



# HMO BENEFIT PLAN AND RATE OVERVIEW



**THE EASY WAY** to pick the health plan that's right for you.  
*Effective July 1, 2009*

## HEALTH MAINTENANCE ORGANIZATION PLANS (HMO)

HMO's are a great choice for individuals and families requiring routine care, with no unusual medical needs that require out-of-network specialists.

Basically, under an HMO, you're required to select a primary care physician who will direct your medical needs through the HMO network. The advantages of an HMO include slightly lower annual premiums, little or no claims filing, and preventive programs.

## INFORMATION ABOUT YOUR RATES

Rates are calculated by adding the rates for each individual. Find the appropriate category for your rate by looking up your age, gender and the Arizona county in which you reside. For more information, call 1-888-463-4875.

# HEALTH NET OF ARIZONA OVERVIEW OF INDIVIDUAL & FAMILY COVERAGE HMO PLANS

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

BENEFITS	HMO \$0 DEDUCTIBLE/70% COINSURANCE	HMO \$1,000 DEDUCTIBLE/70% COINSURANCE
<b>Deductible</b> per calendar year	None	\$1,000 Single/\$2,000 Family
<b>Maximum lifetime benefits</b> in- and out-of-network combined	Unlimited	Unlimited
<b>Out-of-pocket maximum, excluding deductible and copays for office visits and pharmacy benefits</b>	\$7,500 Single/\$15,000 Family	\$3,500 Single/\$7,000 Family
<b>Inpatient hospital services</b> including physician, facility and surgery charges	\$400 Copay/Admit Plus 30%	30%, Subject to Deductible
<b>Outpatient hospital services/ ambulatory surgical center services</b>	\$400 Copay/Visit Plus 30%	30%, Subject to Deductible
<b>Office visits</b> <b>Primary care physician</b>	\$30 Copay/Visit	\$25 Copay/Visit
<b>Specialist</b>	\$45 Copay/Visit	\$50 Copay/Visit
<b>Preventive care</b> routine physicals, annual GYN exams, well-baby care, immunizations and vision and hearing screenings	\$30 Copay/PCP Visit \$45 Copay/Specialist Visit	\$25 Copay/PCP Visit \$50 Copay/Specialist Visit
<b>Outpatient laboratory, X-ray and Mammography services</b> <b>Performed at a physician's office</b>	30%	No Charge
<b>Performed at an independent, non-hospital affiliated lab facility*</b>	30%	No Charge
<b>Performed at a hospital</b>	\$400 Copay/Visit Plus 30%	\$100 Copay/Visit
<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>	30%	\$25 Copay/Visit
<b>Performed at an independent, non-hospital affiliated facility*</b>	30%	\$25 Copay/Visit
<b>Performed at a hospital</b>	\$400 Copay/Visit Plus 30%	\$200 Copay/Visit
<b>Prenatal and postpartum care</b> office visit copayment waived after diagnosis of pregnancy is confirmed	\$30 Copay/PCP Visit Covered after 12 months of enrollment	\$25 Copay/PCP Visit Covered after 12 months of enrollment
<b>Maternity care</b> normal maternity deliveries are covered if the delivery occurs after the member's contract has been in force for 21 months or longer. Complications of pregnancy are covered regardless of the delivery date.	\$400 Copay/Visit Plus 30%	30%, Subject to Deductible
<b>Outpatient prescription drugs</b> up to a 31-day supply. Quantity limits may apply. Out-of-network coverage is for out-of-area emergencies only.	<b>Tier 1:</b> \$10 Copay/Prescription or Refill <b>Tier 2:</b> \$60 Copay/Prescription or Refill <b>Tier 3:</b> \$90 Copay/Prescription or Refill <b>Tier 4:</b> \$120 Copay/Prescription or Refill	<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
<b>Self-injectable drugs</b> tier 2 copayment will apply to preferred insulins. Quantity limits may apply. Out-of-network coverage is for out-of-area emergencies only.	<b>Tier 4:</b> \$120 Copay/Prescription or Refill	<b>Tier 4:</b> \$100 Copay/Prescription or Refill
<b>Emergency room services</b> copayment waived if admitted, inpatient hospital benefit will then apply	\$400 Copay/Visit Plus 30%	\$150 Copay/Visit
<b>Ambulance services</b> medical emergencies only	30%	No Charge
<b>Urgent care services</b>	30%	\$60 Copay/Visit
<b>In-store health care clinic</b>	\$30 Copay/Visit	\$25 Copay/Visit
<b>Rehabilitative services</b> limited to short-term, maximum of 60 days per calendar year, all therapies combined	<b>Inpatient:</b> \$400 Copay/Admit Plus 30% <b>Outpatient:</b> 30%	<b>Inpatient:</b> 30%, Subject to Deductible <b>Outpatient:</b> \$50 Copay/Visit
<b>Skilled nursing facility services</b> limited to 60 days per calendar year	\$400 Copay/Admit Plus 30%	30%, Subject to Deductible
<b>Chiropractic services</b> limited to 12 medically necessary visits per calendar year	\$45 Copay/Visit	\$50 Copay/Visit
<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> \$45 Copay/Individual Visit \$20 Copay/Group Visit	<b>Inpatient:</b> Not Covered <b>Outpatient:</b> \$25 Copay/Individual Visit \$12.50 Copay/Group Visit

\*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.

## HMO PLAN RATES EFFECTIVE JULY 1, 2009

### COCHISE, MARICOPA, PINAL AND SANTA CRUZ COUNTIES

Age	\$0/70%		\$1,000/70%	
	Male	Female	Male	Female
Under 2	\$414	\$414	\$497	\$497
2-6	\$124	\$124	\$149	\$149
7-10	\$103	\$103	\$124	\$124
11-14	\$103	\$103	\$124	\$124
15-17	\$107	\$112	\$128	\$134
18-24	\$118	\$286	\$139	\$341
25-29	\$118	\$331	\$139	\$398
30-34	\$130	\$341	\$154	\$408
35-39	\$161	\$343	\$192	\$410
40-44	\$223	\$349	\$268	\$420
45-49	\$289	\$359	\$347	\$431
50-54	\$397	\$400	\$476	\$480
55-59	\$493	\$508	\$593	\$607
60-64	\$595	\$526	\$714	\$629

### PIMA COUNTY

Age	\$0/70%		\$1,000/70%	
	Male	Female	Male	Female
Under 2	\$406	\$406	\$485	\$485
2-6	\$121	\$121	\$145	\$145
7-10	\$102	\$102	\$122	\$122
11-14	\$102	\$102	\$122	\$122
15-17	\$106	\$109	\$127	\$131
18-24	\$114	\$280	\$136	\$334
25-29	\$114	\$328	\$136	\$394
30-34	\$127	\$331	\$152	\$398
35-39	\$156	\$335	\$187	\$402
40-44	\$217	\$342	\$259	\$409
45-49	\$287	\$349	\$343	\$420
50-54	\$389	\$390	\$467	\$468
55-59	\$481	\$496	\$578	\$595
60-64	\$583	\$516	\$701	\$619

### ALL OTHER COUNTIES

Age	\$0/70%		\$1,000/70%	
	Male	Female	Male	Female
Under 2	\$643	\$643	\$772	\$772
2-6	\$196	\$196	\$235	\$235
7-10	\$163	\$163	\$196	\$196
11-14	\$163	\$163	\$196	\$196
15-17	\$167	\$173	\$199	\$209
18-24	\$180	\$448	\$216	\$535
25-29	\$181	\$520	\$217	\$624
30-34	\$197	\$516	\$236	\$619
35-39	\$250	\$535	\$300	\$642
40-44	\$348	\$545	\$418	\$654
45-49	\$454	\$557	\$545	\$670
50-54	\$622	\$623	\$746	\$748
55-59	\$769	\$791	\$923	\$948
60-64	\$929	\$817	\$1,115	\$982



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, 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/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:

**HMO Plans:** Hospital and professional services for a normal delivery are covered only for expectant members who have been enrolled for 21 consecutive months when delivery occurs. Hospital and professional services for members who have been enrolled less than 21 consecutive months are limited to prenatal care, after 12 months of enrollment, and complications of pregnancy, as defined in the Evidence of Coverage.

With the exception of emergency care and direct access benefits, all services and items must be provided or arranged by your primary care physician. Selected services require authorization by Health Net of Arizona, Inc.

**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.