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PPO HEALTH INSURANCE PLANS FOR INDIVIDUALS AND FAMILIES

Health insurance and more – for the way you live

Effective January 1, 2010



Health Net®
A BETTER DECISION



Welcome to Health Net Life Insurance Company
(Health Net).

Whatever you're looking for in a health insurance plan –
affordability, broad benefit coverage, choice in doctors or
wellness programs to keep you and your family healthy –
you'll find it here.

Affordable. Easy. That's Health Net.

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IMPORTANT INFORMATION. The health benefits and coverage matrices on pages 11–15 are included to help you compare coverage benefits. Be sure to review the plan descriptions, so you know which providers you can choose to get health care services.

Inside the back pocket is the disclosure document we’re required to give everyone before they enroll in one of our health insurance plans. This document explains general insurance plan exclusions and limitations, and is meant to be read with this brochure. If there is a difference between these documents and the Insurance Policy, the Insurance Policy takes precedence.








If you do not have a Health Net PPO Insurance Plans Outline of Coverage and Exclusions and Limitations in the back pocket, please request a copy from your authorized Health Net Agent or your Health Net Sales Representative at **1-800-909-3447, option 2.**

PART 1



HEALTH NET
INSURANCE PLANS
FIT YOUR BUDGET,
FIT YOUR LIFE

Easy x 7 – the advantages of a Health Net insurance plan

-  **Easy to choose** the health insurance plan that fits your budget and your life with our wide range of PPO and HSA-compatible PPO options.¹
-  **Easy to find** a doctor in your neighborhood from the thousands of doctors and hospitals that are part of our statewide networks.
-  **Easy to get care.** All Health Net health insurance plans cover essential preventive care, emergency services and hospitalization.
-  **Easy to use.** Online tools plus people to talk with on the phone add up to a health insurance plan that's actually easy to use.
-  **Easy to afford.** Among the Health Net options that leave some change in your pocket are our \$0 deductible plans and plans that work with Health Savings Accounts for tax-saving opportunities. Plus, our family plan rates are based on the age of the younger spouse to save you a little bit more.
-  **Easy to pay.** Use your credit card. Set up an automatic bank draft. Send us a check. When it comes to paying premiums, the choice is yours.
-  **Easy to stay healthy and get well** with no-cost extras like coaching, interactive guides and education that help you work with your doctor and make informed choices.

¹NetFirst, ValueNet, BalanceNet and Optimum Advantage HSA insurance plans (Policy Form #P30601 CA 4/09) are underwritten by Health Net Life Insurance Company. Health Net Life Insurance Company is a subsidiary of Health Net, Inc.

Helpful definitions

In this guide, you'll see words used that are specific to health care. We've defined them here to make everything fast to read and easy to understand.

Coinsurance

The percentage of covered expenses you pay for covered services, usually after you meet your deductible. These amounts vary by health plan.

Copayment (or copay)

The fixed-dollar fee that a Covered Person is required to pay for covered services when the services are received in addition to any applicable coinsurance and/or deductible payments. The copayment is due and payable to the provider of care at the time the service is received.

Deductible

The set amount a covered person or family unit pays each calendar year for specified covered expenses before Health Net pays any benefits for those covered expenses.

Out-of-pocket

The maximum amount of copayments, coinsurance and deductibles you must pay for covered services for each calendar year.

Participating or Preferred Providers

Physicians, Hospitals or other Providers of health care who have a written agreement with HNL to participate in the PPO network and have agreed to provide insureds with health care at a contracted rate. The Covered Person must pay any deductible(s), copayment or coinsurance required, but is not responsible for any amount charged in excess of the contracted rate. Participating or Preferred Providers can be found online at www.healthnet.com.

PPO (Preferred Provider Organization)

A health care provider arrangement whereby HNL contracts with a group of physicians or other medical care providers who agree to furnish covered services and supplies.



PPO: the freedom to choose, the support to choose wisely

If freedom of choice is what you want, our PPO is the plan for you. You can go to any doctor or hospital in our PPO network – there are more than 13,000 primary physicians, 48,000 specialists and 300 hospitals to choose from. Or you can see a provider not in our network.

- When you choose a **participating** network provider, you pay:
 - A calendar-year deductible, if applicable.
 - A fixed copayment or coinsurance after you've met your calendar-year deductible (up to the calendar-year out-of-pocket maximum).

A *coinsurance* is the percentage of your doctor's bill that is your responsibility. When your doctor submits a bill, we pay our portion and send you a statement called an Explanation of Benefits that lists the amount you owe. Your doctor will then bill you for the amount on this statement.

- When you see a **non-participating** provider, you generally pay:
 - A calendar-year deductible.
 - A coinsurance after you've met your calendar-year deductible (up to the calendar-year out-of-pocket maximum). Note that the copayment/coinsurance is higher when you go out-of-network to a non-participating provider, which means you'll pay more.
 - Charges that exceed allowances for covered services.

Some services may be covered only when you receive them from in-network physicians and facilities. And all hospital care (including outpatient procedures) requires precertification. Of course, in an emergency, go to the closest emergency facility. Emergency care is available worldwide.

IS A HEALTH NET PPO RIGHT FOR YOU?

Yes, if you want:

- Freedom of choice, no referrals required.
- Control over how much you spend – your costs are usually lower when you use our network and participating providers.
- Broad network access throughout California. Plus, when traveling, you'll have access to more than 4,700 hospitals and 490,000 providers available nationwide through an arrangement with First Health®, a national PPO network.
- Time savings convenience – no claim forms to file when you use network services.

(continued next page)

PPO (continued)



PPO PLAN CHOICES

NetFirst

This is our zero-deductible, applicant-only plan created for the active, healthy consumer. Zero-deductible means there is no annual deductible to meet; you pay a \$35 copayment for doctor visits and 35% coinsurance for other services, where applicable. This plan also offers two pharmacy choices: Generic-only for value, or 3-tier for Generic and Brand prescriptions.

ValueNet

A low premium price plan for those who rarely get sick or go to the doctor, ValueNet provides the security of just-in-case coverage plus the flexibility of having two preventive or doctor office visits for a \$35 copayment per visit (annual \$4,000 deductible waived for these visits). All other covered services have a 35% coinsurance after deductible. This applicant-only plan includes a \$10 generic prescription drug benefit.

Applicant-only means the plan only covers one person on a policy. If you have several family members who'd like this plan, they can apply for an individual policy using the same enrollment application form.

BalanceNet

Designed for both individuals and families, BalanceNet combines the security of comprehensive coverage with choice and convenience. The plan includes maternity coverage, features two preventive or doctor office visits for a \$35 copayment per visit (annual deductible waived for these visits), and comes complete with 3-tier prescription drug coverage. The annual deductible is \$3,500 for individuals, \$7,000 for families.

EZ Access HSA: high deductible PPO insurance plans with tax saving opportunities

Health Net's EZ Access plans work just like our PPO plans: you choose whether to see a provider in our network or go to an out-of-network licensed physician or health care professional. When you go out-of-network, you usually pay more for the services you receive. Either way, you don't need a referral from your doctor to see a specialist or go to the hospital.

What's different about HSA-compatible PPOs is that the deductible is higher but you spend less on monthly premiums. Things to know:

- HSA-compatible insurance plans have combined medical and pharmacy deductibles. This means that you pay the full cost of prescriptions and medical care (at our negotiated rates) until your annual deductible has been met.
- The deductible for child and adult preventive care benefits is waived (in-network only). There is a low copayment for preventive care.
- The plan deductible is combined for in-network and out-of-network services.

Plus, you can open an HSA and use tax-free dollars to pay for qualified medical expenses.² Other HSA advantages:

- You have complete control over your health care dollars and can use them when you like.
- Contributions (up to the IRS maximum) and withdrawals are tax-free when used for qualified medical or pharmacy expenses.
- HSA funds can be invested and investment earnings are non-taxable when used for qualified medical expenses.
- Long-term savings, rollover features (no time limit for using the funds) and catch-up contribution for insureds between the ages of 55 and 65.

HSA-COMPATIBLE PPO INSURANCE PLAN CHOICES

Optimum Advantage HSA

These high-deductible PPO insurance plans work well for people who don't go to the doctor often but who want protection against the unexpected. You have a

IS AN HSA-COMPATIBLE PPO RIGHT FOR YOU?

Yes, if you want:

- Freedom of choice, no referrals required.
- Control over how much you spend – your costs are lower when you use our network.
- Broad network access throughout California. Plus, when traveling, you'll have access to more than 4,700 hospitals and 490,000 providers available nationwide through an arrangement with First Health®, a national PPO network.
- Convenience – no claim forms to file when you use network services.
- Tax-saving advantages of a health savings account – a smart way to save, spend and invest your health care dollars.²

choice of two annual deductible amounts – \$2,500 or \$4,500. The higher the deductible amount, the lower your monthly premium.

With Optimum Advantage HSA insurance plans, there are no surprises or hidden costs, and no complicated copayment/coinsurance structure to figure out. After you meet your calendar-year deductible, in-network benefits are paid at 100%. Plus, you have immediate coverage for child and adult preventive care services for which you pay a set copayment.

Once you're enrolled in one of these plans, you may open an HSA at any bank or financial institution that offers them. To make it easy, Health Net has partnered with Bank of America to offer our insureds an HSA that's easy to administer, quick to set up (within 15 calendar days), and comes with a convenient Bank of America VISA® debit card for account access.

²Federal tax information only. State taxes may apply. Qualified medical expenses include plan deductibles and copayments, as well as services such as vision, dental and prescription drugs. A full list of qualified medical expenses is included in IRS publication 502 – Medical and Dental Expenses, which you can find at www.irs.gov. Enter "502" in the search field.

The HSA component of the program is offered by Bank of America, N.A., as trustee of the HSA. Health Net is not affiliated with Bank of America, N.A.

Dental & Vision

A Health Net “PPO Plus” plan³ is a Health Net PPO insurance plan with Health Net dental and vision coverage included. It’s a great way to round out your health coverage while enjoying the convenience of one-stop shopping.

DENTAL COVERAGE BENEFITS

- Choose your own dental providers.
- Budget your care: find out your costs up front with our convenient fee schedule.
- Save – the \$50 deductible is waived for diagnostic and preventative services.

VISION COVERAGE BENEFITS

- Single, bifocal, trifocal and lenticular lenses covered at 100% in-network after copayment.
- Freedom to take your prescription to any vision PPO provider.
- No or low copayments for vision exams and lenses, and allowances for other services.
- Large network of independent providers, including optical retailers LensCrafters,[®] Pearle Vision,[®] Sears Optical,SM JCPenney[®] Optical and Target Optical.[®]
- Secondary purchase plan – unlimited discounts up to 40% on materials and services once initial benefit has been used.

See pages 15–18 of this booklet for benefit details about these plans.



³Dental and vision benefits are underwritten by Health Net Life Insurance Company. Dental benefits are administered by Dental Benefit Administrative Services. Vision benefits are administered by EyeMed Vision Care, LLC. Dental Benefit Administrative Services and EyeMed Vision Care, LLC are not affiliated with Health Net Life Insurance Company. For additional information on dental and vision coverage provided under the Plus option, see the Dental and Vision Summary of Benefits.

Individual Term Life Insurance plans

For added peace of mind, you can purchase Individual Term Life Insurance from Health Net Life Insurance Company.⁴ You can purchase a policy for yourself, for your spouse and/or for a dependent.

- You have a choice of five coverage amounts for policies that cover you or your spouse:
 - \$10,000
 - \$20,000
 - \$30,000
 - \$40,000
 - \$50,000
- \$10,000 policies are available for children aged 1–17.



The monthly premium is based on the age of the person covered by the life insurance policy.

There are a few things to know about our life insurance plans:

SUPPLEMENTAL LIFE INSURANCE MONTHLY 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

- If you wish to purchase life insurance, you must purchase a minimum \$10,000 coverage. The maximum life insurance benefit is \$50,000.
- Not available with modified issue PPO plans, HIPAA guarantee issue and Quick Net plans.
- Rates are subject to change.

⁴Individual 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.

Benefits at-a-glance

THIS CHART IS DESIGNED TO GIVE YOU A QUICK COMPARISON OF HEALTH NET INSURANCE PLANS. INCLUDED IS A SUMMARY OF IN-NETWORK BENEFITS ONLY AND, THEREFORE, IS NOT INTENDED FOR ENROLLMENT PURPOSES. FOR BENEFIT DETAILS, PLEASE SEE THE SUMMARY OF BENEFITS ON THE FOLLOWING PAGES.

	OPTIMUM ADVANTAGE HSA 2500 AND 4500	NETFIRST (applicant only)	VALUENET (applicant only)	BALANCENET
LIFETIME MAXIMUM	\$6 million	\$6 million	\$6 million	\$6 million
CALENDAR YEAR DEDUCTIBLE	\$2,500 or \$4,500 (\$5,000 or \$9,000 family)	\$0	\$4,000	\$3,500 individual / 2 per family
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	\$2,500 or \$4,500 (\$5,000 or \$9,000 family)	\$7,500	\$3,500	\$3,500 individual / 2 per family
DOCTOR VISIT	No charge after deductible	\$35	\$35 (deductible waived for first 2 visits) ¹	\$35 (deductible waived for first 2 visits) ¹
X-RAY AND LAB	No charge after deductible	35%	35%	35%
MATERNITY CARE	Not covered	Not covered	Not covered	35%
ADULT PREVENTIVE CARE	\$40	\$35	\$35 (deductible waived for first 2 visits) ¹	\$35 (deductible waived for first 2 visits) ¹
CHILD PREVENTIVE CARE	\$40	\$35	\$35 (deductible waived for first 2 visits) ¹	\$35 (deductible waived for first 2 visits) ¹
EMERGENCY HEALTH COVERAGE	No charge after deductible	\$100 copay plus 35%	35%	35%
OUTPATIENT SURGERY (hospital or outpatient surgery center)	No charge after deductible	\$500 copay plus 35%	35%	35%
OUTPATIENT FACILITY SERVICES	No charge after deductible	35%	35%	35%
HOSPITALIZATION SERVICES	No charge after deductible	\$500 copay per day plus 35% / 4 day copay max	35%	35%
OUTPATIENT PRESCRIPTION DRUGS	No charge after deductible	Two Rx options 1) 3-tier: \$750 brand deductible \$10 Level I (generic) \$35 Level II (formulary brand) \$50 or 50% (whichever is greater) Level III (non-formulary) 2) Generic: \$10 Level I (generic)	\$10 Level I (generic)	\$750 brand deductible \$10 Level I (generic) \$35 Level II (formulary brand) \$50 or 50% (whichever is greater) Level III (non-formulary)

See page 26 for footnotes.

Summary of benefits – Optimum Advantage HSA

Underwritten by Health Net Life Insurance Company

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

	OPTIMUM ADVANTAGE HSA	
	IN-NETWORK	OUT-OF-NETWORK
LIFETIME MAXIMUM	\$6 million	
CALENDAR YEAR DEDUCTIBLES All benefits including pharmacy are subject to the deductible except preventive care. Health Net will begin to pay covered services in a family plan for each individual in the family once he/she satisfies the individual deductible. The remaining family members must continue to pay a deductible until they either individually meet the individual deductible or until the amount paid by the family reaches the family deductible.	\$2,500 single / \$5,000 family \$4,500 single / \$9,000 family	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (Payments for services not covered by this plan will not apply to this calendar year out-of-pocket maximum.)	\$2,500 single / \$5,000 family \$4,500 single / \$9,000 family (includes deductible)	\$12,500 single / \$25,000 family \$14,500 single / \$29,000 family (includes deductible)
PROFESSIONAL SERVICES Visit to physician (including specialist consultations)	Covered in full after deductible is met	50%
Prenatal and postnatal office visits	Not covered	
X-ray and laboratory procedures ²	Covered in full after deductible is met	50%
Adult preventive care ³ (age 19 and older) Annual preventive physical exam, yearly OB/GYN exam (breast and pelvic exams, Pap smears and mammography)/Yearly prostate cancer screening and exam	\$40 (deductible waived)	Not covered
Child preventive care (newborns to age 18) Checkups, immunizations, vision and hearing exams	\$40 (deductible waived)	Not covered
EMERGENCY HEALTH COVERAGE Emergency room (professional and facility charges)	Covered in full after deductible is met	
Urgent care center (facility charges)	Covered in full after deductible is met	
Ambulance	Covered in full after deductible is met	
OUTPATIENT SERVICES ² Outpatient Surgery (Hospital or outpatient surgery center charges only. Out-of-network maximum allowable charges are \$600 per day.)	Covered in full after deductible is met	50%
Outpatient facility services ² (Out-of-network maximum allowable charges are \$600 per day.)	Covered in full after deductible is met	50%
HOSPITALIZATION SERVICES ² Inpatient, semiprivate hospital room or intensive care unit with ancillary services (Unlimited, except for non-severe mental health and substance abuse treatment. Out-of-network maximum allowable charges are \$600 per day.)	Covered in full after deductible is met	50%
Maternity care in a hospital or skilled nursing facility ²	Not covered	
Surgeon or assistant surgeon and anesthetic service (inpatient hospital setting)	Covered in full after deductible is met	50%
OTHER SERVICES Rehabilitative therapy (includes physical, speech, occupational, respiratory and cardiac therapy)	Covered in full after deductible is met (20 visit maximum per calendar year)	Not covered
Chiropractic care/Acupuncture	Covered in full after deductible is met (12 visit maximum per calendar year / \$20 maximum payable per visit)	Not covered
Mental health for non-severe conditions ^{2,4}	Covered in full after deductible is met (inpatient and outpatient)	50% (inpatient) / Not covered (outpatient)
Diabetic equipment	20%	Not covered
Durable medical equipment (including foot orthotics)	50% (\$2,000 maximum payable per calendar year)	Not covered
OUTPATIENT PRESCRIPTION DRUGS ⁵ Filled at participating pharmacy (up to a 30-day supply); not covered at non-participating pharmacies. <i>Prescription drugs filled through mail order (up to a 90-day supply).</i>	Covered in full after deductible is met	Not covered

See page 26 for footnotes.

Summary of benefits — NetFirst

Underwritten by Health Net Life Insurance Company

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

	NETFIRST (applicant only)	
	IN-NETWORK	OUT-OF-NETWORK
LIFETIME MAXIMUM	\$6 million	
CALENDAR YEAR DEDUCTIBLE	\$0	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (Payments for services not covered by this plan will not apply to this calendar year out-of-pocket maximum.)	\$7,500	\$15,000
PROFESSIONAL SERVICES		
Visit to physician (including specialist consultations)	\$35	50%
X-ray and laboratory procedures ²	35%	50%
Adult preventive care ³ (age 19 and older) Annual preventive physical exam, yearly OB/GYN exam (breast and pelvic exams, Pap smears and mammography)/Yearly prostate cancer screening and exam	\$35	Not covered
Child preventive care (newborns to age 18) Checkups, immunizations, vision and hearing exams	\$35	Not covered
EMERGENCY HEALTH COVERAGE		
Emergency room (professional and facility charges)	\$100 copay plus 35% (copay waived if admitted)	
Urgent care center (facility charges)	35%	
Ambulance	35%	
OUTPATIENT SERVICES ²		
Outpatient Surgery (Hospital or outpatient surgery center charges only. Out-of-network maximum allowable charges are \$600 per day.)	\$500 copay ⁶ plus 35%	\$500 copay ⁶ plus 50%
Outpatient facility services ²	35%	50%
HOSPITALIZATION SERVICES ²		
Inpatient, semiprivate hospital room or intensive care unit with ancillary services (Unlimited, except for non-severe mental health and substance abuse treatment. Out-of-network maximum allowable charge is \$600 per day.)	\$500 copay ⁷ per day plus 35% (4 day maximum copay)	\$500 copay ⁷ per day plus 50% (4 day maximum copay)
Maternity care in a hospital or skilled nursing facility	Not covered	
Surgeon or assistant surgeon and anesthetic service (inpatient hospital setting)	35%	50%
OTHER SERVICES		
Outpatient rehabilitative therapy (includes physical, speech, occupational, respiratory and cardiac therapy) (maximum payable \$500 per calendar year combined in- or out-of-network)	35%	50%
Chiropractic care/Acupuncture	Not covered	
Mental health for non-severe conditions ² (Outpatient: maximum payable \$500 per calendar year. Inpatient: maximum payable \$5,000 per calendar year.)	35%	50%
Diabetic equipment	35%	Not covered
Durable medical equipment (\$2,000 maximum payable per calendar year) (including foot orthotics)	35%	Not covered
OUTPATIENT PRESCRIPTION DRUGS ^{5,8} Filled at participating pharmacy (up to a 30-day supply); not covered at non-participating pharmacies. <i>Prescription drugs filled through participating mail order (up to a 90-day supply) require twice the level of copayment.</i>	Two Rx options available: 1) 3-tier \$750 brand deductible \$10 Level I (generic) \$35 Level II (formulary brand) \$50 or 50% (whichever is greater) Level III (non-formulary brand) or 2) Generic Only \$10 Level I (generic)	Not covered

See page 26 for footnotes.

Summary of benefits — ValueNet

Underwritten by Health Net Life Insurance Company

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

	VALUENET (applicant only)	
	IN-NETWORK	OUT-OF-NETWORK
LIFETIME MAXIMUM	\$6 million	
CALENDAR YEAR DEDUCTIBLES (Not included in calendar year out-of-pocket maximum)	\$4,000	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (Does not include calendar year deductible. Payments for services not covered by this plan will not apply to this calendar year out-of-pocket maximum.)	\$3,500	\$7,000
PROFESSIONAL SERVICES Visit to physician (including specialist consultations)	\$35 (deductible waived for first 2 visits) ¹	Not covered
X-ray and laboratory procedures ²	35%	50%
Adult preventive care ³ (age 19 and older) Annual preventive physical exam, yearly OB/GYN exam (breast and pelvic exams, Pap smears and mammography)/Yearly prostate cancer screening and exam	\$35 (deductible waived for first 2 visits) ¹	Not covered
Child preventive care (newborns to age 18) Checkups, immunizations, vision and hearing exams	\$35 (deductible waived for first 2 visits) ¹	Not covered
EMERGENCY HEALTH COVERAGE Emergency room (professional and facility charges)	35%	
Urgent care center (facility charges)	35%	
Ambulance	35%	
OUTPATIENT SERVICES ² Outpatient Surgery (Hospital or outpatient surgery center charges only. Out-of-network maximum allowable charges are \$600 per day.)	35%	50%
Outpatient facility services ²	35%	50%
HOSPITALIZATION SERVICES ² Inpatient, semiprivate hospital room or intensive care unit with ancillary services (Unlimited, except for non-severe mental health and substance abuse treatment. Out-of-network maximum allowable charges are \$600 per day.)	35%	50%
Maternity care in a hospital or skilled nursing facility	Not covered	
Surgeon or assistant surgeon and anesthetic service (inpatient hospital setting)	35%	50%
OTHER SERVICES Outpatient rehabilitative therapy (includes physical, speech, occupational, respiratory and cardiac therapy) (maximum payable \$500 per calendar year combined in- or out-of-network)	35%	50%
Chiropractic care/Acupuncture	Not covered	
Mental health for non-severe conditions ² (Outpatient: maximum payable \$500 per calendar year. Inpatient: maximum payable \$5,000 per calendar year.)	35%	50%
Diabetic equipment	35%	Not covered
Durable medical equipment (\$2,000 maximum payable per calendar year) (including foot orthotics)	35%	Not covered
OUTPATIENT PRESCRIPTION DRUGS ^{5,8} (medical deductible waived) Filled at participating pharmacy (up to a 30-day supply); not covered at non-participating pharmacies. <i>Prescription drugs filled through participating mail order (up to a 90-day supply) require twice the level of copayment.</i>	\$10 Level I (generic)	Not covered

See page 26 for footnotes.

Summary of benefits — BalanceNet

Underwritten by Health Net Life Insurance Company

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

	BALANCENET	
	IN-NETWORK	OUT-OF-NETWORK
LIFETIME MAXIMUM	\$6 million	
CALENDAR YEAR DEDUCTIBLE Family deductible is met when two family members meet their individual deductibles (Not included in calendar year out-of-pocket maximum)	\$3,500 individual/2 per family	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (Does not include calendar year deductible. Family out-of-pocket maximum is met when two family members meet their individual out-of-pocket maximum. Payments for services not covered by this plan will not apply to this calendar year out-of-pocket maximum.)	\$3,500 individual/2 per family	\$7,000 individual/2 per family
PROFESSIONAL SERVICES Visit to physician (including specialist consultations)	\$35 (deductible waived for first 2 visits) ¹	50%
X-ray and laboratory procedures ²	35%	50%
Adult preventive care ³ (age 19 and older) Annual preventive physical exam, yearly OB/GYN exam (breast and pelvic exams, Pap smears and mammography)/Yearly prostate cancer screening and exam	\$35 (deductible waived for first 2 visits) ¹	Not covered
Child preventive care (newborns to age 18) Checkups, immunizations, vision and hearing exams	\$35 (deductible waived for first 2 visits) ¹	Not covered
EMERGENCY HEALTH COVERAGE Emergency room (professional and facility charges)	35%	
Urgent care center (facility charges)	35%	
Ambulance	35%	
OUTPATIENT SERVICES ² Outpatient Surgery (Hospital or outpatient surgery center charges only. Out-of-network maximum allowable charges are \$600 per day.)	35%	50%
Outpatient facility services ²	35%	50%
HOSPITALIZATION SERVICES ² Inpatient, semiprivate hospital room or intensive care unit with ancillary services (Unlimited, except for non-severe mental health and substance abuse treatment. Out-of-network maximum allowable charges are \$600 per day.)	35%	50%
Maternity care in a hospital or skilled nursing facility	35%	50%
Surgeon or assistant surgeon and anesthetic service (inpatient hospital setting)	35%	50%
OTHER SERVICES Outpatient rehabilitative therapy (includes physical, speech, occupational, respiratory and Cardiac therapy) (maximum payable \$500 per calendar year combined in- or out-of-network)	35%	50%
Chiropractic care/Acupuncture	Not covered	
Mental health for non-severe conditions ² (Outpatient: maximum payable \$500 per calendar year. Inpatient: maximum payable \$5,000 per calendar year.)	35%	50%
Diabetic equipment	35%	Not covered
Durable medical equipment (\$2,000 maximum payable per calendar year) (including foot orthotics)	35%	Not covered
OUTPATIENT PRESCRIPTION DRUGS ^{5,8} (medical deductible waived) Filled at participating pharmacy (up to a 30-day supply); not covered at non-participating pharmacies. <i>Prescription drugs filled through participating mail order (up to a 90-day supply) require twice the level of copayment.</i>	\$750 brand deductible per person \$10 Level I (generic) \$35 Level II (formulary brand) \$50 or 50% (whichever is greater) Level III (non-formulary brand)	Not covered

See page 26 for footnotes.

Summary of benefits – Dental with PPO Plus coverage

THE FOLLOWING IS INTENDED AS A SUMMARY ONLY. THE POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

	PPO PLUS PLANS: DENTAL
CALENDAR YEAR MAXIMUM	\$1,000
ANNUAL DEDUCTIBLE (waived for diagnostic and preventive services)	\$50
	Maximum Allowable Fee
DIAGNOSTIC AND PREVENTIVE	
Diagnostic – periodic oral examination (up to 2x per year)	\$13
Diagnostic – limited oral examination, problem-focused	\$17
Intraoral Radiographs – complete series, including bitewings	\$40
Dental prophylaxis – adult	\$32
Dental prophylaxis – children to age 14	\$25
Sealant (per permanent molar tooth)	\$4
RESTORATIVE – AMALGAM (permanent filling)	
One surface, permanent (Amalgam)	\$22
Two surface, permanent (Amalgam)	\$28
Crown (resin/porcelain)	\$127 resin/\$248 porcelain ⁹
ENDODONTICS – ROOT CANAL (excluding final restorations)	
Anterior	\$121 ¹⁰
Molar	\$193 ¹⁰
ORAL SURGERY (extractions)	
Single tooth, erupted	\$33
Removal of impacted tooth (completely bony)	\$66
PERIODONTICS	
Periodontal scaling and root planing – 4 or more teeth per quadrant	\$23
PROSTHODONTICS	
Prosthetics/prostodontics – Denture (complete upper or lower)	\$264 each
ORTHODONTICS	
Children (through age 19)	Not covered
Adult	Not covered

See page 26 for footnotes.

Dental and vision benefits are underwritten by Health Net Life Insurance Company. Dental benefits are administered by Dental Benefit Administrative Services. Vision benefits are administered by EyeMed Vision Care, LLC. Dental Benefit Administrative Services and EyeMed Vision Care, LLC are not affiliated with Health Net Life Insurance Company. For additional information on dental and vision coverage provided under the Plus option, see the Dental and Vision Summary of Benefits.

Schedule of benefits — Dental with PPO Plus coverage

THIS MATRIX IS INTENDED AS A SUMMARY ONLY. THE POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

COVERED BENEFITS		MAXIMUM ALLOWABLE FEE
Diagnostic procedures		
D0120	Periodic oral examination	\$13
D0140	Limited oral evaluation, problem focused	\$17
D0150	Comprehensive oral examination	\$17
D0210	Intraoral – complete series including bitewings (FMX)	\$40
D0220	Intraoral – periapical, first film	\$10
D0230	Intraoral – periapical, each additional film	\$7
D0240	Intraoral – occlusal film	\$11
D0250	Extraoral – first film	\$13
D0260	Extraoral – each additional film	\$10
D0270	Bitewing – single film	\$10
D0272	Bitewings – two films	\$15
D0274	Bitewings – four films	\$21
D0330	Panoramic film	\$31
Preventive procedures		
D1110	Dental prophylaxis – adult	\$32
D1120	Dental prophylaxis – children to age 14	\$25
D1203	Topical application of fluoride (excluding prophylaxis – child)	\$17
D1351	Sealant, per tooth	\$4
D1510	Space maintainer – fixed, unilateral	\$61
D1515	Space maintainer – fixed, bilateral	\$61
D1520	Space maintainer – removable, unilateral	\$72
D1525	Space maintainer – removable, bilateral	\$72
Restorative procedures		
D2140	Amalgam – one surface, primary	\$19
D2150	Amalgam – two surfaces, primary	\$24
D2160	Amalgam – three surfaces, primary	\$29
D2161	Amalgam – four or more surfaces, primary	\$35
D2140	Amalgam – one surface, permanent	\$22
D2150	Amalgam – two surfaces, permanent	\$28
D2160	Amalgam – three surfaces, permanent	\$33
D2161	Amalgam – four or more surfaces, permanent	\$39
D2330	Resin – one surface, anterior	\$19
D2331	Resin – two surfaces, anterior	\$24
D2332	Resin – three surfaces, anterior	\$29
D2335	Resin – four or more surfaces or involving incisal angle, anterior	\$35
D2390	Resin-based composite crown – anterior, (primary teeth)	\$31
D2510	Inlay metallic, one surface ¹	\$66
D2520	Inlay metallic, two surfaces ¹	\$72
D2530	Inlay metallic, three or more surfaces ¹	\$83
D2543	Onlay – metallic – three surfaces ¹	\$110
D2544	Onlay – metallic – four or more surfaces ¹	\$110
D2710	Crown – resin-based composite (indirect) ¹	\$127
D2720	Crown resin with high noble metal ¹	\$154
D2721	Crown resin with predominantly base metal ¹	\$154

COVERED BENEFITS		MAXIMUM ALLOWABLE FEE
Restorative procedures (continued)		
D2722	Crown resin with noble metal ¹	\$154
D2740	Crown porcelain/ceramic substrate ¹	\$248
D2750	Crown porcelain fused to high noble metal ¹	\$248
D2751	Crown porcelain fused to predominantly base metal ¹	\$248
D2752	Crown porcelain fused to noble metal ¹	\$248
D2790	Crown full cast high noble metal ¹	\$154
D2791	Crown full cast predominantly base metal ¹	\$154
D2792	Crown full cast noble metal ¹	\$154
D2794	Crown – titanium	\$154
D2910	Recement inlay, onlay or partial coverage restoration	\$11
D2915	Recement cast or prefabricated post and core	\$11
D2920	Recement crown	\$11
D2930	Prefabricated stainless steel crown, primary tooth	\$31
D2931	Prefabricated stainless steel crown, permanent tooth	\$31
D2950	Core buildup, including any pins ¹	\$22
D2952	Cast post and core in addition to crown ¹	\$28
D2954	Prefabricated post and core in addition to crown ¹	\$28
Endodontic procedures		
D3110	Pulp cap – direct, excluding final restoration	\$10
D3120	Pulp cap – indirect, excluding final restoration	\$17
D3220	Therapeutic pulpotomy, excluding final restoration – removal of pulp coronal to the dentinoenamel junction and application of medicament, primary teeth only	\$13
D3310	Root canal anterior, excluding final restoration ²	\$121
D3320	Root canal bicuspid, excluding final restoration ²	\$143
D3330	Root canal molar, excluding final restoration ²	\$193
D3346	Retreatment of previous root canal therapy – anterior ²	\$121
D3347	Retreatment of previous root canal therapy – bicuspid ²	\$143
D3348	Retreatment of previous root canal therapy – molar ²	\$193
D3410	Apicoectomy/periradicular surgery, anterior ²	\$66
D3421	Apicoectomy/periradicular surgery, bicuspid (first root) ²	\$88
D3425	Apicoectomy/periradicular surgery, molar (first root) ²	\$88
D3426	Apicoectomy/periradicular surgery (each additional root) ²	\$28
D3430	Retrograde filling, per root ²	\$17

COVERED BENEFITS		MAXIMUM ALLOWABLE FEE
Periodontic procedures		
D4210	Gingivectomy or gingivoplasty, per quadrant ²	\$99
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces – per quadrant	\$28
D4260	Osseous surgery (<i>including flap entry and closure</i>) – four or more contiguous teeth or bounded teeth spaces, per quadrant ²	\$176
D4261	Osseous surgery (<i>including flap entry and closure</i>) – one to three contiguous teeth or bounded teeth spaces – per quadrant ²	\$44
D4341	Periodontal scaling and root planing – four or more teeth – per quadrant ²	\$23
D4342	Periodontal scaling and root planning – one to three teeth, per quadrant ²	\$11
Prosthodontics – removable		
D5110	Complete upper denture ¹	\$264
D5120	Complete lower denture ¹	\$264
D5130	Immediate upper denture ¹	\$264
D5140	Immediate lower denture ¹	\$264
D5211	Upper partial – resin base ¹	\$132
D5212	Lower partial – resin base ¹	\$132
D5213	Upper partial – cast metal base with resin saddles ¹	\$264
D5214	Lower partial – case metal base with resin saddles ¹	\$264
D5281	Removable unilateral partial denture – one piece cast metal ¹	\$88
D5410	Adjust complete denture, upper	\$11
D5411	Adjust complete denture, lower	\$11
D5421	Adjust partial denture, upper	\$11
D5422	Adjust partial denture, lower	\$11
D5510	Repair broken complete denture base	\$22
D5520	Replace missing or broken teeth complete denture, each tooth	\$8
D5610	Repair resin saddle or base	\$22
D5640	Replace tooth on denture, no other repair, each tooth	\$8
D5650	Add tooth to partial denture to replace extracted tooth, not involving clasps	\$9
D5660	Add clasp or rest to existing partial denture	\$9
D5710	Rebase complete upper denture	\$28
D5711	Rebase complete lower denture	\$28
D5720	Rebase partial upper denture	\$28
D5721	Rebase partial lower denture	\$28
D5730	Reline upper complete denture, chairside	\$28
D5731	Reline lower complete denture, chairside	\$28
D5740	Reline upper partial denture, chairside	\$28
D5741	Reline lower partial denture, chairside	\$28
D5750	Reline upper complete denture, laboratory	\$61
D5751	Reline lower complete denture, laboratory	\$61
D5760	Reline upper partial denture, laboratory	\$61
D5761	Reline lower partial denture, laboratory	\$61
D5820	Interim partial denture, anterior stayplate (<i>upper</i>) ¹	\$50
D5821	Interim partial denture, anterior stayplate (<i>lower</i>) ¹	\$50

COVERED BENEFITS		MAXIMUM ALLOWABLE FEE
Prosthodontics – fixed		
D6210	Pontic – cast high noble metal ¹	\$77
D6211	Pontic – cast predominantly base metal ¹	\$77
D6212	Pontic – cast noble metal ¹	\$77
D6214	Pontic – titanium	\$77
D6240	Pontic, porcelain fused to high noble metal ¹	\$138
D6241	Pontic, porcelain fused to predominantly base metal ¹	\$138
D6242	Pontic, porcelain fused to noble metal ¹	\$138
D6250	Pontic, resin with high noble metal ¹	\$94
D6251	Pontic, resin with predominantly base metal ¹	\$94
D6252	Pontic, resin with noble metal ¹	\$94
D6930	Recement fixed partial (<i>bridge</i>)	\$17
Oral surgery		
D7111	Extraction, coronal remnants – deciduous tooth ²	\$22
D7140	Extraction, erupted tooth or exposed root (<i>elevation and/or forceps removal</i>) ²	\$22
D7140	Extraction, erupted tooth or exposed root (<i>elevation and/or forceps removal</i>), each additional tooth when performed on the same visit as the first extraction ²	\$22
D7210	Surgical removal of erupted tooth ²	\$33
D7220	Removal of impacted tooth, soft tissue ²	\$44
D7230	Removal of impacted tooth, partially bony ²	\$55
D7240	Removal of impacted tooth, completely bony ²	\$66
D7241	Removal of impacted tooth, completely bony, complications ²	\$66
D7310	Alveoloplasty in conjunction with extractions, per quadrant ²	\$22
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	\$11
D7320	Alveoloplasty not in conjunction with extractions, per quadrant ²	\$44
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant ²	\$22
D7471	Removal of lateral exostosis (<i>maxilla or mandible</i>), per site ²	\$61
D7970	Excision of hyperplastic tissue, per arch ²	\$55
Adjunctive general services		
D9220	General anesthesia, first 30 minutes	\$28
D9310	Specialist consultation	\$20
D9430	Office visit, regular hours, no other service	\$20
D9440	Office visit, after hours, no other service	\$20

¹Subject to six-month waiting period

²Subject to three-month waiting period

Summary of benefits – Vision with PPO Plus coverage

THE FOLLOWING IS INTENDED AS A SUMMARY ONLY. THE POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

	PPO PLUS PLANS: VISION	
	In-Network You Pay	Out-of-Network You Pay
EXAM WITH DILATION AS NECESSARY Once every 12 months	\$10 copayment	All charges over \$45
EXAM OPTIONS (fit and follow-up) Standard contact lenses	Up to \$55	Not covered
Premium contact lenses	You receive a 10% discount off retail price	Not covered
FRAMES Once every 24 months	\$85 allowance	Not applicable
Any available frame at provider location	\$0 copayment, plus 80% off balance over allowance	All charges over \$45
STANDARD PLASTIC LENSES Single vision	\$25 copayment	All charges over \$43
Bifocal	\$25 copayment	All charges over \$58
Trifocal	\$25 copayment	All charges over \$70
Lenticular	\$25 copayment	All charges over \$125
Standard progressive lens	\$90 copayment	All charges over \$58
Premium progressive lens	\$90 copayment, plus 80% of charge less \$120 allowance	All charges over \$58
LENS OPTIONS UV treatment	You receive a 20% discount off retail price	Not covered
Tint (solid and gradient)	\$0 copayment	Not covered
Standard plastic scratch – Coating	You receive a 20% discount off retail price	Not covered
Standard polycarbonate – Adults	You receive a 20% discount off retail price	Not covered
Standard polycarbonate – Children under age 19	You receive a 20% discount off retail price	Not covered
Standard anti-reflective coating	You receive a 20% discount off retail price	Not covered
Other add-ons	You receive a 20% discount off retail price	Not covered
CONTACT LENSES Once every 24 months in lieu of eyeglass lenses (Contact lens allowance includes materials only.)	\$120 allowance	Not applicable
Conventional	\$25 copayment, plus 85% of charge over allowance	All charges over \$105
Disposable	\$25 copayment, plus balance over allowance	All charges over \$105
Medically necessary (requires pre-authorization)	\$25 copayment	All charges over \$250
LASER VISION CORRECTION LASIK or PRK from U.S. Laser Network	You receive 15% discount off retail price or 5% discount off promotional price	Not covered
ADDITIONAL PAIRS BENEFIT	You receive a 40% discount off complete (frames and lenses) pair eyeglass purchases and a 15% discount off conventional contact lenses once the benefit has been used.	Not covered

Dental and vision benefits are underwritten by Health Net Life Insurance Company. Dental benefits are administered by Dental Benefit Administrative Services. Vision benefits are administered by EyeMed Vision Care, LLC. Dental Benefit Administrative Services and EyeMed Vision Care, LLC are not affiliated with Health Net Life Insurance Company. For additional information on dental and vision coverage provided under the Plus option, see the Dental and Vision Summary of Benefits.

PART 2



NO-COST
EXTRAS

Decision Power:SM Health in Balance

Information, resources and support for every person, every stage of health

When you choose Health Net, you get more than health care coverage. You get Decision Power.⁵

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



**STAYING HEALTHY IS
JUST AS IMPORTANT
AS GETTING WELL.**

Making the most of your health is what Decision Power is all about. We're focused on your whole health, not just one concern or disease. So we work with you to identify potential health risks, and help prevent minor concerns from becoming big problems. And we're here should you face serious medical concerns.



**YOUR HEALTH, YOUR TIME.
YOUR CHOICE.**

Whether you ...

- have a question
- want help with a specific health goal
- need treatment but want to understand all your options
- are living with illness

...**you choose how and when** to use the information, resources and support available. You can use Decision Power online or by calling a Health Coach. Try multiple resources at once, or one at a time. 24 hours a day, seven days a week, Decision Power is here for you.



Log on to www.healthnet.com:

Take the health risk questionnaire (HRQ) – with its instant results and interactive features, the HRQ is your gateway to recommendations and resources based on your unique health profile.

Try a step-by-step plan for losing weight, stopping smoking or boosting nutrition. You can start with our online coaching and self-help tools. Phone coaching support is included so making lasting, healthy changes is easier.

Set up a Personal Health Record to track your health progress and have a complete medical snapshot whenever you need it.

Find support for any kind of mental health concern such as depression, excessive alcohol use, eating disorders, etc.

Be informed – access information resources, such as Healthwise® Knowledgebase, an online health encyclopedia; HEAR® Audio Library, which contains information on 355 health topics; and Health Crossroads® Web Modules, which explains the pros and cons of various treatments.

Know your numbers – with our health trackers (cholesterol, diet, fitness), treatment cost estimator and hospital comparison reports.

⁵Decision PowerSM is not part of Health Net's commercial medical benefit plans nor affiliated with Health Net's provider network and it may be revised or withdrawn without notice. Decision Power services, including Health Coaches, are additional resources that Health Net makes available to enrollees of Health Net Life Insurance Company.

Talk to a Health Coach to get:

1-to-1 consultations and a single point of contact for any and every health question, goal or situation. You can talk to the same Health Coach every time you call, and about any health goal or challenge.

Steps to avoid cardio-metabolic risk – the combination of three or more of the six risk factors (e.g., waist size, blood pressure, HDL cholesterol level) that predict diabetes, heart disease and colon, uterine and prostate cancers.

24-hour answers to health questions or concerns. Always call 9-1-1 or go straight to the emergency room in a life-threatening situation.

Pointers for setting achievable health goals; guidance on evaluating treatment options.

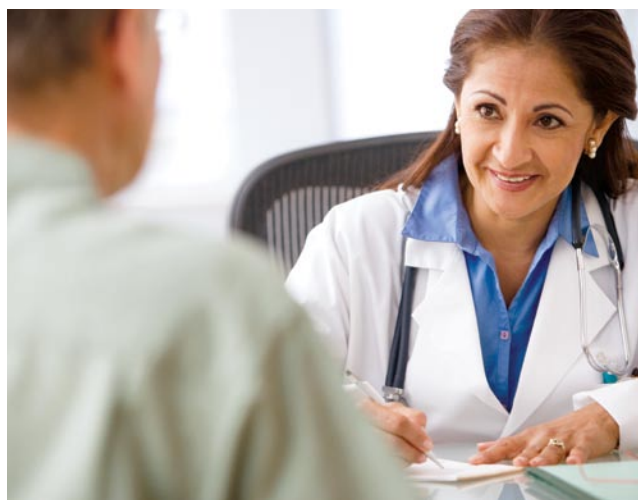
Guidance and support for living with an ongoing illness such as asthma, diabetes, heart disease, etc.

Specialized consultation from nurse case managers to help both patients and family members deal with the complexity of end-stage illnesses.



DOCTOR-PATIENT CONNECTION.

Doctors know medicine. You know your body. With Decision Power, it's easy to learn what questions to ask, how to explain your preferences and to get the support you need from your doctor. The more you know, the easier it is to navigate complicated health choices and make the ones that are right for you.



Decision Power – use it whenever and as often as you like.
Because when it comes to your health,
there's more than one right answer.

SELF-SERVICE AT WWW.HEALTHNET.COM

Once you enroll with Health Net, you'll have a go-to online source for your health plan and easy way to get more of your to-do list done fast: www.healthnet.com.

MY HEALTH NET: AT YOUR FINGERTIPS

You'll find the information you use or need most in your personal "My Health Net" menu that takes you where you want to go in just one mouse click.

PROVIDER SEARCH MADE SIMPLE

Find a specific doctor, locate the nearest hospital or search for the services you need with our search engine. Plus, you can get visual maps that show the precise location of the office or hospital.

QUICK LINKS: CLICK & GO

Order ID cards. Find a nearby pharmacy. Use Decision Power. You can do all this and more using the Quick Links featured on the left of every page.



PART 3



APPLYING FOR HEALTH NET COVERAGE

Take a test drive

Want to know more before you choose Health Net? We would too if we were you. So come on over to www.healthnet.com and take a look around. You can:

- **Compare Plan Costs** – quickly estimate your family's annual health care costs for different plan options.
- **Search Our Doctor Network** to see if your current doctor is included, or find one close to home or work.

- **View Our Drug List** to see what brand name and generic medications we cover, learn about our pharmacy services, and find answers to commonly asked questions.

If you have specific questions, please let us know. A member of our friendly, knowledgeable customer service staff is available to assist you Monday through Friday. Just call your broker or 1-800-909-3447, option 2.

How to apply – 3 easy steps to a better decision

Applying for Health Net medical, dental, vision or life insurance coverage is as easy as, well, 1-2-3:

1 Apply online or through your authorized broker.

Online: www.healthnet.com > Enroll Now

Note that the application MUST be completed, signed and dated by the applicant even if you're working with a broker. Neither the broker nor any other person may complete the Statement of Health or sign the application and agreement on behalf of the applicant(s).

After your application is complete:

- Include payment for the applicable premium amount by check, automatic bank draft or credit card.

- Mail the completed application and check (within 30 days of the date you signed the application) to your agent or directly to Health Net:

Health Net
Individual & Family Plans
Post Office Box 1150
Rancho Cordova, CA 95741-1150

2 Look for your ID card and plan materials in the mail.

3 Enjoy the benefits of membership – big networks, personal service and ground-breaking wellness resources.

If you have any questions, please call your authorized broker or Health Net at 1-800-909-3447, option 2.

Easy. Affordable.
Health Net.

Important things to know about your medical coverage

Who is eligible?

To be eligible for Health Net Individual & Family PPO, you must: be under the age of 65, not be eligible for Medicare, reside continuously in our service area, and meet our application and underwriting requirements for coverage.

In addition, your spouse or domestic partner, if under age 65, and all your unmarried dependent children under 19 years of age also are eligible (subject to underwriting requirements; the NetFirst and ValueNet plans are available to applicant only). 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 Applicant meets all domestic partnership requirements under California law or another recognized state or local agency. The Domestic Partner and Applicant 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 are persons of the same sex who have validly formed a legal union other than marriage in a jurisdiction outside of California which is substantially equivalent to a Domestic Partnership as defined under California law.

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

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

To qualify for a HIPAA plan, you must meet the following requirements:

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

If you want to find out if you qualify, contact us so that we can determine your eligibility and tell you about the available HIPAA plans. If you believe your rights under HIPAA have been violated, please contact the California Department of Insurance at 1-800-927-HELP (4357) or TDD 1-800-482-4833 or visit their website at <https://interactive.web.insurance.ca.gov/contactCSD/contactUs.jsp>

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. You can choose to pay monthly by check, Automatic Bank Draft (ABD) or credit card. A Simple Pay Option form will need to be completed and submitted to Health Net to set up ABD or payment by credit card. If there are changes to the Health Net Individual & Family PPO Policy, including changes in benefits, you will be notified at least 30 days in advance.

Are there any renewal provisions?

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

Does Health Net coordinate benefits?

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

Does Health Net cover the cost of participation in clinical trials?

Routine patient care costs for patients diagnosed with cancer who are accepted into phase I, II, III or IV clinical trials are covered when Medically Necessary, recommended by the Insured's treating Physician and authorized by Health Net. The Physician must determine that participation has a meaningful potential to benefit the Insured and the trial has therapeutic intent. For further information, please refer to the PPO Policy.

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 Life. Health Net Life and each of its

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

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

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

Serious emotional disturbances of a child is when a child under the age of 18 has one or more mental disorders identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance abuse disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following: (a) as a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home, or (ii) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year; (b) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; and/or (c) the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Footnotes for pages 10-15

¹Deductible waived for the first 2 visits of any combination of Professional Services and Preventative Care. Additional visits are covered with coinsurance after deductible.

²Certain services require prior certification from Health Net. Without prior certification, benefit is reduced by 50%. Refer to the Policy for details.

³For preventive health purposes, an annual preventive physical exam is covered based on recommendations published by the U.S. Preventive Services Task Force; one mammogram covered every calendar year.

⁴Treatment of non-severe mental disorders is limited to 20 outpatient visits and 30 inpatient days per calendar year. Refer to the applicable Policy for maximum allowable amounts.

⁵The recommended Drug List is a list of prescription drugs that are covered by this plan. Some drugs require prior authorization from Health Net. For a copy of the Recommended Drug List, go to Health Net's website. Refer to the Policy for complete information on prescription drugs.

⁶Copayment does not apply once annual out-of-pocket maximum is met.

⁷Copayment continues to apply after annual out-of-pocket maximum is met.

⁸Prescription drug charges do not apply to your maximum out-of-pocket limit. Brand deductible per person, if applicable, is in addition to the medical deductible and must be paid for prescription drug covered services before Health Net begins to pay.

⁹Subject to six-month waiting period.

¹⁰Subject to three-month waiting period.

Health Net
Individual & Family Plans
Post Office Box 1150
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NetFirst, ValueNet, BalanceNet and Optimum Advantage HSA insurance plans (Policy Form #P30601 CA 4/09) are underwritten by Health Net Life Insurance Company.

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HEALTH NET PPO INSURANCE PLANS

Outline of Coverage and Exclusions and Limitations



Health Net®
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Outline of coverage

Health Net Life Insurance Company Individual & Family Health Insurance Plans major medical expense coverage

READ YOUR POLICY CAREFULLY

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

MAJOR MEDICAL EXPENSE COVERAGE

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

PRINCIPAL BENEFITS AND COVERAGES

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

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

REPRODUCTIVE HEALTH SERVICES

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

LIFETIME MAXIMUM AND COST SHARING

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

CERTIFICATION (PRIOR AUTHORIZATION OF SERVICES)

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

EXCLUSIONS AND LIMITATIONS

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

- Services or supplies that are not medically necessary.
- Any amounts in excess of the maximum amounts specified in the Policy.
- Pregnancy or maternity services, except as specified in the Policy.
- Cosmetic surgery except as specified in the Policy.

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

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

- Developmental articulation and language disorders.
- However, some of the above conditions shall be covered as shown in the “Schedule of Benefits” section, if Medically Necessary as described in the definitions of “Serious Emotional Disturbances of a Child” and/or “Severe Mental Illness,” and continuous functional improvement in response to the treatment plan is demonstrated by objective evidence.
- Outpatient speech therapy, except as specified in the Policy.
- Services and supplies obtained while in a foreign country with the exception of Emergency Care.
- Home birth.
- Reimbursement for services for which the Covered Person is not legally obligated to pay the provider in the absence of insurance coverage.
- Physical exams for insurance, licensing, employment, school or camp. Any physical, vision or hearing exams that are not related to diagnosis or treatment of illness or injury, except as specifically stated in the Policy.
- Amounts charged by out-of-network providers for covered medical services and treatment that Health Net Life determines to be in excess of the covered expense.
- Treatment of chronic alcoholism, drug addiction and other chemical dependency problems, including detoxification services, except as specifically stated in the Policy.
- Any expenses related to the following items, whether authorized by a physician or not: (a) alteration of the Covered Person’s residence to accommodate the Covered Person’s physical or medical condition, including the installation of elevators; (b) corrective appliances, except prosthetics, casts and splints; (c) air purifiers, air conditioners and humidifiers; and (d) educational services or nutritional counseling, except as specifically provided in the Policy.
- Disposable supplies for home use.
- Services performed by a person who lives in the Covered Person’s home or who is related to the Covered Person by blood or marriage.

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

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

PRE-EXISTING CONDITIONS

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

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

RENEWABILITY OF THIS POLICY

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

PREMIUMS

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

LOSS RATIO

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

Covered services and supplies, exclusions and limitations

Dental and Vision PPO plus coverage

IMPORTANT INFORMATION

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

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

LIMITATIONS TO COVERED SERVICES AND SUPPLIES

1. Type I: Preventive and diagnostic dental services

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

- a) Initial or periodic oral exams, limited to two per 12-month period. Initial exams will be limited to the allowance for a periodic exam.
- b) Intraoral complete series X-rays, including 4 bitewings and up to 14 periapical X-rays, or panoramic film with 4 bitewings, either is limited to one per 36-month period and no payment for any combination of films shall exceed the amount determined for a complete series of X-rays.
- c) Bitewing X-rays series (two or four films), limited to one per 12-month period.
- d) If an intraoral complete or panoramic X-ray with bitewings has not been provided in a 36-month period, then a panoramic film without bitewings is a benefit and is limited to one per 36-month period.
- e) Intraoral periapical X-rays, limited to four films per 6-month period when performed as a separate procedure from a complete series of X-rays.

- f) Intraoral occlusal X-rays, limited to two films per 12-month period.
- g) Extraoral X-rays, limited to two films per 12-month period.
- h) Bitewing X-rays are not covered within a 12-month period from the date of an intraoral complete series X-rays.
- i) Dental prophylaxis (cleaning and scaling), limited to two per 12-month period.
- j) Topical fluoride treatment is limited to one per 12-month period for Dependent children under age 16.
- k) Sealants are limited to one application to an unrestored permanent first or second molar tooth per 36-month period for Dependent children under age 14.
- l) Space maintainers for primary teeth (limited to initial appliance only), including all adjustments and recementation made within 6 months of installation, limited to dependent children under age 14.
- m) Emergency oral exams.
- n) Limited oral evaluation, problem focused.

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

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

- a) Pulpotomy.
- b) Root canal therapy. Reimbursement includes pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care, limited to one time on the same tooth.
- c) Root canal retreatment. Reimbursement includes pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care performed not less than 12 months after the initial therapy, limited to one time on the same tooth per 12-month period.
- d) Apicoectomy/periradicular surgery (anterior, bicuspid, molar, each additional root), paid as a separate benefit only if services are performed not

less than 12 months after the initial root canal therapy is completed. Reimbursement includes pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.

- e) Periodontal scaling and root planing (per quadrant), limited to one time per quadrant per 24-month period and only if not performed on the same date of service as a prophylaxis or any other periodontal procedure.
- f) For non-surgical periodontal procedures that are quadrant based and when there are less than 5 teeth remaining in the quadrant and the need for treatment is indicated, as determined by Health Net Life, payment will be provided at 50 percent of the full quadrant rate. A maximum of 2 quadrants of periodontal procedures will be paid on the same date of service unless supported with documentation for medical need.
- g) For surgical periodontal procedures that are quadrant based and when there are less than 3 teeth requiring treatment, as determined by Health Net Life, payment will be provided at 50 percent of the full quadrant rate. A maximum of 2 quadrants of periodontal procedures will be paid on the same date of service unless supported with documentation for medical need.
- h) Periodontal surgery related services as listed below, limited to:
 - One (1) time per quadrant of the mouth in any 36-month period with charges combined for gingivectomy, gingival curettage, or osseous surgery performed in the same quadrant within the same 36-month period.
- i) Oral surgery services as listed below, including an allowance for local anesthesia and routine postoperative care:
 - Simple extraction;
 - Surgical extractions of erupted or impacted teeth;
 - Alveoloplasty; and
 - Excision of hyperplastic tissue – per arch.

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

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

- k) Specialist consultation.

3. Type II: Basic dental services (Restorative)

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

- a) Amalgam restorations inclusive of any etching and bonding, limited as follows:
 - Multiple restorations (surfaces) on a single tooth are combined for coverage purposes.
 - Benefits for the replacement of an existing amalgam restoration will only be considered for payment if at least 12 months have passed since the existing amalgam restoration was placed.
 - Acid etch is not covered as a separate procedure.
- b) Composite restorations inclusive of any etching and bonding, limited as follows:
 - Multiple restorations (surfaces) on a single anterior tooth are combined for coverage purposes.
 - Acid etch is not covered as a separate procedure.
 - Benefits for the replacement of an existing anterior composite restoration will only be considered for payment if at least 12 months have passed since the existing anterior composite restoration was placed.
 - Benefits for composite resin restorations on posterior teeth (behind the second bicuspid) will be based on the allowance for the corresponding amalgam restoration.
- c) Stainless steel crowns are limited to one per tooth per 36-month period for members age 19 and under for teeth not restorable by an amalgam or composite filling.

4. Type III: Major dental services

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

- a) Inlays and onlays:
 - Are covered only when the tooth cannot be restored by an amalgam filling.
 - Are covered only if more than 5 years have elapsed since last placement; and
 - Limited to persons age 19 and above.
 - Composite or porcelain is not covered on molar teeth.
- b) Porcelain substrate or metal crowns:
 - Porcelain or porcelain fused to metal crowns are not covered on molar teeth.
- c) Crowns:
 - Are covered only when the tooth cannot be restored by an amalgam or composite filling.
 - Are covered only if more than 5 years have elapsed since last placement; and
 - Limited to persons over age 19.
- d) Crown build-up, including pins and pre-fabricated posts. (Current periapical X-ray and narrative should indicate insufficient remaining tooth structure. Coverage is subject to determination of dental necessity.)
- e) Post and core, covered only for endodontically treated teeth requiring crowns.
- f) Full dentures, 1 time per arch, limited as follows:
 - Replacement dentures are covered only if:
 1. Five (5) years have elapsed since last placement and the denture cannot be made serviceable; and
 2. Two (2) years have elapsed after the member's effective date of coverage under the Dental Plan.
- g) Health Net Life will not pay additional benefits for personalized dentures or overdentures and associated treatment.
- h) Partial dentures, including any clasps and rests and all teeth, 1 partial per arch, limited as follows:
 - Replacement partial dentures are covered only if:
 1. Five (5) years have elapsed since last placement (please refer to the Denture or Bridge Replacement/Addition provision for exceptions) and the partial denture cannot be made serviceable; and
 2. Two (2) years have elapsed after the member's effective date of coverage under the Dental Plan.
- i) There is no benefit for precision or semi-precision attachments.
- j) Each additional clasp and rest.
- k) Full or partial dentures, adjustments limited to one time per arch in any 12-month period following the initial 6-month denture placement period.
- l) One repair per arch to full or partial dentures and bridges limited to repairs performed more than 12 months after the initial insertion; repairs are limited to those resulting from normal wear and to one repair every 12 months.
- m) Relining or rebasing dentures, limited to:
 - One (1) time per arch per 36-month period; and
 - For standard dentures, when done within 12 months or the insertion of the denture.
 - For immediate dentures, when done within 6 months after the insertion of the denture.
- n) Stayplates (temporary partial dentures) are limited to the replacement of anterior teeth and only during the healing phase following extractions.
- o) Benefits for the replacement of an existing fixed partial denture are payable only if the existing bridge:
 1. Is more than 5 years old (see the Denture or Bridge Replacement/Addition provision for exceptions);
 2. Cannot be made serviceable; and

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

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

5. Denture or bridge replacement/addition

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

- a) Five (5) years have elapsed since last replacement of the denture or bridge;
- b) The denture or bridge cannot be made serviceable;
- c) The denture or bridge was damaged while in the member's mouth when an injury was suffered while insured under the Policy, and it cannot be made serviceable; and
- d) Two (2) years have elapsed after the member's effective date of coverage under the Dental Plan. However, the following exceptions will apply:
 - Benefits for the replacement of an existing partial denture that is less than 5 years old will be covered if there is a dentally necessary extraction of an additional functioning natural tooth and the partial denture cannot be made serviceable.
 - For an existing fixed partial denture that is less than 5 years old, and an existing abutment or a functioning natural tooth within the same arch is extracted, the covered benefit will be a partial denture.

6. Missing teeth limitation

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

- a) The initial placement of full or partial dentures will be considered a covered dental charge if the placement includes the initial replacement of a

functioning natural tooth extracted while the member is insured under the Policy.

- b) The initial placement of a fixed partial denture will be considered a covered dental charge if the placement includes the initial replacement of a functioning natural tooth extracted while the member is insured under the Policy. However, the following restrictions will apply:
 - Benefits will only be covered for the replacement of the teeth extracted while the member is covered under the Policy and the replacement is furnished within 12 months of the date the tooth was first extracted.
 - Benefits will not be covered for the replacement of other teeth that were missing on the member's effective date. Please refer to the Type III: Major Dental Services section of the Policy for further information.

General exclusions

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

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

6. Implants, related procedures or services involving root form implants.
7. Grafting (bone or tissue) and guided tissue regeneration.
8. Prescription drugs or any medications are not covered.
9. Services, procedures or supplies for which a charge would not have been made in the absence of insurance.
10. Procedures, services or supplies for which the member does not have to pay, except when payment of such benefits is required by law and then only to the extent required by law.
11. Treatment will be considered a covered service and supply only when the member is eligible for services on the date treatment is started. Payment is based on the start date.
12. Services and supplies obtained while outside the United States, except for emergency dental care.
13. Orthodontic services, supplies, or oral surgery procedures for the purposes of orthodontic treatment, inclusive of extractions.
6. Medical or surgical treatment of the eye including, but not limited to, Laser In Situ Keratomileusis (LASIK) and Photorefractive Keratectomy (PRK).
7. Prescription or non-prescription medications.
8. Any eye examination or any corrective eyewear required as a condition of employment.
9. Services or materials which the company determines to be experimental, cosmetic or not medically necessary.
10. Any service or material not prescribed by an ophthalmologist, optometrist or registered dispensing optician.
11. Services and materials furnished in conjunction with excluded services and materials.
12. Services and materials for repair or replacement of broken, lost or stolen lenses, contact lenses or frames.
13. Services and materials that a Covered Person received during a service interval under any other plan offered by the company or one of the company's affiliates.
14. Charges incurred before a Covered Person's effective date of coverage under the Policy or after such coverage terminates.
15. Services or materials received as a result of disease, defect or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
16. Services and materials obtained while outside the United States, except for emergency vision care.
17. Services or materials resulting from or in the course of your or a dependent's regular occupation for pay or profit for which you or your dependent is entitled to benefits under any Worker's Compensation law, employer's liability law or similar law. You must promptly claim and notify the company of all such benefits.

VISION

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

1. Charges for procedures, services or materials that are not included as covered charges.
2. Any portion of a charge in excess of the maximum benefit allowance.
3. Expenses for any non-standard corrective lens materials, including but not limited to the following: coated, dyed, glass lens tints or laminated lenses, blended, or oversize lenses, occupational or recreational lenses, polycarbonate, safety glasses, scratch resistant, UV protection, anti-reflective, or photochromatic/photosensitive lenses.
4. Non-prescription lenses.
5. Orthoptics, vision training and low vision aids and any associated supplemental testing.

18. As follows:

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

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

Prior authorization

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

PPO insurance plans are underwritten by Health Net Life Insurance Company.
Dental and vision benefits are underwritten by Health Net Life Insurance Company. Dental benefits are administered through Dental Benefit Administrative Services.
Vision benefits are administered by EyeMed Vision Care, LLC.

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