HEALTH NET PPO INSURANCE PLANS OUTLINE OF COVERAGE AND EXCLUSIONS AND LIMITATIONS

Health Net®
A BETTER DECISION

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Outline of coverage

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READ YOUR POLICY CAREFULLY

This outline of coverage provides a brief description of the important features of your Health Net PPO Policy (Policy). This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail the rights and obligations of both you and Health Net Life Insurance Company. It is, therefore, important that you read your Policy carefully!

MAJOR MEDICAL EXPENSE COVERAGE

This category of coverage is designed to provide, to persons insured, benefits for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Benefits may be provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, out of hospital care and prosthetic appliances subject to any deductibles, copayment provisions, or other limitations which may be set forth in the Policy.

PRINCIPAL BENEFITS AND COVERAGES

Please refer to the list below for a summary of each plan's covered services and supplies. Also refer to the Policy you receive after you enroll in a plan. The Policy offers more detailed information on the benefits and coverage included in your health insurance plan.

- Inpatient hospital services
- Outpatient hospital services
- Ambulatory surgical center
- Skilled nursing facility
- Professional services
- Routine physical examinations
- Diagnostic imaging (including X-ray) and laboratory procedures
- Home health care agency services
- Outpatient infusion therapy
- Ambulance services – ground ambulance transportation and air ambulance transportation
- Acupuncture
- Diabetes education
- Hospice care
- Radiation therapy, chemotherapy and renal dialysis treatment
- Bariatric (weight loss) surgery
- Prostheses
- Medically necessary corrective footwear
- Rental or purchase of durable medical equipment
- Implanted lens which replaces the organic eye lens
- Cardiac rehabilitation therapy
- Pulmonary rehabilitation therapy
- Allergy testing and treatment
- Self-injectable drugs
- Surgically implanted drugs
- Allergy serum – covered only when provided by a participating provider
- Sterilizations for male and female
- Diabetic equipment
- Reconstructive surgery
- Dental injury
- Phenylketonuria (PKU)
- Care for conditions of pregnancy
- Organ, tissue and bone marrow transplants
- Clinical trials
- Chiropractic benefits
- Mental health care and chemical dependency benefits

REPRODUCTIVE HEALTH SERVICES

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

LIFETIME MAXIMUM AND COST SHARING

Coverage is subject to deductible, coinsurances, copayments and lifetime maximums. Please consult the Policy for complete details.

CERTIFICATION (PRIOR AUTHORIZATION OF SERVICES)

Some services are subject to pre-certification. Please consult the complete list of services in the Policy.

EXCLUSIONS AND LIMITATIONS

The following is a list of services that are not generally covered. For complete details on any plan's exclusions and limitations, please see the Policy for complete details.

- Services or supplies that are not medically necessary
- Any amounts in excess of the maximum amounts specified in the Policy
- Pregnancy or maternity services, except as specified in the Policy
- Cosmetic surgery except as specified in the Policy
- Contraceptive drugs and/or certain contraceptive devices are covered as specified in the Policy. Vaginal contraceptive devices are only covered when a Physician prescribes the device and performs a fitting examination as specified in the Policy.
- Dental services except as specified in the Policy
- Treatment and services for Temporomandibular (Jaw) Joint Disorders (TMJ)
- Surgery and related services for the purposes of correcting the malposition or improper development of the bones of the upper or lower jaw, except when such procedures are Medically Necessary
- Food or dietary, nutritional supplements, except for formulas and special food products to prevent complications of Phenylketonuria (PKU)
- Vision care including certain eye surgeries to replace glasses, except as specified in the Policy
- Optometric services or eye exercises, except as specifically stated elsewhere in the Policy
- Eyeglasses or contact lenses, except as specified in the Policy
- Sex changes
- Services to reverse voluntary surgically induced infertility
- Services or supplies that are intended to impregnate a woman are not covered.
- Certain genetic testing
- Experimental or investigative services
- Routine physical exams, except for preventive care services (e.g., physical exam for insurance, licensing, employment, school, or camp.) Any physical, vision or hearing exams which are not related to diagnosis or treatment of illness or injury, except as specifically stated in Policy.

- Immunizations or inoculations for adults or children, except as described in the "Medical Benefits" section or for foreign travel or occupational purposes
- Services not related to a covered illness or injury
- Custodial or domiciliary care
- Inpatient room and board charges incurred in connection for an admission to a Hospital or other Inpatient treatment facility, primarily for diagnostic tests which 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
- Any services or supplies furnished by a non-eligible institution, which is other than a legally operated Hospital or Medicare-approved Skilled Nursing Facility, or which is primarily a place for the aged, a nursing home or any similar institution, regardless of how designated
- Expenses in excess of a Hospital's (or other Inpatient facility's) most common semi-private room rate
- Infertility services
- Private duty nursing
- Mental and nervous disorder and substance abuse treatment, except as specified in the Policy
- Hyperkinetic syndromes, learning disabilities, behavioral problems or mental retardation unless due to severe mental illness or serious emotional disturbances of a child
- Over-the-counter medical supplies and medications
- Personal comfort items
- Orthotics, unless custom made to fit the Covered Person's body and as specified in the Policy
- The Policy does cover certain Medically Necessary diabetic equipment.
- Educational services or nutritional counseling, except as specified in the Policy
- Hearing aids
- Obesity related services
- Any services received by Medicare benefits without payment of additional premium
- Services received before your effective date of coverage
- Services received after coverage ends
- Services for which no charge is made to the Covered Person in the absence of insurance coverage, except services received at a charitable research Hospital which is not operated by a governmental agency
- Physician self-treatment
- Services provided by immediate family members
- Conditions caused by the Covered Person's commission (or attempted commission) of a felony unless the condition was an injury resulting from an act of domestic violence or an injury resulting from a medical condition
- Conditions caused by release of nuclear energy, when government funds are available
- 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.
- Services for conditions of pregnancy for a surrogate parent are covered, but when compensation is obtained for the surrogacy, we shall have a lien on such compensation to recover its medical expense.
- Any outpatient drugs, medications or other substances dispensed or administered in any outpatient setting except as stated in the Policy
- Sexual dysfunction drugs
- Rehabilitative services rendered in an outpatient facility are not covered.
- Psychosocial speech delay (includes delayed language development)
- Mental retardation or dyslexia
- Attention deficit disorders and associated behavior problems

- Developmental articulation and language disorders
- However, some of the above conditions shall be covered as shown in the "Schedule of Benefits" section, if Medically Necessary as described in the definitions of "Serious Emotional Disturbances of a Child" and/or "Severe Mental Illness," and continuous functional improvement in response to the treatment plan is demonstrated by objective evidence.
- Outpatient speech therapy, except as specified in the Policy
- Services and supplies obtained while in a foreign country with the exception of Emergency Care
- Home birth
- Reimbursement for services for which the Covered Persons is not legally obligated to pay the provider or for which the provider pays no charge
- 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 Policy.
- 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
- 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 Covered Person's residence to accommodate the Covered Person'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
- Disposable supplies for home use
- Services performed by a person who lives in the Covered Person's home or who is related to the Covered Person by blood or marriage

Some services require pre-certification from Health Net prior to receiving services. Please refer to your Policy for details on what services and procedures require pre-certification.

Health Net Life does not require pre-certification for dialysis services or maternity care.

PRE-EXISTING CONDITIONS

Services or supplies received for the treatment of a Pre-Existing Condition during the first 6 consecutive months during which the Covered Person is covered (including any waiting period). Except that:

1. This exclusion shall not apply to a child newly born to, or newly adopted by, an enrolled Policyholder or his or her spouse or domestic partner.
2. This exclusion shall not apply to conditions of pregnancy.
3. If a Covered Person becomes eligible for coverage under this Policy within 63 days of the termination of any Creditable Coverage, that Covered Person will be given credit toward the 6 month waiting period for time covered by the Creditable Coverage.

RENEWABILITY OF THIS POLICY

Subject to the termination provisions discussed in the Policy, coverage will remain in effect for each month premiums are received and accepted by Health Net.

PREMIUMS

We may adjust or change your premium. If we change your premium amount, notice will be mailed to you at least 30 days prior to the premium change effective date. Premiums are automatically adjusted for changes in your and your dependent spouse's or registered domestic partner's ages. Premiums may be adjusted when your residence address changes.

LOSS RATIO

Health Net Life's 2008 ratio for the Individual and Family PPO insurance plans was 86.9 percent.

Exclusions and Limitations

Dental and Vision PPO plus coverage

IMPORTANT INFORMATION

Dental and Vision coverage is only included in the Health Net Life Insurance PPO Plus plans. You must enroll in a PPO Plus plan to obtain dental and vision coverage.

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

LIMITATIONS TO COVERED SERVICES AND SUPPLIES

1. Type I: Preventive and diagnostic dental services

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

a) Initial or periodic oral exams, limited to one per 6-month period. Initial exams will be limited to the allowance for a periodic exam.

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

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

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

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

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

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

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

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

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

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

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

m) Emergency oral exams.

n) Limited oral evaluation, problem focused.

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

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

a) Pulpotomy.

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

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

d) Apicoectomy/periradicular surgery (anterior, bicuspid, molar, each additional root), paid as a separate benefit only if services are performed not less than 12 months after the initial root canal therapy is completed. Reimbursement includes

pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.

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

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

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

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

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

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

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

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

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

k) Specialist consultation.

3. Type II: Basic Dental Services (Restorative)

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

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

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

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

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

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

4. Type III: Major Dental Services

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

a) Inlays and onlays:

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

b) Porcelain substrate or metal crowns:

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

c) Crowns:

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

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

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

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

- Replacement dentures are covered only if:
  1. Five (5) years have elapsed since last placement and the denture cannot be made serviceable; and
  2. Two (2) years have elapsed after the member's effective date of coverage under the Dental Plan.

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

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

- Replacement partial dentures are covered only if:
  1. Five (5) years have elapsed since last placement (please refer to the Denture or Bridge Replacement/Addition provision for exceptions) and the partial denture cannot be made serviceable; and
  2. Two (2) years have elapsed after the member's effective date of coverage under the Dental Plan.

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

j) Each additional clasp and rest.

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

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

m) Relining or rebasing dentures, limited to:

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

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

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

1. Is more than 5 years old (see the Denture or Bridge Replacement/Addition provision for exceptions);
2. Cannot be made serviceable; and

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

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

5. Denture or Bridge Replacement/Addition

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

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

b) The denture or bridge cannot be made serviceable;

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

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

   - Benefits for the replacement of an existing partial denture that is less than 5 years old will be covered if there is a dentally necessary extraction of an additional functioning natural tooth and the partial denture cannot be made serviceable.
   - For an existing fixed partial denture that is less than 5 years old, and an existing abutment or a functioning natural tooth within the same arch is extracted, the covered benefit will be a partial denture.

6. Missing teeth limitation

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

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

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

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

General Exclusions

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

1. Treatment that is: a) not included in the Dental Plan Schedule of Benefits; b) not dentally necessary; or c) Experimental in nature.
2. Services and supplies related to the change of vertical dimension, restoration or maintenance of occlusion, re-implantation, splinting and stabilizing teeth, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for myofascial pain disorders (MPD) or temporomandibular joint disorders (TMJ).
3. Services and supplies provided primarily for cosmetic purposes.
4. Crowns, inlays, cast restorations or other laboratory prepared restorations on teeth that may be restored with an amalgam or composite resin filling.
5. Athletic mouthguards; denture duplication; infection control; separate charges for acid etch; treatment of jaw fractures; orthognathic surgery; exams required by a third party; travel time; transportation costs; professional advice given on the phone.

6. Implants, related procedures or services involving root form implants.
7. Grafting (bone or tissue) and guided tissue regeneration.
8. Prescription drugs or any medications are not covered.
9. Services, procedures or supplies for which a charge would not have been made in the absence of insurance.
10. Procedures, services or supplies for which the member does not have to pay, except when payment of such benefits is required by law and then only to the extent required by law.
11. Treatment will be considered a covered service and supply only when the member is eligible for services on the date treatment is started. Payment is based on the start date.
12. Services and supplies obtained while outside the United States, except for emergency dental care.
13. Orthodontic services, supplies, or oral surgery procedures for the purposes of orthodontic treatment, inclusive of extractions.

VISION

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

1. Charges for procedures, services or materials that are not included as covered charges.
2. Any portion of a charge in excess of the maximum benefit allowance.
3. Expenses for any non-standard corrective lens materials, including but not limited to the following: coated, dyed, glass lens tints or laminated lenses, blended, or oversize lenses, occupational or recreational lenses, polycarbonate, safety glasses, scratch resistant, UV protection, anti-reflective, or photochromatic/photosensitive lenses.
4. Non-prescription lenses.
5. Orthoptics, vision training and low vision aids and any associated supplemental testing.
6. Medical or surgical treatment of the eye including, but not limited to, Laser In Situ Keratomileusis (LASIK) and Photorefractive Keratectomy (PRK).
7. Prescription or non-prescription medications.
8. Any eye examination or any corrective eyewear required as a condition of employment.
9. Services or materials which the company determines to be experimental, cosmetic or not medically necessary.
10. Any service or material not prescribed by an ophthalmologist, optometrist or registered dispensing optician.
11. Services and materials furnished in conjunction with excluded services and materials.
12. Services and materials for repair or replacement of broken, lost or stolen lenses, contact lenses or frames.
13. Services and materials that a Covered Person received during a service interval under any other plan offered by the company or one of the company's affiliates.
14. Charges incurred before a Covered Person's effective date of coverage under the Policy or after such coverage terminates.
15. Services or materials received as a result of disease, defect or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
16. Services and materials obtained while outside the United States, except for emergency vision care.
17. Services or materials resulting from or in the course of your or a dependent's regular occupation for pay or profit for which you or your dependent is entitled to benefits under any Worker's Compensation law, employer's liability law or similar law. You must promptly claim and notify the company of all such benefits.

18. As follows:

    - Charges payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, Health Net Life will always reimburse any state or local medical assistance (Medicaid) agency for covered services and materials.
    - Charges not imposed against the person or for which the person is not liable.

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

Prior authorization

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

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