Value PPO plans
Flexibility and affordability are just two of the ways you will benefit from our Value plans. With a full range of benefits and a comfortable price tag, these plans are sure to fit any budget without skimping on health care coverage.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Value PPO $4,000 deductible, 100% / 50% coinsurance</th>
<th>Value PPO $6,500 deductible, 100% / 50% coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>deductible – per calendar year</td>
<td>In-network $4,000 single / $12,000 family</td>
<td>Out-of-network $8,000 single / $24,000 family</td>
</tr>
<tr>
<td>Maximum lifetime benefits</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Out-of-pocket maximum – excluding deductible and copays</td>
<td>None</td>
<td>$4,000 single / $12,000 family</td>
</tr>
<tr>
<td>Inpatient hospital services – including physician, facility and surgery charges</td>
<td>No charge, subject to deductible</td>
<td>50%, subject to deductible</td>
</tr>
<tr>
<td>Outpatient hospital services / ambulatory surgical center services</td>
<td>No charge, subject to deductible</td>
<td>50%, subject to deductible</td>
</tr>
<tr>
<td>Office visits</td>
<td></td>
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</tr>
<tr>
<td>Primary care physician</td>
<td>$30 copay/visit</td>
<td>50%, subject to deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>$60 copay/visit</td>
<td>50%, subject to deductible</td>
</tr>
<tr>
<td>Preventive care – preventive office visits, preventive lab and X-ray, Pap test and mammogram, prostate screening, immunizations, colorectal cancer screening (including, but not limited to colonoscopy), Women’s Preventive Services1 and vision and hearing screenings</td>
<td>$0 copay/visit</td>
<td>50%, subject to deductible</td>
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<tr>
<td>Outpatient laboratory / X-ray services</td>
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<tr>
<td>Performed at a physician’s office</td>
<td>No charge</td>
<td>50%, subject to deductible</td>
</tr>
<tr>
<td>Performed at an independent, nonhospital-affiliated lab facility2</td>
<td>No charge</td>
<td>50%, subject to deductible</td>
</tr>
<tr>
<td>Performed at a hospital</td>
<td>No charge, subject to deductible</td>
<td>50%, subject to deductible</td>
</tr>
<tr>
<td>Outpatient imaging and testing services (including but not limited to CT scans, MRIs, MRAs and PET / SPECT scans)</td>
<td></td>
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</tr>
<tr>
<td>Performed at a physician’s office</td>
<td>$250 CT</td>
<td>50%, subject to deductible</td>
</tr>
<tr>
<td></td>
<td>$400 MRI / MRA / PET / SPECT</td>
<td></td>
</tr>
<tr>
<td>Performed at an independent, nonhospital-affiliated facility2</td>
<td>$250 CT</td>
<td>50%, subject to deductible</td>
</tr>
<tr>
<td></td>
<td>$400 MRI / MRA / PET / SPECT</td>
<td></td>
</tr>
<tr>
<td>Performed at a hospital</td>
<td>$600 CT</td>
<td>50%, subject to deductible</td>
</tr>
<tr>
<td></td>
<td>$1,000 MRI / MRA / PET / SPECT</td>
<td></td>
</tr>
</tbody>
</table>

1As of 1/1/2013, Women’s Preventive Services include screening for gestational diabetes; human papillomavirus (HPV) DNA testing for women 30 years and older; sexually transmitted infection counseling; and human immunodeficiency virus (HIV) screening and counseling. These services also include FDA-approved contraception methods and sterilization procedures, and contraceptive counseling for women with reproductive capacity; breastfeeding support, supplies and counseling; and interpersonal and domestic violence screening and counseling.

2Some 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 plans 4000 and 6500

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Value PPO $4,000 deductible, 100% / 50% coinsurance</th>
<th>Value PPO $6,500 deductible, 100% / 50% coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal and postpartum care</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Maternity care</td>
<td>Not covered except for complications of pregnancy</td>
<td>Not covered except for complications of pregnancy</td>
</tr>
<tr>
<td>Outpatient prescription drugs up to a 31-day supply. Quantity limits may apply.</td>
<td>$500 prescription deductible per person. Applies to brand-name medications. 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 Self-injectables (specialty drugs) 50% or $500 (whichever is less)</td>
<td>$500 prescription deductible per person. Applies to brand-name medications. 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 Self-injectables (specialty drugs) 50% or $500 (whichever is less)</td>
</tr>
<tr>
<td>Emergency room services – copay waived if admitted, inpatient benefit will then apply</td>
<td>$450 copay/visit</td>
<td>$450 copay/visit</td>
</tr>
<tr>
<td>Ambulance services – medical emergencies only</td>
<td>No charge, subject to deductible</td>
<td>No charge, subject to deductible</td>
</tr>
<tr>
<td>Urgent care services</td>
<td>$60 copay/visit 50%, subject to deductible</td>
<td>$60 copay/visit 50%, subject to deductible</td>
</tr>
<tr>
<td>In-store health care clinic</td>
<td>$30 copay/visit 50%, subject to deductible</td>
<td>$30 copay/visit 50%, subject to deductible</td>
</tr>
<tr>
<td>Rehabilitative services – limited to short-term, maximum of 60 days per calendar year, all therapies combined</td>
<td>Inpatient: No charge, subject to deductible Outpatient: No charge, subject to deductible</td>
<td>Inpatient: No charge, subject to deductible Outpatient: No charge, subject to deductible</td>
</tr>
<tr>
<td>Skilled nursing facility services – limited to 60 days per calendar year</td>
<td>No charge, subject to deductible</td>
<td>No charge, subject to deductible</td>
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<tr>
<td>Mental health services – Outpatient: limited to short-term evaluation or crisis intervention. Maximum of 10 visits per calendar year.</td>
<td>Inpatient: Not covered Outpatient: No charge, subject to deductible</td>
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<td>$60 copay/visit 50%, subject to deductible</td>
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</tr>
</tbody>
</table>

This benefit chart is a summary only. For benefit details, please see your Schedule of Benefits and Evidence of Coverage.
**Value PPO plans 8000 and 10500**

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Value PPO $8,000 deductible, 100% / 50% coinsurance</th>
<th>Value PPO $10,500 deductible, 100% / 50% coinsurance</th>
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<tbody>
<tr>
<td><strong>In-network</strong></td>
<td><strong>Out-of-network</strong></td>
<td><strong>In-network</strong></td>
</tr>
<tr>
<td>Deductible – per calendar year</td>
<td>$8,000 single / $24,000 family</td>
<td>$16,000 single / $48,000 family</td>
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<tr>
<td>Maximum lifetime benefits</td>
<td>Unlimited</td>
<td>Unlimited</td>
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<tr>
<td>Out-of-pocket maximum – excluding deductible and copays</td>
<td>None</td>
<td>$8,000 single / $24,000 family</td>
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<td>No charge, subject to deductible</td>
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<td></td>
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<td>$250 CT $400 MRI / MRA / PET / SPECT 50%, subject to deductible</td>
<td>$250 CT $400 MRI / MRA / PET / SPECT</td>
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<tr>
<td>Performed at an independent, nonhospital-affiliated facility(^2)</td>
<td>$250 CT $400 MRI / MRA / PET / SPECT 50%, subject to deductible</td>
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<tr>
<td>Performed at a hospital</td>
<td>$600 CT $1,000 MRI / MRA / PET / SPECT 50%, subject to deductible</td>
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# Value PPO plans 8000 and 10500

## Benefits | Value PPO $8,000 deductible, 100% / 50% coinsurance | Value PPO $10,500 deductible, 100% / 50% coinsurance

<table>
<thead>
<tr>
<th>In-network</th>
<th>Out-of-network</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
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<td></td>
</tr>
<tr>
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<td>Tier 1: $15 copay/prescription or refill</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 2: $40 copay/prescription or refill</td>
<td>Tier 2: $40 copay/prescription or refill</td>
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<tr>
<td>Tier 3: $75 copay/prescription or refill</td>
<td>Tier 3: $75 copay/prescription or refill</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 4: $100 copay/prescription or refill</td>
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<td></td>
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## Value PPO plan rates effective July 1, 2012

### Cochise, Maricopa, Pinal and Santa Cruz counties

<table>
<thead>
<tr>
<th>Age</th>
<th>Pima County</th>
<th>Cochise, Maricopa, Pinal and Santa Cruz counties</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Value PPO</td>
<td>Value PPO</td>
</tr>
<tr>
<td></td>
<td>$4,000 / 100% / 50%</td>
<td>$6,500 / 100% / 50%</td>
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<tr>
<td></td>
<td>$8,000 / 100% / 50%</td>
<td>$10,500 / 100% / 50%</td>
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<tr>
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<tr>
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</tr>
</tbody>
</table>

### Value PPO

- **Value PPO $4,000 / 100% / 50%**
  - **Male:** 580
  - **Female:** 580

- **Value PPO $6,500 / 100% / 50%**
  - **Male:** 166
  - **Female:** 166

- **Value PPO $8,000 / 100% / 50%**
  - **Male:** 149
  - **Female:** 149

- **Value PPO $10,500 / 100% / 50%**
  - **Male:** 299
  - **Female:** 299

### Pima County

<table>
<thead>
<tr>
<th>Age</th>
<th>Value PPO</th>
<th>Value PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$4,000 / 100% / 50%</td>
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Rates are subject to change. These rates are the Health Net standard rates. You may be assigned to a nonstandard 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 and 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 and 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 enrollment brochure are not comprehensive. For a full list of exclusions and limitations, see the Evidence of Coverage. 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:**

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 Evidence of Coverage. 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.

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 the Evidence of Coverage. In- and out-of-network benefits are subject to a 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.

Preventive health care services are defined as routine physical, Pap test, mammography and PSA screenings. For a complete list, see the Evidence of Coverage.