



PPO BENEFIT PLAN AND RATE OVERVIEW



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

PREFERRED PROVIDER ORGANIZATION PLANS (PPO)

For individuals and families looking for more flexibility, a Preferred Provider Organization (PPO) is a perfect choice. Here, you can select providers from a large network. And, you simply pay a copayment or coinsurance at the time of service. With a PPO plan, you can see an out-of-network provider without a referral. You'll pay a slightly higher deductible for out-of-network services compared to in-network services.

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 PPO PLANS

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

BENEFITS	PPO \$500 Deductible, 80/60% Coinsurance		PPO \$1,000 Deductible, 80/60% 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 in- and out-of-network combined	\$5,000,000		\$5,000,000	
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	40%, Subject to Deductible	20%, Subject to Deductible	40%, Subject to Deductible
Outpatient hospital services/ ambulatory surgical center services	20%, Subject to Deductible	40%, Subject to Deductible	20%, Subject to Deductible	40%, Subject to Deductible
Office visits Primary care physician	\$25 Copay/Visit	40%, Subject to Deductible	\$25 Copay/Visit	40%, Subject to Deductible
Specialist	\$40 Copay/Visit	40%, Subject to Deductible	\$40 Copay/Visit	40%, Subject to Deductible
Preventive care routine physicals, annual GYN exams, well-baby care, immunizations and vision and hearing screenings	\$25 Copay/PCP Visit \$40 Copay/Specialist Visit	40%, Subject to Deductible	\$25 Copay/PCP Visit \$40 Copay/Specialist Visit	40%, Subject to Deductible
Outpatient laboratory/X-ray services/ mammography Performed at a physician's office	No Charge	40%, Subject to Deductible	No Charge	40%, Subject to Deductible
Performed at an independent, non-hospital affiliated lab facility*	No Charge	40%, Subject to Deductible	No Charge	40%, Subject to Deductible
Performed at a hospital	20%, Subject to Deductible	40%, Subject to Deductible	20%, Subject to Deductible	40%, 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	40%, Subject to Deductible	20%, Subject to Deductible	40%, Subject to Deductible
Performed at an independent, non-hospital affiliated facility*	20%, Subject to Deductible	40%, Subject to Deductible	20%, Subject to Deductible	40%, Subject to Deductible
Performed at a hospital	20%, Subject to Deductible	40%, Subject to Deductible	20%, Subject to Deductible	40%, 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. Out-of-network coverage is for out-of-area emergencies only.	Tier 1: \$15 Copay/Prescription or Refill Tier 2: \$35 Copay/Prescription or Refill Tier 3: \$65 Copay/Prescription or Refill Tier 4: \$90 Copay/Prescription or Refill	Out-of-area emergencies only	Tier 1: \$15 Copay/Prescription or Refill Tier 2: \$35 Copay/Prescription or Refill Tier 3: \$65 Copay/Prescription or Refill Tier 4: \$90 Copay/Prescription or Refill	Out-of-area emergencies only
Self-injectable drugs tier 2 copayment will apply to preferred insulins. Quantity limits may apply. Out-of-network coverage is for out-of-area emergencies only.	Tier 4: \$90 Copay/Prescription or Refill	Out-of-area emergencies only	Tier 4: \$90 Copay/Prescription or Refill	Out-of-area emergencies only
Emergency room services copayment waived if admitted, inpatient benefit will then apply	20%, Subject to \$150 Copay/Visit/waived if admitted		20%, Subject to \$150 Copay/Visit/waived if admitted	
Ambulance services medical emergencies only	20%, Subject to Deductible		20%, Subject to Deductible	
Urgent care services	\$60 Copay/Visit	40%, Subject to Deductible	\$60 Copay/Visit	40%, Subject to Deductible
In-store health care clinic	\$25 Copay/Visit	40%, Subject to Deductible	\$25 Copay/Visit	40%, 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	Inpatient: 40%, Subject to Deductible Outpatient: 40%, Subject to Deductible	Inpatient: 20%, Subject to Deductible Outpatient: \$40 Copay/Visit	Inpatient: 40%, Subject to Deductible Outpatient: 40%, Subject to Deductible
Skilled nursing facility services limited to 60 days per calendar year	20%, Subject to Deductible	40%, Subject to Deductible	20%, Subject to Deductible	40%, 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: 40%, Subject to Deductible	Inpatient: Not Covered Outpatient: 20%, Subject to Deductible	Inpatient: Not Covered Outpatient: 40%, 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.

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

BENEFITS	PPO \$2,500 Deductible, 80/60% Coinsurance		PPO \$5,000 Deductible, 80/60% Coinsurance	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible per calendar year	\$2,500 Single/\$5,000 Family	\$5,000 Single/\$10,000 Family	\$5,000 Single/\$10,000 Family	\$10,000 Single/\$20,000 Family
Maximum lifetime benefits in- and out-of-network combined	\$5,000,000		\$5,000,000	
Out-of-pocket maximum, excluding deductible and copays	\$3,000 Single/\$6,000 Family	\$6,000 Single/\$12,000 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	40%, Subject to Deductible	20%, Subject to Deductible	40%, Subject to Deductible
Outpatient hospital services/ ambulatory surgical center services	20%, Subject to Deductible	40%, Subject to Deductible	20%, Subject to Deductible	40%, Subject to Deductible
Office visits Primary care physician	\$30 Copay/Visit	40%, Subject to Deductible	\$30 Copay/Visit	40%, Subject to Deductible
Specialist	\$45 Copay/Visit	40%, Subject to Deductible	\$45 Copay/Visit	40%, Subject to Deductible
Preventive care routine physicals, annual GYN exams, well-baby care, immunizations and vision and hearing screenings	\$30 Copay/PCP Visit \$45 Copay/Specialist Visit	40%, Subject to Deductible	\$30 Copay/PCP Visit \$45 Copay/Specialist Visit	40%, Subject to Deductible
Outpatient laboratory/X-ray services/ mammography Performed at a physician's office	No Charge	40%, Subject to Deductible	No Charge	40%, Subject to Deductible
Performed at an independent, non-hospital affiliated lab facility*	No Charge	40%, Subject to Deductible	No Charge	40%, Subject to Deductible
Performed at a hospital	20%, Subject to Deductible	40%, Subject to Deductible	20%, Subject to Deductible	40%, 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	40%, Subject to Deductible	20%, Subject to Deductible	40%, Subject to Deductible
Performed at an independent, non-hospital affiliated facility*	20%, Subject to Deductible	40%, Subject to Deductible	20%, Subject to Deductible	40%, Subject to Deductible
Performed at a hospital	20%, Subject to Deductible	40%, Subject to Deductible	20%, Subject to Deductible	40%, 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	
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Emergency room services copayment waived if admitted, inpatient benefit will then apply	20%, Subject to \$150 Copay/Visit/waived if admitted		20%, Subject to \$150 Copay/Visit/waived if admitted	
Ambulance services medical emergencies only	20%, Subject to Deductible		20%, Subject to Deductible	
Urgent care services	\$60 Copay/Visit	40%, Subject to Deductible	\$60 Copay/Visit	40%, Subject to Deductible
In-store health care clinic	\$30 Copay/Visit	40%, Subject to Deductible	\$30 Copay/Visit	40%, 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: \$45 Copay/Visit	Inpatient: 40%, Subject to Deductible Outpatient: 40%, Subject to Deductible	Inpatient: 20%, Subject to Deductible Outpatient: \$45 Copay/Visit	Inpatient: 40%, Subject to Deductible Outpatient: 40%, Subject to Deductible
Skilled nursing facility services limited to 60 days per calendar year	20%, Subject to Deductible	40%, Subject to Deductible	20%, Subject to Deductible	40%, 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: 40%, Subject to Deductible	Inpatient: Not Covered Outpatient: 20%, Subject to deductible	Inpatient: Not Covered Outpatient: 40%, 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.

PPO PLAN RATES EFFECTIVE JULY 1, 2009

COCHISE, MARICOPA, PINAL AND SANTA CRUZ COUNTIES

Age	\$500/80%/60%		\$1,000/80%/60%		\$2,500/80%/60%		\$5,000/80%/60%	
	Male	Female	Male	Female	Male	Female	Male	Female
Under 2	\$436	\$436	\$342	\$342	\$260	\$260	\$171	\$171
2-6	\$149	\$149	\$116	\$116	\$88	\$88	\$58	\$58
7-10	\$148	\$148	\$112	\$112	\$86	\$86	\$57	\$57
11-14	\$143	\$143	\$111	\$111	\$85	\$85	\$55	\$55
15-17	\$142	\$164	\$111	\$131	\$84	\$97	\$54	\$64
18-24	\$158	\$253	\$125	\$197	\$94	\$149	\$62	\$98
25-29	\$156	\$253	\$121	\$197	\$94	\$149	\$60	\$99
30-34	\$179	\$254	\$139	\$197	\$105	\$149	\$69	\$99
35-39	\$221	\$293	\$174	\$227	\$132	\$172	\$85	\$111
40-44	\$311	\$317	\$241	\$248	\$184	\$188	\$121	\$123
45-49	\$404	\$470	\$315	\$367	\$240	\$280	\$156	\$182
50-54	\$556	\$553	\$433	\$432	\$327	\$329	\$214	\$213
55-59	\$685	\$667	\$534	\$521	\$403	\$395	\$265	\$257
60-64	\$832	\$730	\$647	\$568	\$492	\$431	\$319	\$282

PIMA COUNTY

Age	\$500/80%/60%		\$1,000/80%/60%		\$2,500/80%/60%		\$5,000/80%/60%	
	Male	Female	Male	Female	Male	Female	Male	Female
Under 2	\$430	\$430	\$335	\$335	\$255	\$255	\$166	\$166
2-6	\$144	\$144	\$113	\$113	\$87	\$87	\$55	\$55
7-10	\$144	\$144	\$111	\$111	\$85	\$85	\$55	\$55
11-14	\$140	\$140	\$110	\$110	\$83	\$83	\$53	\$53
15-17	\$140	\$161	\$110	\$125	\$81	\$95	\$53	\$63
18-24	\$156	\$248	\$121	\$195	\$91	\$147	\$61	\$96
25-29	\$155	\$248	\$120	\$192	\$93	\$144	\$58	\$96
30-34	\$174	\$251	\$138	\$195	\$104	\$147	\$67	\$98
35-39	\$218	\$286	\$170	\$224	\$130	\$169	\$84	\$110
40-44	\$304	\$313	\$236	\$241	\$179	\$186	\$118	\$121
45-49	\$398	\$458	\$310	\$358	\$234	\$274	\$153	\$179
50-54	\$547	\$542	\$426	\$422	\$320	\$320	\$210	\$208
55-59	\$668	\$652	\$522	\$507	\$398	\$385	\$258	\$253
60-64	\$812	\$714	\$633	\$557	\$484	\$423	\$314	\$276

OTHER COUNTIES

Age	\$500/80%/60%		\$1,000/80%/60%		\$2,500/80%/60%		\$5,000/80%/60%	
	Male	Female	Male	Female	Male	Female	Male	Female
Under 2	\$524	\$524	\$411	\$411	\$311	\$311	\$204	\$204
2-6	\$178	\$178	\$140	\$140	\$105	\$105	\$68	\$68
7-10	\$174	\$174	\$134	\$134	\$103	\$103	\$68	\$68
11-14	\$172	\$172	\$133	\$133	\$101	\$101	\$65	\$65
15-17	\$167	\$197	\$133	\$153	\$101	\$114	\$65	\$77
18-24	\$188	\$306	\$148	\$239	\$110	\$181	\$73	\$118
25-29	\$186	\$306	\$146	\$236	\$112	\$179	\$70	\$118
30-34	\$216	\$307	\$166	\$239	\$128	\$181	\$83	\$119
35-39	\$268	\$353	\$208	\$273	\$157	\$208	\$104	\$135
40-44	\$368	\$383	\$290	\$295	\$221	\$226	\$144	\$147
45-49	\$484	\$564	\$377	\$441	\$289	\$335	\$189	\$220
50-54	\$667	\$662	\$517	\$520	\$395	\$395	\$255	\$256
55-59	\$821	\$799	\$641	\$626	\$486	\$474	\$317	\$309
60-64	\$998	\$874	\$774	\$681	\$590	\$521	\$385	\$338

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:

PPO Plans: Eligible expenses for covered services delivered by non-contracted providers and facilities will be an amount determined by Health Net based on a percentage of the Health Net fee schedule, which is generally comparable to eligible expenses for covered services delivered by contracted providers and facilities. This amount may be adjusted by Health Net from time to time and at any time.

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.



In Arizona, benefits are underwritten and/or administered by Health Net of Arizona, Inc., for HMO plans and Health Net Life Insurance Company for indemnity plans and life insurance coverage. Health Net, Inc. is the parent company of both Health Net of Arizona, Inc., and Health Net Life Insurance Company.

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