

INDIVIDUAL & FAMILY PLANS BENEFIT OVERVIEW

Effective October 2006 through September 2007



Health Net Health Plan of Oregon, Inc.
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888.802.7001

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ABOVE AND BEYOND...

HEALTH NET GIVES YOU MORE REASONS THAN EVER TO APPLY NOW!

HEALTH NET GIVES YOU MORE. CHOOSE YOUR PLAN TODAY!

If you want a health plan that lets you take more control of your healthcare decisions, you've come to the right place. Put more sparkle in your benefits. Health Net gives you more. Families. Singles. Kids. People without group coverage. Select from plans specially designed with you in mind. All this from a local health plan with national resources.

Health Net Health Plan of Oregon traces its roots in Oregon back to 1938 when a group of Clackamas County doctors found new ways to provide affordable quality health care. Today, Health Net, Inc. provides health benefits to more than 6.6 million people in 27 states.

QUALITY, CHOICE, BENEFITS. YOU DECIDE.

Customize your health benefits to fit your lifestyle. You can pick from a variety of Health Net plans that fit almost any need. It's your choice.

See your own doctor anywhere with a preferred provider plan (PPO). Benefits are covered at a higher level when you use in-network (INN) providers. With the Topaz First Dollar plan, let us pay your first \$250 from the immediate spending allowance. Diamond 15 and Emerald 40 offer affordable copays for office visits. Pearl 25 HMO (in selected counties) is a managed care plan with no deductible to worry about, and predictable copays for virtually all services. For a simple low-cost PPO, consider the Garnet 50%.

Deductible selections provide the flexibility to adjust premium rates to fit your pocket book. Coinsurance options help regulate affordability. Out-of-pocket maximums provide a built-in protection against unexpected catastrophic costs. Some plans even provide extra benefits, which may include chiropractic, acupuncture, massage therapy, and naturopathy visits.



Disclosure Statement

The Oregon Insurance Division requires that we provide the following information.

This outline of coverage provides a very brief description of the important features of the policy. Please note that this outline is not intended to be part of the insurance contract. Only the actual policy provisions are final and binding. The policy itself sets forth in detail your rights and obligations as well as those of the insurance company. PLEASE READ THE POLICY CAREFULLY!

Individuals who decline coverage under a group health plan to retain or obtain coverage under an individual health plan will be considered late enrollees if they seek enrollment in the group plan at a later date. Late enrollees may be excluded from group plan coverage for up to 12 months, or subjected to a 12-month pre-existing conditions provision.

Major medical expense coverage: Policies of this category are designated to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or illness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayments, coinsurance, or other limitations that may be set forth in the policy.

GET MORE FROM HEALTH NET. THE CHOICE BELONGS TO YOU.

Looking for a health plan that lets you take more control of your health and care decisions? Look no further. Families. Singles. Youngsters. People without group coverage. Find your health plan gem right here.

PEARL 25 HMO

Comprehensive care benefits include a simple \$25 office visit copay, preventive care benefits, and Well Net benefits such as chiropractic, naturopathy, acupuncture and massage therapy. Available to residents of Clackamas, Multnomah and Washington counties.

DIAMOND 15

Deductible choices help manage your health care budget. In-network doctor visits are always just \$15 – no deductible. Preventive benefits, additional accident waiver, and Well Net program benefits make this PPO plan a popular choice for all ages, including children.

TOPAZ FIRST DOLLAR

Relax - the first \$250 is on us. A first-dollar benefit means you get an immediate spending allowance for a variety of services before you are required to meet a deductible. A variety of deductibles helps manage your health care budget. Round that out with alternative care benefits, preventive services, and an accidental injury deductible waiver for a winning combination.

EMERALD 40

Save on premium dollars. See your doctor in-network and pay just \$40 per visit. No deductible applies for office visits or preventive care. Accidental injury benefit included for even more peace of mind.

GARNET 50%

If a lower plan premium is important, we think this plan may just have the lowest rate in town. Choose a zero deductible to access benefits right away. Choose the high deductible option if you want a “back-up” plan after you pay for the small stuff. In either case, this plan covers benefits at 50% until you reach the out-of-pocket maximum safety net. Then, we pay 100% for the rest of the calendar year.

CRYSTAL HDHP

Pick from two high deductible health plan (HDHP) styles.

- 100% Plans: We pay 100% on covered benefits after your deductible is met. What could be more simple?
- 80% Plans: After the deductible, this plan pays 80% until you reach your out-of-pocket maximum safety net.

DENTAL & VISION PLAN OPTION

It's easy to add dental and vision to your health plan. Health Net Dental lets you choose the dentist. Vision exams and vision correction are a snap with Health Net Vision, including simple copays when you choose in-network providers.

UPON REQUEST

Health Net has other plan options available upon request. QUICK NET short term medical coverage is great for people who are between jobs, in a life transition, no longer on parents' health plan, or traveling.

Benefit summaries and rates sheets for PPO Value plans are also available upon request.

OVERVIEW OF INDIVIDUAL & FAMILY COVERAGE OPTIONS

This benefit chart is a summary only. For benefit details, please see the principal benefits and coverage guide.

Benefit	Crystal HDHP 100% Plans H.S.A.-eligible high deductible health plan		Crystal HDHP 80% Plans H.S.A.-eligible high deductible health plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Choices The deductible Coverage Year (CY) is January 1 through December 31.	Individual: \$2,000, or \$5,000 ¹ Family: \$4,000, or \$10,000 ¹	Individual: \$4,000, or \$10,000 ¹ Family: \$8,000, or \$20,000 ¹	Individual: \$1,500, \$2,500, or \$3,500 ¹ Family: \$3,000, \$5,000, or \$7,000 ¹	Individual: \$3,000, \$5,000, or \$7,000 ¹ Family: \$6,000, \$10,000, or \$14,000 ¹
Lifetime maximums	\$2 million combined		\$2 million combined	
Out-of-pocket maximum (OPM)				
Individual	same as deductible ²	2 x deductible ²	\$5,000 ²	\$15,000 ²
Family	same as deductible ²	2 x deductible ²	\$10,000 ²	\$30,000 ²
Professional services				
Office Visit	No charge	50% UCR+	20%	50% UCR+
Well Baby care (8 exams in the first 24 months) ⁶	No charge	50% UCR+	20%	50% UCR+
Annual OB/GYN exam (breast and pelvic exams, cervical cancer screening & mammography) ⁶	No charge	50% UCR+	20%	50% UCR+
X-ray and laboratory procedures	No charge	50% UCR+	20%	50% UCR+
Outpatient services				
Outpatient or ambulatory care center	No charge	50% UCR+	20%	50% UCR+
Outpatient rehab therapy (\$2,500/year max)	No charge	50% UCR+	20%	50% UCR+
Outpatient facility services (other than surgery)	No charge	50% UCR+	20%	50% UCR+
Maternity care				
Physician services for maternity care	No charge	50% UCR+	20%	50% UCR+
Hospitalization services				
Inpatient hospital care	No charge	50% UCR+	20%	50% UCR+
Skilled nursing facility (60 days per year max)	No charge	50% UCR+	20%	50% UCR+
Inpatient rehab therapy (30 days per year max)	No charge	50% UCR+	20%	50% UCR+
Emergency health coverage				
Outpatient emergency room services	No charge	50% UCR+	20%	50% UCR+
Inpatient admission from emergency room	No charge	50% UCR+	20%	50% UCR+
Emergency ambulance (\$3,000 per year max)	No charge	No charge UCR+	20%	20% UCR+
Additional accident				
Accidental injury deductible waiver	Not included		Not included	
Prescription drug coverage***				
Tier 1 & Tier 2 drug list	Subject to medical deductible		Subject to medical deductible	
Tier 3 & Specialty	No charge		50%	
	You pay 100%***		You pay 100%***	
Preventive Benefits Routine physical, prostate screening, vision screening	Included		Included	

NOTES OF INTEREST

The CY deductible for PPO plans is waived for services requiring a copayment and for covered preventive care benefits. Copayments do not apply toward your OPM.

HIGH DEDUCTIBLE HEALTH PLANS

¹The deductible must be met each calendar year (January 1 through December 31) before Health Net pays any claims. With this plan, the deductible applies to the annual out-of-pocket maximum. Family coverage means the subscriber and spouse; the subscriber and child(ren); or the subscriber, spouse and child(ren). Under family coverage, each member's covered expenses count toward the deductible, but the specified family coverage deductible must be met before Health Net pays any claims.

²The annual out-of-pocket maximum (OPM) is included the annual deductible.

PRESCRIPTION DRUG PROGRAM

*** In Pharmacy: Prescription drugs may be filled at a participating pharmacy (up to a 30-day supply).

Mail Order: Prescription drugs may be filled through our participating mail pharmacy (up to a 90 supply).

When Tier 3 brand name drugs are not covered, members will still have the advantage of Health Net's pharmacy discounts.

Visit our website to learn more www.healthnet.com

OVERVIEW OF INDIVIDUAL & FAMILY COVERAGE OPTIONS

This benefit chart is a summary only. For benefit details, please see the principal benefits and coverage guide.

Benefit	Pearl 25 HMO	Diamond 15	
	HMO Network	In-Network	Out-of-Network
Deductible Choices The deductible Coverage Year (CY) is January 1 through December 31.	No deductible	Choice of \$250, \$500, \$1,000, \$2,500, \$5,000 or \$7,500 ^{4,5}	
Lifetime maximums	Unlimited	Family = 3x Individual \$2 million combined	
Out-of-pocket maximum (OPM)			
Individual	\$4,000 single ³	\$4,000 ⁷	\$8,000 ⁷
Family	\$12,000 family ³	\$12,000 ⁷	\$24,000 ⁷
Professional services			
Office Visit	\$25	\$15 ⁶	50% UCR+
Well Baby care (8 exams in the first 24 months) ⁶	\$25	\$15 ⁶	50% UCR+
Annual OB/GYN exam (breast and pelvic exams, cervical cancer screening & mammography) ⁶	\$25	\$15 per visit ⁶	50% UCR+
X-ray and laboratory procedures	\$25	20%	50% UCR+
Outpatient services			
Outpatient or ambulatory care center	\$250	20%	50% UCR+
Outpatient rehab therapy (\$2,500/year max)	\$10	20%	50% UCR+
Outpatient facility services (other than surgery)	\$250	20%	50% UCR+
Maternity care			
Physician services for maternity care	\$250 per pregnancy	20%	50% UCR+
Hospitalization services			
Inpatient hospital care	\$400 per day (until OPM met)	20%	50% UCR+
Skilled nursing facility (60 days per year max)	no charge	20%	50% UCR+
Inpatient rehab therapy (30 days per year max)	\$400 per day	20%	50% UCR+
Emergency health coverage			
Outpatient emergency room services	\$100 per visit (waived if admitted)	20%	50% UCR+
Inpatient admission from emergency room	\$400 per day	20%	50% UCR+
Emergency ambulance (\$3,000 per year max)	20% (UCR plus applies to out-of-network providers)	20% (UCR plus applies to out-of-network providers)	
Additional accident			
Accidental injury deductible waiver**	No deductible	20% (deductible waived **)	50% UCR+ (deductible waived **)
Prescription drug coverage***			
Tier 1 & Tier 2 drug list	\$100 Rx deductible; up to \$4,000 per year	\$100 Rx deductible; up to \$4,000 per year	
Tier 3 & Specialty	50%	50%	
	You pay 100%***	You pay 100%***	
Preventive Benefits Routine physical, prostate screening, vision screening ⁶	Preventive Included	Preventive Included	
Well Net Complementary Care \$500 annual benefit ⁶	Well Net Included	Well Net Included	
Chiro, acupuncture, naturopathy	\$20 copay	\$20 copay	
Massage Therapy	\$25 copay / 9 visits	\$25 copay / 9 visits	

NOTES OF INTEREST

Well Net complementary care program provides services through ASH provider network, and is not subject to a deductible.

The CY deductible for PPO plans is waived for services requiring a copayment and for covered preventive care benefits. Copayments do not apply toward your OPM.

PEARL 25 HMO PLAN

You do not have to pay a deductible for medical coverage with the HMO plan. Prescription drug coverage has a deductible and an annual maximum. Your benefits are subject to copayments listed in this schedule. You must select a Primary Care Provider (PCP) from our HMO network. Your PCP coordinates your health care. Certain services are covered only if provided by a designated Specialty Care provider.

³ After you reach the OPM Copayment maximum in a Calendar Year, we will pay your covered HMO services during the rest of that Calendar Year at 100% of our HMO contract rates.

OVERVIEW OF INDIVIDUAL & FAMILY COVERAGE OPTIONS

This benefit chart is a summary only. For benefit details, please see the principal benefits and coverage guide.

Benefit	Topaz First Dollar	Emerald 40		Garnet 50%		
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Choices The deductible Coverage Year (CY) is January 1 through December 31.	Choice of \$250, \$1,000, \$6,000, or \$10,000 ^{4,5} \$250 Immediate Spending Allowance ⁶	Choice of \$1,000, \$2,500, \$5,000, \$7,500 or \$10,000 ^{4,5}		Choose either \$0 deductible or \$10,000 deductible ^{4,5}		
Lifetime maximums	Family = 3x Individual \$2 million combined	Family = 3x Individual \$2 million combined		Family = 3x Individual \$2 million combined		
Out-of-pocket maximum (OPM)						
Individual	\$6,000 ⁷	\$12,000 ⁷	\$6,000 ⁷	\$12,000 ⁷	\$10,000 ⁷	\$20,000 ⁷
Family	\$18,000 ⁷	\$36,000 ⁷	\$18,000 ⁷	\$36,000 ⁷	\$30,000 ⁷	\$60,000 ⁷
Professional services						
Office Visit	25%	50% UCR+	\$40 ⁶	50% UCR+	50%	50% UCR+
Well Baby care (8 exams in the first 24 months) ⁶	25%	50% UCR+	\$40 ⁶	50% UCR+	not covered	not covered
Annual OB/GYN exam (breast and pelvic exams, cervical cancer screening & mammography) ⁶	25%	50% UCR+	\$40 ⁶	50% UCR+	50%	50% UCR+
X-ray and laboratory procedures	25%	50% UCR+	30%	50% UCR+	50%	50% UCR+
Outpatient services						
Outpatient or ambulatory care center	25%	50% UCR+	30%	50% UCR+	50%	50% UCR+
Outpatient rehab therapy (\$2,500/year max)	25%	50% UCR+	30%	50% UCR+	50%	50% UCR+
Outpatient facility services (other than surgery)	25%	50% UCR+	30%	50% UCR+	50%	50% UCR+
Maternity care						
Physician services for maternity care	25%	50% UCR+	30%	50% UCR+	50%	50% UCR+
Hospitalization services						
Inpatient hospital care	25%	50% UCR+	30%	50% UCR+	50%	50% UCR+
Skilled nursing facility (60 days per year max)	25%	50% UCR+	30%	50% UCR+	50%	50% UCR+
Inpatient rehab therapy (30 days per year max)	25%	50% UCR+	30%	50% UCR+	50%	50% UCR+
Emergency health coverage						
Outpatient emergency room services	25%	50% UCR+	30%	50% UCR+	50%	50% UCR+
Inpatient admission from emergency room	25%	50% UCR+	30%	50% UCR+	50%	50% UCR+
Emergency ambulance (\$3,000 per year max)	25% (UCR plus applies to out-of-network providers)		30% (UCR plus applies to out-of-network providers)		50% (UCR plus applies to out-of-network providers)	
Additional accident						
Accidental injury deductible waiver**	25% (deductible waived**)	50% UCR+ (deductible waived**)	30% (deductible waived**)	50% UCR+ (deductible waived**)	Not included	Not included
Prescription drug coverage***						
Tier 1 & Tier 2 drug list	\$100 Rx deductible; up to \$4,000 per year		\$100 Rx deductible; up to \$2,000 per year		\$100 Rx deductible; up to \$2,000 per year	
Tier 3 & Specialty	50%		50%		50%	
	You pay 100%***		You pay 100%***		You pay 100%***	
Preventive Benefits Routine physical, prostate screening, vision screening ⁶	Preventive Included		Preventive Included		Not included	
Well Net Complementary Care \$500 annual benefit ⁶	Well Net Included		Not included		Not included	
Chiro, acupuncture, naturopathy	\$20 copay		\$20 copay		\$20 copay	
Massage Therapy	\$25 copay / 9 visits		\$25 copay / 9 visits		\$25 copay / 9 visits	

PPO PLANS

**Diamond 15, Topaz First Dollar, and Emerald 40 plans include an Additional Accident benefit. The Calendar Year deductible may be waived for treatment of accidental injury in an Emergency Room (ER) or Urgent Care (UR) facility. ER or UR copays or coinsurance will still apply and follow up treatment is subject to Plan benefits. The Waiver Request form is available through Customer Service, and must be filed within 90 days of the injury.

⁴Unless otherwise specified, you must meet the Calendar Year deductible before Health Net pays any claims.

⁵Your deductible payments do not apply to the annual out-of-pocket maximum.

⁶The CY deductible is waived.

⁷The annual out-of-pocket maximum does not include the annual deductible. After you reach the out-of-pocket maximum in a calendar year, we will pay your covered services during the rest of that calendar year at 100% of our contract rates for PPO services and at 100% of UCR for out-of-network (OON) services. You are still responsible for OON billed charges that exceed UCR.

PRESCRIPTION DRUG PROGRAM

*** In Pharmacy: Prescription drugs may be filled at a participating pharmacy (up to a 30-day supply).

Mail Order: Prescription drugs may be filled through our participating mail pharmacy (up to a 90 supply).

When Tier 3 brand name drugs are not covered, members will still have the advantage of Health Net's pharmacy discounts.



**ADD A SMILE
TO YOUR HEALTH PLAN
Health Net Individual Dental**

Now, you can add dental coverage to any Health Net individual and family health plan to customize your coverage to fit your needs. With Health Net Individual and Family Dental, it's your choice. You're covered no matter which dentist you see.⁸ Take a look at a few coverage highlights below.

HEALTH NET INDIVIDUAL AND FAMILY DENTAL

Diagnostic and Preventive Services

- No Plan deductible and no waiting period
- Plan pays 80% for services such as oral exams, cleaning, X-rays, fluoride treatments and more.

Basic Services

- No waiting period
- Plan pays 80% for services such as amalgam and resin fillings, space maintainers, palliative treatment (pain relief), and more.

Major Services

- Plan pays 50% for services such as crowns, inlays, dentures, root canal treatment, periodontal treatment, extractions, and more.
- 12-month waiting period

There is an annual deductible amount you pay before your plan begins paying for Basic or Major services: \$50 per individual, \$150 per family. The annual maximum benefit for all services combined is \$1,000 for each Plan member.

⁸You can see any licensed dentist and receive benefits for covered services. You do not have to go to a specific network of providers. However, if you do see a participating provider, charges for covered services will be limited to Health Net's contracted amount with the provider, which may save you money.

Dental & Vision starting at \$30!



**IT'S A CLEAR VALUE
Health Net Individual Vision**

Tailor your health benefits to fit your lifestyle. Now, with Health Net's new Vision Plan, you can add vision coverage to any Health Net individual and family health plan. When you use participating vision providers, a simple copay applies for most covered services.⁹ With Health Net Individual and Family Vision plan, you're in the clear. A few coverage highlights are listed below.

HEALTH NET INDIVIDUAL AND FAMILY VISION

Vision Exams

- You pay \$10, and we pay the rest for covered services.

Lenses and Frames

- Lenses: You pay \$25, and we pay the rest for covered services.
- Frames: Covered up to \$100 allowance. Then, 20% discount on any balance.
- Contact Lenses: Up to \$90 allowance for conventional or disposables.

Lens Options include

- UV coating, solid and gradient tint, standard scratch resistance, standard polycarbonate, standard progressive adds to bifocal, standard anti-reflective and more. Copays vary by lens option.

And More . . .

- Laser Vision Correction available at 15% off retail price or 5% off promotional price
- Value Added vision discounts through Health Net's Wellness & Well Rewards programs.

⁹When you see a participating provider, charges for covered services will be limited to Health Net's contracted amount with the provider. If you see a non-participating provider, you are reimbursed for selected services up to a specific reimbursement level. See Vision summary for more information.

Dental & Vision starting at \$30!

ENJOY THE BENEFITS OF HEALTH COVERAGE. APPLY NOW!

WE'VE MADE IT EASY

To request an application call a Health Net sales representative at 1-800-672-5941. An application may be included with this brochure or go to www.healthnet.com to print an application.

Please remember to:

- Type or print clearly in blue or black ink.
- Indicate the health coverage option, and any add-on purchase options you want.

After completing the application, make sure:

- All applicants sign and date the application. This may include you, a spouse and any dependents over age 18, as applicable.
- Health Net receives your application within 30 days of signature date.
- Mail completed application to:
Individual & Family Coverage
Health Net Health Plan of Oregon, Inc.
13221 SW 68th Parkway, Suite 200
Tigard, Oregon 97223

A FINAL REMINDER

- We offer PPO and HSA plan coverage effective the 1st or the 15th of the month. HMO coverage is effective the 1st of the month.
- All applications must be completed by the individual applying for coverage, and are subject to the health statement review and approval.

QUESTIONS?

If you have questions about choosing a coverage options, selecting a doctor or completing the application, please contact your Health Net authorized agent, or call our Individual Sales department at 1-800-672-5941. We'll be happy to assist you.



This benefit chart presents general information only. Refer to the contract for details, limitations and exclusions.

IFP EXCLUSIONS AND LIMITATIONS

Exclusions and Limitations

All the following benefits, accommodations, care services, equipment, medications or supplies are expressly excluded or limited from coverage:

- Any care deemed not Medically Necessary.
- Services or supplies exceeding benefits maximums.
- Treatment of illness or injury for which a third party is responsible.
- Experimental or investigational procedures.
- Non-authorized emergency services as required by Plan contract.
- Expenses for any condition or complication caused by any procedure, treatment, service, drug, device, product or supply excluded from coverage.
- Private room; private duty nurses.
- Temporomandibular joint (TMJ) related services and Orthognathic (jaw) surgery.
- Custodial, respite care.
- Vision services or supplies (except as outlined in your policy).
- Corrective appliances and artificial aids, braces, disposable or non-prescription or over-the-counter supplies.
- Cosmetic services.
- Reduction or augmentation mammoplasty, except as provided in your policy.
- Medical or psychological reports or physical examinations required primarily for your protection and convenience or for third parties.
- Immunizations and inoculations.
- Public facility care; military service disabilities.
- Infertility services and supplies.
- Reversal of voluntary, infertility (sterilization).
- Diagnosis, treatment and rehabilitation services for obesity and eating disorders.
- All organ and tissue transplants or autologous stem cell rescue not explicitly listed as covered.
- Personal comfort items.
- Learning disorders, psychosocial problems, speech delay, conceptual handicap and developmental delay or dyslexia.
- Speech generating devices.
- Rehabilitation, speech and hearing therapy; chiropractic manipulations.
- Medications, surgical treatment or hospitalization for treatment of impotency, penile implants, services, devices, prosthetics or aids related to treatment of any types of sexual dysfunction, congenital or acquired; sperm storage or banking.
- Genetic engineering.
- Non-medical self-help training.
- Bone bank and eye bank charges.
- Counseling or training in connection with family, sexual, marital or occupational issues.
- Orthoptics, pleoptics (visual therapy and/or training), visual analysis.
- Services for which you would not be liable in the absence of our coverage.
- Any illness, condition, or injury occurring in or arising out of the course of employment.
- Court-ordered care, unless determined to be Medically Necessary and Prior Authorized.
- Outpatient prescription or other drugs and medications, including but not limited to insulin and oral chemotherapy drugs. Prescriptions relating to an inpatient/outpatient confinement filled at a hospital pharmacy prior to discharge or use at home (take-home medications) except for prescriptions for a 24-hour supply or less, following an emergency room visit.
- Diagnosis, treatment and rehabilitation services for injuries sustained while practicing for or competing in a professional or semi-professional athletic contest.
- Pain Management Programs.
- Biofeedback.
- Hair analysis.

Individual & Family plans (IFP) are not intended to be sold as an employer-sponsored health benefit plan for employees. Please assure that your employer is not paying your IFP health policy premium.

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- Services or supplies for any illness, injury or condition caused in whole or in part by or related to your use of a motor vehicle when tests show you had a blood alcohol level in excess of that permitted to legally operate a motor vehicle under the laws of the state in which the accident occurred.
- Extraction and storage of autologous blood and derivatives.
- Routine foot care.
- Growth hormone therapy.
- Family planning, counseling and assessment for birth control and birth control devices.
- Preventive and routine examination, services, testing and supplies are excluded for all Members except limited women's health services and except as specifically provided for Members to age 18 in the Preventive Care Value Benefits Supplemental Benefit Schedule if endorsed to your Agreement and except as provided in the IFP Value Plans or as otherwise specified by agreement.
- Circumcisions.
- Drug detoxification; Chemical Dependency including alcohol treatment.
- Known congenital defect or disease unless continually covered with us from birth.
- Alternative Care: All services must be provided by a ASHN preferred provider. Services include chiropractic, naturopathic, acupuncture and massage therapy if endorsed to your Agreement.
- Autologous blood.
- Services of a nutritionist, except for diabetes management and inborn errors of metabolism.

Exclusion Periods

- Services related to an organ transplant, including evaluation, will be covered after a 24-month exclusion period has been satisfied.

Services for the following specified conditions will be covered after a 12-month exclusion period has been satisfied.

- Allergies and their symptoms, including asthma.
- Elective procedures that we determine can be reasonably postponed until the end of the exclusion period.
- Mental disorders.

Services for a pre-existing condition will be covered after a 6-month exclusion period has been satisfied. Pregnancy is subject to the pre-existing conditions.

Upon our receipt of a certificate of Creditable Coverage, the exclusion periods will be reduced by the length of Creditable Coverage under other Health Benefit Plans provided the following conditions are met:

- Creditable Coverage must either remain in effect on the effective date of coverage or was terminated no more than 63 days prior to the effective date, and
- Except for services for a pre-existing condition, the excluded service must have been covered under the other Health Benefit Plan.
- The exclusion periods do not apply to a newborn or newly adopted child.

Health Net Individual & Family Plans
Health Net Health Plan of Oregon, Inc.
13221 SW 68th Parkway
Tigard, Oregon 97223

For more information, call an
Individual & Family Plans
Sales Representative at:
1-800-672-5941

www.healthnet.com