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	
Deductible (per calendar year)	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
	$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 **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
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	
Deductible (per calendar year)	**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
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 **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:** $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
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:** $100 Copay/Prescription or Refill	Out-of-area emergencies only	**Tier 4:** $100 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
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

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PPO PLAN RATES EFFECTIVE JULY 1, 2008

COCHISE, MARICOPA, PINAL AND SANTA CRUZ COUNTIES

	$500/80%/60%		$1,000/80%/60%		$2,500/80%/60%		$5,000/80%/60%	
Age	Male	Female	Male	Female	Male	Female	Male	Female
Under 2	363	363	305	305	232	232	171	171
2-6	124	124	104	104	79	79	58	58
7-10	123	123	100	100	77	77	57	57
11-14	119	119	99	99	76	76	55	55
15-17	118	137	99	117	75	87	54	64
18-24	132	211	112	176	84	133	62	98
25-29	130	211	108	176	84	133	60	99
30-34	149	212	124	176	94	133	69	99
35-39	184	244	155	203	118	154	85	111
40-44	259	264	215	221	164	168	121	123
45-49	337	392	281	328	214	250	156	182
50-54	463	461	387	386	292	294	214	213
55-59	571	556	477	465	360	353	265	257
60-64	693	608	578	507	439	385	319	282

PIMA COUNTY

	$500/80%/60%		$1,000/80%/60%		$2,500/80%/60%		$5,000/80%/60%	
Age	Male	Female	Male	Female	Male	Female	Male	Female
Under 2	358	358	299	299	228	228	166	166
2-6	120	120	101	101	78	78	55	55
7-10	120	120	99	99	76	76	55	55
11-14	117	117	98	98	74	74	53	53
15-17	117	134	98	112	72	85	53	63
18-24	130	207	108	174	81	131	61	96
25-29	129	207	107	171	83	129	58	96
30-34	145	209	123	174	93	131	67	98
35-39	182	238	152	200	116	151	84	110
40-44	253	261	211	215	160	166	118	121
45-49	332	382	277	320	209	245	153	179
50-54	456	452	380	377	286	286	210	208
55-59	557	543	466	453	355	344	258	253
60-64	677	595	565	497	432	378	314	276

OTHER COUNTIES

	$500/80%/60%		$1,000/80%/60%		$2,500/80%/60%		$5,000/80%/60%	
Age	Male	Female	Male	Female	Male	Female	Male	Female
Under 2	437	437	367	367	278	278	204	204
2-6	148	148	125	125	94	94	68	68
7-10	145	145	120	120	92	92	68	68
11-14	143	143	119	119	90	90	65	65
15-17	139	164	119	137	90	102	65	77
18-24	157	255	132	213	98	162	73	118
25-29	155	255	130	211	100	160	70	118
30-34	180	256	148	213	114	162	83	119
35-39	223	294	186	244	140	186	104	135
40-44	307	319	259	263	197	202	144	147
45-49	403	470	337	394	258	299	189	220
50-54	556	552	462	464	353	353	255	256
55-59	684	666	572	559	434	423	317	309
60-64	832	728	691	608	527	465	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:

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.

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.

Pre-existing Condition Limitation (PPO Plans Only): Expenses for conditions for which a member received any medical advice, diagnosis, care or treatment during the 6 month period immediately preceding the member's effective date of coverage will be excluded from coverage the first 12 months of enrollment.

High-Deductible PPO Plans: Preventive health care services are defined as routine physical, pap smear, mammography and PSA screenings. For a complete list see Policy.

Health Net®
A Better Decision

In Arizona, benefits are insured and/or administered by Health Net of Arizona, Inc. for HMO plans and Health Net Life Insurance Company for indemnity plans and life coverage. The Health Net of Arizona, Inc. service area includes all Arizona counties. Participating Providers are neither agents nor employees of Health Net of Arizona, but are independently contracted entities that are legally responsible for their own care, treatment and other services provided to Health Net members.

AZ48527 (5/08) 6016503

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INDIVIDUAL & FAMILY PLAN

PPO BENEFIT PLAN AND RATE OVERVIEW



THE EASY WAY *to pick the health plan that's right for you.*

Effective July 1, 2008

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®
A Better Decision