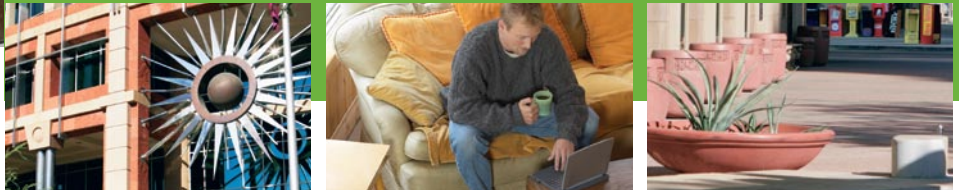




PPO BENEFIT PLAN AND RATE OVERVIEW



INDIVIDUAL PPO *health coverage – made for the way you live*
Effective January 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
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 in- and out-of-network combined	\$5,000,000		\$5,000,000	
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 routine physicals, annual GYN exams, well-baby care, immunizations and vision and hearing screenings	\$30 Copay/PCP Visit \$60 Copay/Specialist Visit	Not Covered	\$30 Copay/PCP Visit \$60 Copay/Specialist Visit	Not Covered
Outpatient laboratory/X-ray services/ mammography 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 (except mammography)	50%, Subject to Deductible	No Charge, Subject to Deductible (except mammography)	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. Out-of-network coverage is for out-of-area emergencies only.	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	Out-of-area emergencies only	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	Out-of-area emergencies only
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

*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	Not Covered	\$30 Copay/PCP Visit \$60 Copay/Specialist Visit	Not Covered	\$25 Copay/PCP Visit \$40 Copay/Specialist Visit	Not Covered
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	
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	Out-of-area emergencies only	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	Out-of-area emergencies only	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	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
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	Inpatient: 20%, Subject to Deductible Outpatient: \$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
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	Inpatient: Not Covered Outpatient: 20%, Subject to Deductible	Inpatient: Not Covered Outpatient: 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	Not Covered	\$30 Copay/PCP Visit \$45 Copay/Specialist Visit	Not Covered	\$30 Copay/PCP Visit \$45 Copay/Specialist Visit	Not Covered
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	
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	Out-of-area emergencies only	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	Out-of-area emergencies only	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	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
Inpatient: 20%, Subject to Deductible Outpatient: \$40 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	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	Inpatient: Not Covered Outpatient: 20%, Subject to Deductible	Inpatient: Not Covered Outpatient: 50%, Subject to Deductible

PPO PLAN RATES EFFECTIVE JANUARY 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	250	250	166	166	150	150	129	129	436	436	342	342	260	260	171	171
2-6	84	84	56	56	51	51	44	44	149	149	116	116	88	88	58	58
7-10	83	83	55	55	50	50	43	43	148	148	112	112	86	86	57	57
11-14	82	82	53	53	48	48	41	41	143	143	111	111	85	85	55	55
15-17	81	93	52	62	47	56	41	48	142	164	111	131	84	97	54	64
18-24	90	143	60	95	54	86	47	74	158	253	125	197	94	149	62	98
25-29	90	143	58	96	53	87	45	75	156	253	121	197	94	149	60	99
30-34	101	143	67	96	61	87	52	75	179	254	139	197	105	149	69	99
35-39	127	165	82	108	75	98	64	84	221	293	174	227	132	172	85	111
40-44	177	180	117	119	106	108	91	93	311	317	241	248	184	188	121	123
45-49	230	269	151	176	137	160	118	137	404	470	315	367	240	280	156	182
50-54	314	316	207	207	188	187	161	161	556	553	433	432	327	329	214	213
55-59	387	379	257	249	233	226	200	194	685	667	534	521	403	395	265	257
60-64	472	414	309	273	280	248	241	213	832	730	647	568	492	431	319	282

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	245	245	161	161	146	146	125	125	430	430	335	335	255	255	166	166
2-6	83	83	53	53	48	48	41	41	144	144	113	113	87	87	55	55
7-10	82	82	53	53	48	48	41	41	144	144	111	111	85	85	55	55
11-14	80	80	51	51	47	47	40	40	140	140	110	110	83	83	53	53
15-17	78	91	51	61	47	55	40	48	140	161	110	125	81	95	53	63
18-24	87	141	59	93	54	84	46	72	156	248	121	195	91	147	61	96
25-29	89	138	56	93	51	84	44	72	155	248	120	192	93	144	58	96
30-34	100	141	65	95	59	86	51	74	174	251	138	195	104	147	67	98
35-39	125	162	81	107	74	97	63	83	218	286	170	224	130	169	84	110
40-44	172	178	114	117	104	106	89	91	304	313	236	241	179	186	118	121
45-49	225	263	148	174	134	157	115	135	398	458	310	358	234	274	153	179
50-54	307	307	204	202	184	183	158	157	547	542	426	422	320	320	210	208
55-59	382	369	250	245	227	222	195	191	668	652	522	507	398	385	258	253
60-64	464	406	304	268	276	242	237	208	812	714	633	557	484	423	314	276

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	298	298	198	198	179	179	154	154	524	524	411	411	311	311	204	204
2-6	101	101	66	66	60	60	51	51	178	178	140	140	105	105	68	68
7-10	99	99	66	66	60	60	51	51	174	174	134	134	103	103	68	68
11-14	97	97	63	63	57	57	49	49	172	172	133	133	101	101	65	65
15-17	97	109	63	75	57	68	49	58	167	197	133	153	101	114	65	77
18-24	106	174	71	114	64	104	55	89	188	306	148	239	110	181	73	118
25-29	107	172	68	114	61	104	53	89	186	306	146	236	112	179	70	118
30-34	123	174	80	115	73	105	63	90	216	307	166	239	128	181	83	119
35-39	151	200	101	131	91	119	78	102	268	353	208	273	157	208	104	135
40-44	212	217	140	143	126	129	109	111	368	383	290	295	221	226	144	147
45-49	277	321	183	213	166	193	143	166	484	564	377	441	289	335	189	220
50-54	379	379	247	248	224	225	192	193	667	662	517	520	395	395	255	256
55-59	466	455	307	300	278	271	239	233	821	799	641	626	486	474	317	309
60-64	566	500	373	328	338	297	290	255	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: 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.

