

Health Net Individual & Family PPO

Net Saver 1500

Coverage Summary of Benefits

Effective July 1, 2005



Health Net Individual & Family PPO Coverage

This document is only a summary of your health coverage. You have the right to view the Policy 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 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 your Policy thoroughly once received, especially all sections that apply to those with special health care needs. Health benefits and coverage matrices on pages 5 to 7 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.

Understanding your coverage choices

What is a PPO?

Health Net's Preferred Provider Organization (PPO) is a network of more than 45,000 physicians statewide. You may select any physician at any time from the network, or you can see physicians outside the PPO network (for a higher cost).

PPO advantages include:

- Freedom to see any physician at any time
- No referral or authorization needed to see specialists
- Lower copayments and coinsurance when you see in-network physicians
- Hospital coverage
- Prescription coverage

CHOOSE THE COVERAGE that's right for you and your family.

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	Net Saver 1500	
	In-Network Provider ¹	Out-of-Network Provider ²
Annual deductible is met when two family members meet their individual deductibles	\$1,500	
Annual out-of-pocket maximum (family maximum is twice this amount)	\$4,000 combined in-network and out-of-network (includes deductible)	
Lifetime Maximum	\$6 million	
Visit to physician	Negotiated fee until OOPM is met, then covered in full	No benefits until OOPM is met, then covered in full
X-ray and laboratory procedures³	Negotiated fee until OOPM is met, then covered in full	No benefits until OOPM is met, then covered in full
Preventive care		
Routine physical exams, including routine lab and X-ray services	Not covered	
Annual OB/GYN exam (breast and pelvic exams, cervical cancer screening and mammography) ⁴	25%	Not covered
Prostate cancer screening and exam	25%	Not covered
Immunizations Standard	Not covered	
To meet foreign travel or occupational requirements	Not covered	
Child preventive care (newborns to age 18); checkups, vision and hearing exams	25%	Not covered
Child preventive care Immunizations	25%	Not covered
Allergy testing and injection services	Negotiated fee until OOPM is met, then covered in full	No benefits until OOPM is met, then covered in full
Maternity and pregnancy³		
Prenatal and postnatal office visits	Not covered	
Maternity care in hospital	Not covered	
Emergency and urgent care		
Emergency room (professional and facility charges)	25%	25%
Urgent care center (facility charges)	25%	25%
Ambulance ³	25%	25%
Inpatient Hospital services (non-emergency care)³		
Physician/surgeon and anesthetics services	25%	50%
Organ and bone marrow transplants (nonexperimental and noninvestigational)	25%	Not covered
Alcohol detoxification ⁷	25%	50% ⁵
	3 days per calendar year combined in-and-out-of-network	

Summary of Benefits continued

Benefit Description	Net Saver 1500	
	In-Network Provider ¹	Out-of-Network Provider ²
Hospital and skilled nursing facility (facility charges)		
Inpatient, semiprivate hospital room or intensive care unit with ancillary services (unlimited, except for mental health and substance abuse treatment)	25%	50% ⁵
Outpatient surgery	25%	50% ⁵
Skilled nursing facility	25% (100-day annual limit combined in- and out-of-network)	50% ⁵
Reproductive health		
Sterilization	25%	not covered
Other services		
Home health services (limited to 60 visits per calendar year combined in- and out-of-network) ³	25%	50%, \$75 maximum payable per day
Hospice services ³	25%	50%
Rehabilitative therapy (includes physical, speech, occupational, respiratory and cardiac therapy) ³	Negotiated fee until OOPM is met, then covered in full Limited to 20 visits per calendar year combined in- and out-of-network	No benefits until OOPM is met, then covered in full
Chiropractic care	Not covered	
Acupuncture	Not covered	
Mental health services for severe conditions ⁶	25% Inpatient / Negotiated fee until OOPM is met Outpatient then covered in full	50% inpatient ⁵ / No benefits until OOPM is met then covered in full Outpatient
Mental health services for nonsevere conditions ^{6,7}	25% Inpatient / Negotiated fee until OOPM is met then covered in full Outpatient	50% inpatient/ not covered outpatient
Durable medical equipment (including foot orthotics) ³	50%	Not covered
Corrective footwear (\$200 maximum payable per calendar year) ³	50%	Not covered
Prosthetics and corrective appliances ³	25%	50%
Outpatient prescription drugs		
Filled at participating pharmacy (up to a 30-day supply); not covered at non-participating pharmacies	Not covered	
Filled through mail order (up to a 90-day supply)	Not covered	

- 1 Of negotiated rate, the rate the Participating or Preferred Provider has agreed to accept for providing a covered service.
- 2 Percentage is a portion of the covered expense based on (C&R) Customary & Reasonable. You are also responsible for any charges in excess of the covered expense.
- 3 Certain services require prior certification from Health Net. Without prior certification, benefit reduced by 50%. Refer to page 16.
- 4 One mammogram for ages 35-39, one every 24 months for ages 40-49, and one every year for age 50 and older.
- 5 Allowable charges are \$600 per day.

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- 6 See page 10 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 \$175.
- 7 Covered expenses incurred for non-severe mental illness and chemical dependency do not apply to the out-of-pocket maximum.

Important things to know about all of your coverage options

Who is eligible?

To be eligible for Health Net Individual & Family PPO you must: be under the age of 65, not be eligible for Medicare, reside continuously in our service area, and meet our application and underwriting requirements for coverage. In addition, your spouse or domestic partner, if under age 65, and all your unmarried dependent children under 19 years of age are also eligible (subject to underwriting requirements). Unmarried dependent children enrolled in an accredited school as full-time students and under 24 years of age are also eligible, if proof of full-time student status is provided.

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

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

Applicants for the PPO Net Saver 1500 must apply through the Internet. An individual who is interested in applying can go to www.healthnet.com, to the California link and go to the Individual and Family Plans link and apply. No mailed or faxed applications will be accepted; no exceptions will be made.

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

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

To qualify for a HIPAA plan, you must:

- have completed a total of 18 months of coverage without a significant break (excluding any employer-imposed waiting period) under a group health plan
- the most recent coverage must have been under a group health plan (COBRA and Cal-COBRA coverage are considered group coverage).
- the applicant must not be eligible for coverage under any group health plan, Medicare or Medicaid, and must not have other health insurance coverage.
- the individual's most recent coverage could not have been terminated due to fraud or nonpayment of premiums.
- if COBRA or Cal-COBRA coverage was available, it must have been elected and such coverage must have been exhausted.

If you want to find out if you qualify, contact us so that we can determine your eligibility and tell you about the available HIPAA plans. If you believe your rights under HIPAA have been violated, please contact the Department of Managed Health Care at 1-888-HMO-2219 or visit the Department's website at www.hmohelp.ca.gov.

How does the monthly billing work?

For the PPO Net Saver 1500 there are two billing options available: automatic bank draft (ABD) or credit card. Your premium will be withdrawn directly for your checking account or charged to your credit card approximately 10-days in advance of the due date. If there are premium increases after the enrollment effective date, you will be notified at least 30 days in advance. If there are changes to the Health Net Individual & Family 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 of the month following our receipt of your written notice to cancel. Health Net has the right to terminate your coverage for any of the following reasons:

- You do not pay your premium on time
- You and/or your family member(s) cease being eligible
- You make false statements about your own or your family's health status
- 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 days written notice. Members are responsible for payment of any services received after termination of coverage at the provider's prevailing nonmember 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.

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 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.

Members not satisfied with the results of the grievance and appeals process may submit the problem to binding arbitration. Health Net uses binding arbitration to settle disputes, including medical malpractice. As a condition of enrollment, Members give up their right to a jury or trial before a judge for the resolution of such disputes.

Important Notice to California Policyholders

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

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**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, or its agent or other representative, her or she may contact:

**California Department of Insurance, Consumer Services Division
300 South Spring Street
South Tower
Los Angeles, CA 90013
1-800-927-HELP**

What are Health Net's premium ratios?

Health Net Life's 2003 ratio for the Individual & Family PPO insurance plans was 68%.

What about continuity of care upon termination of a provider contract?

If Health Net's contract with a physician group or other provider is terminated, Health Net will transfer any affected Members to another contracting physician group or provider and make every effort to ensure continuity of care. At least 60-days prior to termination of a contract with a Physician Group or acute care hospital, Health Net will provide a written notice to affected Members. In addition, the Member may request continued care from a provider whose contract is terminated if at the time of termination the member was receiving care from such a provider for:

- An acute condition
- A serious chronic condition
- A pregnancy (including the duration of the pregnancy and immediate postpartum care)
- A newborn (up to age 36 months), with a maximum duration of coverage of twelve months. This applies only to this provision affecting the continuity of care.)
- A terminal illness (for the duration of the terminal illness)
- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable Copayments and any other exclusions and limitations of this Plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider's contract termination. The Member must request continued care within 30 days upon receiving notification of the provider's date of termination.

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

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

Severe Mental Illness includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder, 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

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requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Do providers limit services for reproductive care?

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

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.

Are there any pre-existing conditions?

Until the policy has been in effect for six consecutive months, covered services will not include any care required in connection with the treatment of any condition, disease or injury for which medical advice, diagnosis, care or treatment, including the use of prescription medications, was recommended by or received from a licensed health care practitioner during the six months immediately preceding the effective date of coverage under the policy.

Credit will be given toward the pre-existing condition waiting period for membership with another creditable health care plan if you apply for coverage under Health Net's Individual & Family PPO insurance plan within 62 days of termination with the previous plan.

When do I submit claims?

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

What are Customary and Reasonable charges?

Customary and Reasonable charges, as determined by Health Net Life, are charges which fall within the common range of fees billed by a majority of physicians for a procedure in a given geographic region, or which are justified based on the complexity or the severity of treatment for a specific case.

If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by Health Net 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.

Exclusions and Limitations

Exclusions and Limitations Common to all Individual & Family Coverage Options

No payment will be made under the Health Net Life Individual & Family PPO for expenses incurred for or which are follow-up care to any of the items below. The following are selective listings only. For a comprehensive listings, see 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 9.
- 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 9.
- Services or supplies provided before the effective date of coverage; services or supplies provided after coverage through this plan has ended are not covered.
- Services for which the Member is not legally obligated to pay or for which no charge is made to the Member.
- Any service or supplies not specifically listed as covered expenses.
- Services or supplies that are intended to impregnate a woman are not covered.
- Oral contraceptives and emergency contraceptives are covered. Vaginal contraceptives are limited to diaphragms, cervical caps and IUDs, 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. *
- Dental care.
- Treatment and services for a Temporomandibular Joint Disorders are covered when determined to be medically necessary, excluding crowns, onlays, bridgework and appliances.
- Any services or supplies furnished by a non-eligible institution that is other than a legally operated hospital or Medicare-approved skilled nursing facility, or that is primarily a place for the aged, a nursing home or any similar institution, regardless of how designated.
- Surgery and related services for the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw, except when such surgery is required due to recent trauma or the existence of tumors or neoplasms, or when otherwise medically necessary.
- Hearing aids.
- Treatment for mental disorders as a condition of parole or probation and court ordered testing.
- Private duty nursing.
- Any eye surgery for the purpose of correcting refractive defects of the eye, unless medically necessary, recommended by the Member’s treating physician and authorized by Health Net.
- Contact or corrective lenses (except an implanted lens that replaces the organic eye lens), vision therapy and eyeglasses.
- 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 Life Policy.

- Any outpatient drugs, medications or other substances dispensed or administered in any setting, except as specifically stated in the Health Net Life Policy.
- Services for a surrogate pregnancy are covered. However, when compensation is obtained for the surrogacy, the plan shall have a lien on such compensation to recover its medical expense.
- Conditions covered by Workers' Compensation or similar laws.
- Although this Plan covers Durable Medical Equipment, it does not cover the following items, : (a) exercise equipment; (b) hygienic equipment, jacuzzis and spas; (c) surgical dressings other than primary dressings that are applied by your Physician Group or a Hospital to lesions of the skin or surgical incisions; and (d) stockings, corrective shoes and arch supports.
- Personal or comfort items
- Disposable supplies for home use
- Home birth, unless the criteria for emergency care have been met.
- Physician self-treatment.
- Physicians treating immediate family members.
- Treatment for alcoholism or drug addiction, except detoxification.

*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.

Additional Exclusions and Limitations for Net Saver 1500

- 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.
- Services or supplies received for the treatment of a pre-existing condition during the first six consecutive months during which the Member is covered.
- Immunizations or inoculations for adults or children, except as described in the Policy.
- Any services not related to the diagnosis or treatment of a covered illness or injury.
- Inpatient room and board charges incurred in connection with an admission to a hospital or other inpatient treatment facility primarily for diagnostic tests that could have been performed safely on an outpatient basis.
- Inpatient room and board charges in connection with a hospital stay primarily for environmental change, physical therapy or treatment of chronic pain.
- Expenses in excess of a hospital's (or other inpatient facility's) most common 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.
- 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.
- Services to diagnose, evaluate or treat infertility are not covered.
- Acupuncture.
- Chiropractic services, including and not limited to office visits, X-rays, adjustments, manipulation and therapy.
- Routine physical examinations.
- 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 15 for definitions).
- Care for conditions of pregnancy, including hospital and professional services. This includes prenatal and postnatal care, and delivery
- Immunizations or inoculations for foreign travel or occupational purposes.
- Allergy serum
- Outpatient Prescription Drugs

PPO coverage certification requirements

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

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

1. Inpatient admissions
 - Any type of facility, including but not limited to:
 - Hospital
 - Skilled Nursing Facility
 - Mental health facility
 - Chemical dependency facility
 - Acute rehabilitation center
 - Hospice
2. Ambulance
 - Air Ambulance
 - Non-emergent transport
3. Ambulatory services
 - Durable Medical Equipment
 - Home Health Care Agency Services including nursing, physical therapy, occupational therapy, speech therapy, home I.V. therapy, Hospice Care, tocolytic services (intravenous drugs used to decrease or stop uterine contractions in premature labor) and home uterine monitoring
 - Prosthesis for major limbs
4. Experimental services, new technology and evolutionary changes in proven technology
5. Orthognatic procedures (surgery performed to correct or straighten jaw and/or other facial bone misalignments to improve function.)
6. Outpatient Diagnostic Imaging:
 - CT Scans
 - MRA (Magnetic Resonance Angiography)
 - MRI (Magnetic Resonance Imaging)

- MUGA Cardiac Scan (Multiple Gated Acquisition)
 - PET (Positron Emission Tomography)
 - SPECT (Single Photon Emission Computed Tomography)
7. Surgical procedures including:
 - Abdominal, ventral, umbilical, incisional hernia repair
 - Blepharoplasty
 - Breast reductions and augmentations
 - Mastectomy for gynecomastia
 - Rhinoplasty
 - Sclerotherapy
 - Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
 8. Temporomandibular Joint (TMJ) Disorder treatment
 9. Transplant-related services including pre-evaluation and pre-treatment services, and the transplant procedure

Exceptions

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

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

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

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

Pregnancy

When a Member gives birth to a child in a hospital, she is entitled to benefits for 48 hours of inpatient care following a vaginal delivery or 96 hours following a cesarean section delivery. Certification penalties will not be applied for that period of time. However, certification must be obtained for a cesarean section if the physician determines that a longer stay is medically necessary.

Modified Issue explained

Q: What is a Modified Issue?

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

Q: How does Health Net calculate Modified Issue premiums?

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

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

Call toll-free
1-800-909-3447

Para los que hablan español
1-800-331-1777

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