Effective February 1, 2004
HEALTH NET OF CALIFORNIA, INC.
INDIVIDUAL & FAMILY EOA AND HMO PLUS PLANS

Principal benefits and coverages for dental care provided with HMO and EOA Plus plans

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

This document describes the Covered Services of this dental plan, as well as Copayment requirements and Exclusions and Limitations of benefits. Covered Services are also subject to the terms and conditions stated in the Evidence of Coverage and Group Agreement. As described in the Evidence of Coverage, except for Emergency Dental Care, Orthodontia, and Health Net of California authorized referrals to specialists, all of the following services must be provided by the Member's Primary Dentist in order to be covered under this dental plan. Occasionally an instance arises where the Primary Dentist deems that the services of a specialist are required. Health Net of California can assist the Member with a referral to a specialist. However, there is no coverage under this Plan for services rendered by a specialist except for orthodontic care.

Services Performed by Primary Care Dentist		Member Pays[1]
DEDUCTIBLES		**None**
LIFETIME MAXIMUMS		**None**
PROFESSIONAL SERVICES		
DIAGNOSTIC		
D0120	Periodic oral evaluation	No Charge
D0140	Limited oral evaluation - problem focused	No Charge
D0150	Comprehensive oral evaluation - new or established patient	No Charge
D0210	Intraoral - complete series (including bitewings)	No Charge
D0220	Intraoral - periapical first film	No Charge
D0230	Intraoral - periapical each additional film	No Charge
D0240	Intraoral - occlusal film	No Charge
D0270	Bitewing - single film	No Charge
D0272	Bitewings - two films	No Charge
D0274	Bitewings - four films	No Charge
	Bitewing xrays are limited to one series of four films in any 12-month period	
D0330	Panoramic film	No Charge
D0460	Pulp vitality tests	No Charge
D0470	Diagnostic casts	No Charge
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Charge
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Charge
PREVENTIVE		
D1110	Prophylaxis - adult (initial)	$8
D1110	Prophylaxis - adult (second in same calendar year)	$23
	Prophylaxis is limited to: (a) one initial treatment every 12 months, and (b) one "second" treatment every 12 months. An additional prophylaxis will be covered if determined to be dentally necessary consistent with professional practice. For example, for high-risk patients, such as women who are pregnant, enrollees undergoing cancer chemotherapy, or enrollees with compromising systemic diseases such as diabetes.	
D1120	Prophylaxis - child (initial)	$8
D1120	Prophylaxis - child (second in same calendar year)	$23
D1201	Topical application of fluoride (including prophylaxis) - child (initial)	$13
D1201	Topical application of fluoride (including prophylaxis) - child (second in same year)	$28
D1203	Topical application of fluoride (prophylaxis not included) - child	$3

D1203	Topical application of fluoride (prophylaxis not included) - adult	$3
D1310	Nutritional counseling for control of dental disease	No Charge

PREVENTIVE - *CONTINUED*

D1330	Oral hygiene instructions	No Charge
D1351	Sealant - per tooth	$5
D1510	Space maintainer - fixed - unilateral	$75
D1515	Space maintainer - fixed - bilateral	$155
D1520	Space maintainer - removable - unilateral	$100
D1525	Space maintainer - removable - bilateral	$170
D1550	Re-cementation of space maintainer	$15

RESTORATIVE

D2140	Amalgam - one surface, primary	$20
D2150	Amalgam - two surfaces, primary	$25
D2160	Amalgam - three surfaces, primary	$37
D2161	Amalgam - four or more surfaces, primary	$37
D2140	Amalgam - one surface, permanent	$25
D2150	Amalgam - two surfaces, permanent	$32
D2160	Amalgam - three surfaces, permanent	$41
D2161	Amalgam - four or more surfaces, permanent	$49
D2330	Resin-based composite - one surface, anterior	$35
D2331	Resin-based composite - two surfaces, anterior	$45
D2332	Resin-based composite - three surfaces, anterior	$55
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$65
D2391	Resin-based composite - one surface, posterior (permanent tooth)	$55
D2392	Resin-based composite - two surfaces, posterior (permanent tooth)	$70
D2393	Resin-based composite - three surfaces, posterior (permanent tooth)	$85
D2394	Resin-based composite - four or more surfaces, posterior (permanent tooth)	$85
D2391	Resin-based composite - one surface, posterior (primary tooth)	$40
D2392	Resin-based composite - two surfaces, posterior (primary tooth)	$55
D2393	Resin-based composite - three surfaces, posterior (primary tooth)	$70
D2394	Resin-based composite - four or more surfaces, posterior (primary tooth)	$70

CROWNS - SINGLE RESTORATIONS ONLY

D2710	Crown - resin (indirect) (excluding molars)	$240 plus actual lab cost of noble or high noble metal
D2720	Crown - resin with high noble metal (excluding molars)	$240 plus actual lab cost of noble or high noble metal
D2721	Crown - resin with predominantly base metal (excluding molars)	$240 plus actual lab cost of noble or high noble metal
D2722	Crown - resin with noble metal (excluding molars)	$240 plus actual lab cost of noble or high noble metal
D2750	Crown - porcelain fused to high noble metal (excluding molars)	$305 plus actual lab cost of noble or high noble metal
D2751	Crown - porcelain fused to predominantly base metal (excluding molars)	$305 plus actual lab cost of noble or high noble metal
D2752	Crown - porcelain fused to noble metal (excluding molars)	$305 plus actual lab cost of noble or high noble metal
D2780	Crown - 3/4 cast high noble metal	$280 plus actual lab cost of noble or high noble metal
D2781	Crown - 3/4 cast predominantly base metal	$280 plus actual lab cost of noble or high noble metal

D2782	Crown - 3/4 cast noble metal	$280 plus actual lab cost of noble or high noble metal

CROWNS - SINGLE RESTORATIONS ONLY - *CONTINUED*

D2790	Crown - full cast high noble metal	$280 plus actual lab cost of noble or high noble metal
D2791	Crown - full cast predominantly base metal	$280 plus actual lab cost of noble or high noble metal
D2792	Crown - full cast noble metal	$280 plus actual lab cost of noble or high noble metal
D2910	Recement inlay	$15
D2920	Recement crown	$21
D2930	Prefabricated stainless steel crown - primary tooth	$55
D2931	Prefabricated stainless steel crown - permanent tooth	$65
D2940	Sedative filling	$20
D2950	Core buildup, including any pins	$23 plus actual lab cost of noble or high noble metal
D2951	Pin retention - per tooth, in addition to restoration	$20 plus actual lab cost of noble or high noble metal
D2952	Cast post and core in addition to crown	$100 plus actual lab cost of noble or high noble metal
D2953	Each additional cast post - same tooth	$100 plus actual lab cost of noble or high noble metal
D2954	Prefabricated post and core in addition to crown	$60
D2957	Each additional prefabricated post - same tooth	$60

ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	$21
D3120	Pulp cap - indirect (excluding final restoration)	$21
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$33
D3310	Anterior (excluding final restoration)	$170
D3320	Bicuspid (excluding final restoration)	$220
D3330	Molar (excluding final restoration)	$290
D3346	Retreatment of previous root canal therapy - anterior	$185
D3347	Retreatment of previous root canal therapy - bicuspid	$240
D3348	Retreatment of previous root canal therapy - molar	$315
D3410	Apicoectomy/periradicular surgery - anterior	$155
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$155
D3425	Apicoectomy/periradicular surgery - molar (first root)	$155
D3426	Apicoectomy/periradicular surgery - (each additional root)	$75
D3430	Retrograde filling - per root	$48
D3450	Root amputation - per root	$85
D3920	Hemisection (including any root removal), not including root canal therapy	$85

PERIODONTICS

D4210	Gingivectomy or gingivoplasty, four or more contiguous teeth or bounded teeth spaces per quadrant	$230
D4211	Gingivectomy or gingivoplasty, one to three teeth, per quadrant	$33
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces, per quadrant	$30
D4241	Gingival flap procedure, including root planing - one to three teeth, per quadrant	$30
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces, per quadrant	$290
D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant	$290

PERIODONTICS - *CONTINUED*

D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces, per quadrant	$30
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	$30
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$20

PROSTHODONTICS (REMOVABLE)

D5110	Complete denture - maxillary	$405
D5120	Complete denture -mandibular	$405
D5130	Immediate denture - maxillary	$420
D5140	Immediate denture -mandibular	$420
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth)	$290
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth)	$290
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$385
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$385
D5410	Adjust complete denture - maxillary	$15
D5411	Adjust complete denture - mandibular	$15
D5421	Adjust partial denture - maxillary	$15
D5422	Adjust partial denture - mandibular	$15
D5510	Repair broken complete denture base	$45
D5520	Replace missing or broken tooth - complete denture (each tooth)	$53
D5610	Repair resin denture base	$45
D5620	Repair cast framework	$58
D5630	Repair or replace broken clasp	$63
D5640	Replace broken teeth - per tooth	$53
D5650	Add tooth to existing partial denture	$58
D5660	Add clasp to existing partial denture	$63
D5710	Rebase complete maxillary denture	$185
D5711	Rebase complete mandibular denture	$185
D5720	Rebase maxillary partial denture	$185
D5721	Rebase mandibular partial denture	$185
D5730	Reline complete maxillary denture (chairside)	$70
D5731	Reline complete mandibular denture (chairside)	$70
D5740	Reline maxillary partial denture (chairside)	$70
D5741	Reline mandibular partial denture (chairside)	$70
D5750	Reline complete maxillary denture (laboratory)	$120
D5751	Reline complete mandibular denture (laboratory)	$120
D5760	Reline maxillary partial denture (laboratory)	$120
D5761	Reline mandibular partial denture (laboratory)	$120
D5820	Interim partial denture (maxillary)	$135
D5821	Interim partial denture (mandibular)	$135
D5850	Tissue conditioning, maxillary	$40
D5851	Tissue conditioning, mandibular	$40

PROSTHODONTICS (FIXED)

D6210	Pontic - cast- high noble metal	$280 plus actual lab cost of noble or high noble metal
D6211	Pontic - cast predominantly base metal	$280
D6212	Pontic - cast noble metal	$280 plus actual lab cost of noble or high noble metal
D6240	Pontic - porcelain fused to high noble metal (excluding molars)	$305 plus actual lab cost of noble or high noble metal

D6241	Pontic - porcelain fused to predominantly base metal (excluding molars)	$305
D6242	Pontic - porcelain fused to noble metal (excluding molars)	$305 plus actual lab cost of noble or high noble metal
D6750	Crown - porcelain fused to high noble metal (excluding molars)	$305 plus actual lab cost of noble or high noble metal
D6751	Crown - porcelain fused to predominantly base metal (excluding molars)	$305 plus actual lab cost of noble or high noble metal
D6752	Crown - porcelain fused to noble metal (excluding molars)	$305 plus actual lab cost of noble or high noble metal
D6780	Crown - 3/4 cast high noble metal	$280 plus actual lab cost of noble or high noble metal
D6781	Crown - 3/4 cast predominantly base metal	$280 plus actual lab cost of noble or high noble metal
D6782	Crown - 3/4 cast noble metal	$280 plus actual lab cost of noble or high noble metal
D6790	Crown - full cast high noble metal	$280 plus actual lab cost of noble or high noble metal
D6791	Crown - full cast predominantly base metal	$280 plus actual lab cost of noble or high noble metal
D6792	Crown - full cast noble metal	$280 plus actual lab cost of noble or high noble metal
D6930	Recement fixed partial denture	$23
	Fixed bridgework will be covered only when a removable partial denture cannot satisfactorily restore the case	
D6970	Cast post and core addition to fixed partial denture retainer	$100 plus actual lab cost of noble or high noble metal
D6971	Cast post as part of fixed partial denture retainer	$100 plus actual lab cost of noble or high noble metal
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$60
D6973	Core build up for retainer, including any pins	$23 plus actual lab cost of noble or high noble metal
D6976	Each additional cast post - same tooth	$100 plus actual lab cost of noble or high noble metal
D6977	Each additional prefabricated post - same tooth	$60

ORAL AND MAXILLOFACIAL SURGERY

D7111	Coronal remnants - deciduous tooth	$35
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$35
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) - each additional tooth	$27
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (root removal - exposed roots)	$43
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$50
D7220	Removal of impacted tooth - soft tissue	$70
D7230	Removal of impacted tooth - partially bony	$105
D7240	Removal of impacted tooth - completely bony	$135
D7250	Surgical removal of residual tooth roots (cutting procedure)	$50

ORTHODONTICS

D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,800
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,800
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,000
D8210	Removable appliance therapy	$115
D8220	Fixed appliance therapy	$220

D8670	Routine orthodontic visits	$17

ADJUNCTIVE GENERAL SERVICES

D9110	Emergency visits - during regular dental office hours	$14 Note: this copay is in addition to specific services copays

PROFESSIONAL VISITS

D9440	Emergency visits - after regular dental office hours	$55 Note: this copay is in addition to specific services copays

AMBULANCE SERVICES ..... **Not Covered**

PRESCRIPTION DRUG COVERAGE ..... **Not Covered**

DURABLE MEDICAL EQUIPMENT ..... **Not Covered**

MENTAL HEALTH SERVICES ..... **Not Covered**

CHEMICAL DEPENDENCY SERVICES ..... **Not Covered**

HOME HEALTH SERVICES ..... **Not Covered**

OTHER SERVICES

MISCELLANEOUS SERVICES

D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$11
D9951	Occlusal adjustment - limited (per quadrant)	$27
D9952	Occlusal adjustment - complete (per quadrant)	$27
D9999	Missed appointments without 24-hour prior notice	$20 Note: The copayment for missed appointments may not apply if: (a) the Member canceled at least 24 hours in advance, or (b) the Member missed the appointment because of an emergency or circumstances beyond the control of the Member
D9999	Transfer of all materials with less than a full mouth x-ray	No Charge
D9999	Transfer of all materials with a full mouth x-ray	No Charge
D9999	Operatory preparation fee (payable per visit in addition to any applicable copayments for covered services rendered)	No Charge

[1]Dental service copayments are for services performed by a Participating General Dentist.

Effective February 1, 2004
HEALTH NET OF CALIFORNIA, INC.
INDIVIDUAL & FAMILY EOA AND HMO PLUS PLANS

PRINCIPAL EXCLUSIONS AND LIMITATIONS FOR DENTAL CARE PROVIDED BY HEALTH NET OF CALIFORNIA.

All dentally necessary services are covered if performed by the Member's Primary Dentist. If services of a dental specialist are required, the Member will be responsible for the specialist's fees.

- Prophylaxis is limited to: (a) one initial treatment every 12 months, and (b) one subsequent treatment every 12 months.
- Fluoride treatment is covered twice in any 12-month period.
- Bitewing X-rays are limited to one series of four films in any 12-month period.
- Full-mouth X-rays are limited to once every 36 months or as needed consistent with professional practice guidelines.
- Periodontal treatments (subgingival curettage and root planing) are limited to five in any 12-month period.
- Replacement of a restoration is covered only when it is dentally necessary.
- Fixed bridgework will be covered only when partial bridgework cannot satisfactorily restore the case.
- Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair.
- Partial dentures will be replaced as dentally necessary consistent with professional standards of practice.
- Full upper and/or lower dentures will be replaced as dentally necessary consistent with professional standards of practice.
- Services that, in the opinion of the attending dentist or Health Net of California, are not dentally necessary.
- Any experimental procedure. Experimental treatment if denied may be appealed through the Independent. Medical Review process and that service shall be covered and provided if required under the Independent Medical Review process.
- Any procedure of implantation.
- Any procedure performed for the purpose of correcting contour, contact or occlusion.
- Any procedure that is not specifically listed as a covered service.
- Elective dentistry and cosmetic dentistry.
- Fees incurred for broken or missed appointments (without 24 hours notice) are the Member's responsibility. However, the copayment for missed appointments may not apply if: (a) the Member canceled at least 24 hours in advance; or (b) the Member missed the appointment because of an emergency or circumstances beyond the control of the Member.
- General anesthesia or intravenous/conscious sedation. However, such services may be covered under the medical services portion of this Plan. See the Plan Contract and EOC for details.
- Hospital charges of any kind.
- Loss or theft of full or partial dentures.
- Oral surgery requiring the setting of fractures or dislocations, orthognathic surgery and extraction solely for orthodontic purposes (does not apply to fractured or dislocated (knocked out) teeth).
- Prescription medications.
- Services that cannot be performed because of the physical or behavioral limitations of the patient.
- Temporomandibular joint treatment (TMJ).

- Treatment of malignancies, cysts, neoplasms or congenital malformations.

DENTAL PLAN GENERAL PROVISIONS
An additional charge will be required for missed appointments. Missed appointments without 24 hours notice will be charged an additional charge. However, the Copayment for missed appointments may not apply if: (1) the Member canceled at least 24 hours in advance; or (2) the Member missed the appointment because of an emergency or circumstances beyond the control of the Member.

GRIEVANCE PROCEDURES AND MANDATORY ARBITRATION
A Member must submit all grievances concerning this dental plan through Health Net of California's internal grievance procedures before a Member may file for arbitration for final and binding resolution of the grievance. Arbitration is the final process for the resolution of any dispute arising out of or relating to this dental plan, whether involving a claim in tort, contract or otherwise.

SERVICES TO WHICH THE MEMBER IS ENTITLED UNDER ANY WORKERS' COMPENSATION LAW OR ACT
This dental plan shall provide coverage for services at the time of need. Where other coverage exists, the Plan may coordinate the benefits and/or assert a lien. It is the responsibility of the Member to execute and deliver relevant documents and/or take such action as may be necessary to assure that the plan is reimbursed for benefits provided by Workers' Compensation. This section does not apply to Medi-Cal Beneficiaries.

ORTHODONTIC BENEFITS
The orthodontic copayment charged for children through age 19 will be $1,800 per case. Adults aged 20 or older will be charged an orthodontic copayment of $2,000 per case. This benefit is limited to 24 months of usual and customary orthodontic banding.

PRINCIPAL ORTHODONTIC EXCLUSIONS AND LIMITATIONS
Health Net of California reserves the right to limit coverage to its choice of participating dentists.

Effective February 1, 2004
HEALTH NET OF CALIFORNIA, INC.
INDIVIDUAL & FAMILY EOA AND HMO PLUS PLANS

Principal benefits and coverages for vision care provided with HMO and EOA Plus plans

Underwritten by Health Net of California and administered by SafeGuard Health Plans, Inc. This benefit is included with HMO 15 Plus, HMO 40 Plus and EOA 15 Plus

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

All of the following services must be provided by the Member's selected Participating Vision Provider in order to be covered under this vision plan.

Summary of vision benefits

COVERED SERVICES	MEMBER PAYS
Deductibles	None
Lifetime maximums	None
PROFESSIONAL SERVICES Vision exam (once every 12 months)	**$10 copayment** An additional examination may be provided consistent with professionally recognized standards of practice within 12 months if medically necessary.
Corrective lenses and spectacle frames or contact lenses (once every 12 months)	**$40 copayment** Frames are covered up to a maximum wholesale allowance of $32, medically necessary contact lenses are covered up to a maximum allowance of $250 (when medically necessary contact lenses are required, the Plan pays the benefits for both contact lenses and spectacles), non-medically necessary contact lenses are covered up to a maximum retail allowance of $80.
Outpatient services	**not covered**
Hospitalization services	**not covered**
Emergency services	Fees charged by a vision care provider in excess of Health Net of California's maximum reimbursement of $40 for an eye examination and $50 for frames, corrective lenses and lens options (a maximum of $90 will be reimbursed for services received)
Ambulance services	**not covered**
Prescription drug coverage	**not covered**
Durable medical equipment	**not covered**
Mental health services	**not covered**
Chemical dependency services	**not covered**
Home health services	**not covered**
Other services	**not covered**

Vision examination

In accordance with professionally recognized standards of practice, this exam will include an analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities.

Frames
If the exam indicates the necessity of spectacles, this vision plan will cover a frame at the service interval and up to the maximum frame allowance indicated above. If the Member selects frames that are more expensive than this allowance, the Member will be charged the difference between the allowance and the wholesale cost of the more expensive frames, plus an additional service fee. This total cost represents a savings to the Member off retail prices.

Lenses
If the exam results in corrective lenses being prescribed for the first time, or if a current wearer of corrective lenses needs new lenses, this vision plan will cover a pair of lenses at the service level indicated above. Coverage is limited to basic lenses that are medically necessary to correct vision. If the Member selects lenses with non-basic features, the Member will be responsible for the provider's charges for the extra features.

Medically necessary contact lenses
Coverage for prescriptions for contact lenses is subject to medical necessity, prior authorization by Health Net of California and all applicable exclusions and limitations. Medically necessary contact lenses are covered at the service interval and up to maximum allowance indicated above.

Non-medically necessary contact lenses
Non-medically necessary (cosmetic) contact lenses, when covered, will be provided in lieu of all other benefits for materials and shall be provided at the same interval as spectacle lenses as indicated above.

Second pair
Participating vision providers will provide a 20% discount off usual and customary fees for a second pair of frames and spectacle lenses (including prescription sunglasses) for Members at the same interval as the first pair of frames and spectacle lenses.

Grievance procedures and mandatory arbitration
Members are required to submit all grievances concerning this vision plan through the Health Net of California internal grievance procedures before a member may file for arbitration for final and binding resolution of the grievance. Arbitration is the final process for the resolution of any dispute arising out of or relating to this vision plan, whether involving a claim in tort, contract or otherwise.

Reimbursement provisions for emergency vision care
If you receive emergency vision care from a provider other than a Health Net of California participating provider, you may be asked to make immediate payment for their services and supplies.

Coverage for services of a provider other than a Health Net of California participating provider is limited to emergency care when a Health Net of California participating provider is not available.

Under these circumstances, Health Net of California will reimburse you up to $40 for an eye examination and up to $50 for frames, corrective lenses and lens options, if you submit a copy of the paid bill to Health Net of California within 60 days of the date of services.

PRINCIPAL EXCLUSIONS AND LIMITATIONS
FOR VISION PROVIDED BY HEALTH NET OF CALIFORNIA

The following vision services and expenses are not covered under the HMO 15 Plus, HMO 40 Plus and EOA 15 Plus plans:

- Coverage limited to care rendered by participating providers.

- Extras and not-medically necessary services and materials. This vision plan is designed to cover medically necessary visual needs rather than cosmetic desires. Charges for services and materials are excluded if Health Net of California determines them to be: (1) beyond the allowances for frames and contact lenses indicated in the Summary of Vision Care Benefits; or (2) not-medically necessary in which case the Member pays the difference between the allowance and the cost of the not-medically necessary lens. Not-medically necessary lens features include special lens fabrication, coated lenses, tinted lenses, dyed lenses, laminated lenses, progressive lenses, blended lenses, oversize lenses, occupational lenses, and any other types of lenses or features that Health Net of California determines to be non-basic or not medically necessary.

- Medically necessary contact lenses. Coverage for prescriptions for contact lenses is subject to medical necessity, prior authorization by Health Net of California, and all applicable exclusions and limitations. Coverage (exclusive of the indicated copayment) for contact lenses will only be authorized: (1) for contact lenses to correct extreme visual acuity problems that cannot be corrected to 20/70 in the better eye with spectacle lenses; (2) following cataract surgery resulting in aphakia; (3) for anisometropia of 4.0 diopters or greater; or (4) for keratoconus or other corneal irregularities. When covered, contact lenses are furnished at the same interval as spectacle lenses are covered under this vision plan. This coverage is in lieu of all other material benefits of this vision plan. For medically necessary contact lenses, participating vision providers have agreed to limit their charges to a reduced amount that is 80% of their usual retail fees. Health Net of California will pay an allowance up to $250 of that reduced amount minus any applicable copayments. The $250 allowance applies to all costs associated with obtaining contact lenses, including the examination, fitting fees and materials. Members are responsible for any reduced amount charged by participating vision providers in excess of the $250 allowance, plus any applicable copayments.

- Non-medically necessary contact lenses. Prescriptions for contact lenses that are not medically necessary are covered up to the maximum retail contact lens benefit allowance indicated above. This coverage is in lieu of all other material benefits of this vision plan. The allowance applies to all costs associated with obtaining contact lenses, including fitting fees and materials. Members are responsible for additional charges in excess of the allowance. If the Member selects contact lenses that are more expensive than this allowance, the Member will be responsible for the provider's charges in excess of the allowance.

- Medical or hospital. Hospital and medical charges of any kind, vision services rendered in a hospital, and medical or surgical treatment of eyes, are excluded.

- Loss or theft.

- Orthoptics, vision training, subnormal vision aids, plano (non-prescription) lenses and any associated testing.

- Lenses secured when there is no prescription change are excluded.

- A second pair of glasses in lieu of bifocals is excluded.

- Experimental services and supplies are excluded. Experimental treatment if denied may be appealed through the Independent Medical Review process. Services shall be covered and provided if required under the Independent Medical Review process.

Please refer to the Plan Contract and Evidence of Coverage for a complete listing of Exclusions and Limitations.