Individual & Family Plans

PPO Guaranteed Issue

Outline of Coverage and Disclosure

Health coverage made easy

January 1, 2013

Underwritten by Health Net Life Insurance Company

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 when they change jobs or are unemployed for brief periods of time, regardless of pre-existing conditions. California law provides similar and additional protections. Applicants who meet requirements outlined under the "Important things to know about all your coverage options," "Who is eligible?" section are eligible to enroll in a guaranteed issue individual health insurance plan from any health insurer that offers individual coverage, including Health Net Life Insurance Company's ("Health Net") Guaranteed Issue PPO insurance plans, without medical underwriting. A health insurer cannot reject your application for guaranteed issue individual health coverage if you meet the eligibility requirements, agree to pay the required premiums and live or work in the plan's service area. Health Net offers the PPO Advantage 6500 and PPO Value 4500 coverage options, to eligible individuals at the Guaranteed Issue Rates listed at the end of this brochure.

This document is only a summary of your health coverage. You have the right to view the Policy prior to enrollment. Your Policy, which you will receive after you enroll, contains the terms and conditions, as well as the governing and exact contractual provisions, of your Health Net coverage. It is important for you to carefully read your Policy thoroughly once received, especially all sections that apply to those with special health care needs. Health benefits and coverage matrices on pages 2 and 3 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.

Important information to know about enrolling in a PPO plan

In-network providers have agreed to provide you covered services and supplies and accept a special contracted rate, called the Contracted Rate, as payment in full. Your share of costs is based on this Contracted Rate. Out-of-network providers have not agreed to participate in the Health Net PPO program. When you use an out-of-network provider, benefits are substantially reduced and you will incur a significantly higher out-of-pocket expense. Your out-of-pocket expense is greater because: (i) You are responsible for a higher percentage cost of the benefits in comparison to the cost of benefits when services are provided by in-network providers; (ii) Health Net's benefit for out-of-network providers is based on either a percentage of the Maximum Allowable Amount, or Health Net's "Limited Fee Schedule." Please refer to the "PPO Summary of Benefits" insert for details; and (iii) You are financially responsible for any amounts these providers charge in excess of this amount.

Understanding your coverage choices

Choosing the right PPO insurance plan

PPO Advantage 6500 and PPO Value 4500: The PPO Advantage 6500 offers two doctor visits each, for a $40 copay (deductible waived). You pay 50 percent coinsurance for hospital and surgery services after you meet your calendar year deductible. Other services are covered in full once the annual out-of pocket-maximum has been met.

The PPO Value 4500 is an applicant-only insurance plan offering two doctor visits, each for a $35 copay (deductible waived). Additional visits are 40 percent coinsurance, after you meet your calendar year deductible.

To obtain a copy of the Policy document, contact your authorized Health Net agent or your Health Net Sales Representative at 1-800-909-3447.

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 Advantage 6500*		*PPO Value 4500*	
	In-network you pay[1]	**Out-of-network you pay**[2]	**In-network you pay**[1]	**Out-of-network you pay**[2]
Calendar year deductible	$6,500 single / $13,000 family	$10,000 single / $20,000 family	$4,500 (available as an applicant-only contract)	
Calendar year out-of-pocket maximum (OOPM)	$9,500 single / $19,000 family (includes deductible)	$15,000 single / $30,000 family (includes deductible)	$2,500 (deductible not included)	$5,000 (deductible not included)
Lifetime maximum	Unlimited		Unlimited	
Visit to physician (including specialist consultations and visits to a CVS Minute Clinic[3])[4]	$40 for first 2 visits (deductible waived), then 50% after deductible	0% after OOPM[5]	$35 for first 2 visits (deductible waived), then 40% after deductible	50%
X-ray and laboratory procedures[4,6]	0% after OOPM[5]		40%	50%
Preventive care services[4] (adult and child) Routine preventive services and immunizations (including preventive services obtained at a CVS Minute Clinic[3]) (deductible waived)[7]	Covered in full	Not covered	Covered in full	Not covered
Maternity and pregnancy Prenatal and postnatal office visits	50% after deductible		40%	50%
Emergency and urgent care Emergency room professional and facility charges (copay waived if admitted)[8]	$100 copay + 50% after deductible		$100 copay + 40%	
Urgent care center facility charges (copay waived if admitted)[8]	$50 copay + 50% after deductible		$50 copay + 40%	
Ambulance (ground and air)[9]	0% after OOPM[5]		40%	
Hospitalization services (non-emergency care)[9] Surgeon and anesthetics services	50% after deductible		40%	50%
Inpatient, semiprivate hospital room or intensive care unit with ancillary services (includes maternity)[10]	50% after deductible		$500 copay per admission + 40%[8]	$500 copay per admission + 50%[8]
Outpatient surgery (hospital or outpatient surgery center charges only)[10]	50% after deductible		$500 copay per surgery + 40%[8]	$500 copay per surgery + 50%[8]
Outpatient facility services[10]	50% after deductible		40%	50%
Reproductive health Sterilization of males	0% after OOPM[5]		40%	50%
Sterilization of females[4]	Covered in full (deductible waived)	Not covered	Covered in full (deductible waived)	Not covered

Benefit description	*PPO Advantage 6500*		*PPO Value 4500*	
	In-network you pay[1]	**Out-of-network you pay[2]**	**In-network you pay[1]**	**Out-of-network you pay[2]**
Other services Rehabilitative therapy includes physical, speech, occupational, respiratory, and cardiac therapy (12 visits per calendar year combined in- and out-of-network)[9,11]	0% after OOPM[5]	Not covered	40%	50%
Chiropractic care	Not covered		Not covered	
Mental health services for nonsevere conditions[9,12]	Inpatient: 50% after deductible Outpatient: 0% after OOPM[5]	Inpatient: 50% after deductible Outpatient: not covered	Inpatient: $500 copay + 40% Outpatient: 40%[8]	Inpatient: $500 copay + 50%[8] Outpatient: not covered
Durable medical equipment (including foot orthotics)[4,9,13]	0% after OOPM[5]	Not covered	40%	Not covered
Outpatient prescription drugs[14,15] Filled at participating pharmacy (up to a 30-day supply); not covered at nonparticipating pharmacies	$15 Level I (generic) $2,500 brand deductible $40 Level II (formulary brand) $60 Level III (nonformulary brand) Specialty drugs – 50% or $500 (whichever is less)	Not covered	$15 Level I (generic) $2,500 brand deductible $40 Level II (formulary brand) $60 Level III (nonformulary brand) Specialty drugs – 50% or $500 (whichever is less)	Not covered
Filled through mail order (up to a 90-day supply)	Twice the level of copay	Not covered	Twice the level of copay	Not covered

PPO footnotes

[1]Insured pays the contracted rate, which is 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 maximum allowable amount. You are also responsible for any charges in excess of the covered expense.

[3]CVS MinuteClinics are only available in select locations in the following counties of California: Orange, Riverside, San Diego, and Los Angeles. For additional information on CVS MinuteClinic services and locations, please visit www.minuteclinic.com.

[4]Preventive care services for women also include: female contraceptive services, devices and supplies, female family planning, female preventive sterilizations, screening for gestational diabetes, domestic violence and HIV, breast feeding devices and supplies, applicable female counseling for sexually transmitted infections, HIV, domestic violence, contraceptives, and breastfeeding support.

[5]Benefit payment will begin after the calendar year out-of-pocket maximum (OOPM) is satisfied. For services that are not payable until the out-of-pocket maximum (OOPM) is met, the eligible charges concurrently apply to both the calendar year deductible and the OOPM. Note: Whether the services are certified or not (uncertified), they will apply toward the accumulation of the OOPM. After the member's OOPM is satisfied, certified services will be payable at 100% of contracted/negotiated rate through PPO and Maximum Allowable Amount through Out-of-Network. Uncertified services will continue to be payable at the applicable uncertified percentage rate.

[6]Calendar year deductible waived when provided in relation to an annual routine physical exam and billed on the same claim.

[7]Covered services based on the United States Preventive Services Task Force (USPSTF) grade A and B recommendations; recommendations of the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC); and comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents.

[8]Copay only applies toward the OOPM and not toward the deductible.

[9]Certain services require prior certification from Health Net. Without prior certification, the benefit is reduced by 50%.

[10]Maximum allowable charges out-of-network are $600 per day.

[11]Additional visits payable if precertified as medically necessary following neurological and orthopedic surgery, cerebral/cardiovascular accident, third degree burns, head trauma or spinal cord injuries.

[12]Inpatient: Maximum allowable per day is $300. Outpatient: Maximum amount payable per visit is $30.

[13]Limited to $2,000 maximum payable per year.

[14]The 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. Some plans will cover most female prescription contraceptives at $0 cost-share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your plan documents and Health Net's Recommended Drug List (RDL) for coverage, cost-share and tier information. The Policy is a legal binding document. If the information in this brochure differs from the information in the Policy, the Policy controls.

[15]Prescription drug charges do not apply to your maximum out-of-pocket limit. Brand deductible per person, if applicable, must be paid for brand-name prescription drug-covered services before Health Net begins to pay.

Health Net Life Insurance Company

Guaranteed Issue Plan Rates

Effective January 1, 2013

These premium rates are subject to change. Rates could decrease or increase, in accordance with the January 1, 2013, Major Risk Medical Insurance Program (MRMIP) rates, which have not yet been released by the California Department of Insurance.

Please note: If you have a birthday during the year that moves you into a new age category, any required rate change will be effective the first of the month following the month in which your birthday occurs.

(+1 or +2 refers to the applicant's spouse and/or dependent children as defined in the Health Net PPO Policy.)

Region 1:

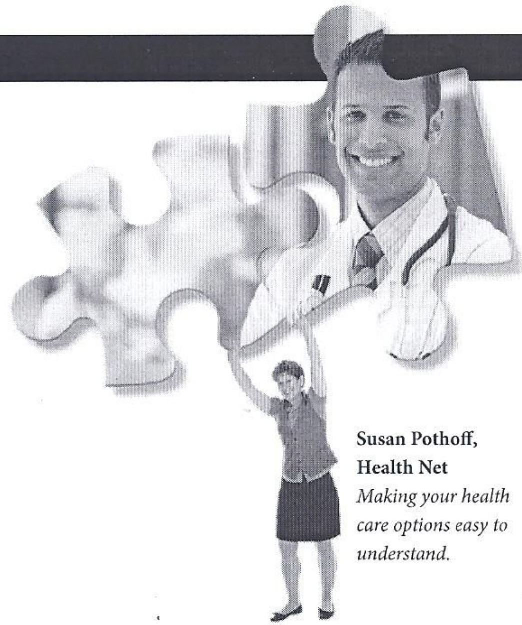
Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba counties

Tier/Age		PPO	
		PPO Value 4500	PPO Advantage 6500
Applicant	under 15	345.00	345.00
	15–29	446.00	446.00
	30–34	593.75	593.75
	35–39	668.00	668.00
	40–44	714.00	714.00
	45–49	764.00	764.00
	50–54	956.25	956.25
	55–59	1,138.50	1,138.50
	60–64	1,138.50	1,138.50
Applicant + 1	under 15		684.75
	15–29		920.00
	30–34		1,080.00
	35–39		1,179.50
	40–44		1,289.75
	45–49		1,505.75
	50–54		1,879.75
	55–59		2,241.25
	60–64		2,241.25
Applicant + 2	under 15		1,105.00
	15–29		1,513.00
	30–34		1,806.50
	35–39		1,920.50
	40–44		1,967.25
	45–49		2,143.75
	50–54		2,455.25
	55–59		2,747.75
	60–64		2,747.75

Region 2:

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

Tier/Age		PPO	
		PPO Value 4500	PPO Advantage 6500
Applicant	under 15	306.75	306.75
	15–29	391.75	391.75
	30–34	497.25	497.25
	35–39	549.50	549.50
	40–44	598.50	598.50
	45–49	646.75	646.75
	50–54	785.00	785.00
	55–59	920.50	920.50
	60–64	920.50	920.50
Applicant + 1	under 15		610.25
	15–29		816.50
	30–34		946.25
	35–39		1,037.50
	40–44		1,135.50
	45–49		1,269.00
	50–54		1,556.25
	55–59		1,805.50
	60–64		1,805.50
Applicant + 2	under 15		1,016.25
	15–29		1,341.00
	30–34		1,609.75
	35–39		1,668.00
	40–44		1,702.00
	45–49		1,792.50
	50–54		2,025.25
	55–59		2,174.25
	60–64		2,174.25



Susan Pothoff, Health Net

Making your health care options easy to understand.

Guaranteed issue plan rates effective January 1, 2013

Region 3:

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

Tier/Age		PPO	
		PPO Value 4500	PPO Advantage 6500
Applicant	under 15	316.25	316.25
	15–29	404.00	404.00
	30–34	510.75	510.75
	35–39	562.25	562.25
	40–44	614.25	614.25
	45–49	664.00	664.00
	50–54	804.25	804.25
	55–59	939.00	939.00
	60–64	939.00	939.00
Applicant + 1	under 15		632.25
	15–29		841.75
	30–34		975.75
	35–39		1,068.75
	40–44		1,172.75
	45–49		1,301.25
	50–54		1,595.50
	55–59		1,840.00
	60–64		1,840.00
Applicant + 2	under 15		1,059.00
	15–29		1,384.00
	30–34		1,660.50
	35–39		1,714.75
	40–44		1,753.50
	45–49		1,837.50
	50–54		2,073.00
	55–59		2,212.00
	60–64		2,212.00

Region 4:

Orange, Santa Barbara and Ventura counties

Tier/Age		PPO	
		PPO Value 4500	PPO Advantage 6500
Applicant	under 15	288.50	288.50
	15–29	372.75	372.75
	30–34	474.25	474.25
	35–39	525.00	525.00
	40–44	571.50	571.50
	45–49	616.25	616.25
	50–54	750.00	750.00
	55–59	880.50	880.50
	60–64	880.50	880.50
Applicant + 1	under 15		573.75
	15–29		775.50
	30–34		898.50
	35–39		986.25
	40–44		1,079.75
	45–49		1,209.50
	50–54		1,486.00
	55–59		1,727.75
	60–64		1,727.75
Applicant + 2	under 15		953.25
	15–29		1,332.00
	30–34		1,528.25
	35–39		1,586.50
	40–44		1,620.50
	45–49		1,710.75
	50–54		1,934.00
	55–59		2,083.75
	60–64		2,083.75

Guaranteed issue plan rates effective January 1, 2013

Region 5:

Los Angeles County

Tier/Age		PPO	
		PPO Value 4500	PPO Advantage 6500
Applicant	under 15	303.25	303.25
	15–29	391.75	391.75
	30–34	500.25	500.25
	35–39	554.75	554.75
	40–44	603.25	603.25
	45–49	650.00	650.00
	50–54	792.25	792.25
	55–59	931.25	931.25
	60–64	931.25	931.25
Applicant + 1	under 15		603.25
	15–29		815.25
	30–34		945.25
	35–39		1,037.25
	40–44		1,135.25
	45–49		1,275.50
	50–54		1,569.25
	55–59		1,827.75
	60–64		1,827.75
Applicant + 2	under 15		1,000.25
	15–29		1,398.00
	30–34		1,605.75
	35–39		1,670.00
	40–44		1,706.25
	45–49		1,805.25
	50–54		2,042.75
	55–59		2,207.00
	60–64		2,207.00

Region 6:

Riverside, San Bernardino and San Diego counties

Tier/Age		PPO	
		PPO Value 4500	PPO Advantage 6500
Applicant	under 15	286.25	286.25
	15–29	368.75	368.75
	30–34	464.75	464.75
	35–39	512.50	512.50
	40–44	560.50	560.50
	45–49	605.75	605.75
	50–54	731.50	731.50
	55–59	856.25	856.25
	60–64	856.25	856.25
Applicant + 1	under 15		569.50
	15–29		769.50
	30–34		889.25
	35–39		976.75
	40–44		1,069.50
	45–49		1,187.00
	50–54		1,452.50
	55–59		1,678.50
	60–64		1,678.50
Applicant + 2	under 15		952.00
	15–29		1,328.25
	30–34		1,517.75
	35–39		1,566.75
	40–44		1,599.50
	45–49		1,675.75
	50–54		1,888.75
	55–59		2,015.50
	60–64		2,015.50

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 Issue PPO insurance plans 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 and Cal-COBRA, if applicable) without a significant break (excluding any employer-imposed waiting periods) in coverage of more than 63 days.
- If COBRA or Cal-COBRA coverage was available, it must have been elected and such coverage must have been exhausted.
- 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 to apply for a Health Net Guaranteed Issue Individual PPO insurance plan

1. Take time to review your options and choose the coverage that best suits your health care needs. Our Health Net Individual 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 HIPAA Guaranteed Issue 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.
   - You must complete Part IV 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).
   - 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. Signatures are required for all applicants over age 18, including dependents. **Note:** Domestic partner is a person eligible for coverage as a dependent provided that the partnership with the principal covered

Please carefully complete all portions of the application to avoid any delays.

person meets all domestic partnership requirements specified by section 297 or 299.2 of the California Family Code.

- The application must be received by Health Net within 30 days from the date of signature.
- A Policy will be effective either on the 1st or the 15th of the month following the date the Underwriting Department has received all of the documents necessary to approve an application.
- If you need help completing the application, please call your Authorized Health Net agent or Health Net.

3. Mail the completed Health Net Individual & Family HIPAA Guaranteed Issue Enrollment Application, 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

Exclusions and limitations

Exclusions and limitations common to PPO Advantage 6500 and PPO Value 4500.

No payment will be made under the Health Net 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 listing, see the Health Net Individual & Family PPO Policy for the PPO coverages.

- Services and supplies which are not medically necessary.
- 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 are experimental or investigational.
- 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 insured 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.

- The following services and supplies are excluded from fertility preservation coverage: gamete or embryo storage; use of frozen gametes or embryos to achieve future conception; pre-implantation genetic diagnosis; donor eggs, sperm or embryos; gestational carriers (surrogates).
- Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

  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. Coverage is also provided 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 insured.
- Dental care. However, this plan does cover medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
- Treatment and services for 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 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 insured'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.
- Any outpatient drugs, medications or other substances dispensed or administered in any setting, except as specifically stated in the Health Net Policy.

- Services for a surrogate pregnancy are covered when the surrogate is a Health Net insured. 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.
- Drugs (including injectable medications) for the treatment of sexual dysfunction when prescribed for the treatment of sexual dysfunction.
- Services to diagnose, evaluate or treat infertility are not covered.
- Bariatric surgery provided for the treatment of morbid obesity is covered when medically necessary, authorized by Health Net and performed at a Health Net designated bariatric surgical center. Health Net has a designated network of bariatric surgical centers to perform weight loss surgery. Your insured physician can provide you with information about these centers. You will be directed to a Health Net designated bariatric surgical center at the time authorization is obtained.
- Conditions caused by the insured'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 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 insured's residence to accommodate the insured'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.
- All benefits provided under the Policy shall be reduced by any amounts to which an insured 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 insured's home or who is related to the insured 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 insured receives services or obtains supplies in a foreign country, benefits will be payable for emergency care only.

- 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.
- Outpatient speech therapy which is not provided in relation to surgery, injury or disease.
- Rehabilitative therapy is limited to services after an acute episode of care for chronic conditions, an acute illness or injury, or an acute exacerbation of such an illness or injury.

Karen Boyd,
Health Net
Making a difference, one member at a time.

For more information please contact

Health Net

PO Box 1150

Rancho Cordova, CA 95741-1150

Individual & Family Plans

1-800-909-3447

Assistance for the hearing and speech impaired

1-800-995-0852

Other options

Coverage for family members over 65 years of age

1-800-944-7287

Coverage for children in a low-income household

1-800-327-0502

Coverage for businesses with 50 and fewer employees

1-800-447-8812

Coverage for businesses with 50+ employees

1-800-448-4411, option 4

Visit www.healthnet.com for the most up-to-date listings

CA95742 (1/13)

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