



ARIZONA 2010 HEALTH NET MEDICARE ADVANTAGE PLANS

Optional Supplemental Benefits - Gold Benefits

*Health Net Ruby 1 (HMO), Health Net Ruby 4 (HMO), and
Health Net Green (HMO) Plans*



OPTIONAL SUPPLEMENTAL BENEFITS – GOLD BENEFITS

Optional benefits enhance your health care coverage! For an additional monthly premium, Health Net gives you two options to enhance your basic medical coverage with routine benefits including dental, vision, acupuncture, and chiropractic care. It's just another way that Health Net offers more health care choices that are right for you.

Gold Option 1 includes coverage for acupuncture, chiropractic care, preventive/comprehensive dental, and routine vision for an additional monthly premium of \$29.

Gold Option 2 includes coverage for preventive/comprehensive dental and routine vision for an additional monthly premium of \$17.

Both options are available to members of the Health Net Ruby 1 (HMO), Health Net Ruby 4 (HMO), and Health Net Green (HMO) plans.

We've made access to these benefits easy. Each Gold Benefit is self-referral. In addition, we have contracted with well-established companies whose network providers are conveniently located.

This booklet provides you with an overview of acupuncture, chiropractic, dental and vision benefits along with the care and treatment they cover. This easy-to-use reference is designed to answer your questions quickly and conveniently.

The following companies are our plan providers:

- Acupuncture and Chiropractic Care – American Specialty Health Networks, Inc. (ASH Networks)
Member Services: 1-800-678-9133 (TTY 1-877-710-2746 for the hearing impaired) Monday through Friday, 5:00 a.m. to 6:00 p.m. (Pacific Time)
- Dental – Health Net Dental (administered through Dental Benefit Providers, Inc.)
Member Services: 1-866-249-4435 (TTY 1-800-855-2881 AT&T Relay Service for the hearing and speech impaired) Monday through Friday from 7:00 a.m. to 10:00 p.m., (Central Time)
- Vision – Health Net Vision (offered through EyeMed Vision Care, LLC)
Member Services: 1-866-392-6058 (TTY 1-866-308-5375 for the hearing impaired) Monday through Saturday, 5:00 a.m. to 8:00 p.m., and Sunday 8:00 a.m. to 5:00 p.m. (Pacific Time)

If all of your questions are not answered in this booklet, please feel free to call our Customer Contact Center at 1-800-977-7522 (TTY 1-800-977-6757 for the hearing impaired), 8:00 a.m. to 8:00 p.m., 7 days a week.

GETTING STARTED WITH YOUR GOLD BENEFITS

To use your benefits, follow these simple steps:

- Read through each section to understand each benefit.
- Select the plan provider you wish to visit from your Health Net Directory of Plan Providers or in the Health Net Dental directory.
- Call and schedule an appointment.
- Identify yourself as a Health Net member.
- Show your Health Net member ID card when you visit the provider.

GOLD OPTION 1

Gold Option 1 provides coverage for acupuncture, chiropractic care, preventive/comprehensive dental, and routine vision care.

ACUPUNCTURE AND CHIROPRACTIC CARE

Health Net offers quality, affordable acupuncture and chiropractic care through an arrangement with American Specialty Health Networks, Inc. (ASH Networks). You may self-refer to any participating acupuncturist or chiropractor through this plan – without consulting your Primary Care Physician.

The ASH Networks-contracted chiropractor or acupuncturist you select will provide the initial examination and will contact ASH Networks for authorization of the treatment plan he/she develops for you based on medical necessity and your list of covered services. Please refer to the Health Net Directory of Plan Providers.

You can receive a maximum of 24 combined¹ visits annually to a contracted provider for acupuncture and/or chiropractic care services. You will pay a \$15 copayment for each visit.

Benefits	Gold Option 1
Office Visit	\$15 copayment
Annual Visit Limit	24 visits per year (Acupuncture and Chiropractic visits combined)

Please note: You pay your plan's Specialist copayment per visit for manual manipulation of the spine to correct subluxation (the Medicare-covered service) when provided by chiropractors or other qualified professionals under your medical plan benefits. This covered benefit is unlimited.

¹ Subject to medical necessity determination and contract limitations and/or exclusions.

For more information about the acupuncture and chiropractic benefits, please contact ASH at 1-800-678-9133 (TTY 1-877-710-2746), Monday through Friday from 5:00 a.m. to 6:00 p.m., Pacific Time.

ACUPUNCTURE

Acupuncture is a treatment that can relieve symptoms of pain, nausea, and some neuromusculoskeletal conditions. Acupuncture stimulates the nerves in the skin and muscle, and can produce a variety of effects. It increases the body's release of natural painkillers in the pain pathways of both the spinal cord and the brain. This modifies the way pain signals are received. But acupuncture does much more than reduce pain, and has a beneficial effect on health. Patients often notice an improved sense of well-being after treatment.

Modern research shows that acupuncture can affect most of the body's systems – the nervous system, muscle tone, hormone outputs, circulation, antibody production and allergic responses, as well as the respiratory, digestive, urinary and reproductive systems.

Benefits of acupuncture include, but are not limited to:

- Pain relief for a wide range of painful conditions
- Help with functional bowel or bladder problems such as IBS or even mild forms of incontinence
- Reduction of menstrual and menopausal symptoms
- Reduction of allergies such as hay fever
- Improvement of other skin problems such as rashes and ulcers, itching and some forms of dermatitis
- Relief of sinus problems
- Help to quit smoking

(Please refer to the Limitations and Exclusions section of your Vendor Benefit Rider (VBR) or Evidence of Coverage (EOC), or other plan documents, to see if these conditions are covered by your plan.)

CHIROPRACTIC CARE

Chiropractic physicians give special attention to physiological and biochemical aspects, including structural, spinal, vascular, nutritional, emotional and environmental relationships.

Procedures specifically include the adjustment and manipulation of the spinal column. Chiropractic is a drug-free, non-surgical science. Many people find chiropractic care very effective, particularly for low back pain. Now you can have convenient, affordable chiropractic care with your Gold Benefits.

Your chiropractic benefits include, but are not limited to:

- Chiropractic manipulation and adjustments (see note below)
- Treatment for the aggravation of an illness or injury
- Treatment for the exacerbation of an illness or injury

Note: Manual manipulation of the spine to correct subluxation is a Medicare-covered service and is covered under your Health Net Medicare Advantage plan benefit. If you choose to use your Gold Benefits visits first and additional chiropractic care is needed, you may elect to continue coverage under your Health Net Medicare Advantage plan benefit. You will pay a higher copayment for each visit, but these visits will not count toward your Gold Benefits annual visit limit. Please refer to your Evidence of Coverage (EOC) or Vendor Benefit Rider (VBR) document for further information.

PREVENTIVE/COMPREHENSIVE DENTAL CARE

Members enrolled in Health Net’s Ruby 1 (HMO), Ruby 4 (HMO), and Green (HMO) plans have two levels of dental benefits and many choices of providers. Members save money when using in-network providers (providers who are

listed in the Health Net Dental directory), or members pay a little more to use providers who are out-of-network (providers who are NOT listed in the Health Net Dental directory). Prior authorization is not required for covered services under Health Net’s PPO dental plan.

Benefits	Gold Option 1	
	In-Network	Out-of-Network
Monthly Premium	\$29	
Calendar Year Maximum	\$1,500	
Calendar Year Deductible	\$0	
Preventive Services (Initial Routine Oral Exam, X-Rays, Cleanings, Routine Scaling, Emergency Exam, Space Maintainers)	Covered at 100%	Covered at 80%
General Services (Fillings, General Anesthetics)	Covered at 100%	Covered at 80%
Major Services (Crowns, Removable and Fixed Bridges, Complete/ Partial Dentures, Endodontics, Periodontics, Oral Surgery)	Covered at 80%	Covered at 50%

REIMBURSEMENT FOR DENTAL CARE

If you see a dentist other than a Health Net PPO Dental provider for covered dental care services, you should ask the dentist to bill Health Net Dental directly. However, if the dentist insists on payment at the time service is provided, you should send a copy of the paid bill to:

Health Net Dental
 Attn: Claims Unit
 P.O. Box 30567
 Salt Lake City, UT 84130-0567

Please include either the dentist’s completed claim form or a separate sheet of paper, if a claim form is unavailable, that includes the following information:

- Name, address, ID number, and group number from your Health Net identification card
- Name and address of the dentist who provided the service (unless stated on the bill)
- An itemized receipt that specifies the covered services provided.

If additional information is needed, the member will be advised in writing. If all or part of the claim is denied, you will receive written notice of the decision within 30 days, including:

- The reason for denial
- Notice of the right to request reconsideration of the denial and an explanation of the grievance and appeals process.

All such claims should be sent to Health Net Dental within 60 calendar days from the date of service to be considered for payment.

This dental plan does not cover services and supplies provided by non-physician/dentist health care practitioners. Additionally, no payment will be made for services received that are not a covered benefit under the Health Net PPO Dental plan. Please refer to this booklet for information on covered services.

You save when using a PPO dentist: Our PPO dentists have agreed to reduce their treatment fees, which will lower your out-of-pocket expenses.

Your Costs: Payment is based on the “usual & customary” charge that is pre-set for each procedure. This charge is determined by the complexity of the treatment and the fee most commonly charged for that procedure in a particular geographic area. This is the “maximum allowable” for any procedure and the benefit will be calculated based on the dentist’s submitted fee or the usual & customary amount – whichever is lower.

Balance Billing: If your dentist charges more than the usual & customary amount for a procedure, you are responsible for the difference between what is charged and the usual & customary amount. This is called “Balance Billing”. If you receive treatment from a PPO dentist, you will not be “Balance Billed” – our PPO dentists have agreed to accept the pre-set usual & customary fees, plus your co-insurance payment, if any, as payment in full.

LIMITATIONS

- **Initial/Routine Oral Exam:** 2 per calendar year
- **Teeth Cleaning:** 2 per consecutive 12 months
- **Bitewing Series:** 2 per calendar year
- **Fluoride Treatment:** 2 per consecutive 12 months, limited to covered persons under the age of 16 years
- **Sealants:** 1 per 36 months², children 17 years and under on permanent molars only
- **Emergency Treatment:** Relief of acute pain, bleeding or infection only

LIMITATIONS – BENEFITS UNDER THIS POLICY ARE LIMITED AS FOLLOWS:

1. Panorex or full mouth X-ray series – once every 36 months²
2. Porcelain, porcelain with metal, or full gold crowns
3. General anesthetics – for oral surgery and periodontics only
4. Replacement of crowns, gold restorative or cast posts - once every five years. (If the tooth can be restored with less expensive materials, the benefit will be based on those materials.)²
5. To restore injured or decayed posterior teeth, the benefit is an amalgam filling.
6. Replacement of dentures – once every five years and only if the original is unserviceable. When a permanent denture replaces a temporary one, charges for both are limited to the charge for the permanent one.²

² Multi-year benefit may not be available in subsequent years.

**HEALTH NET DENTAL
CUSTOMER SERVICE
DEPARTMENT**

For full information, our Health Net Dental Customer Service Department can be reached by calling 1-866-249-4435 (TTY 1-800-855-2881 AT&T Relay Service for the hearing and speech impaired). We are available to answer your calls Monday through Friday from 7:00 a.m. to 10:00 p.m., CST.

Dental benefits underwritten by Health Net of Arizona, Inc., and administered through Dental Benefit Providers, Inc.

VISION CARE

Your Gold Benefits package includes vision care services from a statewide network of vision care professionals. Your plan is easy to use and includes an annual routine eye exam. Health Net carefully screens the vision care professionals in its provider organization to help assure quality of care.

With this plan you can choose to receive your vision care from many offices throughout Arizona. Most are full-service providers, so you can get your examination, lenses and any adjustment all at the same location.

	Gold Option 1	
Benefits	In-Network	Out-of-Network Allowance
Eye Exam (Refractive) (Available once every 12 months)	\$10 copayment	\$45
Contact Lens Fit and Follow Up (Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed)		
Standard	\$0 copayment, paid in full fit and two follow-up visits	\$40
Premium	\$0 copayment, 10% off retail price, then apply \$55 allowance	\$40
Frames, Lens & Options Package (Available once every 24 months) ²	\$250 allowance for frames, lens and lens options; member receives 20% off balance over \$250	Up to \$250 allowance; member pays 100% of balance
Contacts - Conventional (Available once every 24 months) ²	\$0 copayment, \$250 allowance; member receives 15% off balance over \$250	\$250
Disposable	\$0 copayment, \$250 allowance, plus balance over \$250	\$250
Medically necessary	\$0 copayment, paid in full	\$250

² Multi-year benefit may not be available in subsequent years.

YOUR VISION BENEFITS INCLUDE:

EXAM:

There is a \$10 copayment in-network, or a \$45 copayment out-of-network, for an annual visit to your vision provider. In- or out-of-network, you are covered for a vision exam once every 12 months.

FRAMES, LENS & OPTIONS PACKAGE:

Frames, lenses, and lens options are covered up to a \$250 maximum retail benefit allowance in-network, or up to a \$250 maximum retail benefit allowance out-of-network. In-network, members will receive 20% off balance over allowance amount. Out of network, you are responsible for the difference between the retail amount and the \$250 allowance. In- or out-of-network, you are covered for materials once every 24 months². You can choose from any of the frames available at the plan provider's office and apply your frames allowance.

CONTACT LENSES:

Should you choose contact lenses for elective reasons, your vision plan will cover a maximum allowance of \$250 toward the cost in-network, or a maximum of \$250 toward the cost out-of-network. For medically necessary contacts, your vision plan will pay in full for in-network, or \$250 out-of-network.

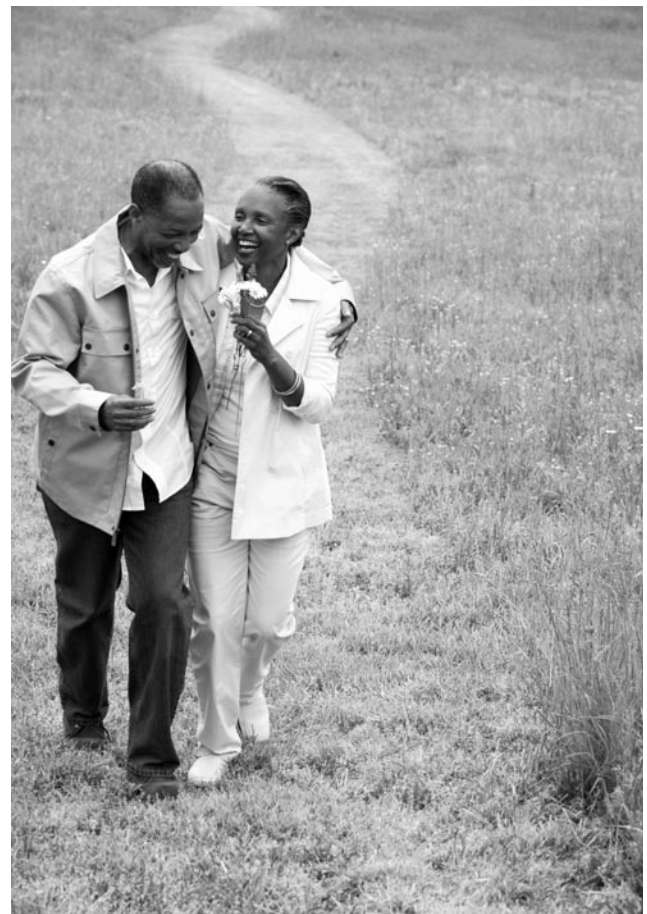
Members will receive 15% off balance over allowance amount for conventional contact lenses. In- or out-of-network, you are covered for one pair of contact lenses once every 24 months².

The contact lenses allowance is in place of the frames and lenses option. Covered services are available once every 24 months².

Note: Coverage of one pair of glasses (or medically necessary contact lenses) following cataract surgery is not covered under the Gold Benefits, but is a Medicare-covered benefit under your Health Net Medicare Advantage Plan. Please refer to your Evidence of Coverage (EOC) or Vendor Benefits Rider (VBR) for further information.

For more information about these vision benefits, please contact Health Net Vision Member Services at 1-866-392-6058 (TTY 1-866-308-5375), Monday through Saturday, 5:00 a.m. to 8:00 p.m., and Sunday from 8:00 a.m. to 5:00 p.m., Pacific Time.

² Multi-year benefit may not be available in subsequent years.



GOLD OPTION 2

Gold Option 2 provides coverage for preventive/comprehensive dental and routine vision care.

PREVENTIVE/COMPREHENSIVE DENTAL CARE

You can see any licensed dentist to receive covered preventive and general comprehensive dental services; however, your cost sharing will be lower if you use plan providers.

	Gold Option 2	
Benefits	In-Network	Out-of-Network
Monthly Premium	\$17	
Calendar Year Maximum	\$1,000	
Calendar Year Deductible	\$0	\$100
Preventive Services (Initial Routine Oral Exam, X-Rays, Cleanings, Routine Scaling, Emergency Exam, Space Maintainers)	Covered at 100%	Covered at 80%
General Services (Fillings, General Anesthetics)	Covered at 80%	Covered at 60%
Major Services (Crowns, Removable and Fixed Bridges, Complete/ Partial Dentures, Endodontics, Periodontics, Oral Surgery)	Covered at 70%	Covered at 50%

REIMBURSEMENT FOR DENTAL CARE

If you see a dentist other than a Health Net PPO Dental provider for covered dental care services, you should ask the dentist to bill Health Net Dental directly. However, if the dentist insists on payment at the time service is provided, you should send a copy of the paid bill to:

Health Net Dental
Attn: Claims Unit
P.O. Box 30567
Salt Lake City, UT 84130-0567

Please include either the dentist's completed claim form or a separate sheet of paper, if a claim form is unavailable, that includes the following information:

- Name, address, ID number, and group number from your Health Net identification card
- Name and address of the dentist who provided the service (unless stated on the bill)
- An itemized receipt that specifies the covered services provided.

If additional information is needed, the member will be advised in writing. If all or part of the claim is denied, you will receive written notice of the decision within 30 days, including:

- The reason for denial.
- Notice of the right to request reconsideration of the denial and an explanation of the grievance and appeals process.

All such claims should be sent to Health Net Dental within 60 calendar days from the date of service to be considered for payment.

This dental plan does not cover services and supplies provided by non-physician/dentist health care practitioners. Additionally, no payment will be made for services received that are not a covered benefit under the Health Net PPO Dental plan. Please refer to this booklet for information on covered services.

You save when using a PPO dentist: Our PPO dentists have agreed to reduce their treatment fees, which will lower your out-of-pocket expenses.

Your Costs: Payment is based on the “usual & customary” charge that is pre-set for each procedure. This charge is determined by the complexity of the treatment and the fee most commonly charged for that procedure in a particular geographic area. This is the “maximum allowable” for any procedure and the benefit will be calculated based on the dentist’s submitted fee or the usual & customary amount – whichever is lower.

Balance Billing: If your dentist charges more than the usual & customary amount for a procedure, you are responsible for the difference between what is charged and the usual & customary amount. This is called “Balance Billing”. If you receive treatment from a PPO dentist, you will not be “Balance Billed” – our PPO dentists have agreed to accept the pre-set usual & customary fees, plus your co-insurance payment, if any, as payment in full.

LIMITATIONS

- **Initial/Routine Oral Exam:** 2 per calendar year
- **Teeth Cleaning:** 2 per consecutive 12 months
- **Bitewing Series:** 2 per calendar year
- **Fluoride Treatment:** 2 per consecutive 12 months

- **Sealants:** 1 per 36 months², children 17 years and under on permanent molars only
- **Emergency Treatment:** Relief of acute pain, bleeding or infection only

² Multi-year benefit may not be available in subsequent years.

LIMITATIONS - BENEFITS UNDER THIS POLICY ARE LIMITED AS FOLLOWS:

1. Panorex or full mouth X-ray series – once every 36 months²
2. Porcelain, porcelain with metal, or full gold crowns
3. General anesthetics – for oral surgery and periodontics only
4. Replacement of crowns, gold restorative or cast posts - once every five years. (If the tooth can be restored with less expensive materials, the benefit will be based on those materials.)²
5. To restore injured or decayed posterior teeth, the benefit is an amalgam filling.
6. Replacement of dentures – once every five years and only if the original is unserviceable. When a permanent denture replaces a temporary one, charges for both are limited to the charge for the permanent one.²

² Multi-year benefit may not be available in subsequent years.

HEALTH NET DENTAL CUSTOMER SERVICE DEPARTMENT

For more information about these benefits, our Health Net Dental Customer Service Department can be reached by calling 1-866-249-4435 (TTY 1-800-855-2881 AT&T Relay Service for the hearing and speech impaired). We are available to answer your calls Monday through Friday from 7:00 a.m. to 10:00 p.m., CST.

Dental benefits underwritten by Health Net of Arizona, Inc., and administered through Dental Benefit Providers, Inc.

VISION CARE

Your Gold Benefits package includes vision care services from a statewide network of vision care professionals. Your plan is easy to use and includes an annual routine exam. Health Net carefully screens the vision care professionals in its provider organization to help assure quality of care.

With this plan you can choose to receive your vision care from many offices throughout Arizona. Most are full-service providers, so you can get your examination, lenses and any adjustment all at the same location.

Benefits	In-Network	Out-of-Network Allowance
Eye Exam (Refractive) (Available once every 12 months)	\$10 copayment	\$35
Contact Lens Fit and Follow Up (Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed)		
Standard	\$0 copayment, paid in full fit and two follow-up visits	\$40
Premium	\$0 copayment, 10% off retail price, then apply \$55 allowance	\$40
Lenses – Standard plastic (Available once every 24 months) ²		
Single	\$0 copayment	\$25
Bifocal	\$0 copayment	\$40
Trifocal	\$0 copayment	\$55
Lenticular	\$0 copayment	\$55
Standard Progressive	\$65 copayment	\$40
Premium Progressive	\$65, 80% of charge less \$120 allowance	\$40

² Multi-year benefit may not be available in subsequent years.

Benefits	In-Network	Out-of-Network Allowance
Lens Options		
UV Coating	\$15 copayment	N/A
Tint	\$15 copayment	N/A
Standard scratch-resistant	\$15 copayment	N/A
Standard polycarbonate	\$40 copayment	N/A
Standard Anti-Reflective Coating	\$45 copayment	N/A
Other Add-Ons and Services	20% off Retail Price	N/A
Frames (Available once every 24 months) ²	\$100 allowance; member receives 20% off balance over \$100	Up to \$45 allowance; member pays 100% of balance
Contacts (Available once every 24 months) ²		
Conventional	\$0 copayment, \$100 allowance; member receives 15% off balance over \$100	\$80
Disposables	\$0 copayment, \$100 allowance; member receives 15% off balance over \$100	\$80
Medically Necessary	\$0 copayment, paid in full	\$200

YOUR VISION BENEFITS INCLUDE:

EXAM:

There is a \$10 copayment for annual visits to your vision provider. After that copayment has been met, you will be covered 100% in-network, or up to a \$35 maximum retail benefit allowance out-of-network. In- or out-of-network, you are covered for a vision exam once every 12 months.

² Multi-year benefit may not be available in subsequent years.

FRAMES:

Frames are covered up to a \$100 maximum retail benefit allowance in-network, or up to a \$45 maximum retail benefit allowance out-of-network. Members will receive 20% off balance over allowance amount. In- or out-of-network, you are covered for materials once every 24 months.² You can choose from any of the frames available at the plan provider's office and apply your frames allowance. If you select frames that exceed your frames allowance, you pay the difference between the retail price of the frames you picked and the allowance.

STANDARD OR BASIC LENSES:

There is a \$0 copayment for standard lenses, available once every 24 months².

In-network

- Single vision – 100% coverage once every 24 months²
- Bifocal – 100% coverage once every 24 months²
- Trifocal – 100% coverage once every 24 months²
- Lenticular – 100% coverage once every 24 months²
- Standard Progressive lenses – \$65 copayment, 100% coverage once every 24 months²
- Premium Progressive lenses – \$65 copayment, 80% of charge less \$120 allowance once every 24 months²

Out-of-network

- Single vision – up to \$25 maximum retail benefit allowance once every 24 months²
- Bifocal – up to \$40 maximum retail benefit allowance once every 24 months²
- Trifocal – up to \$55 maximum retail benefit allowance once every 24 months²
- Lenticular – up to \$55 maximum retail benefit allowance once every 24 months²
- Standard Progressive lenses – up to \$40 maximum retail benefit allowance once every 24 months²
- Premium Progressive lenses – up to \$40 maximum retail benefit allowance once every 24 months²

CONTACT LENSES:

Should you choose contact lenses for elective reasons, your vision plan will cover a maximum allowance of \$100 toward the cost in-network after a \$0 copay, or a maximum of \$80 toward the cost out-of-network. For medically necessary contacts, your vision plan will pay in full for in-network, or \$200 out-of-network.

Members will receive 15% off balance over allowance amount for conventional contact lenses. In- or out-of-network, you are covered for one pair of contact lenses once every 24 months.²

The contact lenses allowance is in place of the frames and lenses option. Covered services are available once every 24 months.²

Note: Coverage of one pair of glasses (or medically necessary contact lenses) following cataract surgery is not covered under the Gold Benefits, but is a Medicare-covered benefit under your Health Net Medicare Advantage Plan. Please refer to your Evidence of Coverage (EOC) or Vendor Benefits Rider (VBR) for further information.

² Multi-year benefit may not be available in subsequent years.

For more information about these vision benefits, please contact Health Net Vision Member Services at 1-866-392-6058 (TTY 1-866-308-5375), Monday through Saturday, 5:00 a.m. to 8:00 p.m., and Sunday from 8:00 a.m. to 5:00 p.m., Pacific Time.



LIMITATIONS AND EXCLUSIONS

Acupuncture and Chiropractic Care Covered Services and Supplies

Acupuncture

1. Services or treatments not approved by ASH Networks as medically/clinically necessary, except for a new patient examination and urgent services.
2. Services or treatments not delivered by contracted acupuncturists for the delivery of acupuncture care to members, except for urgent services.
3. Services for examinations and/or treatments for conditions other than those related to neuromusculoskeletal disorders, nausea or pain syndromes from contracted acupuncturists.
4. Hypnotherapy, behavior training, sleep therapy and weight programs.
5. Thermography.
6. Services, lab tests, X-rays and other treatments not documented as medically/clinically necessary and appropriate or classified as experimental or investigational and/or as being in the research stage.
7. Radiological X-rays (plain film studies), magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, diagnostic radiology and laboratory services.
8. Transportation costs including local ambulance charges.
9. Education programs, non-medical lifestyle or self-help or any self-help physical exercise training or related diagnostic testing.
10. Services or treatments for pre-employment physicals or vocational rehabilitation.
11. Services or treatments caused by or arising out of the course of employment or covered under public liability insurance.
12. Air conditioners, air purifiers, therapeutic mattresses, supplies, durable medical equipment or appliances.
13. Prescription drugs or medicines, including non-legend or proprietary medicine or medication not requiring a prescription order.
14. Services provided by an acupuncturist practicing outside the service area, except for urgent services.
15. Hospitalization, anesthesia, manipulation under anesthesia and other related services.
16. Auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.
17. Adjunctive therapy not associated with acupuncture.
18. Vitamins, minerals or other similar products.
19. Nutrition supplements that are Native American, South American, European or of any other origin.
20. Nutrition supplements obtained by the member through an acupuncturist, health food store, grocery store or by any other means.
21. Clinical laboratory services or any other type of diagnostic test or service.

Chiropractic

1. Services or treatments not approved by ASH Networks as medically necessary, except for a new patient examination and urgent services.
2. Services or treatments not delivered by contracted chiropractors for the delivery of chiropractic care to members, except for urgent services.
3. Services for examinations and/or treatments for conditions other than those related to neuromusculoskeletal disorders from contracted chiropractors.
4. Hypnotherapy, behavior training, sleep therapy and weight programs.
5. Thermography.

6. Services, lab tests, X-rays and other treatments not documented as medically/ clinically necessary and appropriate or classified as experimental or investigational and/or as being in the research stage.
7. Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology and any diagnostic radiology other than covered plain film studies.
8. Transportation costs including local ambulance charges.
9. Education programs, non-medical lifestyle or self-help or any self-help physical exercise training or related diagnostic testing.
10. Services or treatments for pre-employment physicals or vocational rehabilitation.
11. Services or treatments caused by or arising out of the course of employment or covered under public liability insurance.
12. Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all chiropractic appliances or durable medical equipment, except as described in the covered services section.
13. Prescription drugs or medicines, including non-legend or proprietary medicine or medication not requiring a prescription order.
14. Services provided by a chiropractor practicing outside the service area, except for urgent services.
15. Hospitalization, anesthesia, manipulation under anesthesia and other related services.
16. Auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.
17. Adjunctive therapy not associated with spinal, muscle or joint manipulation.
18. Vitamins, minerals or other similar products.

Dental

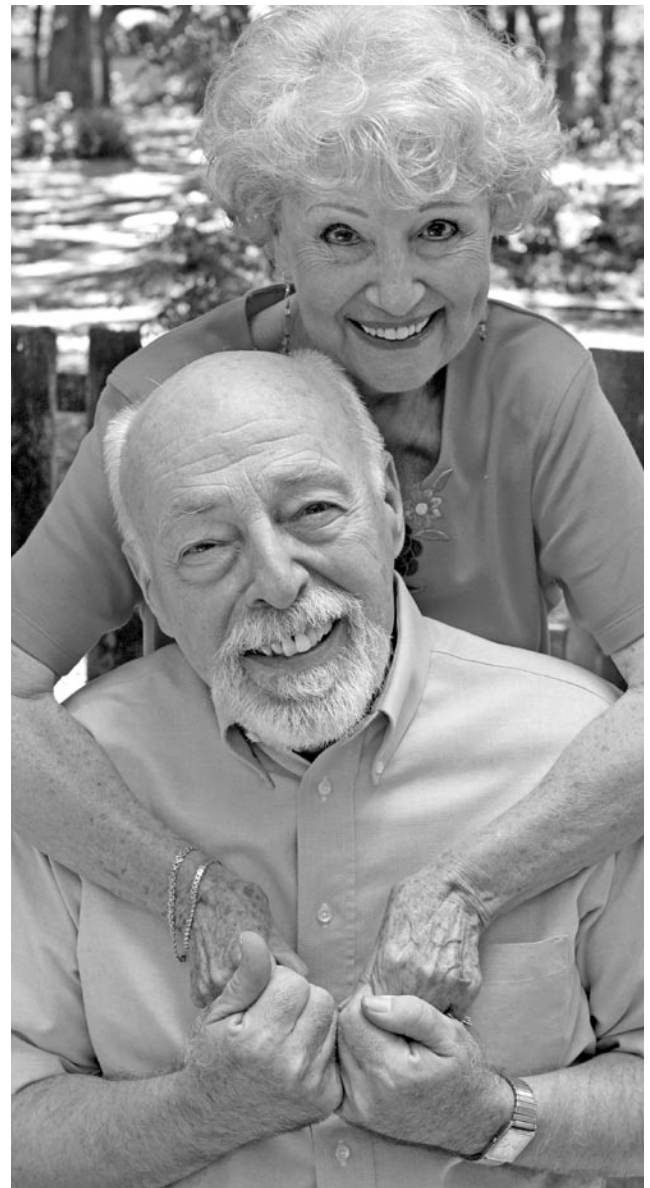
Exclusions – No benefits are payable under this Policy for any expenses incurred for:

1. Any service or supply not listed in this booklet.
2. Any procedure or appliance started before the effective date or after the termination date of the Covered Person's insurance.
3. An appliance delivered or placed more than ninety days after termination of the Covered Person's insurance.
4. Treatment by anyone other than a Dentist or Physician, except where performed by a duly qualified hygienist under the direction of a Dentist or Physician.
5. Dental services that do not have uniform professional endorsement by the American Dental Association.
6. Services or materials that are experimental, cosmetic, or not medically necessary.
7. Services and supplies related to the change of vertical dimension, restoration or maintenance of occlusion, re-implantation, splinting and stabilizing teeth, bite registration, bite analysis, attrition, erosion or abrasion, and treatment for myofascial pain disorders (MPD) or temporomandibular joint dysfunction (TMJ).
8. Replacement of lost or stolen appliances or replacement of any appliance, prosthesis, crown, or bridge placed less than five (5) years before (temporary prosthetics are considered permanent and subject to this exclusion if not replaced by the permanent prosthetic within six (6) months).
9. Initial placement of any bridge or denture unless such placement is necessitated by the extraction of one or more natural teeth while insured under this Policy or is due to irreparable damage caused as a result of injury received while insured under this Policy.

10. Periodontal maintenance, unless following active periodontal therapy.
11. Periodontal scaling or root planing for children under the age of 14.
12. Partial dentures for children under the age of 14 to replace extracted or lost primary or permanent teeth.
13. Prescribed drugs, medications or analgesia, or training in or supplies used for dietary counseling, oral hygiene or plaque control; nitrous oxide or sterilization charges; pulp caps or medicaments.
14. Care rendered within any facility of, or provided by: (1) the United States Government or any agency thereof; (2) any hospital or institution that does not require the Covered Person to pay for such services in the absence of insurance.
15. Any expenses paid by any Workers' Compensation law or act, Employers' Liability law or by any governmental program, law or agency, except for Medicare or Medicaid.
16. Treatment of congenital malfunctions or malformations.
17. Treatment or service not recommended by a dentist.
18. Expenses resulting from injuries sustained or sickness contracted as a result of any war or act of war or participation in a riot or civil disturbance or while committing or attempting to commit a felony.
19. Charges for professional services rendered by any individual who is related to the Covered Person by blood or marriage.
20. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
21. Orthodontic services unless orthodontics is a covered benefit under this Policy or any applicable rider.
22. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.

PLEASE NOTE: Enrollment in the Optional Supplemental Benefit Package is limited to certain times of the year. You may disenroll at any time. (Refer to the applicable Vendor Benefit Rider (VBR) or Evidence of Coverage (EOC) for more information.)

These Optional Supplemental Benefits are not Medicare-covered services; Medicare services are covered under the member's Medicare Advantage plan. Any unused portion of these benefits cannot be carried over from one year to the next. Health Net Ruby 1 (HMO) plan members enrolled in Gold Benefits must continue to pay their monthly health plan premium.



Health Net of Arizona, Inc., is a Medicare Advantage Organization with a Medicare contract. Anyone entitled to Medicare Part A and enrolled in Part B may apply for Health Net's MA/MA-PD plans. Medicare beneficiaries can only enroll in these plans during certain times of the year. Limitations, restrictions, copayments and coinsurances may apply. Benefits vary by geographic area. You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by another third party.

Health Net's contract with Medicare is renewed annually and is not guaranteed available beyond the contract year. In addition, Health Net may reduce its service area and no longer offer services in the area where the beneficiary resides.

In-network providers are those providers who contract with Health Net. Out-of-network providers are those who do not have a contract with Health Net and who accept Medicare's terms and conditions.

This material may be available in other formats. This document is only a summary for informational purposes. It is not a contract. The actual complete terms and conditions of the health plan are set forth in the applicable Vendor Benefit Rider (VBR) or Evidence of Coverage (EOC) document.

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