THERE HAS TO BE

A SIMPLER PLAN.

Effective January 1, 2006

PPO INDIVIDUAL & FAMILY PLANS
Health coverage made easy.

Health Net®
A Better Decision

IMPORTANT INFORMATION TO KNOW ABOUT ENROLLING IN A PPO PLAN UNDERWRITTEN BY HEALTH NET LIFE INSURANCE COMPANY (HEALTH NET)

Please read the following information to know from whom or which group of providers health care may be obtained.

In-network providers have agreed to provide you covered services and supplies and accept a special contracted rate, called the Allowable Charge, 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 Customary and Reasonable Charge, or Health Net's "Limited Fee Schedule." Please refer to the "PPO Summary of Benefits" insert for details.

(iii) You are financially responsible for any amounts these providers charge in excess of this amount. PPOs offer a choice of where you receive services: in-network and out-of-network. Doctors and facilities that are contracted with Health Net PPO are in-network. When you go out-of-network, you will pay more.

CONTENTS

HEALTH COVERAGE MADE SIMPLE

Life isn't always simple – but your health care coverage can be. Our consumer-driven plan designs help simplify the complicated world of health care so you can make confident decisions about your health. And have your expectations met. And be satisfied with the care you receive.

Health Net's mission itself is quite simple: To help you be healthy, secure and comfortable. This brochure packet will answer the key questions you may have about covering yourself or your family, and walk you through the steps you need to select a plan that is right for you.

IS A PPO RIGHT FOR YOU?

PPO plans are designed for people who want to see any licensed physician or health care professional and are willing to pay a bit more for it. Visits to specialists, hospitals and facilities can be made *without* a referral from your personal doctor.

ACCESS TO CARE

PPOs offer a choice of where you receive services: *in-network* and *out-of-network.* Doctors and facilities that are contracted with Health Net PPO are *in-network.* When you go out-of-network, you will pay more.

COST

Depending on your PPO plan, you may owe a *copayment* when you visit your doctor. Your copayment is a fixed dollar amount that you pay when receiving care. In addition, you may pay a *deductible*, which is the amount you pay for covered services before the plan begins to pay. Once plan coverage kicks in, you may also be responsible for *coinsurance.* This is a percentage of your doctor's bill that is your responsibility. When your doctor submits a bill, we pay our portion and send you a statement of the amount you owe. This statement is called an *Explanation of Benefits.* Your doctor should bill you for the amounts on this statement.

HEALTH NET PPO ADVANTAGES INCLUDE

- Choice of more than 50,000 physicians
- Reduced costs and no claim form filing when using Health Net PPO network doctors and facilities
- No referrals or authorizations required to see a physician
- Wide range of specialists
- Care when traveling out of state

CHOOSING THE RIGHT PPO PLAN

Want to know which Health Net PPO plan is the best choice for you? Here is some information to get you started.

ValueChoice: Offered at a low monthly premium with a higher annual deductible, the plan provides basic coverage for those who rarely get sick or visit the doctor. It's designed for the **subscriber only**.

SimpleChoice HSA and **SmartChoice HSA**: The SimpleChoice and SmartChoice HSA-Compatible Plans are high-deductible PPO plans with low monthly premiums, designed to be used with Health Savings Accounts (HSAs). Once you enroll in either of these plans, you open a HSA at a bank or financial institution. The HSA then allows you to save and spend on qualified medical expenses tax-free (including deductibles and copayments).[1] Your total value? The freedom of PPO coverage, low monthly premiums, in-network savings, and a "smarter" ways to save, spend and invest your health care dollars.

SimpleChoice: The SimpleChoice plans are available with five different coverage options. Most benefits are the same as you move from plan to plan. The main differences are in deductibles, preventive care copayments, and premiums (the amount you pay monthly for plan coverage).

SimpleValue: These three zero-deductible, Subscriber-only plans mean you pay copayments for doctor visits and coinsurances only, where applicable. These plans also offer flexible pharmacy choices: Generic Only for value, or Combo for Generic and Brand prescriptions.

FirstChoice: Health Net provides you with $500 of immediately available funds for you and each covered family member. If you're healthy and don't visit your doctor often, the FirstChoice PPO may be the plan for you.

For additional information about any of these plans, refer to the plan grid in the back pocket of this brochure. Or, contact your authorized **Health Net agent** or call Health Net's Individual & Family Plans Department at **1-800-909-3447**.

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

DENTAL AND VISION COVERAGE FROM HEALTH NET

Health Net offers a full line of dental and vision benefits administered through SafeGuard Health Plans and Eyemed Vision Care. These benefits include:

DENTAL

- Choose your own dental providers
- Available fee schedule shows the maximum allowable amount so you know costs up front
- $50 deductible waived for diagnostic and preventative services

VISION

- The flexibility of an out-of-network provider option (PPO)
- Single, bifocal and lenticular lenses covered at 100% in-network
- Freedom to take your prescription to a vision PPO provider

LIFE INSURANCE PLANS[2]

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

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

Health Net Life Insurance Company offers affordable Individual Term Life Insurance in the following amounts: $15,000, $30,000 and $50,000.

MONTHLY TERM LIFE INSURANCE RATES

Age of primary insured	Cost per $1,000	Total monthly cost		
		$15,000	$30,000	$50,000
19–29	$0.19	$2.85	$5.70	$9.50
30–39	$0.22	$3.30	$6.60	$11.00
40–49	$0.50	$7.50	$15.00	$25.00
50–59	$1.37	$20.55	$41.10	$68.50
60–64	$2.00	$30.00	$60.00	$100.00

TERMS

- If you wish to purchase life insurance, you must purchase a minimum coverage of $15,000.
- The maximum life insurance benefit is $50,000.
- You must be at least 19 years old to purchase Individual Term Life Insurance.
- Only available for primary subscriber.
- Not available with modified issue PPO plans, HIPAA guarantee issue and Quick Net plans.

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

HOW DO I APPLY?

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

- Call 1-800-909-3447
- Visit our website at www.healthnet.com and select Enroll Now
- Contact your Health Net authorized agent

If you are signing a paper application:

1. Sign and date the application
2. Include a check payable to Health Net for the applicable premium payment
3. Mail the completed application and check (within 30 days of signature date) to your authorized agent or to:

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

MAKING HEALTH CARE DECISIONS WITH CONFIDENCE

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

DECISION POWER℠
RESOURCES FOR CONFIDENT HEALTH CARE DECISIONS

With Decision Power, you can:

- Talk to a Health Coach *anytime* to discuss your concerns.
- Watch support videos that show why different people choose different treatment courses for the same health condition.
- Learn more about a broad array of health topics, from resources you can trust and understand.
- Assess and monitor your health, using a variety of online tools.

IT'S YOUR LIFE℠ – RESOURCES FOR EVERYDAY CONCERNS

- Get answers to your financial, legal and emotional health concerns.
- Get help finding childcare and elder care resources.
- Access wellness programs and member discounts on things like vitamins, eye care and chiropractic care.

HOSPITAL COMPARISON REPORT

An online tool that shows you which hospitals score highest for a particular medical procedure in key quality categories most important to you.

HEALTHGATE® EBM SOLUTIONS

Online, evidence-based medical information for any given condition to help you become an active participant in your health care.

ONLINE DOCTOR SEARCH

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

TOOLS AND COVERAGE SERVICES

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

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

IMPORTANT THINGS TO KNOW ABOUT YOUR MEDICAL COVERAGE OPTIONS

Health Net Individual & Family PPO plans are underwritten by Health Net Life Insurance Company.

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

In addition, your spouse or domestic partner, if under age 65, and all your unmarried dependent children under 19 years of age also are eligible (subject to underwriting requirements; the ValueChoice 1500 and SimpleValue plans are available to subscribers only). Unmarried dependent children enrolled in an accredited school as full-time students and under 24 years of age are also eligible, if proof of full-time student status is provided.

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:

- Both person have a common residence.
- Neither person is married to someone else or is a member of another domestic partnership that has not been terminated, dissolved, or adjudged a nullity.
- The two persons are not related by blood in a way that would prevent them from being married in California.
- Both persons are at least 18 years old.
- Both persons are members of the same sex, or opposite sex couples if one or both persons is over age 62 and is eligible for old age insurance benefits under the Social Security Act.
- Both persons are capable of consenting to the domestic partnership.

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

To qualify for a HIPAA plan, you *must:*

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

If you want to find out if you qualify, contact us so that we can determine your eligibility and tell you about the available HIPAA plans. If you believe your rights under HIPAA have been violated, please contact the Department of Managed Health Care at 1-888-HMO-2219 or visit the Department's website at www.hmohelp.ca.gov.

How does the monthly billing work?
Your premium must be received by Health Net by the first day of the coverage month. If there are premium increases after the enrollment effective date, you will be notified at least 30 days in advance.

If you choose Health Net's Simple Pay option or credit card billing, you will be exempt from any administrative billing fees. If you do not choose Health Net's Simple Pay option or credit card billing, a $5 per month administrative fee will be charged each month to cover the expense of issuing a monthly bill.

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

- You do not pay your premium on time.
- You and/or your family member(s) cease being eligible.
- You knowingly submit to Health Net materially incorrect or incomplete information which is reasonably relied on by Health Net in issuing or renewing individual and family plan coverage.

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

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 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 non-contracting providers.
- Review of scope of benefits to determine coverage.

If you would like additional information regarding Health Net's Utilization Review System, please call the Customer Contact Center at 1-800-839-2172.

Does Health Net cover the cost of participation in clinical trials?
Routine patient care costs for patients diagnosed with cancer who are accepted into phase I, II, III or IV clinical trials are covered when medically necessary, recommended by the member's treating physician and authorized by Health Net. The physician must determine that participation has a meaningful potential to benefit the member and the trial has therapeutic intent. For further information, please refer to the 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 Insurance 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 Insurance if they meet eligibility criteria set out in the Policy.

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.

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
Post Office 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

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 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.

What if I need a second opinion?
Health Net members have the right to request a second opinion when:

- The member's 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 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 Customer Contact Center at 1-800-839-2172.

What are Health Net's premium ratios?
Health Net Life's 2004 ratio of premium costs to health services paid for the Individual & Family PPO insurance plans was 67 percent.

What is the relationship of the involved parties?
Physician groups, contracting physicians, hospitals and other health care providers are not agents or employees of Health Net Life. 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 Life, their agents or employees, or of physician groups, any physician or hospital, or any other person or organization with which Health Net Life has arranged or will arrange to provide the covered services and supplies of your plan.

What 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 not to exceed 12 months from the contract termination date
- A pregnancy (including the duration of the pregnancy and immediate postpartum care)
- A newborn up to 36 months of age, not to exceed 12 months from the contract termination date
- A terminal illness (for the duration of the terminal illness)
- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable Copayments and any other exclusions and limitations of this Plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider's contract termination. 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 Customer Contact Center 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 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 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 Customer Contact Center at 1-800-839-2172 to ensure that you can obtain the health care services that you need.

Are there any pre-existing conditions?
Until the policy has been in effect for six consecutive months, covered services will not include any care required in connection with the treatment of any condition, disease or injury for which medical advice, diagnosis, care or treatment, including the use of prescription medications, was recommended by or received from a licensed health care practitioner during the six months immediately preceding the effective date of coverage under the policy.

Credit will be given toward the pre-existing condition waiting period for membership with another creditable health care plan if you apply for coverage under Health Net's PPO insurance plan within 62 days of termination with the previous plan.

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 that 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.

For more information, please contact:

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

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

1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

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

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

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