Health Net Guaranteed Issue

Individual & Family HMO and PPO

Coverage Summary of Benefits

Effective February 1, 2005

Health Net Guaranteed Issue & Individual & Family Coverage

The federal Health Insurance Portability and Accountability Act of 1996 (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 requirements outlined under "Important things to know about all your coverage options," "Who is eligible?" 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 and 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. In response, Health Net of California, Inc. offers the HMO 15 and HMO 40 plans, and Health Net Life Insurance Company, Inc. offers the PPO Value Basic 500 and PPO Value 30 coverage options, to eligible individuals at the Guaranteed Issue Rates listed at the end of this Disclosure Form.

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.

This document is only a summary of your health coverage. You have the right to view the Plan Contract and Evidence of Coverages (EOC) for HMO Plans 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 or Policy, which you will receive after you enroll, contains the terms and conditions, as well as the governing and exact contractual provisions, of your Health Net coverage. It is important for you to carefully read this document and your Plan Contract and EOC or Policy thoroughly once received, especially all sections that apply to those with special health care needs. Health benefits and coverage matrices on pages 6 to 13 are included to help you compare coverage benefits.

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

Understanding your coverage choices

What is an HMO?

With an HMO, you select your Primary Care Physician from our Individual & Family Plan HMO network (for information on available providers, see our Individual & Family Plan HMO provider listing, call us at 1-800-909-3447 or visit our website). Your Primary Care Physician oversees all your health care and provides the referral/authorization if specialty care is needed. Primary Care Physicians include general and family practitioners, internists, pediatricians and OB/GYNs. A Primary Care Physician's office is just like any other private doctor's office. When you need to see your doctor, just call for an appointment. To obtain health care, simply present your ID card and pay the appropriate copayment.

Your Primary Care Physician 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 Primary Care Physician.

HMO advantages include:

- No paperwork or claim forms
- Emergency care covered worldwide
- Set copayments for office visits and prenatal, postnatal and newborn care
- Hospital coverage
- No charge for X-ray and laboratory services
- Prescription coverage

Out-of-Pocket Maximum

See the "Principal Benefits and Coverage Matrix—HMO" section for specific information about the out-of-pocket maximum and deductibles for the Guaranteed Issue Plan. The copayments and the calendar year inpatient hospital services deductible that you or your family members pay for covered services apply toward the individual or family out-of-pocket maximum. After you or your family members meet your individual or family out-of-pocket maximum, 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 out-of-pocket maximum, the remaining enrolled family members must continue to pay the copayments and the calendar year deductible for inpatient hospital facility services until either (a) the aggregate of such copayments and deductibles paid by the family reaches the family out-of-pocket maximum or (b) each enrolled family member individually satisfies the individual out-of-pocket maximum. 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 Member's out-of-pocket maximum. See the "Principal Benefits and Coverage Matrix—HMO" section for specific information about which amounts do not apply toward the out-of-pocket maximum. Payments for services not covered by this plan will not be applied to this yearly out-of-pocket maximum. In order for the family out-of-pocket maximum to apply, you and your family must be enrolled as a family unit.

What is a PPO?

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

PPO advantages include:

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

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

Principal benefits and coverage matrix — HMO
THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PLAN CONTRACT AND EVIDENCE OF COVERAGE (EOC) SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Benefit description	HMO 15	HMO 40
Deductibles	$1,000 per calendar year for inpatient hospital services only (prescription drug coverage deductible also applies)[1]	$1,500 per calendar year for inpatient hospital services only (prescription drug coverage deductible also applies)[1]
Lifetime maximums	Unlimited	Unlimited
Out-of-Pocket Maximum (Payments for services not covered by this plan will not be applied to this yearly out-of-pocket maximum)	$3,000 single/ $6,000 family (Includes deductible)	$3,000 single/ $6,000 family (Includes deductible)
Professional services		
Visit to physician	$15	$40
Specialist consultations	$15	$40
Prenatal and postnatal office visits	$15	$40
Preventive Care		
Periodic health evaluations[2]	$15	$40
Vision screenings and exams	$15	$40
Hearing screenings and exams	$15	$40
Immunizations – Standard	$15	$40
Immunizations – To meet foreign travel or occupational requirements	20%	20%
Prostate cancer screening and exam	$15	$40
Annual OB/GYN exam (breast and pelvic exams, cervical cancer screening & mammography)[3]	$15	$40
Allergy testing	$15	$40
Allergy injection services	$15	$40
All other injections	Covered in full	Covered in full
Allergy serum	Covered in full	Covered in full
Outpatient services		
Outpatient services other than surgery	Covered in full	Covered in full
Outpatient surgery	$250	$250
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	$1,500 deductible applies per calendar year for inpatient services
Surgeon or assistant surgeon services	Covered in full	Covered in full
Skilled nursing facility stay (limited to 100 days per calendar year)	$50 per day	$50 per day
Maternity care in hospital or skilled nursing facility	$0 after inpatient hospital services deductible is met	$0 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	Covered in full
Emergency health coverage		
Emergency room (professional and facility charges)	$75 (waived if admitted to hospital)	$100 (waived if admitted to hospital)

Benefit description	HMO 15	HMO 40
Urgent care center (professional and facility charges)	$25	$40
Ambulance services		
Ground ambulance	$50	$80
Air ambulance	$50	$80
Prescription drug coverage $100 calendar year deductible per member applies [1,4,5,6]		
Prescription drugs filled at a participating pharmacy (up to a 30-day supply) [1]	$15 Level I (primarily generic); $25 Level II (primarily brand name); $50 Level III (drugs not on the Recommended Drug List)	$15 Level I (primarily generic); $25 Level II (primarily brand name); $50 Level III (drugs not on the Recommended Drug List)
Prescription drugs filled through mail order (up to a 90-day supply)[1]	$30 Level I (primarily generic); $50 Level II (primarily brand name); $100 Level III (drugs not on the Recommended Drug List)	$30 Level I (primarily generic); $50 Level II (primarily brand name); $100 Level III (drugs not on the Recommended Drug List)
Diabetic supplies (including but not limited to pen delivery systems, blood glucose monitoring strips, Insulin needles and syringes; lancets will be dispensed at no charge. Diabetic supplies are not subject to the prescription drug deductible. See Diabetic supplies under "Other" for additional benefit information.)	$25	$25
Diabetic prescription medications (including but not limited to Insulin and glucogon) [1]	$25	$25
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 support program. For information regarding smoking cessation behavioral support programs available through Health Net, contact Member Services at the telephone number on your Health Net ID Card or visit the Health Net website at www.healthnet.com) [1]	50%	50%
Contraceptive drugs[1]	$15 Level I (primarily generic); $25 Level II (primarily brand name); $50 Level III (drugs not on the Recommended Drug List)	$15 Level I (primarily generic); $25 Level II (primarily brand name); $50 Level III (drugs not on the Recommended Drug List)
Durable medical equipment		
Durable medical equipment	50%	50%
Prosthetic devices	Covered in full	Covered in full

Benefit description	HMO 15	HMO 40
Mental Health services for severe mental illness and serious emotional disturbances of a child conditions [7]		
Outpatient	$15	$40
Inpatient	$1,000 deductible applies per calendar year to inpatient services	$1,500 deductible applies per calendar year to inpatient services
Mental Health services for nonsevere mental illness [7]		
Outpatient	$30	$40
Inpatient	$1,000 deductible applies per calendar year to inpatient services	$1,500 deductible applies per calendar year to inpatient services
Chemical dependency services		
Chemical dependency treatment	Not covered	Not covered
Acute care (detoxification)	$100 per day (unlimited; subject to inpatient services calendar year deductible)	$100 per day (unlimited; subject to inpatient services calendar year deductible)
Home health services		
Home health services (100 visits per calendar year maximum; limited to three visits per day, four-hour maximum per visit)	$15	$40
Other		
Diabetic equipment (includes blood glucose monitors, Insulin pumps, and podiatric devices). See Diabetic supplies under "Prescription drug coverage" for additional benefit information.	$25	$25
X-ray and laboratory procedures	Covered in full	Covered in full
Rehabilitative therapy (includes physical, speech, occupational, and respiratory therapy)	$15	$40
Sterilizations – Vasectomy	$150	$150
Sterilizations – Tubal ligation	$150	$150
Organ and bone marrow transplants (non-experimental and non-investigational)	Covered in full	Covered in full
Hospice services	Covered in full	Covered in full
Family planning counseling	$15	$40

1 Does not apply to the Out-of-Pocket Maximum.

2 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.

3 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.

4 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) are not excluded from coverage, but do require prior authorization from Health Net. 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 Member Services at the number listed on your ID card or visit our website at www.healthnet.com.

5 If the usual and customary charge is less than the applicable copayment, then you will pay the usual and customary charge.

6 The prescription drug calendar year deductible (per member) must be paid for prescription drug covered services before Health Net begins to pay. Prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's usual and customary charge for covered prescription drugs.

7 See page 17 for definitions of severe mental illness or serious emotional disturbances of a child. Treatment of non-severe mental disorders is limited to 20 outpatient visits and 30 inpatient days per calendar year.

Principal benefits and coverage matrix — PPO
THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Benefit Description	PPO Value Basic 500		PPO Value 30	
	In-Network Provider[1]	**Out-of-Network Provider[2]**	**In-Network Provider[1]**	**Out-of-Network Provider[2]**
Annual deductible (family deductible is met when two family members meet their individual deductibles)	**$500**		**$2,500**	
Annual out-of-pocket maximum (family maximum is met when two family members meet their individual annual out-of-pocket maximums)	$3,500 single/ (includes calendar year deductible combined in-and-out-of-network)		$4,500 single/ (includes calendar year deductible)	
Non-preferred providers (family maximum is met when two family members meet their individual annual out-of-pocket maximums)	$3,500 single/ (includes calendar year deductible combined in-and-out-of-network)		$10,000 single	
Lifetime Maximum	$6 million		$6 million	
Visit to physician	$30[3, 4]	50%[4]	$30[3]	50%
X-ray and laboratory procedures[5]	Negotiated fee until out-of-pocket maximum is met, then covered in full	No benefits until out-of-pocket maximum is met, then covered in full	30%	50%
Preventive care				
Adult preventive care (age 19 and older)				
Routine physical exams, including routine lab and X-ray services	Not covered	Not covered	$60[3]	Not covered
Annual OB/GYN exam (breast and pelvic exams, cervical cancer screening and mammography)[6]	$30[3, 4]	Not covered	$30[3]	Not covered
Prostate cancer screening and exam	$30[3, 4]	Not covered	$30[3]	Not covered
Child preventive care (newborns to age 18); checkups, vision and hearing exams	$30[3, 4] additional $30 copay is required for each immunization	Not covered	$30[3]	Not covered

Summary of Benefits continued

Benefit Description	PPO Value Basic 500		PPO Value 30	
	In-Network Provider[1]	Out-of-Network Provider[2]	In-Network Provider[1]	Out-of-Network Provider[2]
Maternity and pregnancy[5]				
Prenatal and postnatal office visits	Not covered	Not covered	30%	50%
Maternity care in hospital	Not covered	Not covered	30%	50%[7]
			$250 per-admission copay [13]	
Emergency and urgent care				
Emergency room (professional and facility charges)[11]	$60 copay plus 20%	$60 copay plus 20%	$60 copay plus 30%[12]	$60 copay plus 30%[12]
Urgent care center (facility charges)[3,11]	$30 copay plus 20%	$30 copay plus 20%	$30 copay plus 30%[12]	$30 copay plus 30%[12]
Ambulance[5]	20%	20%	30%	30%
Hospitalization services (non-emergency care)[5]				
Surgeon and anesthetics services	Negotiated fee until out-of-pocket maximum is met, then covered in full	No benefits until out-of-pocket maximum is met, then covered in full	30%	50%
Inpatient, semiprivate hospital room or intensive care unit with ancillary services (unlimited, except for mental health and substance abuse treatment)	20%	50%[7]	30%	50%[7]
	$250 per-admission copay [13]		$250 per-admission copay [13]	
Outpatient surgery (hospital or outpatient surgery center charges only)	20%	50%	30%	50%
	$250 copay [13]		$250 copay [13]	
Outpatient facility services	20%	50%[7]	30%	50%[7]
Reproductive health				
Sterilization	Negotiated fee until out-of-pocket maximum is met, then covered in full	No benefits until out-of-pocket maximum is met, then covered in full	30%	not covered
Other services				
Rehabilitative therapy (includes physical, speech, occupational, respiratory and cardiac therapy) [5]	Not covered	Not covered	30%	50% ($25 maximum payable per visit)
			20 visits per calendar year combined in-and-out-of-network	

Summary of Benefits continued

Benefit Description	PPO Value Basic 500		PPO Value 30	
	In-Network Provider[1]	Out-of-Network provider[2]	In-Network Provider[1]	Out-of-Network provider[2]
Chiropractic care (12-visit calendar year maximum combined in- and out-of-network/$20 maximum payable per visit)	50%	Not covered	50%	Not covered
Mental health services for severe conditions [5,8,13]	$250 per-admission copay plus 20% inpatient / $30 outpatient [3, 4]	$250 per-admission copay plus 50% inpatient[7]/50% outpatient [4]	$250 per-admission copay plus 30% inpatient / $30 outpatient [3]	$250 per-admission copay plus 50% inpatient[7]/50% outpatient
Mental health services for nonsevere conditions [5,8]	$250 per-admission copay plus 20% inpatient / 20% outpatient [4]	$250 per-admission copay plus 50% inpatient / not covered outpatient	$250 per-admission copay plus 30% inpatient / 30% outpatient	$250 per-admission copay plus 50% inpatient / not covered outpatient
Durable medical equipment (including foot orthotics) [5]	50% ($500 calendar year maximum)	Not covered	50%	Not covered
Outpatient prescription drugs[9]				
Filled at participating pharmacy (up to a 30-day supply); not covered at non-participating pharmacies	$100 deductible then $15 Level I (generic); $35 Level II (brand); $50 Level III (non-formulary) $1,000 maximum per calendar year	Not covered	$100 deductible then $15 Level I (generic); $35 Level II (brand); $50 Level III (non-formulary)	Not covered
Filled through mail order (up to a 90-day supply)	$100 deductible then $30 Level I (generic); $70 Level II (brand)); $100 Level III (non-formulary) $1,000 maximum per calendar year	Not covered	$100 deductible then $30 Level I (generic); $70 Level II (brand)); $100 Level III (non-formulary)	Not covered

1 Of negotiated rate, the rate the Participating or Preferred Provider has agreed to accept for providing a covered service.
2 Percentage is a portion of the covered expense based on (C & R) Customary & Reasonable. You are also responsible for any charges in excess of the covered expense.
3 Calendar year deductible waived.
4 Two-visit maximum per year per adult, four-visit maximum per year per child (visits are combined in- and out-of-network). After the visit maximums are satisfied no additional benefit payments will be made for the remainder of the calendar year. In addition, benefits exceeding visit limitation will not apply to the out-of-pocket maximum.
5 Certain services require prior certification from Health Net. Without prior certification, benefit reduced by 50%. Refer to page 26.
6 One mammogram for ages 35-39, one every 24 months for ages 40-49, and one every year for age 50 and older.
7 Maximum allowable charges are $600 per day.

8 See page 17 for definitions of severe mental illness or serious emotional disturbances of a child. Treatment of non-severe mental disorders is limited to Participating or Preferred Providers for outpatient services, with the following maximums: 20 outpatient visits, $30 maximum payable per outpatient visit; 30 inpatient days per calendar year; and a maximum allowable limit per day for inpatient services of $300. Covered expenses for non-severe mental illness and chemical dependency do not apply to the out-of-pocket maximum.

9 Pharmacy deductible is separate from the medical deductible. The Recommended Drug List is a list of the prescription drugs that are covered by this plan. It is prepared by Health Net and given to Member physicians and participating pharmacies. Some drugs require prior authorization from Health Net. Also, if your condition requires the use of a drug that is not in the Recommended Drug List, your physician may request the drug through the prior authorization process. Urgent prior authorization requests are handled within 72 hours. For a copy of the Recommended Drug List, call Member Services at the number listed on your ID card or visit our web site at www.healthnet.com. Prescription drug charges do not apply to your maximum out-of-pocket limit.

10 X-ray and laboratory procedures are subject to the calendar year deductible when not provided and coded in relation to an annual routine physical exam. The member is responsible for the copayment and any charges in excess of the $200 maximum payable per calendar year.

11 The emergency room and urgent care copay are waived if admitted to the hospital for an emergency. The emergency room and urgent care copay are per visit and do not apply to the out-of-pocket maximum. The calendar year deductible applies to emergency room visits.

12 For PPO Value Plans only, the Calendar Year deductible will be waived for an accidental injury. Accidental Injury is physical harm or disability, which is the result of a specific, unexpected or unintentional incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental Injury does not include illness and must be treated in an Emergency Room (ER) or Urgent Care facility. The Calendar Year deductible will be waived only for that day's treatment in the ER or Urgent Care, the ER or Urgent Care copay will still apply; follow up treatment will be subject to the calendar year deductible. A completed Accident Waiver Form must be submitted within 60 days of the accident and is required in order for the claim to be reviewed. Once approved the calendar year deductible will be waived. The Member will continue to pay any charges billed in excess of Covered Expenses.

13 The inpatient/outpatient copay applies to the out-of-pocket maximum and continues to apply once the out-of-pocket maximum is met.

Important things to know about all of your coverage options

Who is eligible?
Applicants who meet the following requirements are eligible to enroll in Health Net's Guaranteed HMOs and PPOs, without underwriting. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance. *To be considered an eligible individual:*

- The applicant must be under the age of 65.
- The applicant must not be eligible for Medicare.
- The applicant must reside continuously in our service area.
- The most recent coverage must have been under a group health plan (COBRA and Cal-COBRA coverage are considered group coverage).
- The applicant must have a total of 18 months of coverage (including COBRA, if applicable) without a significant break (excluding any employer-imposed waiting periods) in coverage of more than 63 days.
- If COBRA coverage was available, it must have been elected and such coverage must have been exhausted. This would include the Cal-COBRA for employers with 2 to 20 employees.
- 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.

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 you choose Health Net's Simple Pay or Credit Card option you will be exempt from any administrative billing fees. If you do not choose Health Net's Simple Pay or Credit Card option a $5 per month administrative fee will be charged each month to cover the expense of issuing a monthly bill. If there are changes to the Health Net Individual & Family HMO Plan Contract and EOC or PPO Policy, including changes in benefits, you will be notified at least 30 days in advance.

Can benefits be terminated?
You may cancel your coverage at any time by giving Health Net written notice. In such event, termination will be effective on the first day of the month following our receipt of your written notice to cancel. Health Net has the right to terminate your coverage for any of the following reasons:

- You do not pay your premium on time.
- You and/or your family member(s) cease being eligible.
- You make false statements about your own or your family's health status.
- You and/or your family member(s) repeatedly or materially disrupt the operations of the Physician Group or Health Net to the extent that your behavior substantially impairs Health Net's ability to furnish or arrange services for you or other Health Net membes, 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 day's written notice. If your coverage is terminated because Health Net ceases to offer al like policies, you may be entitled to Conversion coverage. Should such a termination occur, information on Conversion coverage will be proviced 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.

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 or PPO insurance plans subject to policies and procedures that lead to efficient and prudent use of resources and, ultimately, to continuous improvement of quality of care. Health Net bases the approval or denial of services on the following main procedures:

- Evaluation of medical services to assess medical necessity and appropriate level of care
- Implementation of case management for long-term or chronic conditions
- Review and authorization of inpatient admission and referrals to noncontracting providers
- Review of scope of benefits to determine coverage

If you would like additional information regarding Health Net's Utilization Review System, please call the Member Services department 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 Health Net Individual & Family HMO Plan Contract and EOC or PPO Policy.

What if I have a disagreement with Health Net?
Members dissatisfied with the quality of care received, or who believe they were denied service or a claim in error, may file a grievance or appeal. 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 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.

Health Net
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 Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

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

Health Net Life Insurance Company
Individual & Family Plans
P.O. Box 1150
Rancho Cordova, CA 95741-1150
1-800-909-3447

If a member has been unable to resolve a problem concerning his or her insurance coverage, after discussions with Health Net Life Insurance Company, or its agent or other representative, her or she may contact:

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

What 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, contact the Member Services Department at 1-800-839-2172.

What are Health Net's premium ratios?
Health Net's 2002 ratio of premium costs to health services paid for Individual & Family HMO plans was 63.3%. Health Net Life's 2002 ratio for the Individual & Family PPO insurance plans was 81.7%.

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 or Health Net Life. Health Net or Health Net Life and each of their 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 or 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 or Health Net Life 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, Health Net will provide a written notice to affected Members. In addition, the Member may request continued care from a provider whose contract is terminated if at the time of termination the Member was receiving care from such a provider for:

- An acute condition
- A serious chronic condition
- A pregnancy (including the duration of the pregnancy and immediate postpartum care)
- A newborn (up to 36 months of age, with a maximum duration of coverage of twelve months. This applies only to this provision affecting the continuity of care)
- A terminal illness (for the duration of the terminal illness)

- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment

For definitions of acute condition, serious chronic condition and terminal illness see the "Definitions" section of this Plan Contract.

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

If you would like more information on how to request continued care, or request a copy of our continuity of care policy, please contact the Member Services department at 1-800-839-2172.

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.

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 Evidence of Coverage or Policy and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Health Net's Member Services Department at 1-800-839-2172 to ensure that you can obtain the health care services that you need.

Additional Items for HMO coverage only

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 contacting Member Services at the telephone number on their Health Net ID card.

When and how does Health Net pay my medical bills?
Health Net will coordinate the payment for covered services when you receive care from your Primary Care Physician or when you are referred by your Primary Care Physician to a specialist. We have agreements with these physicians that eliminate the need for claim forms. Simply present your Member identification card.

Am I required to see my primary care physician if I have an emergency?
When your situation is life threatening, call 911. If your situation is not so severe and you cannot call your Primary Care Physician (medical) or Physician Group (medical), or the Administrator (mental illness or chemical dependency) and you need medical care right away, go to the nearest medical center or Hospital.

An emergency is defined as any otherwise covered service that a reasonable person with an average knowledge of health and medicine would seek if he or she was having serious symptoms (including Severe Mental Illness and Serious Emotional Disturbances of a Child), and believed that 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 includes ambulance and ambulance transport services provided through the "911" emergency response system, if the request is made for emergency care, as well as additional screening, examination and evaluation by a Physician (or other health care provider acting within the scope of his or her license) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate such condition within the capacity of the facility.

Am I liable for payment of certain services?
Health Net is 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 Plan. 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.

Under the HMO plans, 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 employers or insurance brokers, who is not authorized to have that information. We will only release information if you give us special consent in writing. The only time we would release such information without your special consent is when we have to comply with a law, court order, or subpoena. Often, Health Net is required to comply with aggregated measurement and data reporting requirements. In those cases, we protect your privacy by not releasing any information that identifies our members.

Privacy Practices
For a description of how protected health information about you may be used and disclosed and how you can get access to this information, please see the Notice of Privacy Practices in your Plan Contract.

How does Health Net deal with new technologies?
New technologies are those procedures, drugs or devices that have recently been developed for the treatment of specific diseases or conditions, or are new applications of existing procedures, drugs or devices. New technologies are considered investigational or experimental during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to

be considered investigational or experimental if clinical study has not shown safety or effectiveness or if they are not considered standard care by the appropriate medical specialty. Approved technologies are integrated into Health Net Benefits.

Health Net determines whether new technologies should be considered medically appropriate, or investigational or experimental, following extensive review of medical research by appropriately specialized physicians. Health Net requests review of new technologies by an independent, expert medical reviewer in order to determine medical appropriateness or investigational or experimental status of a technology or procedure.

The expert medical reviewer also advises Health Net when patients require quick determinations of coverage, when there is no guiding principle for certain technologies, or when the complexity of a patient's medical condition requires expert evaluation.

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 that 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 (i.e., 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 Items for PPO coverage only

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

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

If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by Health Net Life or a grievance that has remained unresolved for more than 30 days, you may call the Department of Insurance for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services.

Exclusions and Limitations
Exclusions and Limitations Common to all Individual & Family Coverage Options

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

- Services and Supplies which Health Net or Health Net Life determine are not medically necessary, except as set out under "Does Health Net cover the cost of participation in clinical trials?" and "What if I have a disagreement with Health Net" on page 15.
- Custodial Care. Custodial Care is not rehabilitative care and is primarily provided to assist a patient in meeting the activities of daily living such as: help in walking, getting in and out of bed, bathing, dressing, feeding and preparation of special diets, and supervision of medications which are ordinarily self-administered, but not care that requires skilled nursing services on a continuing basis.
- Procedures that Health Net or Health Net Life determines to be experimental or investigational, except as set out under "Does Health Net cover the cost of participation in clinical trials?" and "What if I have a disagreement with Health Net" on page15.
- Services or supplies provided before the effective date of coverage; services or supplies provided after coverage through this plan has ended are not covered.
- Reimbursement for services for which the Member is not legally obligated to pay the provider or for which the provider pays no charge.
- Any service or supplies not specifically listed as covered expenses, unless coverage is required by state or federal law.
- Services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include, but are not limited to, collection, storage or purchase of sperm or ova.
- Oral contraceptives and emergency contraceptives are covered. Vaginal contraceptives are limited to diaphragms, cervical caps and IUDs, are only covered when a contracted physician performs a fitting examination and in the case of diaphragms and cervical caps, prescribes the device. IUDs are only available through the Member Physician's office, are covered as a medical benefit, and are limited to one fitting and device per year, unless additional fittings or devices are medically necessary. Diaphragms and cervical caps are only available through a prescription from a pharmacy and are limited to one prescription per year unless additional fittings or devices are medically necessary. Injectable contraceptives are covered as a medical benefit when administered by a physician.
- Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance. *
- Dental care.
- Treatment and services for a Temporomandibular Joint Disorders are covered when determined to be medically necessary, excluding crowns, onlays, bridgework and appliances.
- 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 or Policy. Any institution that is primarily a place for the aged, a nursing home or any 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.
- Services to reverse voluntary surgically induced infertility.
- Sex change procedures or treatment.

- Physical exams for insurance, licensing, employment, school or camp. Any physical, vision or hearing exams that are not related to diagnosis or treatment of illness or injury, except as specifically stated in the Health Net HMO Plan Contract and EOC or Health Net Life Policy.
- Any outpatient drugs, medications or other substances dispensed or administered in any setting, except as specifically stated in the Health Net HMO Plan Contract and EOC or Health Net Life Policy.
- Services for a surrogate pregnancy are covered. However, when compensation is obtained for the surrogacy, the plan shall have a lien on such compensation to recover its medical expense.
- Although this plan does cover Durable Medical Equipment, it does not cover the following items: (a) exercise equipment; (b) hygienic equipment, jacuzzis and spas; (c) surgical dressings other than primary dressings that are applied by your Physician Group or a Hospital to lesions of the skin or surgical incisions; and (d) stockings, corrective shoes and arch supports.
- Personal or comfort items.
- Disposable supplies for home use.
- Home birth, unless the criteria for emergency care have been met.
- Physician self-treatment.
- Physicians treating immediate family members.
- Treatment for alcoholism or drug addiction, except detoxification.
- Services and supplies for the collection, preservation and storage of umbilical cord blood, cord blood stem cells and adult stem cells.
- Drugs (including injectable medications) for the treatment of sexual dysfunction when prescribed for the treatment of sexual dysfunction.

*When a Medically Necessary mastectomy has been performed, breast reconstruction surgery and surgery performed on either breast to restore or achieve symmetry (balanced proportions) in the breast are covered. In addition when surgery is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, to do either of the following: improve function or create a normal appearance to the extent possible, unless the surgery offers a minimal improvement in the appearance of the member.

Additional Exclusions and Limitations for HMO Plans Only

- Chiropractic services, including and not limited to office visits, X-rays, adjustments, manipulation and therapy.
- Home health care (limited to 100 combined visits per calendar year; maximum three visits per day and four hours per visit).
- Medical services or supplies that are not authorized by Health Net or the physician group according to Health Net's procedures.
- Services and supplies rendered by a nonparticipating physician without authorization from Health Net or the Physician Group.
- Diagnostic procedures or testing for genetic disorders, except for prenatal diagnosis of fetal genetic disorders in cases of high-risk pregnancy.
- Nonprescription drug, medical equipment or supply that can be purchased without a prescription (except when prescribed by a physician for management and treatment of diabetes). If a drug that was previously available by prescription becomes available in an over-the-counter (OTC) form in the same prescription strength, then any prescription drugs that are similar agents and have comparable clinical effect(s), will only be covered when Prior Authorization is obtained from Health Net. However, if a higher dosage form of a nonprescription drug or over-the-counter drug is only available by prescription, that higher dosage 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 purposes.
- 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.

Additional Exclusions and Limitations for All PPO Plans

- Conditions caused by the Member's commission (or attempted commission) of a felony.
- Conditions caused by release of nuclear energy, when government funds are available.

- Amounts charged by Out-of-Network providers for covered medical services and treatment that Health Net Life determines to be in excess of the covered expense.
- Optometric services, eye exercises including orthoptics, except as specifically stated elsewhere in the Policy.
- Immunizations or inoculations for adults or children, except as described in the Policy.
- Any services not related to the diagnosis or treatment of a covered illness or injury.
- Inpatient room and board charges incurred in connection with an admission to a hospital or other inpatient treatment facility primarily for diagnostic tests that could have been performed safely on an outpatient basis.
- Inpatient room and board charges in connection with a hospital stay primarily for environmental change, physical therapy or treatment of chronic pain.
- Expenses in excess of a hospital's (or other inpatient facility's) most common semiprivate room rate
- Treatment of chronic alcoholism, drug addiction and other chemical dependency problems, including detoxification services, except as specifically stated in the Policy.
- Any expenses related to the following items, whether authorized by a physician or not: (a) alteration of the Member's residence to accommodate the Member's physical or medical condition, including the installation of elevators; (b) corrective appliances, except prosthetics, casts and splints; (c) air purifiers, air conditioners and humidifiers; and (d) educational services or nutritional counseling, except as specifically provided in the Policy.
- Treatment or surgery for obesity, weight reduction or weight control, except when provided for morbid obesity, as determined by Health Net Life.
- All benefits provided under the Policy shall be reduced by any amounts to which a Member is entitled under the program commonly referred to as Medicare when federal law permits Medicare to pay before an individual health plan.
- Services performed by a person who lives in the Member's home or who is related to the Member by blood or marriage.
- Any services provided by, or for which payment is made by, a local, state or federal government agency. This limitation does not apply to Medi-Cal, Medicaid or Medicare.
- If the Member receives services or obtains supplies in a foreign country, benefits will be payable for emergency care only.
- Services to diagnose, evaluate or treat infertility are not covered.
- Acupuncture.
- Chiropractic services, including and not limited to office visits, X-rays, adjustments, manipulation and therapy.
- Routine physical examinations.
- Hyperkinetic syndromes, learning disabilities, behavior problems or mental retardation regardless of the type of service. Certain conditions are covered if their level of severity meets the criteria of Serious Emotional Disturbances of a Child or Severe Mental Illness (see page 15 for definitions).

Additional Exclusions and Limitations for:

PPO Value Basic 500 option only

- Care for conditions of pregnancy, including hospital and professional services. This includes prenatal and postnatal care, and delivery.
- Immunizations or inoculations for foreign travel or occupational purposes.
- Allergy serum
- Routine physical examinations
- Rehabilitative services

Additional HMO Product Information – Mental Health and chemical dependency services

Health Net has contracted exclusively with Health Net affiliate, Managed Health Network (the Administrator) specializing in mental health and chemical dependency services.

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 health 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.

Additional HMO Product Information - Prescription Drug Program

Health Net is contracted with many major pharmacies, supermarket-based pharmacies and privately owned pharmacies in California. To find a conveniently located Participating Pharmacy, please visit our website at www.healthnet.com or call Health Net Member Services.

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

Prescriptions By Mail 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 Member Services at 1-800-839-2172.

Note: Schedule II narcotic drugs are not covered through mail order. See the Health Net Individual and 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)

The Health Net Recommended Drug List is the approved list of medications covered for illnesses and conditions. It was developed to identify the safest and most effective medications for Health Net Members while attempting to maintain affordable pharmacy benefits.

We specifically suggest to all Health Net contracting Primary Care Physicians and specialists that they refer to this list when choosing drugs for patients who are Health Net members. When your physician prescribes medications listed in the Recommended Drug List, it ensures that you are receiving a high quality prescription medication that is also of high value.

The Recommended Drug List is updated regularly, based on input from the Health Net Pharmacy and Therapeutics (P&T) Committee. This 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 atwww.healthnet.com or call Member Services at 1-800-839-2172.

Drugs not on the List: Level III drugs

Level III drugs are prescription drugs that are not listed on the Recommended Drug List and are not excluded from coverage. Some Level III drugs require prior authorization from Health Net.

What is "prior authorization"?

Some 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 e-mail. We must receive the appeal within 60 days of the date of the denial notice. Please refer to your Health Net Evidence of Coverage for details regarding your right to appeal.

To submit an appeal:
- Call Health Net Member Services at 1-800-839-2172
- Visit www.healthnet.com for information on e-mailing Health Net Member Services
- Write to:
  Health Net Member Services
  P.O. Box 10348
  Van Nuys, CA 91410-0348

PPO coverage certification requirements

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

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

1. Inpatient admissions
   Any type of facility, including but not limited to:
   - Hospital
   - Skilled Nursing Facility
   - Mental health facility
   - Chemical dependency facility
   - Acute rehabilitation center
   - Hospice
2. Ambulance
   - Air Ambulance
   - Non-emergent transport
3. Ambulatory services
   - Durable Medical Equipment
   - Home Health Care Agency Services including nursing, physical therapy, occupational therapy, speech therapy, home I.V. therapy, Hospice Care, tocolytic services (intravenous drugs used to decrease or stop uterine contractions in premature labor) and home uterine monitoring
   - Prosthesis for major limbs
4. Experimental services, new technology and evolutionary changes in proven technology
5. Orthognatic procedures (surgery performed to correct or straighten jaw and/or other facial bone misalignments to improve function.)
6. Outpatient Diagnostic Imaging:
   - CT Scans
   - MRA (Magnetic Resonance Angiography)
   - MRI (Magnetic Resonance Imaging)
   - MUGA Cardiac Scan (Multiple Gated Acquisition)
   - PET (Positron Emission Tomography)
   - SPECT (Single Photon Emission Computed Tomography)
7. Surgical procedures including:
   - Abdominal, ventral, umbilical, incisional hernia repair
   - Blepharoplasty
   - Breast reductions and augmentations
   - Mastectomy for gynecomastia
   - Rhinoplasty
   - Sclerotherapy
   - Uvulopalatopharyngoplasty (UPPP) and laser assisted UPPP
8. Temporomandibular Joint (TMJ) Disorder treatment
9. Transplant-related services including pre-evaluation and pre-treatment services, and the transplant procedure

Exceptions

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

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

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

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

Pregnancy

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

Health Net of California, Inc.
Guaranteed Issue Individual HMO plan rates effective October 1, 2004

Region 1 Los Angeles County

	Age	HMO 15	HMO 40
Subscriber	1 - 4	210	172
	5 - 18	193	172
	19 - 24	347	227
	25 - 29	407	262
	30 - 34	502	332
	35 - 39	550	364
	40 - 44	580	381
	45 - 49	638	402
	50 - 54	706	468
	55 - 59	847	551
	60 - 64	847	551
Sub & Spouse	19 - 24	687	442
	25 - 29	808	517
	30 - 34	998	657
	35 - 39	1090	721
	40 - 44	1153	755
	45 - 49	1269	796
	50 - 54	1405	927
	55 - 59	1687	1094
	60 - 64	1687	1094
Sub & Child	19 - 24	538	390
	25 - 29	599	425
	30 - 34	692	497
	35 - 39	738	529
	40 - 44	771	546
	45 - 49	828	567
	50 - 54	896	631
	55 - 59	1037	714
	60 - 64	1037	714
Sub & Children	19 - 24	726	555
	25 - 29	788	594
	30 - 34	883	662
	35 - 39	929	696
	40 - 44	961	711
	45 - 49	1019	733
	50 - 54	1085	798
	55 - 59	1226	881
	60 - 64	1226	881
Family	19 - 24	1034	745
	25 - 29	1155	820
	30 - 34	1345	959
	35 - 39	1439	1024
	40 - 44	1500	1056
	45 - 49	1615	1099
	50 - 54	1751	1228
	55 - 59	2034	1396
	60 - 64	2034	1396

Region 2 Merced, Tulare, Sacramento, San Joaquin, Sonoma, Stanislaus*, W. El Dorado^, W. Placer^ Counties

	Age	HMO 15	HMO 40
Subscriber	1 – 4	238	186
	5 – 18	216	186
	19 – 24	393	242
	25 – 29	466	281
	30 – 34	578	359
	35 – 39	629	391
	40 – 44	665	410
	45 – 49	726	434
	50 – 54	801	502
	55 – 59	963	592
	60 – 64	963	592
Sub & Spouse	19 - 24	779	475
	25 - 29	925	553
	30 - 34	1150	709
	35 - 39	1252	774
	40 - 44	1321	815
	45 - 49	1444	861
	50 - 54	1597	995
	55 - 59	1918	1177
	60 - 64	1918	1177
Sub & Child	19 - 24	609	420
	25 - 29	680	458
	30 - 34	793	536
	35 - 39	845	568
	40 - 44	881	590
	45 - 49	942	612
	50 - 54	1017	679
	55 - 59	1179	771
	60 - 64	1179	771
Sub & Children	19 - 24	825	601
	25 - 29	896	640
	30 - 34	1009	718
	35 - 39	1061	750
	40 - 44	1095	771
	45 - 49	1155	793
	50 - 54	1233	861
	55 - 59	1393	951
	60 - 64	1393	951
Family	19 - 24	1173	803
	25 - 29	1318	881
	30 - 34	1542	1037
	35 - 39	1644	1102
	40 - 44	1716	1143
	45 - 49	1836	1187
	50 - 54	1989	1323
	55 - 59	2311	1503
	60 - 64	2311	1503

^ZIP codes for western El Dorado include: 95623, 95630 and 95762 only. See region 7 for additional El Dorado County ZIP codes. ZIP codes for Western Placer County include: 95602-04, 95648, 95650, 95658, 95661, 95663, 95677-78, 95746-47 and 95765 only. See region 7 for additional Placer County ZIP codes.

Region 3 Riverside, San Bernardino and Ventura Counties

	Age	HMO 15	HMO 40
Subscriber	1 - 4	225	184
	5 - 18	208	184
	19 - 24	376	245
	25 - 29	444	283
	30 - 34	548	363
	35 - 39	601	397
	40 - 44	633	417
	45 - 49	692	441
	50 - 54	772	510
	55 - 59	930	602
	60 - 64	930	602
Sub & Spouse	19 - 24	743	483
	25 - 29	881	558
	30 - 34	1088	718
	35 - 39	1192	786
	40 - 44	1258	823
	45 - 49	1379	873
	50 - 54	1537	1012
	55 - 59	1853	1199
	60 - 64	1853	1199
Sub & Child	19 - 24	580	422
	25 - 29	650	458
	30 - 34	754	538
	35 - 39	805	575
	40 - 44	839	592
	45 - 49	898	616
	50 - 54	978	687
	55 - 59	1136	781
	60 - 64	1136	781
Sub & Children	19 - 24	786	601
	25 - 29	854	638
	30 - 34	959	718
	35 - 39	1010	752
	40 - 44	1043	771
	45 - 49	1104	796
	50 - 54	1184	866
	55 - 59	1340	958
	60 - 64	1340	958
Family	19 - 24	1119	808
	25 - 29	1255	881
	30 - 34	1464	1041
	35 - 39	1566	1111
	40 - 44	1632	1148
	45 - 49	1755	1197
	50 - 54	1911	1337
	55 - 59	2229	1522
	60 - 64	2229	1522

Region 4 Alameda, Contra Costa, San Francisco, San Mateo, Santa Clara, Santa Cruz and Solano Counties

	Age	HMO 15	HMO 40
Subscriber	1 - 4	254	210
	5 - 18	232	210
	19 - 24	422	274
	25 - 29	504	323
	30 - 34	623	408
	35 - 39	677	449
	40 - 44	713	468
	45 - 49	776	497
	50 - 54	861	570
	55 - 59	1039	679
	60 - 64	1039	679
Sub & Spouse	19 - 24	837	539
	25 - 29	1002	640
	30 - 34	1238	810
	35 - 39	1347	888
	40 - 44	1418	927
	45 - 49	1544	983
	50 - 54	1716	1134
	55 - 59	2071	1349
	60 - 64	2071	1349
Sub & Child	19 - 24	653	475
	25 - 29	735	524
	30 - 34	852	611
	35 - 39	908	648
	40 - 44	944	667
	45 - 49	1007	696
	50 - 54	1092	772
	55 - 59	1269	879
	60 - 64	1269	879
Sub & Children	19 - 24	884	679
	25 - 29	966	726
	30 - 34	1083	815
	35 - 39	1139	852
	40 - 44	1175	871
	45 - 49	1238	900
	50 - 54	1323	976
	55 - 59	1500	1083
	60 - 64	1500	1083
Family	19 - 24	1257	910
	25 - 29	1423	1009
	30 - 34	1658	1180
	35 - 39	1768	1258
	40 - 44	1838	1294
	45 - 49	1964	1352
	50 - 54	2136	1503
	55 - 59	2491	1717
	60 - 64	2491	1717

Region 5 Orange and San Diego Counties

	Age	HMO 15	HMO 40
Subscriber	1 - 4	225	184
	5 - 18	206	184
	19 - 24	374	245
	25 - 29	444	283
	30 - 34	546	359
	35 - 39	597	391
	40 - 44	626	410
	45 - 49	687	436
	50 - 54	769	505
	55 - 59	924	599
	60 - 64	924	599
Sub & Spouse	19 - 24	740	482
	25 - 29	883	558
	30 - 34	1085	709
	35 - 39	1185	776
	40 - 44	1247	813
	45 - 49	1367	862
	50 - 54	1529	1005
	55 - 59	1840	1190
	60 - 64	1840	1190
Sub & Child	19 - 24	577	420
	25 - 29	650	458
	30 - 34	750	534
	35 - 39	799	568
	40 - 44	832	587
	45 - 49	893	611
	50 - 54	973	682
	55 - 59	1128	776
	60 - 64	1128	776
Sub & Children	19 - 24	782	599
	25 - 29	854	638
	30 - 34	956	713
	35 - 39	1005	748
	40 - 44	1036	765
	45 - 49	1095	789
	50 - 54	1177	861
	55 - 59	1332	956
	60 - 64	1332	956
Family	19 - 24	1114	805
	25 - 29	1255	881
	30 - 34	1457	1034
	35 - 39	1558	1102
	40 - 44	1619	1136
	45 - 49	1741	1185
	50 - 54	1901	1328
	55 - 59	2212	1517
	60 - 64	2212	1517

Region 6 Fresno, Kern and Kings Counties

	Age	HMO 15	HMO 40
Subscriber	1 - 4	232	194
	5 - 18	213	194
	19 - 24	385	252
	25 - 29	459	295
	30 - 34	568	376
	35 - 39	619	415
	40 - 44	653	429
	45 - 49	714	456
	50 - 54	788	527
	55 - 59	947	619
	60 - 64	947	619
Sub & Spouse	19 - 24	764	497
	25 - 29	913	582
	30 - 34	1129	745
	35 - 39	1233	820
	40 - 44	1299	852
	45 - 49	1420	905
	50 - 54	1568	1044
	55 - 59	1886	1231
	60 - 64	1886	1231
Sub & Child	19 - 24	597	437
	25 - 29	672	480
	30 - 34	779	561
	35 - 39	832	599
	40 - 44	864	614
	45 - 49	924	641
	50 - 54	998	711
	55 - 59	1156	805
	60 - 64	1156	805
Sub & Children	19 - 24	806	624
	25 - 29	883	667
	30 - 34	990	750
	35 - 39	1041	786
	40 - 44	1075	803
	45 - 49	1136	830
	50 - 54	1209	898
	55 - 59	1369	992
	60 - 64	1369	992
Family	19 - 24	1148	835
	25 - 29	1299	920
	30 - 34	1513	1085
	35 - 39	1617	1158
	40 - 44	1683	1190
	45 - 49	1804	1245
	50 - 54	1952	1384
	55 - 59	2270	1570
	60 - 64	2270	1570

Region 7 E. El Dorado^, Marin, E. Placer^ and Yolo Counties

	Age	HMO 15	HMO 40
Subscriber	1 - 4	312	259
	5 - 18	284	259
	19 - 24	517	340
	25 - 29	629	405
	30 - 34	772	517
	35 - 39	840	561
	40 - 44	879	585
	45 - 49	947	611
	50 - 54	1043	704
	55 - 59	1252	832
	60 - 64	1252	832
Sub & Spouse	19 - 24	1027	674
	25 - 29	1252	803
	30 - 34	1536	1026
	35 - 39	1672	1116
	40 - 44	1750	1165
	45 - 49	1886	1214
	50 - 54	2080	1400
	55 - 59	2494	1656
	60 - 64	2494	1656
Sub & Child	19 - 24	801	592
	25 - 29	913	657
	30 - 34	1054	767
	35 - 39	1124	813
	40 - 44	1162	837
	45 - 49	1231	862
	50 - 54	1326	952
	55 - 59	1536	1083
	60 - 64	1536	1083
Sub & Children	19 - 24	1083	844
	25 - 29	1196	908
	30 - 34	1337	1020
	35 - 39	1408	1063
	40 - 44	1445	1088
	45 - 49	1513	1114
	50 - 54	1610	1206
	55 - 59	1819	1333
	60 - 64	1819	1333
Family	19 - 24	1542	1131
	25 - 29	1767	1262
	30 - 34	2051	1483
	35 - 39	2188	1571
	40 - 44	2267	1622
	45 - 49	2403	1672
	50 - 54	2595	1855
	55 - 59	3011	2115
	60 - 64	3011	2115

^ZIP codes for Eastern El Dorado include: 95613-14, 95619, 95629, 95633-36, 95643, 95651, 95656, 95664, 95667, 95672, 95682, 95684, 95709, 95720-21, 95726, 95735, 96150-52 and 96154-58 only. See region 2 for additional El Dorado County ZIP codes. ZIP codes for Eastern Placer County include: 95631, 95681, 95701, 95703, 95713-15, 95717, 95722, 95724, 95736, 96140-43, 96145-46, 96148 and 96162 only.

Health Net Life Insurance Company
Guaranteed Issue Individual PPO Insurance Plan rates effective February 1, 2005
(1 or +2 refers to the subscriber's spouse and/or dependent children as defined in the Health Net Life Insurance Company PPO Policy)

Region 1
Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba counties

	Age	PPO Value Basic 500	PPO Value 30
Subscriber	< 15	177.25	208.25
	15 - 29	206.50	242.75
	30 - 34	277.25	325.75
	35 - 39	315.50	370.75
	40 - 44	409.75	481.50
	45 - 49	469.00	551.00
	50 - 54	582.00	684.00
	55 - 59	704.00	827.25
	60 - 64	704.00	827.25
Subscriber + 1	< 15	359.50	422.50
	15 - 29	489.25	575.00
	30 - 34	592.00	695.50
	35 - 39	666.50	783.25
	40 - 44	809.25	951.00
	45 - 49	919.75	1,080.75
	50 - 54	1,136.75	1,335.75
	55 - 59	1,382.25	1,624.25
	60 - 64	1,382.25	1,624.25
Subscriber + 2	< 15	541.25	636.00
	15 - 29	729.50	857.25
	30 - 34	853.00	1,002.25
	35 - 39	945.75	1,111.50
	40 - 44	1,103.75	1,297.00
	45 - 49	1,210.25	1,422.25
	50 - 54	1,453.75	1,708.00
	55 - 59	1,725.00	2,026.75
	60 - 64	1,725.00	2,026.75

Region 2
Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus counties

	Age	PPO Value Basic 500	PPO Value 30
Subscriber	< 15	170.50	200.25
	15 - 29	201.00	236.00
	30 - 34	252.50	296.50
	35 - 39	288.75	339.50
	40 - 44	358.00	420.75
	45 - 49	404.50	475.25
	50 - 54	496.00	582.75
	55 - 59	604.50	710.25
	60 - 64	604.50	710.25
Subscriber + 1	< 15	364.00	427.50
	15 - 29	447.50	526.00
	30 - 34	526.50	618.75
	35 - 39	592.50	696.25
	40 - 44	696.50	818.50
	45 - 49	793.25	932.25
	50 - 54	963.00	1,131.75
	55 - 59	1,166.50	1,370.75
	60 - 64	1,166.50	1,370.75
Subscriber + 2	< 15	570.25	670.25
	15 - 29	695.00	816.75
	30 - 34	803.25	943.75
	35 - 39	871.75	1,024.25
	40 - 44	964.50	1,133.25
	45 - 49	1,051.25	1,235.25
	50 - 54	1,242.50	1,460.00
	55 - 59	1,471.25	1,728.75
	60 - 64	1,471.25	1,728.75

Region 3
Alameda, Contra Costa, Marin, San Francisco, San Mateo and Santa Clara counties

	Age	PPO Value Basic 500	PPO Value 30
Subscriber	< 15	168.75	198.25
	15 - 29	201.25	236.50
	30 - 34	253.25	297.75
	35 - 39	286.25	336.25
	40 - 44	357.25	420.00
	45 - 49	395.75	465.00
	50 - 54	490.50	576.25
	55 - 59	599.75	704.75
	60 - 64	599.75	704.75
Subscriber + 1	< 15	367.50	431.75
	15 - 29	446.25	524.25
	30 - 34	535.00	628.75
	35 - 39	589.75	693.00
	40 - 44	700.50	823.25
	45 - 49	786.25	924.00
	50 - 54	963.75	1,132.50
	55 - 59	1,163.50	1,367.25
	60 - 64	1,163.50	1,367.25
Subscriber + 2	< 15	573.00	673.50
	15 - 29	694.50	816.00
	30 - 34	812.75	954.75
	35 - 39	877.25	1,030.75
	40 - 44	967.75	1,137.25
	45 - 49	1,058.50	1,243.75
	50 - 54	1,244.25	1,462.00
	55 - 59	1,450.00	1,704.00
	60 - 64	1,450.00	1,704.00

Region 4
Orange, Santa Barbara and Ventura counties

	Age	PPO Value Basic 500	PPO Value 30
Subscriber	< 15	179.50	211.00
	15 - 29	193.75	227.50
	30 - 34	257.50	302.50
	35 - 39	299.50	352.00
	40 - 44	358.75	421.50
	45 - 49	420.00	493.50
	50 - 54	511.25	600.50
	55 - 59	613.00	720.50
	60 - 64	613.00	720.50
Subscriber + 1	< 15	350.25	411.50
	15 - 29	448.75	527.25
	30 - 34	553.25	650.00
	35 - 39	613.00	720.25
	40 - 44	730.00	857.75
	45 - 49	825.25	969.75
	50 - 54	1,011.25	1,188.25
	55 - 59	1,221.50	1,435.25
	60 - 64	1,221.50	1,435.25
Subscriber + 2	< 15	518.50	609.25
	15 - 29	679.25	798.25
	30 - 34	811.75	954.00
	35 - 39	899.25	1,056.50
	40 - 44	993.75	1,167.75
	45 - 49	1,104.25	1,297.50
	50 - 54	1,306.50	1,535.25
	55 - 59	1,533.25	1,801.75
	60 - 64	1,533.25	1,801.75

Region 5
Los Angeles county

	Age	PPO Value Basic 500	PPO Value 30
Subscriber	< 15	180.75	212.50
	15 - 29	197.00	231.50
	30 - 34	258.00	303.25
	35 - 39	301.50	354.50
	40 - 44	371.25	436.25
	45 - 49	429.25	504.25
	50 - 54	520.25	611.50
	55 - 59	618.25	726.50
	60 - 64	618.25	726.50
Subscriber + 1	< 15	344.75	405.00
	15 - 29	459.75	540.25
	30 - 34	555.25	652.25
	35 - 39	625.25	734.75
	40 - 44	740.00	869.75
	45 - 49	839.75	986.75
	50 - 54	1,035.75	1,217.00
	55 - 59	1,253.00	1,472.25
	60 - 64	1,253.00	1,472.25
Subscriber + 2	< 15	508.75	597.75
	15 - 29	695.00	816.50
	30 - 34	827.75	972.75
	35 - 39	921.25	1,082.50
	40 - 44	1,018.75	1,197.25
	45 - 49	1,137.00	1,336.00
	50 - 54	1,338.50	1,573.00
	55 - 59	1,557.00	1,829.50
	60 - 64	1,557.00	1,829.50

Region 6
Riverside, San Bernardino, and San Diego counties

	Age	PPO Value Basic 500	PPO Value 30
Subscriber	< 15	166.75	196.00
	15 - 29	175.75	206.50
	30 - 34	238.75	280.50
	35 - 39	285.00	335.00
	40 - 44	328.50	386.00
	45 - 49	387.25	455.00
	50 - 54	466.50	548.25
	55 - 59	557.00	654.50
	60 - 64	557.00	654.50
Subscriber + 1	< 15	329.50	387.25
	15 - 29	397.50	467.25
	30 - 34	503.00	591.25
	35 - 39	565.00	663.75
	40 - 44	647.25	760.50
	45 - 49	732.75	861.00
	50 - 54	903.25	1,061.50
	55 - 59	1,088.25	1,278.75
	60 - 64	1,088.25	1,278.75
Subscriber + 2	< 15	493.25	579.75
	15 - 29	633.00	743.75
	30 - 34	745.00	875.25
	35 - 39	824.25	968.50
	40 - 44	910.00	1,069.25
	45 - 49	1,018.50	1,197.00
	50 - 54	1,201.25	1,411.50
	55 - 59	1,379.75	1,621.00
	60 - 64	1,379.75	1,621.00

How to apply for a Health Net Guaranteed Issue Individual HMO or PPO* Plan

1. Take time to review your options and choose the coverage that best suits your health care needs. Our Health Net Individual HMO and PPO provider listings define where in California our coverage is available. If you have questions, need help choosing one of our coverage options, completing the application, or if the application is missing from your enrollment information, please call us toll free at 1-800-909-3447 or contact your authorized Health Net agent.

2. Complete the Health Net Individual & Family Enrollment Application
   - You, the applicant, must accurately complete **all** applicable portions of the application. Your agent may not complete your application for you. Make sure you answer all questions – incomplete applications will be returned.
   - If you wish to ONLY apply for Guaranteed Issue plan coverage, you do not need to answer the Health Questionnaire, Part IV of the enrollment application. However, you must complete Part V(d) and attach proof of creditable coverage. If you do not have proof of creditable coverage, attach any other evidence of creditable coverage (including pay stubs, papers containing enrollment and disenrollment dates, or COBRA award termination letters). If you are ineligible for a Guaranteed Issue plan, we will process you for a standard plan ONLY if you have completed the Health Questionnaire, Part IV of the enrollment application.
   - HMO Only: Each member of your family may select a different Primary Care Physician. Health Net requires that you and your enrolled family members select a Primary Care Physician whose office is located within a 30 mile radius of your (or your respective family member's) residence or office. If you don't choose a doctor when you complete your enrollment application, we'll assign one to you based on your residential ZIP code. If you need help selecting a doctor, give us a call at 1-800-909-3447 or visit our web site at www.healthnet.com
   - Please type or print clearly in *blue or black ink*.

- Make sure you and your spouse or Domestic Partner (if applicable) sign and date the application and this form. Signatures are required for all applicants over age 18, including dependents. NOTE: A Domestic Partner is defined as two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. A registered domestic partnership is established in California when both persons file a *Declaration of Domestic Partnership* with the Secretary of State and at the time of the filing all of the following are true: (a) Both persons have a common residence; (b) Neither person is married to someone else or is a member of another domestic partnership that has not been terminated, dissolved, or adjudged a nullity; (c) The two persons are not related by blood in a way that would prevent them from being married in California; (d) Both persons are at least 18 years old; (e) Both persons are members of the same sex, or opposite sex couples if one or both persons is over age 62 and is eligible for old age insurance benefits under the Social Security Act; and (f) Both persons are capable of consenting to the domestic partnership.
   - The application must be received by Health Net within 30 days from the date of signature.
   - Remember, applications received by the 25th of the month will be processed for coverage starting the 1st of the following month. We also offer PPO coverage effective the 15th of the month. See the application for details.
   - If you need help completing the application, please call your Authorized Health Net agent or Health Net.

3. Please designate the applicants for guaranteed issue coverage, your effective date and your Guaranteed Issue plan choice below in Parts A, B and C.

4. Mail the completed Health Net Individual & Family Enrollment Application, this form, your certificate(s) of creditable coverage or other evidence of creditable coverage, and your personal check for the applicable first month's premium (made payable to Health Net) to your authorized Health Net agent or Health Net at the address below.

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

**Underwritten by Health Net Life Insurance Company.*

Health Net Guaranteed Issue Individual HMO or PPO* Plan

Part A. Applicant Information

Please complete the below so that we can attach this page to your enrollment application

Primary Applicant

Last Name	First Name	M.I.	Social Security Number

Spouse or Domestic Partner

Last Name	First Name	M.I.	Social Security Number

Dependent

Last Name	First Name	M.I.	Social Security Number

Dependent

Last Name	First Name	M.I.	Social Security Number

Dependent

Last Name	First Name	M.I.	Social Security Number

Part B. Requested Effective Date

Requested effective date___________________________

Part C. Choice of Coverage

- ☐ Health Net HMO 15
- ☐ Health Net HMO 40
- ☐ Health Net Life PPO Value Basic 500
- ☐ Health Net Life PPO Value 30

If you have questions, please contact your authorized Health Net agent or call 1-800-909-3447 and a representative will assist you.

**Underwritten by Health Net Life Insurance Company.*

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

Call toll-free
1-800-909-3447

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

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

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