家庭計畫 (IFP) 申請人請撥打 800-909-3447，按 2。投保首選醫師 / 醫療組織 (PPO) 計畫者，請致電 1-800-927-4357 與加州保險部聯絡，詢求額外協助。投保管理式醫療組織 (HMO) 計畫者，請撥打加州醫療保健計畫管理局 (DMHC) 協助專線，電話 1-888-HMO-2219。
Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch và được người khác đọc giúp các tài liệu bằng ngôn ngữ của quý vị. Để được giúp đỡ, xin gọi chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị. Những người muốn xin bảo hiểm của Chương Trình Bảo Hiểm Cá Nhân và Gia Đình (IFP), xin gọi số 800-909-3447, bấm số 2. Để được giúp đỡ thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357 nếu quý vị muốn tham gia một chương trình PPO. Nếu quý vị đang tham gia một chương trình HMO, xin gọi Đường Dây Trợ Giúp của DMHC tại số 1-888-HMO-2219.
Vietnamese

무료 언어 지원 서비스. 무료 통역사 서비스 및 여러분에게 편한 언어로 서류 낭독 서비스를 받을 수 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 적힌 안내 번호로 전화해 주십시오. 개인 및 가족 플랜 (IFP) 가입 신청자님은 안내번호 800-909-3447번, 옵션 2를 이용해 주십시오. PPO 플랜에 가입하신 경우, 더 많은 도움이 필요하신 분은 캘리포니아 보험 담당국 안내번호 1-800-927-4357번으로 문의하십시오. HMO 플랜에 가입하신 경우, DMHC (보건관리부) 헬프라인, 안내번호 1-888-HMO-2219번으로 문의하십시오.
Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa iyong wika ang mga dokumento. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card. Para sa Individual and Family Plan (IFP) applicants, mangyaring tumawag sa 800-909-3447, opsyon 2. Para sa karagdagang tulong, tumawag sa CA Dept. of Insurance sa 1-800-927-4357 kung ikaw ay nag-eenroll sa isang PPO plan. Kung ikaw ay nag-eenroll sa isang HMO plan, tawagan ang DMHC Helpline sa 1-888-HMO-2219.
Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար ձեր լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված համարով: Անհատական և Ընտանեկան Ծրագրի (Individual and Family Plan/IFP) դիմորդներից խնդրվում է զանգահարել 800-909-3447 համարով, ընտրանք 2: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք, եթե գրանցվում եք PPO ծրագրում: Եթե գրանցվում եք HMO ծրագրում, 1-888-HMO-2219 համարով զանգահարեք DMHC-ի Օգնության գծին:
Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и вам могут прочесть документы на вашем языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте. Участники планов индивидуального или семейного страхования (Individual and Family Plan, IFP): пожалуйста, звоните по номеру 800-909-3447, добавочный 2. Если вы участвуете в плане системы предпочтительного выбора (Preferred Provider Organization, PPO), для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по телефону 1-800-927-4357. Если вы состоите в плане организаций медицинского обслуживания (Health Maintenance Organizations, HMO), пожалуйста, звоните в горячую линию Департамента организованного медицинского обслуживания (DMHC) по телефону 1-888-HMO-2219.
Russian

無料の言語サービス。日本語で通訳をご提供し、書類をお読みします。また、お手元にお届けできる翻訳書類もあります。サービスをご希望の方は、IDカード記載の番号までお問い合わせください。個人・家族プラン（IFP）への加入申込の方は、800-909-3447（ダイアル後 2 を選択）までお問い合わせください。更なるお問い合わせ事項がある場合、PPO プランにご加入の方は、 カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。HMOプランにご加入 の方は、 カリフォルニア州管理医療庁（DMHC）の相談窓口、1-888-466-2219 までご連絡ください。
Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی برخوردار شده و بگوئید مدارک به زبان خودتان برایتان خوانده شوند. برای دریافت کمک با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است تماس بگیرید. متقاضیان «طرح افراد و خانواده ها» (IFP) لطفاً به شماره 800-909-3447 گزینه 2 تلفن کنند. برای دریافت کمک بیشتر به اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تلفن کنید اگر در یک طرح PPO ثبت نام میکنید. اگر در یک طرح HMO ثبت نام میکنید به خط کمکی DMHC به شماره 1-888-HMO-2219 تلفن کنید.
Farsi

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਵਿਅਕਤੀਗਤ ਅਤੇ ਪਰਿਵਾਰਕ ਪਲਾਨ (IFP) ਅਰਜ਼ੀਦਾਤਾ ਕਿਰਪਾ ਕਰਕੇ 800-909-3447, ਔਪਸ਼ਨ 2 ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕਿਸੇ PPO ਪਲਾਨ ਲਈ ਨਾਂ ਲਿਖਵਾ ਰਹੇ ਹੋ ਤਾਂ ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ। ਜੇ ਤੁਸੀਂ ਕਿਸੇ HMO ਪਲਾਨ ਲਈ ਨਾਂ ਲਿਖਵਾ ਰਹੇ ਹੋ ਤਾਂ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਮੈਨੇਜਡ ਹੈਲਥ ਕੇਅਰ (DMHC) ਦੀ ਹੈਲਪਲਾਈਨ ਨੂੰ 1-888-HMO-2219 ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ।
Punjabi

ការបកប្រែភាសាដោយឥតអស់ថ្លៃ ។ អ្នកអាចទទួលអ្នកបកប្រែភាសា និងឲ្យគេអានឯកសារជូនអ្នកជាភាសាខ្មែរបាន ។ សំរាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខមានកត់នៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក ។ គំរោងបុគ្គលម្នាក់ៗ និងជាគ្រួសារ (IFP) សូមទូរស័ព្ទទៅលេខ 800-909-3447 ចុចជំរើសទី 2។ សំរាប់ជំនួយថែមទៀត សូមទូរស័ព្ទទៅ ក្រសួងធានារ៉ាប់រងកាលីហ្វ័រនីញ៉ា តាមលេខ 1-800-927-4357 បើសិនជាអ្នកកំពុងតែចុះឈ្មោះក្នុងគំរោង PPO ។ បើសិនជាអ្នកកំពុងតែចុះឈ្មោះក្នុងគំរោង HMO សូមទូរស័ព្ទទៅខ្សែជំនួយ DMHC តាមលេខ 1-888-HMO-2219 ។
Khmer

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi. Koj yuav thov tau kom muaj ib tug neeg txhais lus rau koj. Koj yuav thov tau kom muaj ib tug neeg nyeem cov ntawv thiab xa ib co ntaub ntawv ua koj hom lus tuaj rau koj. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID. Cov neeg thov kev pab hauv pawg Tus Kheej thiab Tsev Neeg (Individual and Family Plan [IFP]) thov hu rau 800-909-3447, xaiv nqe 2. Yog xav tau kev pab ntxiv hu rau CA Lub Caj Meem Fai Saib Xyuas Txog Kev Tswj Txoj Kev Kho Mob (Dept. of Insurance) ntawm 1-800-927-4357 yog hais tias koj koom rau hauv ib qho kev pab los ntawm PPO. Yog hais tias koj koom rau hauv ib qho kev pab los ntawm HMO, hu rau DMHC Tus Xov Tooj Muab Kev Pab ntawm 1-888-HMO-2219.
Hmong

خدمات لغوية بدون تكلفة. يمكنك الاستعانة بمترجم وطلب قراءة الوثائق لك بلغتك. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك (ID). المتقدمين بطلبات الحصول على تأمين لشخص واحد أو لعائلة (IFP) رجاء الاتصال بالرقم 800-909-3447، خيار 2. للحصول على المزيد من المساعدة، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357 إذا كنت مشتركاً في برنامج PPO. وإذا كنت مشتركاً في برنامج HMO اتصل بالخط الساخن لـ DMHC على الرقم 1-888-HMO-2219.
Arabic

ບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດໄດ້ຮັບບໍລິການແປພາສາແລະມີຜູ້ອ່ານເອກກະສານໃຫ້ທ່ານຟັງເປັນພາສາຂອງທ່ານເອງ. ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມໝາຍເລກທີ່ລະບຸໄວ້ໃນບັດປະກັນໄພຂອງທ່ານ. ຜູ້ຂໍເອົາແຜນການ Individual and Family Plan (IFP) ຂໍໃຫ້ໂທຕາມໝາຍເລກ 800-909-3447 ແລ້ວເລືອກ ຂໍ້ທີ 2. ຖ້າຫາກທ່ານກຳລັງຈະລົງທະບຽນແຜນການ PPO, ໃຫ້ໂທໄປຫາກົມປະກັນໄພແຫ່ງລັດຄາລິຟໍເນຍຕາມ ໝາຍເລກ 1-800-927-4357 ເພື່ອຈະໄດ້ຮັບຄວາມຊ່ວຍເຫລືອເພີ່ມຕື່ມ. ຖ້າຫາກທ່ານກຳລັງຈະລົງທະບຽນແຜນການ HMO, ໃຫ້ໂທຕາມສາຍດ່ວນ DMHC ຕາມໝາຍເລກ 1-888-HMO-2219.
Laotian

LANGUAGE PREFERENCE FORM
FORMULARIO DE PREFERENCIA DE IDIOMA
慣用語言資料表

TALK TO US – WE SPEAK YOUR LANGUAGE

Is English your second language? Is it easier to read and speak in a language other than English?

If yes, please complete this form and return it with your Enrollment Application. If you are accepted for enrollment, our records will be updated with this information. This information will help:

- Allow those whose preferred language is one of the two most prevalent non-English languages in Health Net's enrollment to receive certain plan documents in your preferred language.
- Provide you with interpreter assistance for health services in your preferred language.

Health Net is required to collect written and spoken language information in order to comply with California Department of Managed Health Care and California Department of Insurance language assistance regulations, however, you are not required to provide this information. Health Net will protect your information, including race, ethnicity, and your language choices.

HABLE CON NOSOTROS, HABLAMOS SU IDIOMA

¿Es el inglés su segundo idioma? ¿Le resulta más fácil leer y hablar en un idioma distinto del inglés?

Si la respuesta es sí, llene este formulario y devuélvalo junto con su Formulario de Inscripción. Si su solicitud de inscripción es aceptada, actualizaremos nuestros registros con esta información, la que nos servirá para:

- Permitir que aquellas personas cuyo idioma preferido es uno de los dos idiomas extranjeros más comunes entre todos los que se inscriben en Health Net, reciban ciertos documentos del plan en su idioma preferido.
- Brindarle la asistencia de un intérprete para servicios de salud en su idioma preferido.

A Health Net se le exige recopilar información sobre el idioma escrito y hablado para cumplir con los reglamentos sobre asistencia del idioma del Departamento de Cuidado Médico de California y el Departamento de Seguros de California, sin embargo, no es obligación que usted proporcione esta información. Health Net protegerá su información, incluidos su raza, origen étnico y sus alternativas de idioma.

請與我們交談 — 我們會說您的語言

英語是您的第二語言嗎？ 您是否覺得用英語以外的另一種語言來閱讀和溝通比較容易？

如果是的話，請您填寫這份表格，並連同您的投保申請書一併繳回。 如果您的投保申請獲准，我們會把本表的資料更新到紀錄中。 這些資料能幫助：

- 慣用語言為康寧保健投保時最通用的兩種非英文語言者，得以收到其慣用語言版本的部分計畫文件。
- 在您取得保健服務時以您慣用的語言提供您口譯員協助。

按加州醫療保健計畫管理局和加州保險局的語言協助法令規定，康寧保健必須收集書寫和口語使用語言的資訊，但是您無須提供這些資訊。 康寧保健會保護您所提供的資訊，包括種族、族裔和您的語言選擇。

Name/ Nombre/ 姓名：_____

Social Security Number/ Número del Seguro Social/ 社會安全號碼：_____

Written Language/ Idioma Escrito/ 書寫語言：_____

Spoken Language/ Idioma Hablado/ 口說語言： _____

Race (optional)/ Raza (opcional)/ 種族 (非必填)：_____

Ethnicity (optional)/ Origen Étnico (opcional)/ 族裔 (非必填)：_____