



# PPO BENEFIT PLAN AND RATE OVERVIEW



## INDIVIDUAL PPO HEALTH COVERAGE – MADE FOR THE WAY YOU LIVE

*Effective January 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
<b>Deductible</b> 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
<b>Maximum lifetime benefits</b>	Unlimited		Unlimited	
<b>Out-of-pocket maximum, excluding deductible and copays</b>	None	\$3,500 single / \$10,500 family	None	\$6,000 single / \$18,000 family
<b>Inpatient hospital services</b> including physician, facility and surgery charges	No charge, subject to deductible	50%, subject to deductible	No charge, subject to deductible	50%, subject to deductible
<b>Outpatient hospital services / ambulatory surgical center services</b>	No charge, subject to deductible	50%, subject to deductible	No charge, subject to deductible	50%, subject to deductible
<b>Office visits</b>				
<b>Primary care physician</b>	\$30 copay/visit	50%, subject to deductible	\$30 copay/visit	50%, subject to deductible
<b>Specialist</b>	\$60 copay/visit	50%, subject to deductible	\$60 copay/visit	50%, subject to deductible
<b>Preventive care</b> 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
<b>Outpatient laboratory / X-ray services</b>				
<b>Performed at a physician's office</b>	No charge	50%, subject to deductible	No charge	50%, subject to deductible
<b>Performed at an independent, non-hospital-affiliated lab facility<sup>1</sup></b>	No charge	50%, subject to deductible	No charge	50%, subject to deductible
<b>Performed at a hospital</b>	No charge, subject to deductible	50%, subject to deductible	No charge, subject to deductible	50%, subject to deductible
<b>Outpatient imaging and testing services</b> including but not limited to CT scans, MRIs, MRAs and PET / SPECT scans				
<b>Performed at a physician's office</b>	\$250 CT \$400 MRI / MRA / PET / SPECT	50%, subject to deductible	\$250 CT \$400 MRI / MRA / PET / SPECT	50%, subject to deductible
<b>Performed at an independent, non-hospital-affiliated facility<sup>1</sup></b>	\$250 CT \$400 MRI / MRA / PET / SPECT	50%, subject to deductible	\$250 CT \$400 MRI / MRA / PET / SPECT	50%, subject to deductible
<b>Performed at a hospital</b>	\$600 CT \$1,000 MRI / MRA / PET / SPECT	50%, subject to deductible	\$600 CT \$1,000 MRI / MRA / PET / SPECT	50%, subject to deductible
<b>Prenatal and postpartum care</b>	Not covered		Not covered	
<b>Maternity care</b>	Not covered except for complications of pregnancy		Not covered except for complications of pregnancy	
<b>Outpatient prescription drugs</b> up to a 31-day supply. Quantity limits may apply.	<b>Tier 1:</b> \$15 copay/prescription or refill <b>Tier 2:</b> \$40 copay/prescription or refill <b>Tier 3:</b> \$75 copay/prescription or refill <b>Tier 4:</b> \$100 copay/prescription or refill	50%, subject to deductible	<b>Tier 1:</b> \$15 copay/prescription or refill <b>Tier 2:</b> \$40 copay/prescription or refill <b>Tier 3:</b> \$75 copay/prescription or refill <b>Tier 4:</b> \$100 copay/prescription or refill	50%, subject to deductible
<b>Emergency room services</b> copayment waived if admitted, inpatient benefit will then apply	\$450 copay/visit		\$450 copay/visit	
<b>Ambulance services</b> medical emergencies only	No charge, subject to deductible		No charge, subject to deductible	
<b>Urgent care services</b>	\$60 copay/visit	50%, subject to deductible	\$60 copay/visit	50%, subject to deductible
<b>In-store health care clinic</b>	\$30 copay/visit	50%, subject to deductible	\$30 copay/visit	50%, subject to deductible
<b>Rehabilitative services</b> limited to short-term, maximum of 60 days per calendar year, all therapies combined	<b>Inpatient:</b> No charge, subject to deductible <b>Outpatient:</b> No charge, subject to deductible	50%, subject to deductible	<b>Inpatient:</b> No charge, subject to deductible <b>Outpatient:</b> No charge, subject to deductible	50%, subject to deductible
<b>Skilled nursing facility services</b> 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
<b>Mental health services</b> Outpatient: limited to short-term evaluation or crisis intervention. Maximum of 10 visits per calendar year.	<b>Inpatient:</b> Not covered <b>Outpatient:</b> No charge, subject to deductible	<b>Inpatient:</b> Not covered <b>Outpatient:</b> 50%, subject to deductible	<b>Inpatient:</b> Not covered <b>Outpatient:</b> No charge, subject to deductible	<b>Inpatient:</b> Not covered <b>Outpatient:</b> 50%, subject to deductible
<b>Chiropractic</b> 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

<sup>1</sup>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	
<b>Tier 1:</b> \$15 copay/prescription or refill <b>Tier 2:</b> \$40 copay/prescription or refill <b>Tier 3:</b> \$75 copay/prescription or refill <b>Tier 4:</b> \$100 copay/prescription or refill	50%, subject to deductible	<b>Tier 1:</b> \$15 copay/prescription or refill <b>Tier 2:</b> \$40 copay/prescription or refill <b>Tier 3:</b> \$75 copay/prescription or refill <b>Tier 4:</b> \$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
<b>Inpatient:</b> No charge, subject to deductible <b>Outpatient:</b> No charge, subject to deductible	50%, subject to deductible	<b>Inpatient:</b> No charge, subject to deductible <b>Outpatient:</b> 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
<b>Inpatient:</b> Not covered <b>Outpatient:</b> No charge, subject to deductible	<b>Inpatient:</b> Not covered <b>Outpatient:</b> 50%, subject to deductible	<b>Inpatient:</b> Not covered <b>Outpatient:</b> No charge, subject to deductible	<b>Inpatient:</b> Not covered <b>Outpatient:</b> 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
<b>Deductible</b> 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
<b>Maximum lifetime benefits</b>	Unlimited		Unlimited	
<b>Out-of-pocket maximum, excluding deductible and copays</b>	\$2,500 single / \$5,000 family	\$5,000 single / \$10,000 family	\$3,000 single / \$6,000 family	\$6,000 single / \$12,000 family
<b>Inpatient hospital services</b> including physician, facility and surgery charges	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
<b>Outpatient hospital services / ambulatory surgical center services</b>	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
<b>Office visits</b>				
<b>Primary care physician</b>	\$25 copay/visit	50%, subject to deductible	\$25 copay/visit	50%, subject to deductible
<b>Specialist</b>	\$40 copay/visit	50%, subject to deductible	\$40 copay/visit	50%, subject to deductible
<b>Preventive care</b> 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
<b>Outpatient laboratory / X-ray services Performed at a physician's office</b>	No charge	50%, subject to deductible	No charge	50%, subject to deductible
<b>Performed at an independent, non-hospital-affiliated lab facility<sup>1</sup></b>	No charge	50%, subject to deductible	No charge	50%, subject to deductible
<b>Performed at a hospital</b>	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
<b>Outpatient imaging and testing services</b> including but not limited to CT scans, MRIs, MRAs and PET / SPECT scans				
<b>Performed at a physician's office</b>	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
<b>Performed at an independent, non-hospital-affiliated facility<sup>1</sup></b>	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
<b>Performed at a hospital</b>	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
<b>Prenatal and postpartum care</b>	Not covered		Not covered	
<b>Maternity care</b>	Not covered except for complications of pregnancy		Not covered except for complications of pregnancy	
<b>Outpatient prescription drugs</b> up to a 31-day supply. Quantity limits may apply.	<b>Tier 1:</b> \$15 copay/prescription or refill <b>Tier 2:</b> \$40 copay/prescription or refill <b>Tier 3:</b> \$75 copay/prescription or refill <b>Tier 4:</b> \$100 copay/prescription or refill	50%, subject to deductible	<b>Tier 1:</b> \$15 copay/prescription or refill <b>Tier 2:</b> \$40 copay/prescription or refill <b>Tier 3:</b> \$75 copay/prescription or refill <b>Tier 4:</b> \$100 copay/prescription or refill	50%, subject to deductible
<b>Emergency room services</b> copayment waived if admitted, inpatient benefit will then apply	\$300 copay/visit		\$300 copay/visit	
<b>Ambulance services</b> medical emergencies only	20%, subject to deductible		20%, subject to deductible	
<b>Urgent care services</b>	\$60 copay/visit	50%, subject to deductible	\$60 copay/visit	50%, subject to deductible
<b>In-store health care clinic</b>	\$25 copay/visit	50%, subject to deductible	\$25 copay/visit	50%, subject to deductible
<b>Rehabilitative services</b> limited to short-term, maximum of 60 days per calendar year, all therapies combined	<b>Inpatient:</b> 20%, subject to deductible <b>Outpatient:</b> \$40 copay/visit	50%, subject to deductible	<b>Inpatient:</b> 20%, subject to deductible <b>Outpatient:</b> \$40 copay/visit	50%, subject to deductible
<b>Skilled nursing facility services</b> limited to 60 days per calendar year	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
<b>Mental health services</b> Outpatient: limited to short-term evaluation or crisis intervention. Maximum of 10 visits per calendar year.	<b>Inpatient:</b> Not covered <b>Outpatient:</b> 20%, subject to deductible	<b>Inpatient:</b> Not covered <b>Outpatient:</b> 50%, subject to deductible	<b>Inpatient:</b> Not covered <b>Outpatient:</b> 20%, subject to deductible	<b>Inpatient:</b> Not covered <b>Outpatient:</b> 50%, subject to deductible
<b>Chiropractic</b> 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

<sup>1</sup>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.

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	
<b>Tier 1:</b> \$15 copay/prescription or refill <b>Tier 2:</b> \$40 copay/prescription or refill <b>Tier 3:</b> \$75 copay/prescription or refill <b>Tier 4:</b> \$100 copay/prescription or refill	50%, subject to deductible	<b>Tier 1:</b> \$15 copay/prescription or refill <b>Tier 2:</b> \$40 copay/prescription or refill <b>Tier 3:</b> \$75 copay/prescription or refill <b>Tier 4:</b> \$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
<b>Inpatient:</b> 20%, subject to deductible <b>Outpatient:</b> \$45 copay/visit	50%, subject to deductible	<b>Inpatient:</b> 20%, subject to deductible <b>Outpatient:</b> \$45 copay/visit	50%, subject to deductible
20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
<b>Inpatient:</b> Not covered <b>Outpatient:</b> 20%, subject to deductible	<b>Inpatient:</b> Not covered <b>Outpatient:</b> 50%, subject to deductible	<b>Inpatient:</b> Not covered <b>Outpatient:</b> 20%, subject to deductible	<b>Inpatient:</b> Not covered <b>Outpatient:</b> 50%, subject to deductible
\$60 copay/visit	50%, subject to deductible	\$60 copay/visit	50%, subject to deductible

COCHISE, MARICOPA, PINAL AND SANTA CRUZ COUNTIES

PPO PLAN RATES EFFECTIVE JANUARY 1, 2011

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	508	508	337	337	304	304	262	262	888	888	695	695	528	528	358	358
1	218	218	145	145	130	130	112	112	380	380	298	298	226	226	153	153
2-6	122	122	81	81	75	75	64	64	216	216	169	169	128	128	86	86
7-14	120	120	79	79	71	71	61	61	212	212	162	162	124	124	84	84
15-18	118	135	76	90	68	81	59	69	206	238	161	190	122	141	81	96
19-22	99	160	67	105	60	95	52	82	174	282	138	219	103	166	71	112
23	100	159	66	105	60	95	52	82	175	282	138	219	104	165	70	113
24	101	159	66	106	60	96	52	83	176	282	138	218	105	165	70	113
25	102	159	66	106	60	96	52	83	176	281	138	218	106	165	70	113
26	102	159	66	106	61	96	52	83	177	281	138	218	106	165	70	113
27	103	159	66	106	61	96	51	83	178	281	138	218	107	165	70	113
28	105	160	68	106	62	96	53	83	183	282	142	219	109	166	72	113
29	108	160	70	107	64	97	55	84	188	283	146	219	112	166	74	114
30	110	161	72	107	66	97	56	84	193	284	150	220	114	167	76	114
31	112	161	74	107	68	97	58	84	198	285	153	221	116	167	79	114
32	114	162	76	108	69	98	59	84	203	287	157	222	119	168	81	115
33	120	166	79	110	72	100	62	86	212	295	164	228	124	173	84	117
34	125	171	82	113	75	103	64	88	220	303	171	235	129	178	87	120
35	130	176	85	116	77	105	66	90	228	312	179	241	135	183	90	122
36	135	180	88	119	80	108	69	92	236	320	186	248	140	188	94	125
37	141	185	91	121	83	110	71	94	244	329	193	255	146	193	97	127
38	152	188	99	123	90	112	77	96	266	333	208	259	158	196	105	130
39	164	191	107	126	98	114	83	98	287	338	224	263	170	199	114	132
40	176	194	115	128	105	116	90	99	308	343	240	267	182	202	123	135
41	187	197	124	130	112	118	96	101	329	348	255	271	195	205	131	138
42	199	200	132	132	120	120	102	103	350	352	271	275	207	208	140	140
43	209	219	138	144	125	131	107	112	367	384	285	300	217	228	147	153
44	219	237	144	156	131	142	112	122	384	416	298	325	228	247	153	165
45	228	256	150	168	137	152	117	131	402	448	312	350	238	266	160	178
46	238	274	156	180	142	163	122	140	419	480	326	375	248	286	167	191
47	248	293	163	191	148	174	127	149	436	511	340	400	259	305	173	203
48	266	302	175	198	159	179	137	154	469	528	365	412	278	315	186	210
49	284	311	187	204	170	184	146	159	502	544	391	425	297	324	199	216
50	302	320	199	210	181	190	155	164	535	561	416	438	315	334	212	222
51	321	329	212	216	192	195	165	168	568	577	442	451	334	344	225	229
52	339	339	224	223	202	200	174	173	600	593	467	464	353	353	237	235
53	355	353	235	232	213	209	183	180	629	619	490	483	370	368	249	245
54	371	367	246	241	223	218	192	188	658	644	512	503	387	382	261	255
55	388	381	257	250	233	227	200	195	687	669	535	523	404	397	273	265
56	404	395	268	259	243	235	209	202	716	695	558	543	421	412	284	275
57	421	409	279	269	253	244	218	209	745	720	581	562	438	426	296	285
58	440	417	291	274	264	249	227	214	778	734	606	573	458	434	309	291
59	459	425	303	280	275	254	236	218	812	749	632	584	479	443	321	297
60	478	433	315	285	285	259	245	222	845	763	657	594	499	451	333	302
61	497	441	327	291	296	264	254	226	878	777	683	605	519	459	346	308
62	516	449	339	296	307	269	264	231	911	792	709	616	539	467	358	314
63	535	457	350	302	318	274	273	235	944	806	734	626	559	475	371	319
64	555	465	362	307	329	279	282	239	977	820	760	637	579	484	383	325

PIMA COUNTY

PPO PLAN RATES EFFECTIVE JANUARY 1, 2011

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	806	806	627	627	477	477	320	320
1	197	197	129	129	117	117	100	100	345	345	269	269	205	205	137	137
2-6	111	111	71	71	64	64	55	55	193	193	152	152	116	116	75	75
7-14	109	109	70	70	63	63	54	54	190	190	147	147	112	112	74	74
15-18	105	121	68	82	63	74	54	64	188	216	147	167	109	128	73	87
19-22	82	134	56	89	51	80	43	69	147	235	114	186	85	139	59	93
23	83	133	55	89	51	80	43	69	148	235	115	185	86	139	59	93
24	84	133	55	89	50	80	43	69	149	235	115	184	88	138	59	93
25	84	132	55	89	50	79	43	69	150	235	116	183	89	137	58	93
26	85	131	55	88	50	79	43	69	150	235	116	182	90	137	58	93
27	86	131	55	88	49	79	43	69	151	235	117	181	91	136	58	93
28	88	132	56	89	51	80	44	69	155	236	120	183	93	137	59	94
29	91	133	58	90	52	81	45	70	158	237	124	184	95	138	61	95
30	93	134	60	90	54	81	46	70	162	238	127	185	97	139	63	95
31	95	135	61	91	56	82	48	71	165	240	130	187	99	140	65	96
32	97	136	63	92	57	83	49	72	169	241	134	188	100	141	66	97
33	101	140	65	94	60	85	51	73	176	248	139	193	105	145	69	99
34	105	143	68	96	62	87	53	75	184	254	144	198	109	149	72	101
35	109	147	71	98	65	89	55	76	191	261	150	204	114	153	75	103
36	114	151	74	100	68	91	57	78	199	267	155	209	118	157	78	106
37	118	155	77	102	70	93	59	79	206	274	160	214	122	161	81	108
38	127	158	83	104	76	94	65	81	223	278	174	217	132	164	88	110
39	137	161	90	106	82	96	70	82	240	283	187	220	142	167	95	112
40	146	163	96	107	88	97	75	83	258	287	200	223	152	170	102	113
41	155	166	103	109	94	99	80	84	275	292	214	226	162	173	109	115
42	165	169	110	111	100	100	85	86	292	296	227	228	172	176	116	117
43	173	184	115	121	105	109	89	94	307	322	239	249	181	192	122	128
44	182	199	120	131	109	119	94	102	322	348	250	270	189	207	128	139
45	190	214	126	142	114	128	98	110	337	373	262	291	198	223	133	149
46	199	229	131	152	119	137	102	118	352	399	274	312	206	239	139	160
47	207	244	136	162	124	146	106	126	367	425	285	333	215	254	145	171
48	222	252	146	167	133	150	114	129	394	439	307	344	231	262	156	176
49	237	259	157	171	142	155	122	133	422	454	328	354	247	270	166	181
50	252	266	167	176	151	159	130	137	449	468	349	365	263	278	177	186
51	268	274	177	180	160	163	138	140	476	482	371	376	279	285	188	191
52																

## OTHER COUNTIES

PPO PLAN RATES EFFECTIVE JANUARY 1, 2011

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	605	605	403	403	365	365	314	314	1,065	1,065	836	836	633	633	425	425
1	259	259	173	173	156	156	134	134	457	457	358	358	271	271	182	182
2-6	147	147	96	96	88	88	75	75	258	258	203	203	152	152	101	101
7-14	143	143	94	94	85	85	73	73	251	251	194	194	148	148	99	99
15-18	141	158	92	109	83	98	71	84	242	286	193	223	147	165	97	115
19-22	117	194	79	126	71	115	61	99	207	340	163	266	121	202	83	134
23	118	193	78	126	70	115	61	99	208	340	164	265	123	201	83	134
24	119	193	78	126	70	115	61	99	209	340	165	264	124	201	82	134
25	120	192	78	126	70	115	61	99	210	339	165	264	125	200	82	134
26	121	192	77	126	70	115	61	99	211	339	166	263	126	200	82	134
27	122	191	77	126	70	115	61	99	212	339	167	262	128	199	82	134
28	126	192	80	127	73	116	63	100	219	340	171	263	131	200	85	135
29	129	193	83	128	75	116	65	100	225	342	175	265	135	201	88	136
30	132	194	85	128	78	117	67	101	232	343	179	266	138	202	91	137
31	136	195	88	129	80	117	69	101	239	344	184	268	142	203	94	137
32	139	196	91	130	83	118	72	102	245	346	188	269	145	204	97	138
33	144	202	95	133	86	121	75	104	255	355	197	277	151	210	101	142
34	150	207	99	137	90	124	78	107	266	365	205	284	157	216	105	145
35	156	213	103	140	94	127	81	109	276	375	214	292	162	222	109	149
36	161	219	108	143	97	130	84	112	286	385	222	299	168	228	114	152
37	167	224	112	147	101	133	87	114	296	395	231	306	174	234	118	156
38	181	228	121	149	109	135	94	116	320	401	250	311	189	237	127	158
39	195	231	130	152	117	137	101	118	343	407	269	315	204	241	137	160
40	210	235	139	154	126	139	108	120	367	413	288	319	219	244	147	163
41	224	238	148	157	134	141	116	121	390	419	307	323	234	248	157	165
42	238	241	157	159	142	143	123	123	414	426	327	327	248	251	166	167
43	250	263	165	174	149	157	129	135	436	463	343	358	261	274	175	183
44	262	285	173	188	157	170	136	146	457	501	359	388	274	297	183	199
45	275	306	181	203	164	183	142	158	479	538	375	419	287	320	192	215
46	287	328	189	217	172	197	148	169	501	576	391	450	300	342	201	231
47	299	349	198	232	179	210	155	181	523	614	407	480	312	365	209	246
48	321	361	211	239	192	216	165	186	562	633	437	496	335	377	224	254
49	343	372	225	245	204	223	176	191	602	652	467	511	358	389	238	261
50	365	384	239	252	216	229	186	197	641	672	497	527	381	400	253	268
51	387	395	253	259	229	236	197	202	681	691	527	543	403	412	268	275
52	409	406	267	266	241	242	207	207	720	710	558	558	426	424	282	283
53	428	423	280	278	253	252	218	216	755	741	586	582	447	441	297	295
54	448	440	293	289	266	262	228	225	789	771	613	605	467	459	311	307
55	468	457	307	301	278	273	239	233	823	801	641	629	488	477	325	319
56	487	474	320	312	290	283	249	242	858	832	669	652	508	494	340	331
57	507	491	333	324	302	293	260	251	892	862	697	675	529	512	354	343
58	530	502	348	330	316	299	271	256	932	879	727	688	552	522	370	349
59	552	512	364	337	329	304	283	261	973	896	757	700	575	533	386	356
60	575	522	379	343	343	310	295	266	1,013	913	787	713	599	544	402	363
61	597	532	394	349	357	316	306	271	1,053	930	817	725	622	554	417	370
62	620	542	409	356	370	322	318	277	1,093	947	847	738	646	565	433	376
63	643	553	424	362	384	327	329	282	1,133	964	877	750	669	576	449	383
64	665	563	439	368	397	333	341	287	1,173	981	907	763	692	586	465	390

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.

