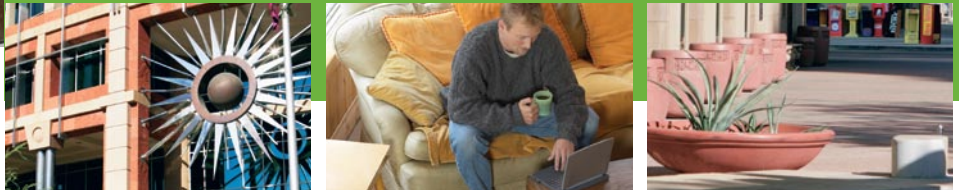




# PPO BENEFIT PLAN AND RATE OVERVIEW



**INDIVIDUAL PPO** *health coverage – made for the way you live*  
*Effective July 1, 2010*

## 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> in- and out-of-network combined	\$5,000,000		\$5,000,000	
<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> routine physicals, annual GYN exams, well-baby care, immunizations and vision and hearing screenings	\$30 Copay/PCP Visit \$60 Copay/Specialist Visit	50%, Subject to Deductible	\$30 Copay/PCP Visit \$60 Copay/Specialist Visit	50%, Subject to Deductible
<b>Outpatient laboratory/X-ray services/ mammography</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 (except mammography)	50%, Subject to Deductible	No Charge, Subject to Deductible (except mammography)	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. Out-of-network coverage is for out-of-area emergencies only.	<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	Out-of-area emergencies only	<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	Out-of-area emergencies only
<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

<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		Advantage PPO \$500 Deductible, 80/50% Coinsurance	
In-Network	Out-of-Network	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	\$500 Single/\$1,000 Family	\$1,000 Single/\$2,000 Family
\$5,000,000		\$5,000,000		\$5,000,000	
None	\$7,500 Single/\$22,500 Family	None	\$10,000 Single/ \$30,000 Family	\$2,500 Single/\$5,000 Family	\$5,000 Single/\$10,000 Family
No Charge, Subject to Deductible	50%, Subject to Deductible	No Charge, Subject to Deductible	50%, Subject to Deductible	20%, 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	20%, Subject to Deductible	50%, Subject to Deductible
\$30 Copay/Visit	50%, Subject to Deductible	\$30 Copay/Visit	50%, Subject to Deductible	\$25 Copay/Visit	50%, Subject to Deductible
\$60 Copay/Visit	50%, Subject to Deductible	\$60 Copay/Visit	50%, Subject to Deductible	\$40 Copay/Visit	50%, Subject to Deductible
\$30 Copay/PCP Visit \$60 Copay/Specialist Visit	50%, Subject to Deductible	\$30 Copay/PCP Visit \$60 Copay/Specialist Visit	50%, Subject to Deductible	\$25 Copay/PCP Visit \$40 Copay/Specialist 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	50%, Subject to Deductible	No Charge	50%, Subject to Deductible
No Charge, Subject to Deductible (except mammography)	50%, Subject to Deductible	No Charge, Subject to Deductible (except mammography)	50%, Subject to Deductible	No Charge, Subject to Deductible (except mammography)	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	20%, 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	20%, Subject to Deductible	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	20%, Subject to Deductible	50%, Subject to Deductible
Not Covered		Not Covered		Not Covered	
Not covered except for complications of pregnancy		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	Out-of-area emergencies only	<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	Out-of-area emergencies only	<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	Out-of-area emergencies only
\$450 Copay/Visit		\$450 Copay/Visit		\$300 Copay/Visit	
No Charge, Subject to Deductible		No Charge, Subject to Deductible		20%, Subject to Deductible	
\$60 Copay/Visit	50%, 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	\$25 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	<b>Inpatient:</b> 20%, Subject to Deductible <b>Outpatient:</b> \$40 Copay/Visit	50%, Subject to Deductible
No Charge, Subject to Deductible	50%, Subject to Deductible	No Charge, Subject to Deductible	50%, Subject to Deductible	20%, 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	<b>Inpatient:</b> Not Covered <b>Outpatient:</b> 20%, Subject to Deductible	<b>Inpatient:</b> Not Covered <b>Outpatient:</b> 50%, Subject to Deductible

Advantage PPO \$1,000 Deductible, 80/50% Coinsurance		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	In-Network	Out-of-Network
\$1,000 Single/\$2,000 Family	\$2,000 Single/\$4,000 Family	\$2,500 Single/\$5,000 Family	\$5,000 Single/\$10,000 Family	\$5,000 Single/\$10,000 Family	\$10,000 Single/\$20,000 Family
\$5,000,000		\$5,000,000		\$5,000,000	
\$3,000 Single/\$6,000 Family	\$6,000 Single/\$12,000 Family	\$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	20%, Subject to Deductible	50%, Subject to Deductible	20%, Subject to Deductible	50%, Subject to Deductible
\$25 Copay/Visit	50%, Subject to Deductible	\$30 Copay/Visit	50%, Subject to Deductible	\$30 Copay/Visit	50%, Subject to Deductible
\$40 Copay/Visit	50%, Subject to Deductible	\$45 Copay/Visit	50%, Subject to Deductible	\$45 Copay/Visit	50%, Subject to Deductible
\$25 Copay/PCP Visit \$40 Copay/Specialist Visit	50%, Subject to Deductible	\$30 Copay/PCP Visit \$45 Copay/Specialist Visit	50%, Subject to Deductible	\$30 Copay/PCP Visit \$45 Copay/Specialist 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	50%, Subject to Deductible	No Charge	50%, Subject to Deductible
No Charge, Subject to Deductible (except mammography)	50%, Subject to Deductible	No Charge, Subject to Deductible (except mammography)	50%, Subject to Deductible	No Charge, Subject to Deductible (except mammography)	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	20%, Subject to Deductible	50%, Subject to Deductible
Not Covered		Not Covered		Not Covered	
Not covered except for complications of pregnancy		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	Out-of-area emergencies only	<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	Out-of-area emergencies only	<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	Out-of-area emergencies only
\$300 Copay/Visit		\$300 Copay/Visit		\$300 Copay/Visit	
20%, Subject to Deductible		20%, Subject to Deductible		20%, Subject to Deductible	
\$60 Copay/Visit	50%, Subject to Deductible	\$60 Copay/Visit	50%, Subject to Deductible	\$60 Copay/Visit	50%, Subject to Deductible
\$25 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> \$40 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	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	<b>Inpatient:</b> Not Covered <b>Outpatient:</b> 20%, Subject to Deductible	<b>Inpatient:</b> Not Covered <b>Outpatient:</b> 50%, Subject to Deductible

# PPO PLAN RATES EFFECTIVE JULY 1, 2010

## 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
Under 2	277	277	184	184	166	166	143	143	484	484	379	379	288	288	195	195
2-6	93	93	62	62	57	57	49	49	165	165	129	129	98	98	66	66
7-10	92	92	61	61	55	55	48	48	164	164	124	124	95	95	65	65
11-14	91	91	59	59	53	53	45	45	159	159	123	123	94	94	63	63
15-17	90	103	58	69	52	62	45	53	157	182	123	145	93	108	62	73
18-24	100	159	67	105	60	95	52	82	175	281	139	218	104	165	71	112
25-29	100	159	64	106	59	96	50	83	173	281	134	218	104	165	68	113
30-34	112	159	74	106	68	96	58	83	199	282	154	218	116	165	79	113
35-39	141	183	91	120	83	109	71	93	245	325	193	252	146	191	97	126
40-44	196	200	130	132	118	120	101	103	345	352	267	275	204	208	138	140
45-49	255	298	167	195	152	177	131	152	448	521	349	407	266	311	178	207
50-54	348	350	230	230	208	207	179	179	617	613	480	479	363	365	244	243
55-59	429	420	285	276	258	251	222	215	760	740	592	578	447	438	302	293
60-64	523	459	343	303	311	275	267	236	923	810	718	630	546	478	363	321

## 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
Under 2	257	257	169	169	153	153	131	131	451	451	351	351	267	267	179	179
2-6	87	87	56	56	50	50	43	43	151	151	119	119	91	91	59	59
7-10	86	86	56	56	50	50	43	43	151	151	116	116	89	89	59	59
11-14	84	84	53	53	49	49	42	42	147	147	115	115	87	87	57	57
15-17	82	95	53	64	49	58	42	50	147	169	115	131	85	100	57	68
18-24	91	148	62	98	57	88	48	76	164	260	127	205	95	154	66	103
25-29	93	145	59	98	53	88	46	76	163	260	126	201	98	151	62	103
30-34	105	148	68	100	62	90	53	78	183	263	145	205	109	154	72	106
35-39	131	170	85	112	78	102	66	87	229	300	178	235	136	177	90	118
40-44	180	187	120	123	109	111	93	95	319	328	248	253	188	195	127	130
45-49	236	276	155	183	141	165	121	142	418	480	325	376	245	287	165	193
50-54	322	322	214	212	193	192	166	165	574	569	447	443	336	336	226	224
55-59	401	387	262	257	238	233	205	200	701	684	548	532	418	404	278	272
60-64	487	426	319	281	290	254	249	218	852	749	664	584	508	444	338	297

## 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
Under 2	330	330	220	220	199	199	171	171	581	581	456	456	345	345	232	232
2-6	112	112	73	73	67	67	57	57	197	197	155	155	116	116	77	77
7-10	110	110	73	73	67	67	57	57	193	193	149	149	114	114	77	77
11-14	108	108	70	70	63	63	54	54	191	191	147	147	112	112	74	74
15-17	108	121	70	83	63	75	54	64	185	218	147	170	112	126	74	88
18-24	118	193	79	126	71	115	61	99	208	339	164	265	122	201	83	134
25-29	119	191	75	126	68	115	59	99	206	339	162	262	124	199	80	134
30-34	136	193	89	128	81	116	70	100	240	340	184	265	142	201	95	136
35-39	167	222	112	145	101	132	87	113	297	391	231	303	174	231	118	154
40-44	235	241	155	159	140	143	121	123	408	425	322	327	245	251	164	167
45-49	307	356	203	236	184	214	159	184	537	625	418	489	321	372	215	251
50-54	420	420	274	275	248	250	213	214	740	734	573	577	438	438	290	292
55-59	517	505	340	333	308	301	265	258	910	886	711	694	539	526	361	352
60-64	628	555	414	364	375	329	322	283	1107	969	858	755	654	578	439	385

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:** 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.



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