INDIVIDUAL & FAMILY PLANS
HMO SUMMARY OF BENEFITS

Health coverage made easy.

Effective January 1, 2010

Health Net®
A BETTER DECISION

This document is only a summary of your health coverage. You have the right to view the 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. Your Plan Contract and EOC, which you will receive after you enroll, contain the terms and conditions, as well as the governing and exact contractual provisions, of your Health Net coverage. It is important for you to carefully read this document and your Plan Contract and EOC thoroughly once you receive them, especially all sections that apply to those with special health care needs. Health benefits and coverage matrices on pages 4–7 are included to help you compare coverage benefits.

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

TABLE OF CONTENTS

COVERAGE YOU CAN COUNT ON 2

IS AN HMO RIGHT FOR YOU? 3

HMO 15 4

HMO 40 6

DENTAL AND VISION COVERAGE 8

LIFE INSURANCE PLANS 9

HOW TO APPLY 10

MAKING HEALTH CARE DECISIONS WITH CONFIDENCE 11

TOOLS AND COVERAGE SERVICES 12

IMPORTANT THINGS TO KNOW ABOUT YOUR MEDICAL COVERAGE 13

EXCLUSIONS AND LIMITATIONS 21

DENTAL COVERAGE INCLUDED WITH HMO PLUS PLANS 23

VISION COVERAGE INCLUDED WITH HMO PLUS PLANS 28

COVERAGE YOU CAN COUNT ON.

When it comes to your health, we've got you covered. Our Individual & Family HMO plans include coverage for your office visits, hospitalization, emergency care and much more. They also come with unique services for your health care decisions and wellness – even life and family concerns. Plus, you have the option of adding dental, vision and life insurance. Our goal is to help you make confident decisions about your health coverage, so that you can choose the plan that's right for you.

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). 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 later in this guide. All treatments recommended by such providers must be authorized by your PCP.

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.

HEALTH NET HMO ADVANTAGES INCLUDE:

- Wide range of covered benefits
- Set office visit copayments
- More than 34,000 physicians and other specialists
- No claim form filing
- Ability to choose a separate PCP for each member

CHOOSING THE RIGHT HMO PLAN

In this brochure, you'll find information about our HMO 15 and HMO 40 plans. Want to know which one is right for you? Here is some information to get you started.

HMO 15: If you visit the doctor on a regular basis, the HMO 15 may be your best option. You may pay more each month (premium), but you'll have a lower copayment ($15) each time you go to the doctor or see a specialist.

HMO 40: If you don't visit the doctor that often, this could be a plan for you. Your payment each month (premium) won't be as high, but you'll have a higher copayment ($40) each time you go to the doctor or see a specialist.

HMO 15 Plus[1] and HMO 40 Plus[1]: A Health Net "HMO Plus" plan is a Health Net HMO 15 or HMO 40 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 affilitated with Health Net of California, Inc.

Summary of benefits – HMO 15

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.

	HMO 15
DEDUCTIBLES	$1,000 per calendar year for inpatient hospital services only (outpatient prescription drug deductible applies[1])
LIFETIME MAXIMUMS	Unlimited
OUT-OF-POCKET MAXIMUM (Payments for services not covered by this plan will not apply to this calendar year out-of-pocket maximums[2])	$3,000 single/$6,000 family
PROFESSIONAL SERVICES Visit to physician	$15
Specialist consultations	$15
Prenatal and postnatal office visits	$15
PREVENTIVE CARE Periodic health evaluations and annual preventive physical examinations[3]	$15
Vision screenings and exams	$15
Hearing screenings and exams	$15
Immunizations – standard	$15
Immunizations – to meet foreign travel or occupational requirements	20%
Prostate cancer screening and exam	$15
OB/GYN exam (breast and pelvic exams, cervical cancer screening and mammography)[4]	$15
Allergy testing	$15
Allergy injection services	$15
All other injections	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 health and chemical dependency treatment)	$1,000 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 or skilled nursing facility	Covered in full after inpatient hospital services deductible is met
Physician visit to hospital or skilled nursing facility (excluding care for chemical dependency and mental disorders)	Covered in full
EMERGENCY HEALTH COVERAGE Emergency room (professional and facility charges)	$75 (waived if admitted to hospital)
Urgent care center (professional and facility charges)	$25
AMBULANCE SERVICES Ground / air ambulance	$50
PRESCRIPTION DRUG COVERAGE[5, 6, 7, 9] Prescription drugs filled at a participating pharmacy (up to a 30-day supply)[1]	$100 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 deductible, then $30 Level I (primarily generic) $50 Level II (primarily brand name and diabetic supplies, including insulin) $100 Level III Drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)
Smoking cessation drugs (Covered up to a 12-week course of therapy per calendar year if you are concurrently enrolled in a comprehensive smoking cessation behavioral modification support program. For information regarding smoking cessation behavioral 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%

Summary of benefits – HMO 15 (continued)

	HMO 15
Contraceptive devices[1]	$100 deductible, then $15 Level I (primarily generic) $25 Level II (primarily brand name) $50 Level III Drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)
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[8]	Outpatient: $15 Inpatient: Covered in full
OTHER MENTAL DISORDERS[8] Outpatient	$40 (limited to 20 visits per calendar year)
Inpatient	Covered in full (limited to 30 days per calendar year)
CHEMICAL DEPENDENCY 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)	$15
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)	$15
Sterilizations	$150
Organ and stem cell transplants (non-experimental and noninvestigational professional services)	Covered in full
Prostheses[9]	Covered in full
Family planning counseling	$15
OPTIONAL DENTAL AND VISION COVERAGE (included with HMO Plus plans, additional premium required, refer to the rate guide) Dental benefits[10]	For details see "Dental coverage included with HMO Plus plans" later in this guide
Vision benefits[10]	For details see "Vision coverage included with HMO Plus plans" later in this guide

[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 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 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 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] For preventive health purposes, a periodic health evaluation and diagnostic preventive procedures are covered, based on recommendations published by the U.S. Preventive Services Task Force. In addition, a covered annual cervical cancer screening test includes a Pap test, a human papillomavirus (HPV) screening test that is approved by the 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 are handled in a timely fashion, not to exceed 72 hours, as appropriate and Medically Necessary, for the nature of the Member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 5 days, as appropriate and Medically Necessary, for the nature of the Member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination. For a copy of the Recommended Drug List, call 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 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.

[8] 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 17.)

[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 benefit include insulin, specific brands of glucose monitors and blood glucose testing strips, Ketone urine testing strips, lancets and lancet puncture devices, specific brands of pen delivery systems (including pen needles) for the administration of insulin and specific brands of insulin syringes. Additionally, the following supplies are covered under the medical benefit as specified: visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin are provided through the prostheses benefit; 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] Dental and Vision benefits provided by Health Net of California, Inc. Dental benefits are administered by Dental Benefit Providers of California, Inc. (DBP) Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to provide and administer vision benefits.

Summary of benefits – HMO 40

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.

	HMO 40
DEDUCTIBLES	$1,500 per calendar year for inpatient hospital services only (outpatient prescription drug deductible applies[1])
LIFETIME MAXIMUMS	Unlimited
OUT-OF-POCKET MAXIMUM (Payments for services not covered by this plan will not apply to this calendar year out-of-pocket maximums[2])	$3,000 single/$6,000 family
PROFESSIONAL SERVICES Visit to physician	$40
Specialist consultations	$40
Prenatal and postnatal office visits	$40
PREVENTIVE CARE Periodic health evaluations and annual preventive physical examinations[3]	$40
Vision screenings and exams	$40
Hearing screenings and exams	$40
Immunizations – standard	$40
Immunizations – to meet foreign travel or occupational requirements	20%
Prostate cancer screening and exam	$40
OB/GYN exam (breast and pelvic exams, cervical cancer screening and mammography)[4]	$40
Allergy testing	$40
Allergy injection services	$40
All other injections	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 health 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 or skilled nursing facility	Covered in full after inpatient hospital services deductible is met
Physician visit to hospital or skilled nursing facility (excluding care for chemical dependency and mental disorders)	Covered in full
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 / air ambulance	$80
PRESCRIPTION DRUG COVERAGE[5, 6, 7, 9] Prescription drugs filled at a participating pharmacy (up to a 30-day supply)[1]	$100 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 deductible, then $30 Level I (primarily generic) $50 Level II (primarily brand name and diabetic supplies, including insulin) $100 Level III Drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)
Smoking cessation drugs (covered up to a 12-week course of therapy per calendar year if you are concurrently enrolled in a comprehensive smoking cessation behavioral modification support program. For information regarding smoking cessation behavioral 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%

Summary of benefits – HMO 40 (continued)

	HMO 40
Contraceptive devices[1]	$100 deductible, then $15 Level I (primarily generic) $25 Level II (primarily brand name) $50 Level III Drugs listed on the Recommended Drug List (or drugs not on the Recommended Drug List)
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[8]	Outpatient: $40 Inpatient: Covered in full
OTHER MENTAL DISORDERS[8] Outpatient	$40 (limited to 20 visits per calendar year)
Inpatient	Covered in full (limited to 30 days per calendar year)
CHEMICAL DEPENDENCY 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
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 professional services)	Covered in full
Prostheses[9]	Covered in full
Family planning counseling	$40
OPTIONAL DENTAL AND VISION COVERAGE (included with HMO Plus plans, additional premium required, refer to the rate guide) Dental benefits[10]	For details see "Dental coverage included with HMO Plus plans" later in this guide
Vision benefits[10]	For details see "Vision coverage included with HMO Plus plans" later in this guide

[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 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 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 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] For preventive health purposes, a periodic health evaluation and diagnostic preventive procedures are covered, based on recommendations published by the U.S. Preventive Services Task Force. In addition, a covered annual cervical cancer screening test includes a Pap test, a human papillomavirus (HPV) screening test that is approved by the 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 are handled in a timely fashion, not to exceed 72 hours, as appropriate and Medically Necessary, for the nature of the Member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 5 days, as appropriate and Medically Necessary, for the nature of the Member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination. For a copy of the Recommended Drug List, call 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 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.

[8] 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 17.)

[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 benefit include insulin, specific brands of glucose monitors and blood glucose testing strips, Ketone urine testing strips, lancets and lancet puncture devices, specific brands of pen delivery systems (including pen needles) for the administration of insulin and specific brands of insulin syringes. Additionally, the following supplies are covered under the medical benefit as specified: visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin are provided through the prostheses benefit; 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] Dental and Vision benefits provided by Health Net of California, Inc. Dental benefits are administered by Dental Benefit Providers of California, Inc. (DBP) Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to provide and administer vision benefits.

Dental and vision coverage

Optional dental and vision coverage with Health Net HMO Plus[1] – 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 copayments or at no charge
- Orthodontic benefits
- No annual maximums
- No waiting periods – benefits begin immediately
- Posterior (back teeth) resin fillings

VISION

- A network-based provider selection at time of service
- Thousands of credentialed optometrists, ophthalmologists and opticians
- Vision exams for a set copayment

[1]A Health Net "HMO Plus" plan is a Health Net HMO 15 or HMO 40 plan with Health Net Dental and Vision coverage included. The "Plus" indicates the addition of the optional coverage.

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.

YOU CAN TRUST HEALTH NET LIFE INSURANCE COMPANY FOR YOUR TERM LIFE INSURANCE NEEDS

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.

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 and/or a dependent. $10,000 policies are available for children aged 1–17.
- Not available with HIPAA guarantee 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.

How to apply

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

- Call 1-800-909-3447, 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 > *Search Our Doctor Network*. 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 broker.

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
   Post Office Box 1150
   Rancho Cordova, CA 95741-1150

Making health care decisions with confidence

What really makes us different? Our programs and services that help you make confident health care decisions that are right for you.

DECISION POWER℠ HEALTH IN BALANCE

Decision Power brings together under one roof the information, resources and personal support that fit you, your health and your life.

- Take the Health Risk Questionnaire (HRQ) to assess your health and identify potential risks.
- Get online coaching and self-help tools for smoking cessation, weight management, nutrition, stress reduction and other support tools.
- Set up your Personal Health Record, a safe, secure way to track your medical information.
- Know your numbers by tracking your cholesterol, diet and exercise.

Use Decision Power online or by calling a Health Coach, 24 hours a day, seven days a week, in ways that work best for you.

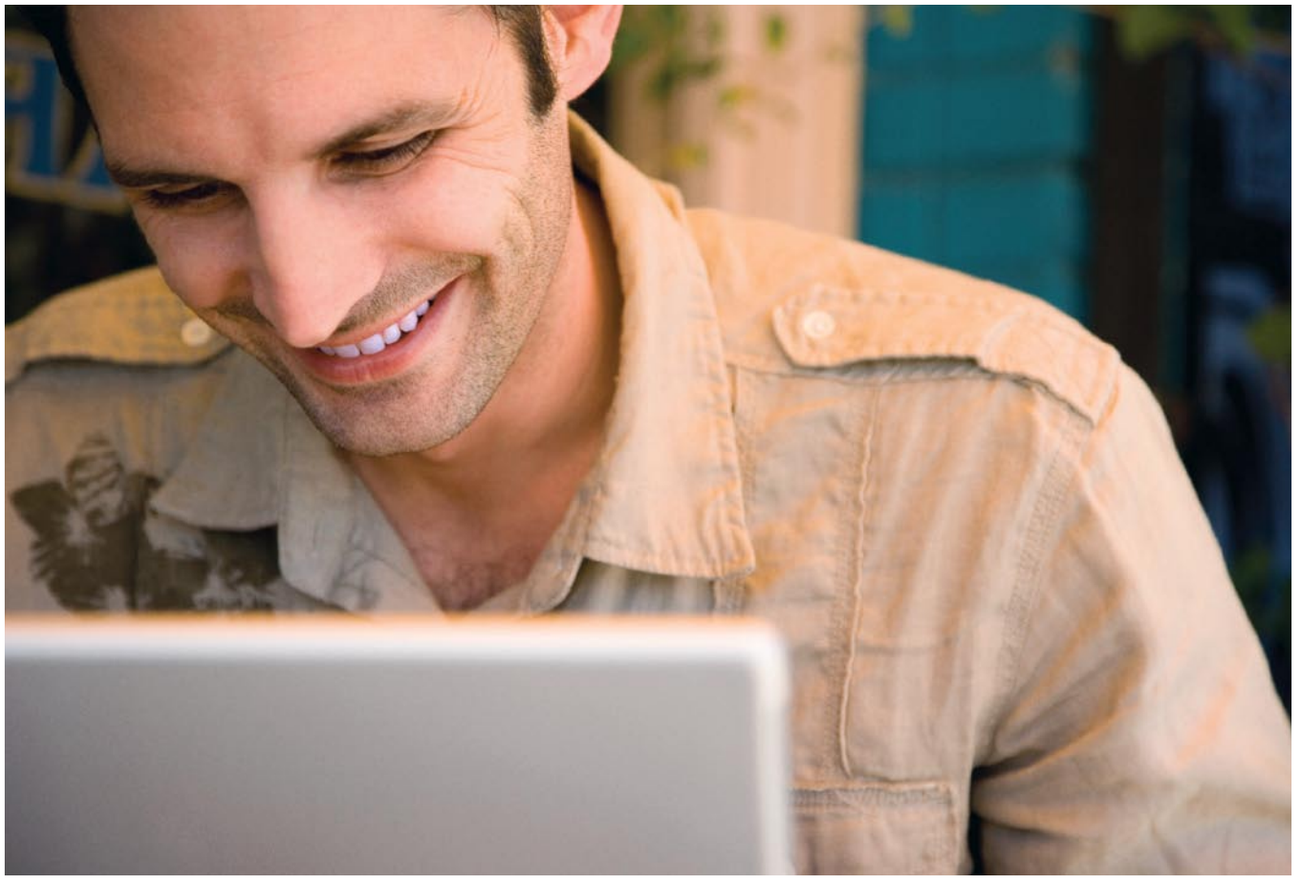
ONLINE DOCTOR SEARCH

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

Tools and coverage services

We make things easy so that you can get plan information you need – without the hassle. Here's how.

- **Assistance 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. It also has a 24/7 interactive voice response unit for basic coverage questions.
- **Online information:** Once enrolled, you can log on to www.healthnet.com to update personal information, see your plan details, order new ID cards and more.
- **Easy payment options:** To help make paying for your coverage even simpler, you can pay by automatic bank draft (funds are deducted directly from your account) or credit card.
- **Variety of coverage choices:** 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.



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, if under age 65, and all your unmarried dependent children under 19 years of age also are eligible (subject to underwriting requirements). Unmarried dependent children enrolled in an accredited school as full-time students and under 24 years of age are also eligible, if proof of full-time student status is provided.

Domestic Partner is defined as two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. A domestic partner is a person eligible for coverage provided that the partnership with the Subscriber meets all domestic partnership requirements under California law or another recognized state or local agency. The Domestic Partner and Subscriber must meet the following requirements:

- Both persons have a common residence.
- Neither person is married to someone else or is a member of another domestic partnership that has not been terminated, dissolved or judged a nullity.
- The two persons are not related by blood in a way that would prevent them from being married in California.
- Both persons are at least 18 years old.
- Both persons are members of the same sex, or opposite sex couples if one or both persons is over age 62 and is eligible for Social Security benefits.
- Both persons are capable of consenting to the domestic partnership.
- Both file a Declaration of Domestic Partnership with the Secretary of State or an equivalent document from another recognized state or local agency, or both persons of the same sex who have validly formed a legal union other than marriage in a jurisdiction outside of California which is substantially equivalent to a Domestic Partnership as defined under California law.

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

The Federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people covered under existing group health plans to maintain coverage regardless of pre-existing conditions when they change jobs or are unemployed for brief periods of time. California law provides similar and additional protections. Applicants who meet the following requirements are eligible to enroll in a guaranteed issue individual health plan from any health plan that offers individual coverage, including Health Net's Guaranteed 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; and
- 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 30 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 for any of the following reasons:

- You do not pay your premium on time (if you do not pay your premium on time, Health Net may terminate your coverage upon 15 days' written notice, retroactive to the day following the last day for which premiums were last paid);
- You fail to cancel any other non-group coverage upon becoming eligible under this plan;
- You move out of the Plan's service area;
- You and/or your family member(s) cease being eligible;
- You and/or your family member(s) repeatedly or materially disrupt the operations of the Physician Group or Health Net to the extent that your behavior substantially impairs Health Net's ability to furnish or arrange services for you or other Health Net members, or the physician's office or Contracting Physician Group's ability to provide services to other patients;
- You and/or your family member(s) threaten the safety of the health care provider, his or her office staff, the contracting Physician Group or Health Net personnel if such behavior does not arise from a diagnosed illness or condition.

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

Can coverage be rescinded?

To determine whether or not you will be offered enrollment in an individual and 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 A PLAN CONTRACT:

Health Net may rescind the Plan Contract, subject to California law governing rescissions:

- For any nondisclosure or misrepresentation in the written information submitted by you on or with your enrollment application of a material fact if, before issuing a Plan Contract, Health Net made reasonable efforts to complete medical underwriting and resolve all reasonable questions arising from written information submitted by you on or with your enrollment application; or
- For any willful nondisclosure or misrepresentation in the written information submitted by you on or with your enrollment application of a material fact.

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

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 written notice 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; and
- Explain that your monthly premium will be modified to reflect the number of members that remain under the Plan Contract.

If the Plan Contract is rescinded:

- Health Net may revoke your coverage as if it never existed;
- Health Net will refund all premium amounts paid by you, less any medical expenses paid by Health Net on your behalf; and
- Health Net reserves its right to obtain any other legal remedies arising from the rescission that are consistent with California law.

If your coverage is rescinded, you have the right to appeal Health Net's decision to rescind such coverage. If Health Net denies your appeal, you have the right to seek assistance from the California Department of Managed Health Care. The California Department of Managed Health Care will review the final decision and confirm that Health Net has met its obligations under California law.

Are there any renewal provisions?

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

Does Health Net coordinate benefits?

There are no Coordination of Benefit provisions for individual plans in the State of California.

What is utilization review?

Health Net makes medical care covered under our Individual & Family HMO 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 non-contracting 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 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, may file a grievance or appeal. In addition, plan members can request an independent medical review of disputed health care services from the Department of Managed Health Care if they believe that health care services eligible for coverage and payment under their Health Net plan was improperly denied, modified or delayed by Health Net or one of its contracting providers.

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

Members not satisfied with the results of the grievance 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 Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department's 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 2008 ratio of premium costs to health services paid for the Individual & Family HMO plans was 80.8 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 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 the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders), autism, anorexia nervosa, and bulimia nervosa.

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

risk of suicide or risk of violence due to mental disorder; and/or (c) the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Do providers limit services for reproductive care?

Some hospitals and other providers do not provide one or more of the following services that may be covered under your Plan Contract and 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 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 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

Mental disorder 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.

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

- When Health Net members need mental disorders or chemical dependency care, simply call the toll-free line. For a referral, intake specialists and clinicians are on duty to take calls 24 hours a day, seven days a week. This 24-hour availability enhances your access, and reduces the possibility of going to a nonparticipating provider for care.
- Members who call for non-emergency care will always be referred for an initial evaluation. You will be given the name of a qualified mental health professional from a comprehensive specialty network. There are no additional requirements, and all evaluations are scheduled within ten days from the time of your call or at your convenience. This kind of prompt response to non-emergency situations minimizes your overall costs.
- In an emergency, call 911, or you may call the Administrator at 1-888-426-0030.
- Every member who calls for services is guaranteed an initial evaluation.

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 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 on 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 Health Net's 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.

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

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

The appeal may be submitted in writing, by telephone or through email. We must receive the appeal within 60 days of the date of the denial notice. Please refer to your 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.
- Write to:
  Health Net Customer Contact Center
  P.O. 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.
- Custodial care. Custodial care is not rehabilitative care and is primarily provided to assist a patient in meeting the activities of daily living, such as: help in walking, getting in and out of bed, bathing, dressing, feeding and preparation of special diets, and supervision of medications 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, and services or supplies provided after midnight on the effective date of cancellation of coverage through this plan, 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]
- Dental care. However, effective July 1, 2010, this plan does cover medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.[2]
- Treatment and services for temporomandibular joint (TMJ) disorders are covered when determined to be medically necessary, excluding crowns, inlays or onlays, bridgework and appliances.
- This Plan only covers services or supplies provided by a legally operated Hospital, Medicare-approved skilled Nursing Facility, or other properly licensed facility as specified in the Plan Contract and EOC. 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.
- Surgery and related services for the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw, except when such surgery is required due to trauma or the existence of tumors or neoplasms, or when otherwise medically necessary.
- Hearing aids.
- Treatment for mental disorders as a condition of parole or probation and court-ordered testing.
- Private duty nursing.
- Any eye surgery for the purpose of correcting refractive defects of the eye, unless medically necessary, recommended by the Member's treating physician and authorized by Health Net.
- Contact or corrective lenses (except an implanted lens that replaces the organic eye lens), vision therapy and eyeglasses.[2]

[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.

[2]The HMO 15 Plus and HMO 40 Plus plans include certain dental and vision services as described in this guide. For dental and vision benefit information for these plans, refer to the benefits sections later in this guide, or the Plan Contract and EOC.

- 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).
- Physical exams (including psychological examinations or drug screening) for insurance, licensing, employment, school or camp. Any physical, vision or hearing exams that are not related to diagnosis or treatment of illness or injury, except as specifically stated in the Health Net HMO Plan Contract and EOC.
- Any outpatient drugs, medications or other substances dispensed or administered in any setting, except as specifically stated in the Health Net HMO Plan Contract and EOC.
- 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, jacuzzis and spas; (c) surgical dressings other than primary dressings that are applied by your Physician Group or a Hospital to lesions of the skin or surgical incisions; and (d) stockings, corrective shoes and arch supports.
- Personal or comfort items.
- Disposable supplies for home use.
- Home birth, unless the criteria for emergency care have been met.
- Physician self-treatment.
- Treatment by immediate family members.
- Treatment of chemical dependency, except detoxification.
- 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 and supplies rendered by a non-participating 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 educational and professional services.
- Treatment, testing or screening of learning disabilities, except for some conditions when the level of severity meets the criteria of severe mental illness or serious emotional disturbances of a child.
- 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 designated bariatric surgical center. Health Net has a designated network of bariatric surgical centers to perform weight loss surgery. Your member physician can provide you with information about these centers. You will be directed to a Health Net designated bariatric surgical center at the time authorization is obtained.

Dental coverage included with HMO Plus[1] plans

PRINCIPLE BENEFITS AND COVERAGES FOR DENTAL CARE WITH HMO PLUS PLANS

Dental coverage for HMO Plus plans is provided by Health Net of California and administered by Dental Benefit Providers of California, Inc. (DBP). This benefit is included with HMO 15 Plus and HMO 40 Plus only.

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 *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 20th 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. Your dental benefits do not have deductibles or any annual maximum dollar benefit limitations. Simply present your Health Net Dental member ID card to the participating primary dentist you selected. It's that simple!

Please note: The HMO 15 Plus and HMO 40 Plus Plans are not available in all counties. Please see the Individual & Family Plans Rate Guide for details.

[1]A Health Net "HMO Plus" plan is a Health Net HMO 15 or HMO 40 plan with Health Net Dental and Vision coverage included. The "Plus" indicates the addition of the optional coverage.

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

COVERED BENEFITS		MEMBER PAYS
	Preventive (continued)	
D1120	Prophylaxis – child (initial)	$8
D1120	Prophylaxis – child (second in same calendar year)	$23
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
D2385	Resin-based composite – one surface, posterior (permanent tooth)	$55
D2386	Resin-based composite – two surfaces, posterior (permanent tooth)	$70
D2387	Resin-based composite – three or more surfaces, posterior (permanent tooth)	$85
D2391	Resin-based composite – one surface, posterior (primary tooth)	$40
D2392	Resin-based composite – two surfaces, posterior (primary tooth)	$55
D2393	Resin-based composite – three surfaces, posterior (primary tooth)	$70
D2394	Resin-based composite – four or more surfaces, posterior (primary tooth)	$70
	Crowns – Single restorations only	
D2710	Crown – resin-based composite (excluding molars)	$240 plus actual lab cost of noble or high noble metal
D2712	Crown – 3/4 resin-based composite (indirect), (excluding molars)	$240 plus actual lab cost of noble or high noble metal

COVERED BENEFITS		MEMBER PAYS
	Crowns – Single restorations only (continued)	
D2720	Crown – resin with high noble metal (excluding molars)	$240 plus actual lab cost of noble or high noble metal
D2721	Crown – resin with predominantly base metal (excluding molars)	$240 plus actual lab cost of noble or high noble metal
D2722	Crown – resin with noble metal (excluding molars)	$240 plus actual lab cost of noble or high noble metal
D2750	Crown – porcelain fused to high noble metal (excluding molars)	$305 plus actual lab cost of noble or high noble metal
D2751	Crown – porcelain fused to predominantly base metal (excluding molars)	$305 plus actual lab cost of noble or high noble metal
D2752	Crown – porcelain fused to noble metal (excluding molars)	$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 in addition to crown	$60
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
	Periodontics	
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

COVERED BENEFITS		MEMBER PAYS
	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
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
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

COVERED BENEFITS		MEMBER PAYS
	Prosthodontics (fixed) (continued)	
D6240	Pontic – porcelain fused to high noble metal (excluding molars)	$305 plus actual lab cost of noble or high noble metal
D6241	Pontic – porcelain fused to predominantly base metal (excluding molars)	$305 plus actual lab cost of noble or high noble metal
D6242	Pontic – porcelain fused to noble metal (excluding molars)	$305 plus actual lab cost of noble or high noble metal
D6710	Crown – indirect resin-based composite (excluding molars)	$305 plus actual lab cost of noble or high noble metal
D6750	Crown – porcelain fused to high noble metal (excluding molars)	$305 plus actual lab cost of noble or high noble metal
D6751	Crown – porcelain fused to predominantly base metal (excluding molars)	$305 plus actual lab cost of noble or high noble metal
D6752	Crown – porcelain fused to noble metal (excluding molars)	$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
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

COVERED BENEFITS		MEMBER PAYS
	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	Emergency visits – during regular dental office hours *This copay is in addition to specific services copays.*	$14
	Professional visits	
D9440	Emergency visits – after regular dental office hours *This copay is in addition to specific services copays.*	$55
	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 of California participating orthodontists 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 of California reserves the right to limit coverage to its choice of participating dentists.

PRINCIPAL EXCLUSIONS AND LIMITATIONS FOR DENTAL CARE WITH HMO PLUS PLANS PROVIDED BY HEALTH NET OF CALIFORNIA

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 of California, are not dentally necessary.
- Any experimental procedure. Experimental treatment if denied may be appealed through the Independent Medical Review process and that service shall be covered and provided if required under the Independent Medical Review 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 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.

Vision coverage included with HMO Plus[1] 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 administer vision services benefits. This benefit is included with HMO 15 Plus and HMO 40 Plus.

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 *Provider Search*. If you need help in selecting a provider, call the Health Net Vision Member Services department at 1-866-392-6058.

[1]A Health Net "HMO Plus" plan is a Health Net HMO 15 or HMO 40 plan with Health Net Dental and Vision coverage included. The "Plus" indicates the addition of the optional coverage.

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	YOU PAY
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 receive 10% 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

COVERED BENEFITS	YOU PAY
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[2]	$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 contact lens follow-up visit after the initial fitting examination.

[2] 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 of California and all applicable exclusions and limitations.

Non-medically necessary conventional or disposable contact lenses
Non-medically necessary conventional or disposable contact lenses are covered up to a maximum retail allowance of $80. When covered, non-medically 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 15 Plus and HMO 40 Plus plans:

- Coverage limited to care rendered by participating vision providers.
- Extras and non-medically necessary services and materials. Charges for services and materials are excluded if Health Net of California determines them to be: (1) beyond the allowances for frames, lenses and contact lenses indicated in the Summary of Vision Care Benefits; or (2) otherwise non-medically necessary services.
- Medically necessary contact lenses. Coverage for prescriptions for contact lenses is subject to medical necessity, prior authorization by Health Net of California and all applicable exclusions and limitations. When covered, medically necessary 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.
- Non-medically 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 (non-prescription) lenses.
- A second pair of glasses in lieu of bifocals is excluded.

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

For more information, please contact:

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

Individual & Family Plans:
1-800-909-3447

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)

Telecommunications Device
for the Hearing and Speech Impaired:
1-800-995-0852

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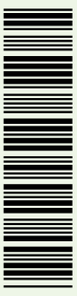

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