Individual and Family
HMO Plans

Health coverage made easy

Vicki Major,
Health Net
We seek to make a difference one member at a time.

Health Net®

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Health Coverage Made Easy

This document is only a summary of your health coverage. You have the right to view the plan's Plan Contract and Evidence of Coverage (EOC) prior to enrollment. To obtain a copy of this document, contact your authorized Health Net Agent, or your Health Net Sales Representative at 1-800-909-3447. The plan's Plan Contract and EOC, 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 the plan's Plan Contract and EOC thoroughly once you receive them, especially all sections that apply to those with special health care needs. Health benefits and coverage matrices on pages 4–9 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 coverage may be obtained.

We're committed to providing a health plan that's simple to use and easy to access.

Herminia Escobedo, Health Net
We're here to support your health.

Coverage *You Can Count On*

When it comes to your health, we've got you covered. Our Individual & Family HMO plans include coverage for doctor's office visits, hospitalization, emergency care and much more.

We believe that staying healthy is just as important as getting better, so we give you tools and resources to make taking care of your health easy and convenient – like online access to wellness information, and resources to deal with life and family issues. Plus, you have the option of adding dental, vision and life insurance for more comprehensive coverage.

Is an HMO right for you?

HMO plans are designed for people who would like one doctor to coordinate their medical care at predictable costs. This doctor is called your primary care physician (PCP). Health Net requires the designation of a PCP. A PCP provides and coordinates your medical care. You have the right to designate any PCP who participates in our Health Net Individual HMO network and who is available to accept you or your family members, subject to the requirements of the physician group. For children, a pediatrician may be designated as the PCP. Until you make your primary care physician designation, Health Net designates one for you. For information on how to select a PCP and for a list of the participating PCPs, refer to your Health Net Individual HMO Directory, available on the Health Net website at www.healthnet.com. Your PCP oversees all your health care and provides the referral/ authorization if specialty care is needed. PCPs include general and family practitioners, internists, pediatricians and OB/GYNs. Most services require only a fixed copayment from you.

To obtain health care, simply present your ID card and pay the appropriate copayment. Your PCP 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 below. All treatments recommended by such providers must be authorized by your PCP.

You do not need prior authorization from Health Net or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, refer to your Health Net Individual HMO Directory, available on the Health Net

website at www.healthnet.com. Refer to the "Mental Disorders and Chemical Dependency Services" section on page 39 for information about receiving care for mental disorders and chemical dependency.

Your PCP belongs to a larger group of health care professionals, called a participating physician group. If you need care from a specialist, your PCP refers you to one within this group.

Timely access to non-emergency health care services

The California Department of Managed Health Care (DMHC) has issued regulations (Title 28, Section 1300.67.2.2) with requirements for timely access to non-emergency health care services.

You may contact Health Net at the number shown on the back cover, 7 days per week, 24 hours per day to access triage or screening services. Health Net provides access to covered health care services in a timely manner. For further information, please refer to the Individual and Family Plan EOC or contact the Health Net Customer Contact Center at the phone number on the back cover.

Health Net HMO advantages include:

- A wide range of covered benefits.
- Set office visit copays.
- More than 42,700 physicians and other specialists.
- No claim form filing.
- The ability to choose a separate PCP for each member.

The right HMO plan

In this brochure, you'll find information about our HMO Value 50 and HMO 40 plans. Here is some information to get you started.

HMO Value 50: Gives you the benefits of a Health Net HMO plan with no medical deductible and a $50 copay for doctor and specialist visits.

HMO 40: If you don't visit the doctor that often, this could be a plan for you. You pay a $40 copayment each time you go to the doctor or see a specialist.

HMO Value 50 Plus and HMO 40 Plus[1]: A Health Net "HMO Plus" plan is a Health Net HMO plan with Health Net dental and vision coverage included. The "Plus" indicates the addition of the optional coverage.[1] For more information, refer to the plan grids on the following pages. Or, contact your authorized Health Net agent or call Health Net's Individual & Family Plans Department at 1-800-909-3447.

[1]Dental and Vision benefits provided by Health Net of California, Inc. Dental benefits administered by Dental Benefit Providers of California, Inc (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net of California, Inc. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to provide and administer vision benefits. EyeMed Vision Care, LLC is not affiliated with Health Net of California, Inc.

HMO Value 50

Plan Overview

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.

The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments are usually billed after the service is received.

Benefit description	*HMO Value 50*
Lifetime maximum	Unlimited
Out-of-pocket maximum (payments for services not covered by this plan will not apply to this calendar year out-of-pocket maximum)[1]	$5,500 single / $11,000 family
Professional services Visit to physician	$50
Specialist consultations	$50
Prenatal and postnatal office visits[2]	$50
Preventive care services Periodic health evaluations and annual preventive physical examinations[3]	Covered in full
Vision exams (for diagnosis or treatment)	$50
Hearing exams (for diagnosis or treatment)	$50
Immunizations – standard	Covered in full
Immunizations – to meet foreign travel or occupational requirements	$50
Prostate cancer screening and exam	Covered in full
Well-woman exam (breast and pelvic exams, cervical cancer screening and mammography)[4]	Covered in full
Allergy testing	$50
Allergy injection services	$50
All other injections	Office-based injectable medications: covered in full Self-administered injectable medications: 30%
Allergy serum	Covered in full
Outpatient services Outpatient surgery	Hospital charges: 50% Outpatient surgery center charges: 45%
Outpatient facility services (other than surgery)	50%
Hospitalization services Semiprivate hospital room or intensive care unit with ancillary services (unlimited, except for non-severe mental disorders and chemical dependency treatment)	50%
Surgeon or assistant surgeon services	Covered in full
Skilled nursing facility stay (limited to 100 days per calendar year)	$0/day (1–10) / $25/day (11–100)
Maternity care in hospital	50%
Physician visit to hospital or skilled nursing facility (excluding care for chemical dependency)	Covered in full
Emergency health coverage Emergency room (professional and facility charges)	$300 (waived if admitted to hospital)
Urgent care center (professional and facility charges)	$75
Ambulance services (ground and air)	$100

Benefit description	*HMO Value 50*
Prescription drug coverage[5,6,7,8] Prescription drugs filled at a participating pharmacy (up to a 30-day supply)[9]	$400 brand name drug deductible, then $15 Level I (primarily generic) $35 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) to a copayment maximum of $100
Prescription drugs filled through mail order (up to a 90-day supply)[9]	$400 brand name drug deductible, then $30 Level I (primarily generic) $70 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) to a maximum copayment of $300
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 modification support program. For information regarding smoking cessation behavioral modification support programs available through Health Net, contact the Customer Contact Center at the telephone number on the back of your Health Net ID card or visit the Health Net website at www.healthnet.com. See Decision Power® Health & Wellness.).[9]	50%
Contraceptive devices[9] (received at a participating pharmacy)	$400 brand name drug deductible, then $35
Durable medical equipment (includes nebulizers, face masks and tubing for the treatment of asthma)[10]	50% (limited to a maximum payment of $2,000 per Calendar Year. Maximum does not apply to diabetic equipment and supplies or nebulizers, face masks and tubing used for the treatment of asthma). All calculations of the calendar year benefit maximum for Durable Medical Equipment are based on the total aggregate amount of benefits paid under this plan.
Mental health services Severe mental illness and serious emotional disturbances of a child conditions[11]	Outpatient: $40 Inpatient: 50%
Other mental disorders[11]	Outpatient: $40 (limited to 20 visits per calendar year) Inpatient: 50% (limited to 30 days per calendar year)
Chemical dependency services Chemical dependency treatment	Not covered
Acute care (detoxification)	50%
Home health care services (100 visits per calendar year maximum; limited to three visits per day, four-hour maximum per visit)	$50 per visit
Hospice services	Covered in full
Other services Diabetic equipment (includes blood glucose monitors, insulin pumps and corrective footwear)[8]	20%
Laboratory procedures and diagnostic imaging (including X-ray) services	Covered in full
CT, SPECT, MRI, MUGA and PET	$300
Rehabilitative therapy (includes physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)	$50
Sterilizations	$150
Organ and stem cell transplants (non-experimental and noninvestigational)	Covered in full
Prostheses[8]	Covered in full
Family planning counseling	$50

HMO 40

Plan Overview

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 40*
Deductibles	$1,500 per calendar year for inpatient hospital services only (outpatient prescription drug deductible applies[1,8])
Lifetime maximum	Unlimited
Out-of-pocket maximum (payments for services not covered by this plan will not apply to this calendar year out-of-pocket maximum)[2]	$3,000 single / $6,000 family
Professional services	
Visit to physician	$40
Specialist consultations	$40
Prenatal and postnatal office visits[3]	$40
Preventive care services	
Periodic health evaluations and annual preventive physical examinations[4]	Covered in full
Vision exams (for diagnosis or treatment)	$40
Hearing exams (for diagnosis or treatment)	$40
Immunizations – standard	Covered in full
Immunizations – to meet foreign travel or occupational requirements	20%
Prostate cancer screening and exam	Covered in full
Well-woman exam (breast and pelvic exams, cervical cancer screening and mammography)[5]	Covered in full
Allergy testing	$40
Allergy injection services	$40
All other injections – including self-administered injectable medications	Covered in full
Allergy serum	Covered in full
Outpatient services	
Outpatient surgery (hospital or outpatient surgery center charges only)	$250
Outpatient facility services (other than surgery)	Covered in full
Hospitalization services	
Semiprivate hospital room or intensive care unit with ancillary services (unlimited, except for non-severe mental disorders and chemical dependency treatment)	$1,500 deductible applies per calendar year for inpatient services
Surgeon or assistant surgeon services	Covered in full
Skilled nursing facility stay (limited to 100 days per calendar year)	$50 per day
Maternity care in hospital	Covered in full after inpatient hospital services deductible is met
Physician visit to hospital or skilled nursing facility (excluding care for chemical dependency)	Covered in full
Emergency health coverage	
Emergency room (professional and facility charges)	$100 (waived if admitted to hospital)
Urgent care center (professional and facility charges)	$40
Ambulance services (ground and air)	$80

Benefit description	*HMO 40*
Prescription drug coverage[6,7,8,9] Prescription drugs filled at a participating pharmacy (up to a 30-day supply)[1]	$100 prescription drug deductible, then $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]	$100 prescription drug deductible, then $30 Level I (primarily generic) $50 Level II (primarily brand name, peak flow meters, inhaler spacers 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 modification support program. For information regarding smoking cessation behavioral modification support programs available through Health Net, contact the Customer Contact Center at the telephone number on the back of your Health Net ID card or visit the Health Net website at www.healthnet.com. See Decision Power® Health & Wellness.).[1]	50%
Contraceptive devices[1] (received at a participating pharmacy)	$100 prescription drug deductible, then $25
Durable medical equipment (includes nebulizers, face masks and tubing for the treatment of asthma)	50%
Mental health services Severe mental illness and serious emotional disturbances of a child conditions[10]	Outpatient: $40 Inpatient: Covered in full
Other mental disorders[10]	Outpatient: $40 (limited to 20 visits per calendar year) Inpatient: Covered in full (limited to 30 days per calendar year)
Chemical dependency services Chemical dependency treatment	Not covered
Acute care (detoxification)	$100 per day (unlimited)
Home health care services (100 visits per calendar year maximum; limited to three visits per day, four-hour maximum per visit)	$40 per visit
Hospice services	Covered in full
Other Diabetic equipment (includes blood glucose monitors, insulin pumps and corrective footwear)[9]	$25
Laboratory procedures and diagnostic imaging (including X-ray) services	Covered in full
Rehabilitative therapy (includes physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)	$40
Sterilizations	$150
Organ and stem cell transplants (non-experimental and noninvestigational)	Covered in full
Prostheses[9]	Covered in full
Family planning counseling	$40

Footnotes

HMO Value 50 – pages 4-5

[1] Copayments that you or your family members pay for covered services and supplies apply toward the individual or family out-of-pocket maximum (OOPM). After you or your family members meet your OOPM, you pay no additional amounts for covered services and supplies for the balance of the calendar year, except as otherwise noted. Once an individual member in a family satisfies the individual OOPM, the remaining enrolled family members must continue to pay the copayments until either (a) the aggregate of such copayments paid by the family reaches the family OOPM or (b) each enrolled family member individually satisfies the individual OOPM. You are responsible for all charges related to services not covered by the health plan. Amounts that are paid toward certain covered services or supplies are not applicable to a members' OOPM, as noted in this matrix. Payments for services not covered by this plan will not be applied to this yearly OOPM. For the family OOPM to apply, you and your family must be enrolled as a family.

[2] Prenatal, postnatal and newborn care office visits for preventive care are covered in full. See copayment listing for "Periodic health evaluations and annual preventive physical examinations." If the primary purpose of the office visit is unrelated to a preventive service or if other non-preventive services are received during the same office visit, a $50 copayment will apply for the non-preventive services.

[3] For preventive health purposes, covered services include, but are not limited to, periodic health evaluations and diagnostic preventive procedures, including preventive care services for pregnancy, based on recommendations published by the U.S. Preventive Services Task Force. In addition, an annual cervical cancer screening test is covered and includes a Pap test, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA.

[4] 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.

[5] 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. Health Net will approve a drug not on the List at the brand-name copayment, if the member's physician demonstrates medical necessity. Health Net will approve a drug not on the List at the brand-name copayment, if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 72 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary 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 which is reasonably necessary and requested by Health Net to make the determination. For a copy of the Recommended Drug List, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.healthnet.com.

[6] Percentage copayments will be based on Health Net's contracted pharmacy rate. If the pharmacy's retail price is less than the applicable copayment, then you will only pay the pharmacy's retail price.

[7] The brand name prescription drug deductible (per member, per calendar year) must be paid for prescription drug covered services before Health Net begins to pay. The brand name prescription drug 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.

[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: (a) visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin are provided through the prostheses benefit; and (b) Glucagon, 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] Does not apply to out-of-pocket maximum, except copayments for peak flow meters, inhaler spacers used for the treatment of asthma, and diabetic supplies.

[10] Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services. (See "What are severe mental illness and serious emotional disturbances of a child?" under "Important Things to Know about Your Medical Coverage" for definitions, page 35.)

HMO 40 – pages 6–7

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

[2] Copayments and the inpatient hospital services deductible that you or your family members pay for covered services and supplies apply toward the individual or family out-of-pocket maximum (OOPM). After you or your family members meet your OOPM, you pay no additional amounts for covered services and supplies for the balance of the calendar year, except as otherwise noted. Once an individual member in a family satisfies the individual OOPM, the remaining enrolled family members must continue to pay the copayments and the deductible for inpatient hospital facility services until either (a) the aggregate of such copayments and deductibles paid by the family reaches the family OOPM, or (b) each enrolled family member individually satisfies the individual OOPM. You are responsible for all charges related to services not covered by the health plan. Amounts that are paid toward certain covered services or supplies are not applicable to a members' OOPM, as noted in this matrix. Payments for services not covered by this plan will not be applied to this yearly OOPM. For the family OOPM to apply, you and your family must be enrolled as a family.

[3] Prenatal, postnatal and newborn care office visits for preventive care are covered in full. See copayment listing for "Periodic health evaluations and annual preventive physical examinations." If the primary purpose of the office visit is unrelated to a preventive service or if other non-preventive services are received during the same office visit, a $40 copayment will apply for the non-preventive services.

[4] For preventive health purposes, covered services include, but are not limited to, periodic health evaluations and diagnostic preventive procedures, including preventive care services for pregnancy, based on recommendations published by the U.S. Preventive Services Task Force. In addition, an annual cervical cancer screening test is covered and includes a Pap test, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA.

[5] 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.

[6] 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. Health Net will approve a drug not on the List at the brand name copayment, if the member's physician demonstrates medical necessity. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 72 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary 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 which is reasonably necessary and requested by Health Net to make the determination. For a copy of the Recommended Drug List, call Health Net's Customer Contact Center at the number listed on the back of your Health Net ID card or visit our website at www.healthnet.com.

[7] Percentage copayments will be based on Health Net's contracted pharmacy rate. If the pharmacy's retail price is less than the applicable copayment, then you will only pay the pharmacy's retail price.

[8] 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 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.

[9] 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 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; and Glucagon, 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).

[10] Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services. (See "What are severe mental illness and serious emotional disturbances of a child?" under "Important Things to Know about Your Medical Coverage" for definitions, page 35.)

Dental and Vision *Coverage*

Optional dental and vision coverage with Health Net HMO Plus is available to you with no deductibles! Health Net offers dental benefits administered through Dental Benefit Providers of California, Inc. and vision benefits through EyeMed Vision Care, LLC.

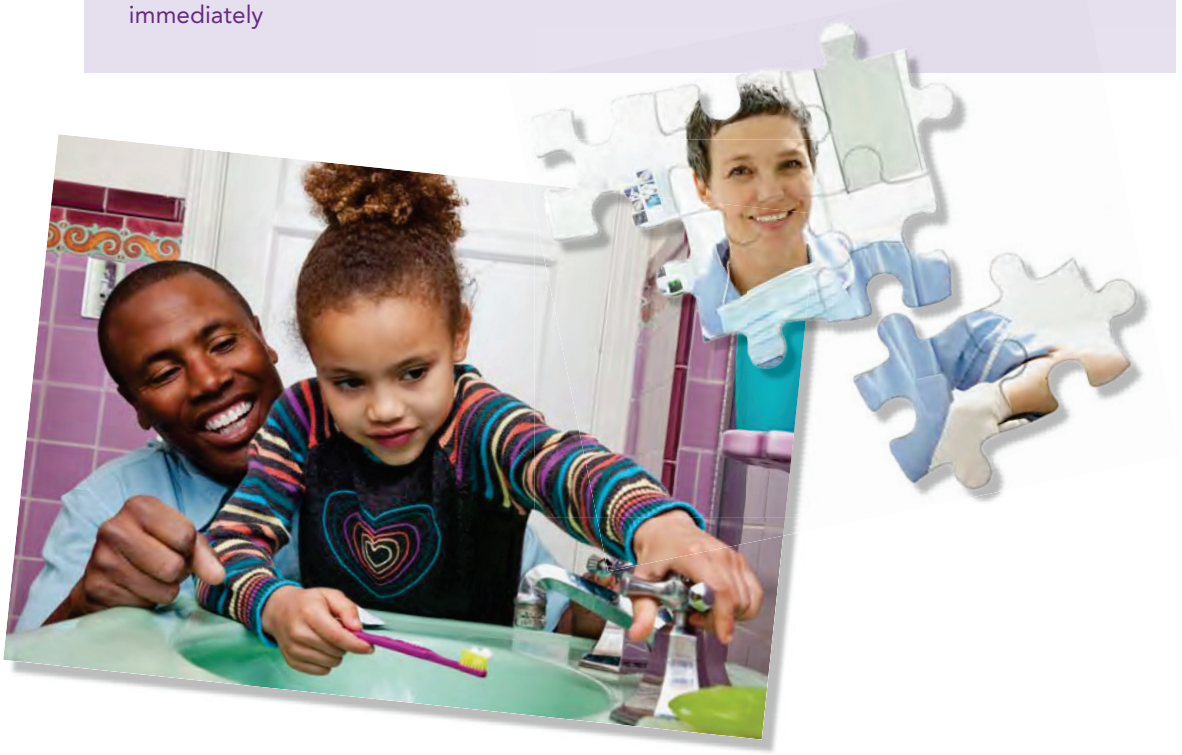
These benefits include:

Dental

- Established network of credentialed dentists
- Preventive dental care provided at set copays or at no charge
- Orthodontic benefits
- No annual maximums
- No waiting periods – benefits begin immediately

Vision

- A network-based provider selection at time of service
- Thousands of credentialed optometrists, ophthalmologists and opticians
- Vision exams for a set copay
- Competitive coverage for contacts and glasses (frames and lenses)



Life Insurance *Plans*[2]

You have big dreams for your children. You want to make sure they grow up in a comfortable home and have adequate necessities. But what if death robs your family of your support? All of these dreams can still come true – if you plan now to provide the financial resources your family will need.

Health Net Life Insurance Company offers affordable Individual Term Life Insurance in the following amounts: $10,000, $20,000, $30,000, $40,000 and $50,000.

You can trust Health Net life insurance company for your term life insurance needs.

Monthly term life insurance rates

Age	*$10,000*	*$20,000*	*$30,000*	*$40,000*	*$50,000*
1–17	$1.00	n/a	n/a	n/a	n/a
18–29	$1.90	$3.80	$5.70	$7.60	$9.50
30–39	$2.40	$4.80	$7.20	$9.60	$12.00
40–49	$5.00	$10.00	$15.00	$20.00	$25.00
50–59	$13.70	$27.40	$41.10	$54.80	$68.50
60–64	$20.00	$40.00	$60.00	$80.00	$100.00

Terms

- If you wish to purchase life insurance, you must purchase a minimum coverage of $10,000.
- The maximum life insurance benefit is $50,000.
- You can purchase a policy for yourself, your spouse/domestic partner and/or a dependent. $10,000 policies are available for children aged 1–17.
- Not available with modified issue HMO plans and HIPAA guaranteed issue plans.
- Rates are subject to change.

[2]Individual Term Life Insurance is underwritten by Health Net Life Insurance Company. Since you apply for health insurance with Health Net, there is no additional information required to review your eligibility for Individual Term Life Insurance. Coverage will not become effective until approved in writing by Health Net Life Insurance Company.

Making Health Care Decisions with Confidence

What does health mean? For every person, there is a different definition. That's why Health Net created Decision Power®.

Decision Power brings together under one roof the information, resources and personal support that fit you, your health and your life. Whether you're focused on staying fit, dealing with back pain or facing a serious diagnosis, we're here to help you work with your doctor and make informed decisions.

Always available, you can use Decision Power as much as you like, in the way that works best for you. Get guidance setting achievable health goals. Focus on weight loss with a step-by-step online plan. Work with a Health Coach to evaluate treatment options.

All Health Net plans come complete with Decision Power. Because when it comes to your health, there's more than one right answer.

Online doctor search

Locate a PCP and participating physician group by specialty, location and more. Even get a printable map with driving directions.

Health Net Mobile

Health Net Mobile is an easy way to connect to your HealthNet.com online account. Access plan, copay and deductible information on the go, as well as check your Mobile ID card to verify eligibility. Available for Apple, AndroidTM, Blackberry and other web-enabled devices!

Aristotle Ibay, Health Net
We understand the needs of our members

How To Apply

To apply for medical, dental, vision or life insurance coverage with Health Net:

- Call 1-800-909-3447, option 2, or
- Contact your Health Net authorized agent.

If you are completing a paper application:

1 Make sure you choose a primary care physician (PCP). Finding a PCP is easy with Health Net's doctor search. To find the most up-to-date list, log on to www.healthnet.com > *ProviderSearch*.

You'll find a complete listing of our Individual & Family Plan network physicians, and you can search by specialty, city, county or doctor's name. You can also call 1-800-909-3447 to request provider information, or contact your Health Net authorized agent.

2 Sign and date the application. (Each person over the age of 18 listed on the application must sign and date the application.)

3 Include a check payable to Health Net for the applicable premium payment.

4 Mail the completed application and check (within 30 days of signature date) to your authorized Health Net agent or to:

Health Net
Individual & Family Coverage
PO Box 1150
Rancho Cordova, CA 95741-1150

Tools and Coverage Services

We make things easy so that you can get plan information you need – Here's how.

- **Help when you need it:** Our Customer Contact Center is available 8:00 a.m. to 6:00 p.m., Monday through Friday, to provide same-day resolution for claims and other issues. We also offer a 24/7 interactive voice response unit for basic coverage questions.
- **Access online:** Once enrolled, you can log on to www.healthnet.com to update personal information, see your plan details, order new ID cards and more.
- **Payments are quick and easy:** To help make paying for your coverage even simpler, you can pay by automatic bank draft (funds are deducted directly from your account).
- **Coverage options that fit:** We offer a range of plans to suit your individual needs, including the optional benefit of dental, vision and life insurance.
- **Strong networks:** You have access to a large network of services, including pharmacy, mental health and substance abuse providers, and specialized services such as neonatal intensive care, end-stage renal disease and pain management.

Tina Machi, Health Net
We work to help resolve issues for you.

Dental Coverage *included with* HMO Plus *Plans*

Principle benefits and coverages for dental care with HMO Plus Plans

Dental coverage for HMO Plus plans is provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). This benefit is included with HMO Value 50 Plus and HMO 40 Plus only.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at the telephone number on your Health Net dental ID card or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

Selecting a dentist

Our dental plan makes it easy for you to choose a personal dental provider. When you enroll, you must select a dentist for your entire family from our list of primary dentists in your area. To find a primary care dentist online:

Step 1: Go to www.healthnet.com. At the bottom of the page you will find a drop down for Health Net Dental, click on it and choose California Commercial Health Plans.

Step 2: The site will bring you to a Health Net Disclaimer page, click Continue.

Step 3: Now you have arrived at the Health Net Dental website. To locate a provider, you can click on Locate Dentist on the left hand side of the screen, or you can click on the first bullet in the body of the page Dentist Locator.

Step 4: Next, click on Health Net DHMO CA ONLY, under the plan name options and choose a search criteria that best meets your needs.

Step 5: Next, enter the appropriate data to search.

Step 6: Once data is entered, just click Submit at the bottom of the page for the results of the search. You may change your primary dentist once a month. Primary dentist changes made prior to the 15th of the month are effective the first of the following month. Simply select a new dentist from the listing of primary dentists and call Health Net Dental's Customer Contact Center at 1-866-249-2382 with your change. We also offer orthodontic coverage for adults and children. Simply select your orthodontist from the directory at any time during the year.

Copayments

Copayments are your share of costs for covered services and are paid to the dentist at the time of care. Simply present your Health Net Dental member ID card to the participating primary dentist you selected. It's that simple!

Your dental benefits do not have deductibles or any annual maximum dollar benefit limitations.

Please note: The HMO Value 50 Plus and HMO 40 Plus plans are not available in all counties. Please see the Individual & Family Plans Rate Guide for details.

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

Summary of dental benefits

Covered benefits		*Member pays*
Deductibles		none
Lifetime maximums		none
Professional services – Diagnostic		
D0120	Periodic oral evaluation – established patient	no charge
D0140	Limited oral evaluation – problem focused	no charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	no charge
D0150	Comprehensive oral evaluation – new or established patient	no charge
D0210	X-rays intraoral – complete series (including bitewings)	no charge
D0220	X-rays intraoral – periapical first film	no charge
D0230	X-rays intraoral – periapical each additional film	no charge
D0240	X-rays intraoral – occlusal film	no charge
D0270	X-rays bitewing – single film	no charge
D0272	X-rays bitewings – two films	no charge
D0273	X-rays bitewings – three films	no charge
D0274	X-rays bitewings – four films Bitewing X-rays are limited to one series of four films in any 12-month period.	no charge
D0330	Panoramic film	no charge
D0350	Oral / facial photographic images	no charge
D0460	Pulp vitality tests	no charge
D0470	Diagnostic casts	no charge
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	no charge
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	no charge
D0486	Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	no charge
Preventive		
D1110	Prophylaxis – adult (initial)	$8
D1110	Prophylaxis – adult (second in same calendar year) Prophylaxis is limited to: (a) one initial treatment every 12 months, and (b) one "second" treatment every 12 months. An additional prophylaxis will be covered if determined to be dentally necessary consistent with professional practice. For example, for high-risk patients, such as women who are pregnant, enrollees undergoing cancer chemotherapy, or enrollees with compromising systemic diseases such as diabetes.	$23
D1120	Prophylaxis – child (initial)	$8
D1120	Prophylaxis – child (second in same calendar year)	$23

Covered benefits		*Member pays*
D1203	Topical application of fluoride (prophylaxis not included) – child	$3
D1204	Topical application of fluoride (prophylaxis not included) – adult	$3
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	$3
D1310	Nutritional counseling for control of Dental disease	no charge
D1330	Oral hygiene instructions	no charge
D1351	Sealant – per tooth	$5
D1510	Space maintainer – fixed – unilateral	$75
D1515	Space maintainer – fixed – bilateral	$155
D1520	Space maintainer – removable – unilateral	$100
D1525	Space maintainer – removable – bilateral	$170
D1550	Re-cementation of space maintainer	$15
D1555	Removal of fixed space maintainer	$15
Restorative		
D2140	Amalgam – one surface, primary	$20
D2150	Amalgam – two surfaces, primary	$25
D2160	Amalgam – three surfaces, primary	$37
D2161	Amalgam – four or more surfaces, primary	$37
D2140	Amalgam – one surface, permanent	$25
D2150	Amalgam – two surfaces, permanent	$32
D2160	Amalgam – three surfaces, permanent	$41
D2161	Amalgam – four or more surfaces, permanent	$49
D2330	Resin-based composite – one surface, anterior	$35
D2331	Resin-based composite – two surfaces, anterior	$45
D2332	Resin-based composite – three surfaces, anterior	$55
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$65
D2391	Resin-based composite – one surface, posterior (primary tooth)	$40
D2391	Resin-based composite – one surface, posterior (permanent tooth)	$55
D2392	Resin-based composite – two surfaces, posterior (primary tooth)	$55
D2392	Resin-based composite – two surfaces, posterior (permanent tooth)	$70
D2393	Resin-based composite – three surfaces, posterior (primary tooth)	$70
D2393	Resin-based composite – three surfaces, posterior (permanent tooth)	$85
D2394	Resin-based composite – four or more surfaces, posterior (primary tooth)	$70
D2394	Resin-based composite – four or more surfaces, posterior (permanent tooth)	$85
	Crowns – Single restorations only	
D2710	Crown – resin-based composite (indirect)	$240 plus actual lab cost of noble or high noble metal
D2712	Crown – 3/4 resin-based composite (indirect)	$240 plus actual lab cost of noble or high noble metal
D2720	Crown – resin with high noble metal	$240 plus actual lab cost of noble or high noble metal
D2721	Crown – resin with predominantly base metal	$240 plus actual lab cost of noble or high noble metal

Covered benefits		*Member pays*
Crowns – Single restorations only (continued)		
D2722	Crown – resin with noble metal	$240 plus actual lab cost of noble or high noble metal
D2750	Crown – porcelain fused to high noble metal	$305 plus actual lab cost of noble or high noble metal
D2751	Crown – porcelain fused to predominantly base metal	$305 plus actual lab cost of noble or high noble metal
D2752	Crown – porcelain fused to noble metal	$305 plus actual lab cost of noble or high noble metal
D2780	Crown – 3/4 cast high noble metal	$280 plus actual lab cost of noble or high noble metal
D2781	Crown – 3/4 cast predominantly base metal	$280 plus actual lab cost of noble or high noble metal
D2782	Crown – 3/4 cast noble metal	$280 plus actual lab cost of noble or high noble metal
D2790	Crown – full cast high noble metal	$280 plus actual lab cost of noble or high noble metal
D2791	Crown – full cast predominantly base metal	$280 plus actual lab cost of noble or high noble metal
D2792	Crown – full cast noble metal	$280 plus actual lab cost of noble or high noble metal
D2794	Crown – titanium	$280 plus actual lab cost of noble or high noble metal
D2910	Recement inlay, onlay or partial coverage restoration	$15
D2915	Recement cast or prefabricated post and core	$15
D2920	Recement crown	$21
D2930	Prefabricated stainless steel crown – primary tooth	$55
D2931	Prefabricated stainless steel crown – permanent tooth	$65
D2940	Sedative filling	$20
D2950	Core buildup, including any pins	$23 plus actual lab cost of noble or high noble metal
D2951	Pin retention – per tooth, in addition to restoration	$20 plus actual lab cost of noble or high noble metal
D2952	Post and core in addition to crown, indirectly fabricated	$100 plus actual lab cost of noble or high noble metal
D2953	Each additional indirectly fabricated post – same tooth	$100 plus actual lab cost of noble or high noble metal

Covered benefits		*Member pays*
Crowns – Single restorations only (continued)		
D2954	Prefabricated post and core	$60 in addition to crown
D2957	Each additional prefabricated post – same tooth	$60
D2970	Temporary crown (fractured tooth)	no charge
Endodontics		
D3110	Pulp cap – direct (excluding final restoration)	$21
D3120	Pulp cap – indirect (excluding final restoration)	$21
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$33
D3310	Anterior (excluding final restoration)	$170
D3320	Bicuspid (excluding final restoration)	$220
D3330	Molar (excluding final restoration)	$290
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$170
D3346	Retreatment of previous root canal therapy – anterior	$185
D3347	Retreatment of previous root canal therapy – bicuspid	$240
D3348	Retreatment of previous root canal therapy – molar	$315
D3410	Apicoectomy/periradicular surgery – anterior	$155
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	$155
D3425	Apicoectomy/periradicular surgery – molar (first root)	$155
D3426	Apicoectomy (each additional root)	$75
D3430	Retrograde filling – per root	$48
D3450	Root amputation – per root	$85
D3920	Hemisection (including any root removal), not including root canal therapy	$85
Periododontics		
D4210	Gingivectomy or gingivoplasty, four or more contiguous teeth or bounded teeth spaces, per quadrant	$230
D4211	Gingivectomy or gingivoplasty, one to three contiguous teeth or bounded teeth spaces, per quadrant	$33
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces, per quadrant	$30
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces, per quadrant	$30
D4260	Osseous surgery, including flap entry and closure – four or more contiguous teeth or bounded teeth spaces, per quadrant	$290
D4261	Osseous surgery, including flap entry and closure – one to three contiguous teeth or bounded teeth spaces, per quadrant	$290
D4341	Periodontal scaling and root planing – four or more teeth, per quadrant	$30
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant	$30
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$20
Prosthodontics (removable) – Dentures replaced within any five-year period are not covered		
D5110	Complete denture – maxillary	$405
D5120	Complete denture – mandibular	$405
D5130	Immediate denture – maxillary	$420

Covered benefits		*Member pays*
Prosthodontics (removable) (continued)		
D5140	Immediate denture – mandibular	$420
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$290
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$290
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$385
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$385
D5410	Adjust complete denture – maxillary	$15
D5411	Adjust complete denture – mandibular	$15
D5421	Adjust partial denture – maxillary	$15
D5422	Adjust partial denture – mandibular	$15
D5510	Repair broken complete denture base	$45
D5520	Replace missing or broken tooth – complete denture (each tooth)	$53
D5610	Repair resin denture base	$45
D5620	Repair cast framework	$58
D5630	Repair or replace broken clasp	$63
D5640	Replace broken teeth – per tooth	$53
D5650	Add tooth to existing partial denture	$58
D5660	Add clasp to existing partial denture	$63
D5710	Rebase complete maxillary denture	$185
D5711	Rebase complete mandibular denture	$185
D5720	Rebase maxillary partial denture	$185
D5721	Rebase mandibular partial denture	$185
D5730	Reline complete maxillary denture – chairside	$70
D5731	Reline complete mandibular denture – chairside	$70
D5740	Reline maxillary partial denture – chairside	$70
D5741	Reline mandibular partial denture – chairside	$70
D5750	Reline complete maxillary denture – laboratory	$120
D5751	Reline complete mandibular denture – laboratory	$120
D5760	Reline maxillary partial denture – laboratory	$120
D5761	Reline mandibular partial denture – laboratory	$120
D5820	Interim partial denture – maxillary	$135
D5821	Interim partial denture – mandibular	$135
D5850	Tissue conditioning – maxillary	$40
D5851	Tissue conditioning – mandibular	$40
Prosthodontics (fixed)		
D6205	Pontic – indirect resin-based composite (excluding molars)	$280 plus actual lab cost of noble or high noble metal
D6210	Pontic – cast high noble metal	$280 plus actual lab cost of noble or high noble metal
D6211	Pontic – cast predominantly base metal	$280 plus actual lab cost of noble or high noble metal

Covered benefits		*Member pays*
Prosthodontics (fixed) (continued)		
D6212	Pontic – cast noble metal	$280 plus actual lab cost of noble or high noble metal
D6214	Pontic – titanium	$305 plus actual lab cost of noble or high noble metal
D6240	Pontic – porcelain fused to high noble metal	$305 plus actual lab cost of noble or high noble metal
D6241	Pontic – porcelain fused to predominantly base metal	$305 plus actual lab cost of noble or high noble metal
D6242	Pontic – porcelain fused to noble metal	$305 plus actual lab cost of noble or high noble metal
D6710	Crown – indirect resin-based composite	$305 plus actual lab cost of noble or high noble metal
D6750	Crown – porcelain fused to high noble metal	$305 plus actual lab cost of noble or high noble metal
D6751	Crown – porcelain fused to predominantly base metal	$305 plus actual lab cost of noble or high noble metal
D6752	Crown – porcelain fused to noble metal	$305 plus actual lab cost of noble or high noble metal
D6780	Crown – 3/4 cast high noble metal	$280 plus actual lab cost of noble or high noble metal
D6781	Crown – 3/4 cast predominantly base metal	$280 plus actual lab cost of noble or high noble metal
D6782	Crown – 3/4 cast noble metal	$280 plus actual lab cost of noble or high noble metal
D6790	Crown – full cast high noble metal	$280 plus actual lab cost of noble or high noble metal
D6791	Crown – full cast predominantly base metal	$280 plus actual lab cost of noble or high noble metal
D6792	Crown – full cast noble metal	$280 plus actual lab cost of noble or high noble metal
D6794	Crown – titanium	$280 plus actual lab cost of noble or high noble metal
D6930	Recement fixed partial denture Fixed bridgework will be covered only when a removable partial denture cannot satisfactorily restore the case.	$23
D6970	Post and core addition to fixed partial denture retainer, indirectly fabricated	$100 plus actual lab cost of noble or high noble metal
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$60
D6973	Core build up for retainer, including any pins	$23 plus actual lab cost of noble or high noble metal

Regular dental care is important to maintain your overall health and wellness.

Covered benefits		*Member pays*
D6976	Each additional indirectly fabricated post – same tooth	$100 plus actual lab cost of noble or high noble metal
D6977	Each additional prefabricated post – same tooth	$60
D9120	Fixed partial denture sectioning	no charge
Oral and maxillofacial surgery		
D7111	Extraction, coronal remnants – deciduous tooth	$35
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$35
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) – each additional tooth	$27
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (root removal – exposed roots)	$43
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$50
D7220	Removal of impacted tooth – soft tissue	$70
D7230	Removal of impacted tooth – partially bony	$105
D7240	Removal of impacted tooth – completely bony	$135
D7250	Surgical removal of residual tooth roots (cutting procedure)	$50
Orthodontics		
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,800
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,800
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,000
D8210	Removable appliance therapy	$115
D8220	Fixed appliance therapy	$220
D8670	Routine orthodontic visits	$17
Adjunctive general services		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$14 (This copay is in addition to specific services copays.)
Professional visits		
D9440	Office visits – after regularly scheduled hours	$55 (This copay is in addition to specific services copays.)
Other services		
D9930	Treatment of complications (post-surgical) – unusual circumstances, by report	$11
D9951	Occlusal adjustment – limited (per quadrant)	$27
D9952	Occlusal adjustment – complete (per quadrant)	$27
D9999	Missed appointments without 24-hour prior notice *The copayment for missed appointments may not apply if: (a) the member canceled at least 24 hours in advance, or (b) the member missed the appointment because of an emergency or circumstances beyond the control of the member.*	$20
D9999	Transfer of all materials with less than a full mouth X-ray	No charge
D9999	Transfer of all materials with a full mouth X-ray	No charge
D9999	Operatory preparation fee (payable per visit in addition to any applicable copayments for covered services rendered)	No charge

Occasionally an instance arises where the general dentist deems that the services of a specialist are required. Health Net of California can assist the member with a referral to a specialist. However, there is no coverage under the plan for services rendered by a specialist except for orthodontic care.

Dental codes from "Current Dental Terminology© American Dental Association."

Dental plan general provisions

An additional charge will be required for missed appointments. Missed appointments without 24 hours' notice will be charged an additional charge. However, the copayment for missed appointments may not apply if: (1) the member canceled at least 24 hours in advance; or (2) the member missed the appointment because of an emergency or circumstances beyond the control of the member.

Orthodontic benefits

The orthodontic copayment charged by Health Net for children through age 19 will be $1,800 per case. Adults aged 20 or older will be charged an orthodontic copayment of $2,000 per case. This benefit is limited to 24 months of usual and customary orthodontic banding.

Principal orthodontic exclusions and limitations

Health Net reserves the right to limit coverage to its choice of participating dentists.

Principal exclusions and limitations for dental care with HMO Plus plans

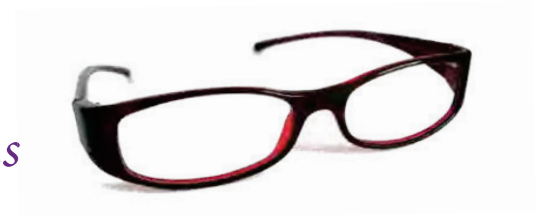
All dentally necessary services are covered if performed by the member's primary dentist. If services of a dental specialist are required, the member will be responsible for the specialist's fees.

- Prophylaxis is limited to: (a) one initial treatment every 12 months, and (b) one subsequent treatment every 12 months.
- Fluoride treatment is covered twice in any 12-month period.
- Bitewing X-rays are limited to one series of four films in any 12-month period.
- Full-mouth X-rays are limited to once every 36 months or as needed consistent with professional practice guidelines.
- Periodontal treatments (subgingival curettage and root planing) are limited to five in any 12-month period.
- Replacement of a restoration is covered only when it is dentally necessary.
- Fixed bridgework will be covered only when partial bridgework cannot satisfactorily restore the case.
- Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair.
- Partial dentures will be replaced as dentally necessary consistent with professional standards of practice.
- Full upper and/or lower dentures will be replaced as dentally necessary consistent with professional standards of practice.
- Services that, in the opinion of the attending dentist or Health Net, are not dentally necessary.
- Any experimental procedure. Experimental treatment if denied may be appealed through the Independent Medical Review (IMR) process, and that service shall be covered and provided if required under the IMR process.
- Any procedure of implantation.
- Any procedure performed for the purpose of correcting contour, contact or occlusion.
- Any procedure that is not specifically listed as a covered service.
- Elective dentistry and cosmetic dentistry.
- Fees incurred for broken or missed appointments (without 24 hours' notice) are the member's responsibility. However, the copayment for missed appointments may not apply if: (a) the member canceled at least 24 hours in advance; or (b) the member missed the appointment because of an emergency or circumstances beyond the control of the member.
- General anesthesia or intravenous/conscious sedation. However, such services may be covered under the medical services portion of this Plan. See the plan's Plan Contract and EOC for details.

- Hospital charges of any kind.
- Loss or theft of full or partial dentures.
- Oral surgery requiring the setting of fractures or dislocations, orthognathic surgery and extraction solely for orthodontic purposes (does not apply to fractured or dislocated (knocked-out) teeth).
- Prescription medications.
- Services that cannot be performed because of the physical or behavioral limitations of the patient.
- Temporomandibular joint treatment (TMJ).
- Treatment of malignancies, cysts, neoplasms or congenital malformations.

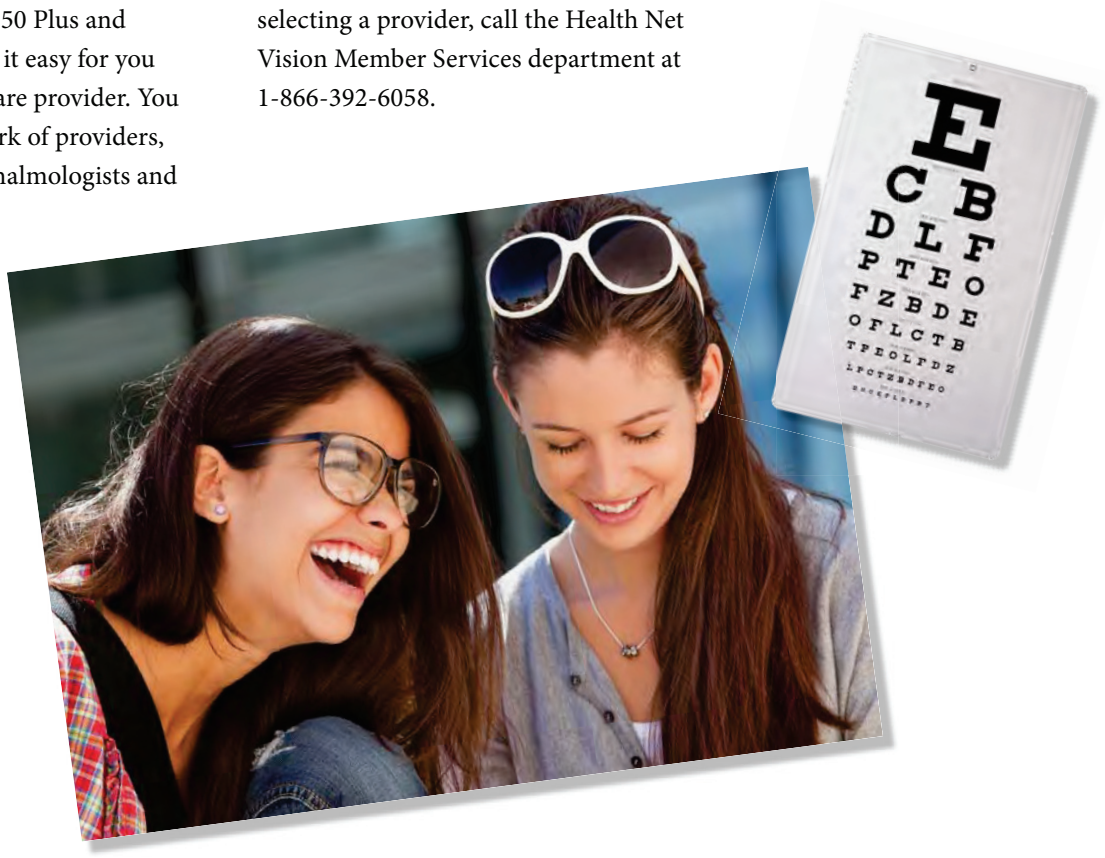
Christian Aparicio, Health Net
We aim to make health care benefits easier to understand.

Vision Coverage *Included with* HMO Plus *Plans*



Principal benefits and coverages for vision care provided with HMO Plus plans

Provided by Health Net of California. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to provide vision services benefits. This benefit is included with HMO Value 50 Plus and HMO 40 Plus only. We make it easy for you to choose a personal vision care provider. You can select from a large network of providers, including optometrists, ophthalmologists and dispensing opticians. For names, addresses and phone numbers of participating vision providers, log on to www.healthnet.com and click on ProviderSearch. If you need help in selecting a provider, call the Health Net Vision Member Services department at 1-866-392-6058.



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

Summary of vision benefits

Covered benefits	*Member pays*
Deductibles	none
Lifetime maximums	none
Professional services Examination with dilation, as medically necessary	$10 copayment
Examination for contact lens Standard contact lens fit and follow-up	up to $55
Premium contact lens fit and follow-up	you receive10% off retail
Materials Frames (once every 12 months; $80 allowance)	$0 copayment
Standard plastic eyeglass lenses (once every 12 months) Single vision	$40 copayment
Bifocal	$40 copayment
Trifocal	$40 copayment
Lenticular	$40 copayment
Standard progressive lenses	$105 copayment
Premium progressive lenses	$105 copayment, plus 80% of charge, less $120 allowance
Lens options (in addition to standard lenses) UV coating	you receive 20% off retail price
Tint (solid and gradient)	you receive 20% off retail price
Standard plastic scratch-resistance	you receive 20% off retail price
Standard polycarbonate	you receive 20% off retail price
Standard anti-reflective	you receive 20% off retail price
Other add-ons and service	you receive 20% off retail price
Contact lenses (every 12 months) (in lieu of eyeglass lenses; includes material only): Medically necessary contact lenses[1]	$0
Non-medically necessary contact lenses Conventional contact lenses ($80 allowance)	$0 copayment, plus 15% off of the balance over the allowance
Disposable contact lenses ($80 allowance)	$0 copayment, plus balance over the allowance

Limitation: In accordance with professionally recognized standards of practice, this Plan covers one complete vision examination once every 12 months. Benefits may not be combined with any discounts, promotional offerings or other group benefit plans. Allowances are one-time-use benefits. No remaining balance. Examination for contact lenses is in addition to the member's vision examination. There is no additional copayment for a contact lens follow-up visit after the initial fitting examination.

[1]Contact lenses are defined as medically necessary if the individual is diagnosed with one of the following conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High ametropia exceeding -12 D or +9 D in spherical equivalent.
- Anisometropia of 3 D or more.
- Patients whose vision can be corrected two (2) lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Vision examination

In accordance with professionally recognized standards of practice, this exam will include an analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities.

Frames

If the exam indicates the necessity of eyeglasses, this vision plan will cover a frame once every 12 months up to a maximum of $80 retail frame allowance plus 20% off balance over allowance. If the member selects frames that are more expensive than this allowance, the member will be charged 80% of the difference between the allowance and the retail cost of the more expensive frames.

Eyeglass lenses

If the exam results in corrective lenses being prescribed for the first time, or if a current wearer of corrective lenses needs new lenses, this vision plan will cover a pair of lenses at the service level indicated above. Coverage is limited to standard single vision, bifocal, trifocal or lenticular plastic lenses that are medically necessary to correct vision.

Medically necessary contact lenses

Coverage of medically necessary contact lenses is subject to medical necessity, prior authorization by Health Net and all applicable exclusions and limitations.

Nonmedically necessary conventional or disposable contact lenses

Nonmedically necessary conventional or disposable contact lenses are covered up to a maximum retail allowance of $80. When covered, nonmedically necessary contact lenses will be provided in lieu of eyeglass lenses, and will be provided at the same interval as eyeglass lenses. If the member selects contact lenses that are more expensive than this allowance, the member will be responsible for the provider's charges in excess of this allowance as noted above.

Second pair

Participating vision providers offer discounts up to 40% off their normal fees for secondary purchases once the initial benefit has been exhausted.

Principal exclusions and limitations for vision benefits provided with Health Net HMO Plus Plans

The following vision services and expenses are not covered under the HMO Value 50 Plus or HMO 40 Plus plans:

- Coverage limited to care rendered by participating vision providers.
- Extras and nonmedically necessary services and materials. Charges for services and materials are excluded if Health Net determines them to be: (1) beyond the allowances for frames, lenses and contact lenses indicated in the Summary of Vision Benefits; or (2) otherwise nonmedically necessary services.
- Medically necessary contact lenses. Coverage for prescriptions for contact lenses is subject to medical necessity, prior authorization by Health Net and all applicable exclusions and limitations. When covered, contact lenses are furnished at the same coverage interval as eyeglass lenses under this vision plan. This coverage is in lieu of all eyeglass lenses and frames.
- Nonmedically necessary contact lenses. Prescriptions for contact lenses that are not medically necessary are covered up to the maximum retail contact lens benefit allowance indicated above. This coverage is in lieu of all eyeglass lenses at the same interval as eyeglass lenses. The allowance applies to all costs associated with obtaining contact lenses. If the member selects contact lenses that are more expensive than this allowance, the member will be responsible for the provider's charges in excess of the allowance.

- Medical or hospital. Hospital and medical charges of any kind, vision services rendered in a hospital, and medical or surgical treatment of eyes, are excluded.
- Replacement due to loss, theft or destruction is excluded, except when replacement is at the regular interval of coverage under this vision benefit.
- Orthoptics, vision training and any associated testing; subnormal vision aids and plano (nonprescription) lenses.
- A second pair of glasses in lieu of bifocals is excluded.

Please refer to the plan's Plan Contract and Evidence of Coverage for a complete listing of exclusions and limitations.

Important Things *to Know about Your* Medical Coverage

Who is eligible?

To be eligible for Health Net Individual & Family HMO, 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 (see below for definition), if under age 65, and your children age 19 to 26, are also eligible (subject to underwriting requirements). For persons under age 19, see "Special enrollment for children under 19 years of age" below.

Special enrollment for children under 19 years of age

Your children under 19 years of age are eligible to enroll in an Individual & Family Plan during the following periods and cannot be declined due to a pre-existing medical condition.

a. Open Enrollment Period – Annually, during the month of the child's birth date.

b. Late Enrollee Period – Within 63 days after a qualifying event, if the child is without coverage and did not enroll during the initial open enrollment period, or during the child's birth month, because of any of the following qualifying events:

- The child lost dependent coverage due to:
  - The termination or change in employment status of the child or the person through whom the child was covered;
  - The loss of an employer's contribution toward an employee's or dependent's coverage;
  - The death of the person through whom the child was covered as a dependent;
  - Legal separation or divorce;
  - The loss of coverage under the Healthy Families Program, Access for Infants and Mothers Program (AIM) or the Medi-Cal program.
- The child became a resident of California during a month that was not the child's birth month.
- The child is born as a resident of California and did not enroll in the month of birth.
- The child is mandated to be covered pursuant to a valid state or federal court order.
- The child is adopted.
- The child exhausted COBRA or Cal-COBRA continuation coverage.

Proof of the child's date of birth or qualifying event will be required.

Domestic partner

Domestic partner is the subscriber's same-sex spouse if the subscriber and spouse are a couple who meet all of the requirements of Section 308(c) of the California Family Code, or the subscriber's registered domestic partner who meets all the requirements of Sections 297 or 299.2 of the California Family Code.

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

Your children under 19 years of age are eligible to enroll in an Individual & Family Plan during certain enrollment periods and cannot be declined due to a pre-existing medical condition. See "Special enrollment for children under 19 years of age" under "Who is eligible?" earlier in this guide. 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 HMO 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?
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 60 days in advance.

If there are changes to the Health Net Individual & Family HMO Plan Contract and EOC, 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 individually for any of the following reasons:

- You do not pay your premium on time. (Health Net will issue a 30-day prior notice of our right to terminate your coverage for nonpayment of premium. The 30-day prior notice will be sent on or before the first day of the month for which premiums are due and will describe the 30-day grace period, which grace period begins after the last day of paid coverage. If you do not pay your premiums by the first day of the month for which premiums are due, Health Net can terminate your coverage after the 30-day grace period.)
- You and/or your family member(s) cease being eligible (see the "Who is eligible?" section).
- You commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the agreement. Some examples include: misrepresenting eligibility information about you or a dependent; presenting an invalid prescription or physician order; or misusing a Health Net Member ID card (or letting someone else use it).

Health Net can terminate your coverage, together with all like policies, by giving 90 days' 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 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.

Can coverage be rescinded or cancelled for fraud or intentional misrepresentation of material fact?

Your children under 19 years of age are eligible to enroll in an Individual & Family Plan during certain enrollment periods and cannot be declined due to a pre-existing medical condition. See "Special enrollment for children under 19 years of age" under "Who is eligible?" earlier in this guide.

For all others, to determine whether or not you will be offered enrollment in an Individual & Family plan, Health Net will review your medical history based on the information you provide in your enrollment application, including the Statement of Health portion of the enrollment application and any supplemental health questionnaires Health Net requests during its review of your medical history. This process is called medical underwriting.

When Health Net can rescind or cancel a plan contract:

Within the first 24 months of coverage, Health Net may rescind the Plan Contract for any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact in the written information submitted by you or on your behalf on or with your enrollment application.

Health Net may cancel a Plan Contract for any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the Plan Contract.

A material fact is information which, if known to Health Net, would have caused Health Net to decline to issue coverage.

Cancellation of a Plan Contract

If this Plan Contract is cancelled, you will be sent a notice of cancellation and cancellation will be effective upon the date the notice of cancellation is mailed.

Rescission of a Plan Contract

If the Plan Contract is rescinded, Health Net shall have no liability for the provision of coverage under the Plan Contract.

By signing the enrollment application, you represent that all responses to the Statement of Health are true, complete and accurate, to the best of your knowledge, and that, should Health Net accept your enrollment application, the enrollment application will become part of the Plan Contract between Health Net and you. By signing the enrollment application, you further agree to comply with the terms of the Plan Contract.

If, after enrollment, Health Net investigates your enrollment application information, Health Net must notify you of this investigation, the basis of the investigation, and offer you an opportunity to respond. If Health Net makes a decision to rescind your coverage, such decision will be first sent for review to an independent third-party auditor contracted by Health Net. If the Plan Contract is rescinded, Health Net will provide a 30-day written notice prior to the effective date of the termination that will:

- Explain the basis of the decision and your appeal rights;
- Clarify that all members covered under your coverage, other than the individual whose coverage is rescinded, may continue to remain covered without medical underwriting;
- Explain that your monthly premium will be modified to reflect the number of members that remain under the Plan Contract; and
- Explain your right to appeal Health Net's decision to rescind coverage.

If the Plan Contract is rescinded:

- Health Net may revoke your coverage as if it never existed, and you will lose health benefits including coverage for treatment already received;
- Health Net will refund all premium amounts paid by you, less any medical expenses paid by Health Net on behalf of you, and may recover from you any amounts paid under the Plan Contract from the original date of coverage; and
- Health Net reserves its right to obtain any other legal remedies arising from the rescission that are consistent with California law.

If Health Net denies your appeal, you have the right to seek assistance from the California Department of Managed Health Care.

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 benefits or contract provisions. You will be notified 60 days in advance of any changes in fees.

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 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.
- 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 plan's Plan Contract and Evidence of Coverage.

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, or subject to or received an adverse benefit determination, may file a grievance or appeal. An adverse

benefit determination includes: (a) rescission of coverage, even if it does not have an adverse effect on a particular benefit at the time; (b) determination of an individual's eligibility to participate in this Health Net plan; (c) determination that a benefit is not covered; (d) an exclusion or limitation of an otherwise covered benefit based on a pre-existing condition exclusion or a source of injury exclusion; or, (e) determination that a benefit is experimental, investigational, or not medically necessary or appropriate. In addition, plan members can request an Independent Medical Review (IMR) 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 were 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 IMR of Health Net's decision from the Department of Managed Health Care if they meet eligibility criteria set out in the plan's Plan Contract and Evidence of Coverage.

Members not satisfied with the results of the grievance hearing 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.

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 IMR. If you are eligible for an 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 website, **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, call the Customer Contact Center at 1 800-839-2172.

What are Health Net's premium ratios?
Health Net's 2011 ratio of premium costs to health services paid for the Individual & Family HMO plans was 102 percent.

What is the relationship of the involved parties?
Physician groups, contracting physicians, hospitals and other health care providers are not agents or employees of Health Net. Health Net and each of its 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, its agents or employees, or of physician groups, any physician or hospital, or any other person or organization with which Health Net 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 age 36 months, not to exceed twelve months from the contract termination date.
- A terminal illness (for the duration of the terminal illness).
- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment.

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable copayments and any other exclusions and limitations of this Plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider's contract termination. 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 call the Customer Contact Center at the number on the back of 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 (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 professionally recognized standards including but not limited to the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, as amended to date), 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, as amended to date, other than a primary substance abuse disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following: (a) as a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home, or (ii) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year; (b) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to mental disorder; and/or (c) the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Do providers limit services for reproductive care?
Some hospitals and other providers do not provide one or more of the following services that may be covered under the plan's Plan Contract and EOC 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 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 calling 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?
We will coordinate the payment for covered services when you receive care from your primary care physician or when your primary care physician refers you to a specialist. We have agreements with these physicians that eliminate the need for claim forms. Simply present your Health Net member ID 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 chemical dependency). 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 capability 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 air and ground 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?

We are 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's Plan Contract and EOC; and

(b) services not covered by the Individual & Family HMO Plans.

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 nonparticipating provider.

Can I be reimbursed for out-of-network claims?

Some nonparticipating 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 nonparticipating 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 an employer or insurance broker, 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 and EOC.

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 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 (e.g., 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 *HMO Product* Information

Mental disorders and chemical dependency services

The mental disorders and chemical dependency benefits are administered by MHN Services, an affiliate behavioral health administrative services company (the Administrator) which contracts with Health Net to administer these benefits. When you need to see a Participating Mental Health Professional, contact the Administrator by calling the Health Net Customer Contact Center at the phone number on your Health Net ID card. The Administrator will help you identify a participating mental health professional, a participating independent physician or a subcontracted independent provider association (IPA) within the network, close to where you live or work, with whom you can make an appointment.

Certain services and supplies for mental disorders and chemical dependency may require prior authorization by the Administrator in order to be covered. No prior authorization is required for outpatient office visits, but a voluntary registration with the Administrator is encouraged.

Please refer to the Individual & Family HMO Plan Contract and EOC for a more complete description of mental disorder and chemical dependency services and supplies, including those that require prior authorization by the Administrator.

Prescription drug program

Health Net is contracted with many major pharmacies including supermarket-based pharmacies and privately owned pharmacies in California. Please visit our website at www.healthnet.com to find a conveniently located participating pharmacy or call Health Net's Customer Contact Center at 1-800-839-2172.

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

Prescriptions By Mail Order 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's Customer Contact Center 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 name)

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. The 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.
- 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 Health Net's 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.

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. You may obtain a list of drugs requiring prior authorization by visiting our website at www.healthnet.com or contact the Health Net Customer Contact Center at the phone number on the back cover.

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 the plan's Plan Contract and EOC for details regarding your right to appeal.

To submit an appeal:

- Call Health Net's Customer Contact Center at 1-800-839-2172;
- Visit www.healthnet.com for information about emailing Health Net's Customer Contact Center; or
- Write to:

  Health Net Customer Contact Center
  PO Box 10348
  Van Nuys, CA 91410-0348

Exclusions *and* Limitations

Exclusions and limitations common to all Individual & Family Plan coverage options.

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

- Services and supplies that Health Net determines 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?" earlier in this guide.
- Ambulance and paramedic services that do not result in transportation or that do not meet the criteria for emergency care, unless such services are medically necessary and prior authorization has been obtained.
- Custodial care. Custodial care is not rehabilitative care and is provided to assist a patient in meeting the activities of daily living, such as: help in walking, getting in and out of bed, bathing, dressing, feeding and preparation of special diets, and supervision of medications that are ordinarily self-administered, but not care that requires skilled nursing services on a continuing basis.
- Procedures that Health Net 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?" earlier in this guide.
- 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 member 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 fitting and 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]
- Treatment and services for temporomandibular joint (TMJ) disorders are covered when determined to be medically necessary, excluding crowns, onlays, bridgework and appliances.

[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.

- 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's Plan Contract and EOC. Any institution that is primarily a place for the aged, a nursing home or a similar institution, regardless of how it is designated, is not an eligible institution. Services or supplies that are provided by such institutions are not covered.
- Dental care. However, 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.[2]
- 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. See the "Dental care" exclusion above for information regarding cleft palate procedures.
- Hearing aids.
- Private duty nursing. Shift care and any portion of shift care services are also not covered.
- Any eye surgery for the purpose of correcting refractive defects of the eye, unless medically necessary, recommended by the member's treating physician and authorized by Health Net.
- Contact or corrective lenses (except an implanted lens that replaces the organic eye lens), vision therapy and eyeglasses.[2]
- Services to reverse voluntary surgically induced infertility.
- Sex change procedures or treatment.
- Any services or supplies not related to the diagnosis or treatment of a covered condition, illness or injury. However, the Plan does cover medically necessary services and supplies for medical conditions directly related to non-covered services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery).
- Any outpatient drugs, medications or other substances dispensed or administered in any setting, except as specifically stated in the plan's Plan Contract and EOC.
- Services for a surrogate pregnancy are covered when the surrogate is a Health Net member. When compensation is obtained for the surrogacy, the plan shall have a lien on such compensation to recover its medical expense.
- Although this Plan covers durable medical equipment, it does not cover the following items: (a) exercise equipment; (b) hygienic equipment and supplies; (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; (d) jacuzzis and whirlpools; (e) orthodontic appliances to treat dental conditions related to disorders of the temporomandibular (jaw) joint; (f) support appliances such as stockings, over the counter support devices or orthotics, and devices or orthotics for improving athletic performance or sports-related activities; (g) orthotics that are not custom made to fit the member's body; (h) corrective footwear (such as corrective shoes or foot orthotics), that is not incorporated into a cast, brace or strapping of the foot, unless it is medically necessary for the management and treatment of diabetes ; and (i) durable medical equipment after the calendar year maximum (when applicable) has been met. See the benefit matrices earlier in this guide.
- Personal or comfort items.
- Disposable supplies for home use.
- Home birth, unless the criteria for emergency care have been met.

[2]The HMO Value 50 Plus and HMO 40 Plus plans include certain dental and vision services as described in this guide. For dental and vision benefit information for this plan, refer to the benefits sections earlier in this guide, or the plan's Plan Contract and EOC.

- Physician self-treatment.
- Treatment by immediate family members.
- Chiropractic services.
- Home health care (limited to 100 combined visits per calendar year; maximum three visits per day and four hours per visit).
- Services or supplies that are not authorized by Health Net, the Administrator (mental disorders or chemical dependency) or the physician group (medical) according to Health Net's or the Administrator's procedures.
- Services for the treatment of chemical dependency (other than detoxification) are not covered.
- 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 nonprescription drug or over-the-counter drug is only available by prescription, that higher dosage drug will be covered.
- Routine foot care, unless medically necessary for a diabetic condition.
- Acupuncture.
- Services to diagnose, evaluate or treat infertility are not covered.
- Services related to or consisting of education or training, including for employment or professional purposes, are not covered, even if provided by an individual licensed as a health care provider by the state of California.
- 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?" earlier in this guide.
- Drugs (including injectable medications) for the treatment of sexual dysfunction when prescribed for the treatment of sexual dysfunction.
- Bariatric surgery provided for the treatment of morbid obesity is covered when medically necessary, authorized by Health Net and performed at a Health Net Bariatric Surgery Performance Center by a Health Net Bariatric Surgery Performance Center network surgeon who is affiliated with the Health Net Bariatric Surgery Performance Center. Health Net has a specific network of facilities and surgeons, which are designated as Bariatric Surgery Performance Centers to perform weight loss surgery. Your member physician can provide you with information about this network. You will be directed to a Health Net Bariatric Surgery Performance Center at the time authorization is obtained.
- Therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus (aversion therapy) is not covered.

- Coverage for rehabilitation therapy is limited to medically necessary services provided by a Plan-contracted physician, licensed physical, speech or occupational therapist, or other contracted provider, acting within the scope of his or her license, to treat physical or mental health conditions, subject to any required authorization from the Plan or the member's medical group. The services must be based on a treatment plan authorized as required by the Plan or the member's medical group.
- Electro-convulsive therapy is not covered except as authorized by the Administrator.
- The following types of treatment are only covered when provided in connection with covered treatment for a Mental Disorder or Chemical Dependency: (a) treatment for co-dependency; (b) treatment for psychological stress; and (c) treatment of marital or family dysfunction. Treatment of delirium, dementia, amnesic disorders (as defined in the DSM-IV) and mental retardation are covered for medically necessary medical services, but are covered for accompanying behavioral and/or psychological symptoms only if amenable to psychotherapeutic or psychiatric treatment. In addition, Health Net will cover only those mental disorder or chemical dependency services which are delivered by providers who are licensed in accordance with California law and are acting within the scope of such license.
- Services that do not meet national standards for professional medical or mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, hypnotherapy and crystal healing therapy are not covered. For information regarding requesting an Independent Medical Review of a denial of coverage "What if I have a disagreement with Health Net?" earlier in this guide.
- Coverage for biofeedback therapy is limited to medically necessary treatment of certain physical disorders such as incontinence and chronic pain.
- Psychological testing except as conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification. Also excluded is coverage for scoring of automated computer based reports, unless the scoring is performed by a provider qualified to perform it.
- Residential treatment that is not medically necessary is excluded. Admissions that are not considered medically appropriate and are not covered include admissions for wilderness center training; for Custodial Care, for a situational or environmental change; or as an alternative to placement in a foster home or halfway house.
- Services in a state hospital are limited to treatment or confinement as the result of an emergency or urgently needed care.
- Treatment or consultations provided by telephone are not covered.
- Medical, mental health care or chemical dependency services as a condition of parole or probation, and court-ordered testing are limited to medically necessary covered services.
- For the HMO Value 50 plan, physician visits to a member's home are not covered.
- For the HMO Value 50 plan, routine physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp, or other nonpreventive purposes are not covered. A routine examination is one that is not otherwise medically indicated or Physician-directed and is obtained for the purposes of checking a Member's general health in the absence of symptoms or other nonpreventive purpose. Examples include examinations taken to obtain employment, or examinations administered at the request of a third party, such as a school, camp or sports organization.

For more information, please contact

Health Net

Individual and Family Coverage

PO Box 1150

Rancho Cordova, CA 95741-1150

Individual & Family Plans

1-800-909-3447 *(English)*

1-877-891-9050 *(Cantonese)*

1-877-339-8596 *(Korean)*

1-877-891-9053 *(Mandarin)*

1-800-331-1777 *(Spanish)*

1-877-891-9051 *(Tagalog)*

1-877-339-8621 *(Vietnamese)*

Assistance for the hearing and speech impaired

1-800-995-0852

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