



PPO BENEFIT PLAN AND RATE OVERVIEW



INDIVIDUAL PPO HEALTH COVERAGE – MADE FOR THE WAY YOU LIVE

Effective June 1, 2011

PREFERRED PROVIDER ORGANIZATION (PPO)

If you're looking for flexibility and choice in your health care coverage, a PPO plan could be just right for you. With our Health Net PPO Individual & Family Plans, you get lots of deductible options to suit your needs.

Our Value and Advantage PPO plans offer a number of deductible levels designed for your health care needs and budget. Every plan lets you choose doctors and hospitals that work best for you, whether in or out of our provider network – you'll pay less when you use in-network providers. And you can see specialists without a referral. Flexibility and choice doesn't get easier than that.

Take a closer look at our Health Net PPO Individual & Family Plans. Then choose the plan that fits the way you live.

YOUR MONTHLY PLAN PREMIUM RATES

Turn to the rate page in this brochure to find your monthly plan premium rate. Find your age, gender and the Arizona county where you live. It's that simple!

If other members of your family are also applying for coverage, follow the same process, then add up the rates for each individual.

Call Health Net Individual & Family Plans at 1-888-463-4875, option 3, for more information.



HEALTH NET OF ARIZONA OVERVIEW OF INDIVIDUAL & FAMILY COVERAGE PPO PLANS

This benefit chart is a summary only. For benefit details, please see your Schedule of Benefits and Policy.

BENEFITS	Value PPO \$3,500 Deductible, 100/50% Coinsurance		Value PPO \$6,000 Deductible, 100/50% Coinsurance	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible per calendar year	\$3,500 single / \$10,500 family	\$7,000 single / \$21,000 family	\$6,000 single / \$18,000 family	\$12,000 single / \$36,000 family
Maximum lifetime benefits	Unlimited		Unlimited	
Out-of-pocket maximum, excluding deductible and copays	None	\$3,500 single / \$10,500 family	None	\$6,000 single / \$18,000 family
Inpatient hospital services including physician, facility and surgery charges	No charge, subject to deductible	50%, subject to deductible	No charge, subject to deductible	50%, subject to deductible
Outpatient hospital services / ambulatory surgical center services	No charge, subject to deductible	50%, subject to deductible	No charge, subject to deductible	50%, subject to deductible
Office visits Primary care physician	\$30 copay/visit	50%, subject to deductible	\$30 copay/visit	50%, subject to deductible
Specialist	\$60 copay/visit	50%, subject to deductible	\$60 copay/visit	50%, subject to deductible
Preventive care Preventive office visits, preventive lab and X-ray, Pap smear and mammogram, prostate screening, immunizations, colorectal cancer screening (including, but not limited to colonoscopy), vision and hearing screenings	\$0 copay/visit	50%, subject to deductible	\$0 copay / visit	50%, subject to deductible
Outpatient laboratory / X-ray services Performed at a physician's office	No charge	50%, subject to deductible	No charge	50%, subject to deductible
Performed at an independent, non-hospital-affiliated lab facility	No charge	50%, subject to deductible	No charge	50%, subject to deductible
Performed at a hospital	No charge, subject to deductible	50%, subject to deductible	No charge, subject to deductible	50%, subject to deductible
Outpatient imaging and testing services including but not limited to CT scans, MRIs, MRAs and PET / SPECT scans Performed at a physician's office	\$250 CT \$400 MRI / MRA / PET / SPECT	50%, subject to deductible	\$250 CT \$400 MRI / MRA / PET / SPECT	50%, subject to deductible
Performed at an independent, non-hospital-affiliated facility	\$250 CT \$400 MRI / MRA / PET / SPECT	50%, subject to deductible	\$250 CT \$400 MRI / MRA / PET / SPECT	50%, subject to deductible
Performed at a hospital	\$600 CT \$1,000 MRI / MRA / PET / SPECT	50%, subject to deductible	\$600 CT \$1,000 MRI / MRA / PET / SPECT	50%, subject to deductible
Prenatal and postpartum care	Not covered		Not covered	
Maternity care	Not covered except for complications of pregnancy		Not covered except for complications of pregnancy	
Outpatient prescription drugs up to a 31-day supply. Quantity limits may apply.	Tier 1: \$15 copay/prescription or refill Tier 2: \$40 copay/prescription or refill Tier 3: \$75 copay/prescription or refill Tier 4: \$100 copay/prescription or refill	50%, subject to deductible	Tier 1: \$15 copay/prescription or refill Tier 2: \$40 copay/prescription or refill Tier 3: \$75 copay/prescription or refill Tier 4: \$100 copay/prescription or refill	50%, subject to deductible
Emergency room services copayment waived if admitted, inpatient benefit will then apply	\$450 copay/visit		\$450 copay/visit	
Ambulance services medical emergencies only	No charge, subject to deductible		No charge, subject to deductible	
Urgent care services	\$60 copay/visit	50%, subject to deductible	\$60 copay/visit	50%, subject to deductible
In-store health care clinic	\$30 copay/visit	50%, subject to deductible	\$30 copay/visit	50%, subject to deductible
Rehabilitative services limited to short-term, maximum of 60 days per calendar year, all therapies combined	Inpatient: No charge, subject to deductible Outpatient: No charge, subject to deductible	50%, subject to deductible	Inpatient: No charge, subject to deductible Outpatient: No charge, subject to deductible	50%, subject to deductible
Skilled nursing facility services limited to 60 days per calendar year	No charge, subject to deductible	50%, subject to deductible	No charge, subject to deductible	50%, subject to deductible
Mental health services Outpatient: limited to short-term evaluation or crisis intervention. Maximum of 10 visits per calendar year.	Inpatient: Not covered Outpatient: No charge, subject to deductible	Inpatient: Not covered Outpatient: 50%, subject to deductible	Inpatient: Not covered Outpatient: No charge, subject to deductible	Inpatient: Not covered Outpatient: 50%, subject to deductible
Chiropractic Covered services for spinal manipulations are covered when determined to be medically necessary by Health Net.	\$60 copay/visit	50%, subject to deductible	\$60 copay/visit	50%, subject to deductible

Some facilities are affiliated with a hospital. You will be charged a higher copay for services rendered at a hospital-affiliated facility. Contact the place of service for more information or our Customer Contact Center at 1-888-463-4875.

Value PPO \$7,500 Deductible, 100/50% Coinsurance		Value PPO \$10,000 Deductible, 100/50% Coinsurance	
In-Network	Out-of-Network	In-Network	Out-of-Network
\$7,500 single / \$22,500 family	\$15,000 single / \$45,000 family	\$10,000 single / \$30,000 family	\$20,000 single / \$60,000 family
Unlimited		Unlimited	
None	\$7,500 single / \$22,500 family	None	\$10,000 single / \$30,000 family
No charge, subject to deductible	50%, subject to deductible	No charge, subject to deductible	50%, subject to deductible
No charge, subject to deductible	50%, subject to deductible	No charge, subject to deductible	50%, subject to deductible
\$30 copay/visit	50%, subject to deductible	\$30 copay/visit	50%, subject to deductible
\$60 copay/visit	50%, subject to deductible	\$60 copay/visit	50%, subject to deductible
\$0 copay/visit	50%, subject to deductible	\$0 copay/visit	50%, subject to deductible
No charge	50%, subject to deductible	No charge	50%, subject to deductible
No charge	50%, subject to deductible	No charge	50%, subject to deductible
No charge, subject to deductible	50%, subject to deductible	No charge, subject to deductible	50%, subject to deductible
\$250 CT \$400 MRI / MRA / PET /SPECT	50%, subject to deductible	\$250 CT \$400 MRI / MRA / PET /SPECT	50%, subject to deductible
\$250 CT \$400 MRI / MRA / PET /SPECT	50%, subject to deductible	\$250 CT \$400 MRI / MRA / PET /SPECT	50%, subject to deductible
\$600 CT \$1,000 MRI / MRA / PET /SPECT	50%, subject to deductible	\$600 CT \$1,000 MRI / MRA / PET /SPECT	50%, subject to deductible
Not covered		Not covered	
Not covered except for complications of pregnancy		Not covered except for complications of pregnancy	
Tier 1: \$15 copay/prescription or refill Tier 2: \$40 copay/prescription or refill Tier 3: \$75 copay/prescription or refill Tier 4: \$100 copay/prescription or refill	50%, subject to deductible	Tier 1: \$15 copay/prescription or refill Tier 2: \$40 copay/prescription or refill Tier 3: \$75 copay/prescription or refill Tier 4: \$100 copay/prescription or refill	50%, subject to deductible
\$450 copay/visit		\$450 copay/visit	
No charge, subject to deductible		No charge, subject to deductible	
\$60 copay/visit	50%, subject to deductible	\$60 copay/visit	50%, subject to deductible
\$30 copay/visit	50%, subject to deductible	\$30 copay/visit	50%, subject to deductible
Inpatient: No charge, subject to deductible Outpatient: No charge, subject to deductible	50%, subject to deductible	Inpatient: No charge, subject to deductible Outpatient: No charge, subject to deductible	50%, subject to deductible
No charge, subject to deductible	50%, subject to deductible	No charge, subject to deductible	50%, subject to deductible
Inpatient: Not covered Outpatient: No charge, subject to deductible	Inpatient: Not covered Outpatient: 50%, subject to deductible	Inpatient: Not covered Outpatient: No charge, subject to deductible	Inpatient: Not covered Outpatient: 50%, subject to deductible
\$60 copay/visit	50%, subject to deductible	\$60 copay/visit	50%, subject to deductible

HEALTH NET OF ARIZONA OVERVIEW OF INDIVIDUAL & FAMILY COVERAGE PPO PLANS

BENEFITS	Advantage PPO \$500 Deductible, 80/50% Coinsurance		Advantage PPO \$1,000 Deductible, 80/50% Coinsurance	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible per calendar year	\$500 single / \$1,000 family	\$1,000 single / \$2,000 family	\$1,000 single / \$2,000 family	\$2,000 single / \$4,000 family
Maximum lifetime benefits	Unlimited		Unlimited	
Out-of-pocket maximum, excluding deductible and copays	\$2,500 single / \$5,000 family	\$5,000 single / \$10,000 family	\$3,000 single / \$6,000 family	\$6,000 single / \$12,000 family
Inpatient hospital services including physician, facility and surgery charges	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Outpatient hospital services / ambulatory surgical center services	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Office visits				
Primary care physician	\$25 copay/visit	50%, subject to deductible	\$25 copay/visit	50%, subject to deductible
Specialist	\$40 copay/visit	50%, subject to deductible	\$40 copay/visit	50%, subject to deductible
Preventive care Preventive office visits, preventive lab and X-ray, Pap smear and mammogram, prostate screening, immunizations, colorectal cancer screening (including, but not limited to colonoscopy), vision and hearing screenings	\$0 copay/visit	50%, subject to deductible	\$0 copay/visit	50%, subject to deductible
Outpatient laboratory / X-ray services Performed at a physician's office	No charge	50%, subject to deductible	No charge	50%, subject to deductible
Performed at an independent, non-hospital-affiliated lab facility¹	No charge	50%, subject to deductible	No charge	50%, subject to deductible
Performed at a hospital	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Outpatient imaging and testing services including but not limited to CT scans, MRIs, MRAs and PET / SPECT scans				
Performed at a physician's office	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Performed at an independent, non-hospital-affiliated facility¹	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Performed at a hospital	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Prenatal and postpartum care	Not covered		Not covered	
Maternity care	Not covered except for complications of pregnancy		Not covered except for complications of pregnancy	
Outpatient prescription drugs up to a 31-day supply. Quantity limits may apply.	Tier 1: \$15 copay/prescription or refill Tier 2: \$40 copay/prescription or refill Tier 3: \$75 copay/prescription or refill Tier 4: \$100 copay/prescription or refill	50%, subject to deductible	Tier 1: \$15 copay/prescription or refill Tier 2: \$40 copay/prescription or refill Tier 3: \$75 copay/prescription or refill Tier 4: \$100 copay/prescription or refill	50%, subject to deductible
Emergency room services copayment waived if admitted, inpatient benefit will then apply	\$300 copay/visit		\$300 copay/visit	
Ambulance services medical emergencies only	20%, subject to deductible		20%, subject to deductible	
Urgent care services	\$60 copay/visit	50%, subject to deductible	\$60 copay/visit	50%, subject to deductible
In-store health care clinic	\$25 copay/visit	50%, subject to deductible	\$25 copay/visit	50%, subject to deductible
Rehabilitative services limited to short-term, maximum of 60 days per calendar year, all therapies combined	Inpatient: 20%, subject to deductible Outpatient: \$40 copay/visit	50%, subject to deductible	Inpatient: 20%, subject to deductible Outpatient: \$40 copay/visit	50%, subject to deductible
Skilled nursing facility services limited to 60 days per calendar year	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Mental health services Outpatient: limited to short-term evaluation or crisis intervention. Maximum of 10 visits per calendar year.	Inpatient: Not covered Outpatient: 20%, subject to deductible	Inpatient: Not covered Outpatient: 50%, subject to deductible	Inpatient: Not covered Outpatient: 20%, subject to deductible	Inpatient: Not covered Outpatient: 50%, subject to deductible
Chiropractic Covered services for spinal manipulations are covered when determined to be medically necessary by Health Net.	\$60 copay/visit	50%, subject to deductible	\$60 copay/visit	50%, subject to deductible

¹Some facilities are affiliated with a hospital. You will be charged a higher copay for services rendered at a hospital-affiliated facility. Contact the place of service for more information or our Customer Contact Center at 1-888-463-4875.

Advantage PPO \$2,500 Deductible, 80/50% Coinsurance		Advantage PPO \$5,000 Deductible, 80/50% Coinsurance	
In-Network	Out-of-Network	In-Network	Out-of-Network
\$2,500 single / \$5,000 family	\$5,000 single / \$10,000 family	\$5,000 single / \$10,000 family	\$10,000 single / \$20,000 family
Unlimited		Unlimited	
\$3,000 single / \$6,000 family	\$6,000 single / \$12,000 family	\$3,000 single / \$6,000 family	\$6,000 single / \$12,000 family
20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
\$30 copay/visit	50%, subject to deductible	\$30 copay/visit	50%, subject to deductible
\$45 copay/visit	50%, subject to deductible	\$45 copay/visit	50%, subject to deductible
\$0 copay/visit	50%, subject to deductible	\$0 copay/visit	50%, subject to deductible
No charge	50%, subject to deductible	No charge	50%, subject to deductible
No charge	50%, subject to deductible	No charge	50%, subject to deductible
20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Not covered		Not covered	
Not covered except for complications of pregnancy		Not covered except for complications of pregnancy	
Tier 1: \$15 copay/prescription or refill Tier 2: \$40 copay/prescription or refill Tier 3: \$75 copay/prescription or refill Tier 4: \$100 copay/prescription or refill	50%, subject to deductible	Tier 1: \$15 copay/prescription or refill Tier 2: \$40 copay/prescription or refill Tier 3: \$75 copay/prescription or refill Tier 4: \$100 copay/prescription or refill	50%, subject to deductible
\$300 copay/visit		\$300 copay/visit	
20%, subject to deductible		20%, subject to deductible	
\$60 copay/visit	50%, subject to deductible	\$60 copay/visit	50%, subject to deductible
\$30 copay/visit	50%, subject to deductible	\$30 copay/visit	50%, subject to deductible
Inpatient: 20%, subject to deductible Outpatient: \$45 copay/visit	50%, subject to deductible	Inpatient: 20%, subject to deductible Outpatient: \$45 copay/visit	50%, subject to deductible
20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Inpatient: Not covered Outpatient: 20%, subject to deductible	Inpatient: Not covered Outpatient: 50%, subject to deductible	Inpatient: Not covered Outpatient: 20%, subject to deductible	Inpatient: Not covered Outpatient: 50%, subject to deductible
\$60 copay/visit	50%, subject to deductible	\$60 copay/visit	50%, subject to deductible

PPO PLAN RATES EFFECTIVE JUNE 1, 2011

COCHISE, MARICOPA, PINAL AND SANTA CRUZ COUNTIES																
Age	VALUE PPO \$3,500/100%/50%		VALUE PPO \$6,000/100%/50%		VALUE PPO \$7,500/100%/50%		VALUE PPO \$10,000/100%/50%		ADVANTAGE PPO \$500/80%/50%		ADVANTAGE PPO \$1,000/80%/50%		ADVANTAGE PPO \$2,500/80%/50%		ADVANTAGE PPO \$5,000/80%/50%	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0	526	526	349	349	315	315	271	271	971	971	760	760	578	578	392	392
1	226	226	150	150	135	135	116	116	416	416	326	326	247	247	167	167
2-6	126	126	84	84	78	78	66	66	236	236	185	185	140	140	94	94
7-14	124	124	82	82	73	73	63	63	232	232	177	177	136	136	92	92
15-18	122	140	79	93	70	84	61	71	225	260	176	208	133	154	89	105
19-22	102	166	69	109	62	98	54	85	190	309	151	240	113	182	78	123
23	104	165	68	109	62	98	54	85	191	309	151	240	114	181	77	124
24	105	165	68	110	62	99	54	86	193	309	151	238	115	181	77	124
25	106	165	68	110	62	99	54	86	193	307	151	238	116	181	77	124
26	106	165	68	110	63	99	54	86	194	307	151	238	116	181	77	124
27	107	165	68	110	63	99	53	86	195	307	151	238	117	181	77	124
28	109	166	70	110	64	99	55	86	200	309	155	240	119	182	79	124
29	112	166	72	111	66	100	57	87	206	310	160	240	123	182	81	125
30	114	167	75	111	68	100	58	87	211	311	164	241	125	183	83	125
31	116	167	77	111	70	100	60	87	217	312	167	242	127	183	86	125
32	118	168	79	112	71	101	61	87	222	314	172	243	130	184	89	126
33	124	172	82	114	75	104	64	89	232	323	179	249	136	189	92	128
34	129	177	85	117	78	107	66	91	241	331	187	257	141	195	95	131
35	135	182	88	120	80	109	68	93	249	341	196	264	148	200	98	133
36	140	186	91	123	83	112	71	95	258	350	203	271	153	206	103	137
37	146	191	94	125	86	114	73	97	267	360	211	279	160	211	106	139
38	157	195	102	127	93	116	80	99	291	364	228	283	173	214	115	142
39	170	198	111	130	101	118	86	101	314	370	245	288	186	218	125	144
40	182	201	119	132	109	120	93	102	337	375	263	292	199	221	135	148
41	194	204	128	135	116	122	99	105	360	381	279	296	213	224	143	151
42	206	207	137	137	124	124	106	107	383	385	296	301	226	228	153	153
43	216	227	143	149	129	136	111	116	401	420	312	328	237	249	161	167
44	227	245	149	161	136	147	116	126	420	455	326	356	249	270	167	181
45	236	265	155	174	142	157	121	136	440	490	341	383	260	291	175	195
46	246	284	161	186	147	169	126	145	458	525	357	410	271	313	183	209
47	257	303	169	198	153	180	131	154	477	559	372	438	283	334	189	222
48	275	313	181	205	165	185	142	159	513	578	399	451	304	345	203	230
49	294	322	194	211	176	190	151	165	549	595	428	465	325	354	218	236
50	313	331	206	217	187	197	160	170	585	614	455	479	345	365	232	243
51	332	341	219	224	199	202	171	174	621	631	484	493	365	376	246	251
52	351	351	232	231	209	207	180	179	656	649	511	508	386	386	259	257
53	367	365	243	240	220	216	189	186	688	677	536	528	405	403	272	268
54	384	380	255	249	231	226	199	195	720	705	560	550	423	418	286	279
55	402	394	266	259	241	235	207	202	752	732	585	572	442	434	299	290
56	418	409	277	268	252	243	216	209	783	760	610	594	461	451	311	301
57	436	423	289	278	262	253	226	216	815	788	636	615	479	466	324	312
58	455	432	301	284	273	258	235	221	851	803	663	627	501	475	338	318
59	475	440	314	290	285	263	244	226	888	819	691	639	524	485	351	325
60	495	448	326	295	295	268	254	230	924	835	719	650	546	493	364	330
61	514	456	338	301	306	273	263	234	961	850	747	662	568	502	379	337
62	534	465	351	306	318	278	273	239	997	866	776	674	590	511	392	344
63	554	473	362	313	329	284	283	243	1033	882	803	685	612	520	406	349
64	574	481	375	318	341	289	292	247	1069	897	831	697	633	529	419	356

PIMA COUNTY																
Age	VALUE PPO \$3,500/100%/50%		VALUE PPO \$6,000/100%/50%		VALUE PPO \$7,500/100%/50%		VALUE PPO \$10,000/100%/50%		ADVANTAGE PPO \$500/80%/50%		ADVANTAGE PPO \$1,000/80%/50%		ADVANTAGE PPO \$2,500/80%/50%		ADVANTAGE PPO \$5,000/80%/50%	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0	459	459	302	302	273	273	234	234	850	850	661	661	503	503	337	337
1	197	197	129	129	117	117	100	100	364	364	284	284	216	216	144	144
2-6	111	111	71	71	64	64	55	55	203	203	160	160	122	122	79	79
7-14	109	109	70	70	63	63	54	54	200	200	155	155	118	118	78	78
15-18	105	121	68	82	63	74	54	64	198	228	155	176	115	135	77	92
19-22	82	134	56	89	51	80	43	69	155	248	120	196	90	147	62	98
23	83	133	55	89	51	80	43	69	156	248	121	195	91	147	62	98
24	84	133	55	89	50	80	43	69	157	248	121	194	93	145	62	98
25	84	132	55	89	50	79	43	69	158	248	122	193	94	144	61	98
26	85	131	55	88	50	79	43	69	158	248	122	192	95	144	61	98
27	86	131	55	88	49	79	43	69	159	248	123	191	96	143	61	98
28	88	132	56	89	51	80	44	69	163	249	126	193	98	144	62	99
29	91	133	58	90	52	81	45	70	167	250	131	194	100	145	64	100
30	93	134	60	90	54	81	46	70	171	251	134	195	102	147	66	100
31	95	135	61	91	56	82	48	71	174	253	137	197	104	148	69	101
32	97	136	63	92	57	83	49	72	178	254	141	198	105	149	70	102
33	101	140	65	94	60	85	51	73	186	261	147	203	111	153	73	104
34	105	143	68	96	62	87	53	75	194	268	152	209	115	157	76	106
35	109	147	71	98	65	89	55	76	201	275	158	215	120	161	79	109
36	114	151	74	100	68	91	57	78	210	281	163	220	124	165	82	112
37	118	155	77	102	70	93	59	79	217	289	169	226	129	170	85	114
38	127	158	83	104	76	94	65	81	235	293	183	229	139	173	93	116
39	137	161	90	106	82	96	70	82	253	298	197	232	150	176	100	118
40	146	163	96	107	88	97	75	83	272	302	211	235	160	179	108	119
41	155	166	103	109	94	99	80	84	290	308	226	238	171	182	115	121
42	165	169	110	111	100	100	85	86	308	312	239	240	181	186	122	123
43	173	184	115	121	105	109	89	94	324	339	252	262	191	202	129	135
44	182	199	120	131	109	119	94	102	339	367	264	285	199	218	135	147
45	190	214	126	142	114	128	98	110	355	393	276	307	209	235	140	157
46	199	229	131	152	119	137	102	118	371	421	289	329	217	252	147	169
47	207	244	136	162	124	146	106	126	387	448	300	351	227	268	153	180
48	222	252	146	167	133	150	114	129	415	463	324	363	243	276	164	186
49	237	259	157	171	142	155	122	133	445	479	346	373	260	285	175	191
50	252	266	167	176	151	159	130	137	473	493	368	385	277	293	187	196
51	268	274	177	180	160	163	138	140	502	508	391	396	294	300	198	201
52	283	281	188	185	169	168	146	144	531	524	413	408	311	309	209	

OTHER COUNTIES

Age	VALUE PPO \$3,500/100%/50%		VALUE PPO \$6,000/100%/50%		VALUE PPO \$7,500/100%/50%		VALUE PPO \$10,000/100%/50%		ADVANTAGE PPO \$500/80%/50%		ADVANTAGE PPO \$1,000/80%/50%		ADVANTAGE PPO \$2,500/80%/50%		ADVANTAGE PPO \$5,000/80%/50%	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0	626	626	417	417	378	378	325	325	1165	1165	915	915	693	693	465	465
1	268	268	179	179	161	161	139	139	500	500	392	392	296	296	199	199
2-6	152	152	99	99	91	91	78	78	282	282	222	222	166	166	110	110
7-14	148	148	97	97	88	88	76	76	275	275	212	212	162	162	108	108
15-18	146	164	95	113	86	101	73	87	265	313	211	244	161	181	106	126
19-22	121	201	82	130	73	119	63	102	226	372	178	291	132	221	91	147
23	122	200	81	130	72	119	63	102	228	372	179	290	135	220	91	147
24	123	200	81	130	72	119	63	102	229	372	181	289	136	220	90	147
25	124	199	81	130	72	119	63	102	230	371	181	289	137	219	90	147
26	125	199	80	130	72	119	63	102	231	371	182	288	138	219	90	147
27	126	198	80	130	72	119	63	102	232	371	183	287	140	218	90	147
28	130	199	83	131	76	120	65	104	240	372	187	288	143	219	93	148
29	134	200	86	132	78	120	67	104	246	374	191	290	148	220	96	149
30	137	201	88	132	81	121	69	105	254	375	196	291	151	221	100	150
31	141	202	91	134	83	121	71	105	261	376	201	293	155	222	103	150
32	144	203	94	135	86	122	75	106	268	379	206	294	159	223	106	151
33	149	209	98	138	89	125	78	108	279	388	216	303	165	230	110	155
34	155	214	102	142	93	128	81	111	291	399	224	311	172	236	115	159
35	161	220	107	145	97	131	84	113	302	410	234	319	177	243	119	163
36	167	227	112	148	100	135	87	116	313	421	243	327	184	249	125	166
37	173	232	116	152	105	138	90	118	324	432	253	335	190	256	129	171
38	187	236	125	154	113	140	97	120	350	439	274	340	207	259	139	173
39	202	239	135	157	121	142	105	122	375	445	294	345	223	264	150	175
40	217	243	144	159	130	144	112	124	401	452	315	349	240	267	161	178
41	232	246	153	162	139	146	120	125	427	458	336	353	256	271	172	181
42	246	249	162	165	147	148	127	127	453	466	358	358	271	275	182	183
43	259	272	171	180	154	162	134	140	477	507	375	392	286	300	191	200
44	271	295	179	195	162	176	141	151	500	548	393	424	300	325	200	218
45	285	317	187	210	170	189	147	164	524	589	410	458	314	350	210	235
46	297	339	196	225	178	204	153	175	548	630	428	492	328	374	220	253
47	309	361	205	240	185	217	160	187	572	672	445	525	341	399	229	269
48	332	374	218	247	199	224	171	193	615	693	478	543	366	412	245	278
49	355	385	233	254	211	231	182	198	659	713	511	559	392	426	260	286
50	378	397	247	261	224	237	193	204	701	735	544	577	417	438	277	293
51	401	409	262	268	237	244	204	209	745	756	577	594	441	451	293	301
52	423	420	276	275	249	250	214	214	788	777	610	610	466	464	309	310
53	443	438	290	288	262	261	226	224	826	811	641	637	489	482	325	323
54	464	455	303	299	275	271	236	233	863	843	671	662	511	502	340	336
55	484	473	318	312	288	283	247	241	900	876	701	688	534	522	356	349
56	504	491	331	323	300	293	258	250	939	910	732	713	556	540	372	362
57	525	508	345	335	313	303	269	260	976	943	763	738	579	560	387	375
58	549	520	360	342	327	309	280	265	1020	962	795	753	604	571	405	382
59	571	530	377	349	341	315	293	270	1064	980	828	766	629	583	422	389
60	595	540	392	355	355	321	305	275	1108	999	861	780	655	595	440	397
61	618	551	408	361	369	327	317	280	1152	1017	894	793	680	606	456	405
62	642	561	423	368	383	333	329	287	1196	1036	927	807	707	618	474	411
63	666	572	439	375	397	338	341	292	1240	1055	959	821	732	630	491	419
64	688	583	454	381	411	345	353	297	1283	1073	992	835	757	641	509	427



Rates are subject to change. The above rates are the Health Net standard rates. You may be assigned to a non-standard rate based upon the results of the medical underwriting process.

PROTECTING YOUR HEALTH INFORMATION

Once you become a Health Net member, Health Net uses and discloses a member's protected health information for purposes of treatment, payment, health care operations, and where permitted or required by law. Health Net provides members with a Notice of Privacy Practices that describes how it uses and discloses protected health information; the individual's rights to access and to request amendments, restrictions, and an accounting of disclosures of protected health information; and the procedures for filing complaints. Health Net will provide you the opportunity to approve or refuse the release of your information for non-routine releases such as marketing. Health Net provides access to members to inspect or obtain a copy of the member's protected health information in designated record sets maintained by Health Net. Health Net protects oral, written and electronic information across the organization by using reasonable and appropriate security safeguards. Health Net releases protected health information to plan sponsors for administration of self-funded plans but does not release protected health information to plan sponsors or employers for insured products unless the plan sponsor is performing a payment or health care operation function for the plan.

EXCLUSIONS AND LIMITATIONS

The exclusions and limitations presented in this Benefit Overview are not comprehensive. For a full list of exclusions and limitations see the Evidence of Coverage for HMO Plans or Policy for PPO Plans. You may obtain a copy of these documents prior to enrolling or at any time by contacting us at 1-888-463-4875.

Exclusions and limitations include but are not limited to:

PPO Plans: Precertification is required for certain services. Failure to obtain precertification will result in a reduction in benefits. For a comprehensive list of services requiring precertification see the Policy. Services that must be precertified include, but are not limited to: Hospital inpatient admissions (non-emergency, including acute, subacute or rehabilitation), hospital observation stays (less than 24 hours), mental health and substance abuse inpatient admissions, skilled nursing inpatient facility admissions, transplants/transplant services, select outpatient procedures, select rehabilitative programs and therapies, select durable medical equipment, home health care services (including home infusion therapy), non-emergent ambulance and transportation services, prosthetics, oncology services, podiatry services, sleep studies, oxygen and related breathing equipment, epidural steroid injections, magnetic resonance imaging (MRI), computerized axial tomography (CAT), positron emission tomography (PET) scans, magnetic resonance angiography (MRA), self-injectable medications (except insulin), select in-office pharmacy injectables.

Coverage for maternity services is limited to complications of pregnancy.

HMO and PPO Plans: The following services and/or procedures are either limited in coverage or excluded from coverage under these health plans. These services include, but are not limited to: comfort/convenience items, hearing aids, cosmetic surgery, court-ordered care, custodial care, experimental/investigational procedures and drugs, gender alterations, infertility services, inpatient mental health services, long-term rehabilitative services, obesity, paternity testing, radial keratotomy, substance abuse treatment programs, mail-order prescriptions, employment counseling, exercise programs, fraudulent services, missed appointments, temporomandibular joint disorder, vocational programs. For a complete list, refer to either the Evidence of Coverage for HMO Plans or Policy for PPO Plans.

In- and out-of-network benefits are subject to deductible, then a percentage of eligible medical expenses.

All drugs covered by your outpatient prescription benefit are placed in one of four tiers on the Preferred Drug List (PDL). The lower the tier, the lower your copayment. The Health Net PDL is a listing of covered medications. Some drugs on the PDL may require prior authorization from Health Net. Prescriptions are limited to a 31-day supply. Other quantity limitations may apply.

Skilled nursing coverage is limited to 60 days per calendar year.

Expenses you incur for the following cannot be used to satisfy the out-of-pocket maximum: failure to follow prior authorization/precertification guidelines, mental illness, substance abuse, infertility, use of emergency room for non-emergent care, prescription drugs, copayments, limitations, exclusions. Check your Evidence of Coverage or Policy.

