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INDIVIDUAL & FAMILY PLAN

HSA BENEFIT PLAN AND RATE OVERVIEW



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

Effective November 1, 2007

HIGH-DEDUCTIBLE HSA-COMPATIBLE PPO PLANS

When it comes to health care, finances are always a concern. Adding a Health Savings Account (HSA) to a high-deductible health plan can provide cost-conscious health coverage and real tax advantages. Our HSA-Compatible plans offer you peace of mind—knowing that medical expenses are covered while still giving you control of your health care dollars. It's simple and cost-effective. It's definitely a secure health plan for your future, and a plan ahead of the rest.

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.

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HEALTH NET OF ARIZONA OVERVIEW OF **INDIVIDUAL AND FAMILY** HIGH-DEDUCTIBLE PPO PLANS (HSA-COMPATIBLE)

This benefit chart is a summary only. For benefit details, please see your Schedule of Benefits and Policy. The information below shows the high-deductible PPO plans that can be used in conjunction with a Health Savings Account.

BENEFITS	PPO $1,750/$3,500/100/50%		PPO $2,600/$5,150/100/50%		PPO $2,600/$5,150/80/50%	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible[1] (includes medical and prescription; per calendar year)	$1,750 Individual $3,500 Family	$3,500 Individual $7,000 Family	$2,600 Individual $5,150 Family	$5,200 Individual $10,300 Family	$2,600 Individual $5,150 Family	$5,200 Individual $10,300 Family
Maximum lifetime benefits (in- and out-of-network combined)	$5,000,000		$5,000,000		$5,000,000	
Out-of-pocket maximum, excluding deductible	$0 Individual $0 Family	$6,500 Individual $13,000 Family	$0 Individual $0 Family	$4,800 Individual $9,700 Family	$2,500 Individual $5,000 Family	$4,800 Individual $9,700 Family
Inpatient hospital services (including physician, facility and surgery charges)	0%, Subject to Deductible	50%, Subject to Deductible	0%, Subject to Deductible	50%, Subject to Deductible	20%, Subject to Deductible	50%, Subject to Deductible
Outpatient hospital services/ ambulatory surgical center services	0%, Subject to Deductible	50%, Subject to Deductible	0%, Subject to Deductible	50%, Subject to Deductible	20%, Subject to Deductible	50%, Subject to Deductible
Office visits	0%, Subject to Deductible	50%, Subject to Deductible	0%, Subject to Deductible	50%, Subject to Deductible	20%, Subject to Deductible	50%, Subject to Deductible
Preventive care (routine physicals, annual GYN exams, well-baby care, immunizations and vision and hearing screenings) No charge for first $300 per member per calendar year, does not apply to ages 0 through 4.	0%, Subject to Deductible No charge for first $300.	50%, Subject to Deductible	0%, Subject to Deductible No charge for first $300.	50%, Subject to Deductible	20%, Subject to Deductible No charge for first $300.	50%, Subject to Deductible
Outpatient laboratory and X-ray services	0%, Subject to Deductible	50%, Subject to Deductible	0%, Subject to Deductible	50%, Subject to Deductible	20%, Subject to Deductible	50%, Subject to Deductible
Outpatient imaging and testing services (including but not limited to CT scans, MRIs, MRAs and PET/ SPECT scans)	0%, Subject to Deductible	50%, Subject to Deductible	0%, Subject to Deductible	50%, Subject to Deductible	20%, Subject to Deductible	50%, Subject to Deductible
Prenatal and postpartum care	Not Covered		Not Covered		Not Covered	
Maternity care	Not covered except for complications of pregnancy		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.)	0%, Subject to Deductible	Out-of-area emergencies only	0%, Subject to Deductible	Out-of-area emergencies only	**Tier 1** $15 **Tier 2** $40 **Tier 3** $75 **Tier 4** $100 Subject to Deductible*	Out-of-area emergencies only
Self-injectable drugs (tier 2 copayment will apply to preferred insulin vials. Quantity limits may apply. Out-of-network coverage is for out-of-area emergencies only.)	0%, Subject to Deductible	Out-of-area emergencies only	0%, Subject to Deductible	Out-of-area emergencies only	**Tier 4** $100 Subject to Deductible*	Out-of-area emergencies only
Emergency room services	0%, Subject to Deductible	0%, Subject to Deductible	0%, Subject to Deductible	0%, Subject to Deductible	20%, Subject to Deductible	20%, Subject to Deductible
Ambulance services (medical emergency only)	0%, Subject to Deductible	0%, Subject to Deductible	0%, Subject to Deductible	0%, Subject to Deductible	20%, Subject to Deductible	20%, Subject to Deductible
Urgent care services	0%, Subject to Deductible	50%, Subject to Deductible	0%, Subject to Deductible	50%, Subject to Deductible	20%, Subject to Deductible	50%, Subject to Deductible
Rehabilitative services (limited to short-term, maximum of 60 days per calendar year)	0%, Subject to Deductible	50%, Subject to Deductible	0%, Subject to Deductible	50%, Subject to Deductible	20%, Subject to Deductible	50%, Subject to Deductible
Skilled nursing facility services (limited to 60 days per calendar year)	0%, Subject to Deductible	50%, Subject to Deductible	0%, Subject to Deductible	50%, Subject to Deductible	20%, 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:** 0%, Subject to Deductible	**Inpatient:** Not Covered **Outpatient:** 50%, Subject to Deductible	**Inpatient:** Not Covered **Outpatient:** 0%, 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

[1] There are no individual deductibles with the family plan designs.
* Prescription drug copays apply after deductible amount is met.

HIGH-DEDUCTIBLE (HSA-COMPATIBLE) PPO INDIVIDUAL AND FAMILY PLAN RATES EFFECTIVE NOVEMBER 1, 2007

COCHISE, MARICOPA, PINAL AND SANTA CRUZ COUNTIES

	$1,750/$3,500/100%/50%		$2,600/$5,150/100%/50%		$2,600/$5,150/80%/50%	
Age	Male	Female	Male	Female	Male	Female
Under 2	228	228	196	196	161	161
2-6	78	78	67	67	55	55
7-10	77	77	66	66	54	54
11-14	75	75	64	64	53	53
15-17	74	85	63	73	52	60
18-24	82	132	71	113	58	93
25-29	82	132	71	113	58	93
30-34	92	132	79	113	65	93
35-39	116	150	100	129	82	106
40-44	162	164	139	141	114	116
45-49	210	245	180	210	148	173
50-54	286	289	246	248	202	204
55-59	353	346	303	297	249	244
60-64	431	378	370	325	304	267

PIMA COUNTY

	$1,750/$3,500/100%/50%		$2,600/$5,150/100%/50%		$2,600/$5,150/80%/50%	
Age	Male	Female	Male	Female	Male	Female
Under 2	223	223	192	192	157	157
2-6	75	75	66	66	54	54
7-10	75	75	65	65	53	53
11-14	74	74	63	63	52	52
15-17	72	84	61	72	51	59
18-24	80	129	70	111	57	90
25-29	80	129	70	111	56	91
30-34	90	129	77	111	64	91
35-39	114	147	98	127	80	103
40-44	159	161	137	137	112	114
45-49	205	240	177	206	144	169
50-54	281	284	242	242	198	200
55-59	346	340	298	291	244	239
60-64	422	370	363	319	298	261

ALL OTHER COUNTIES

	$1,750/$3,500/100%/50%		$2,600/$5,150/100%/50%		$2,600/$5,150/80%/50%	
Age	Male	Female	Male	Female	Male	Female
Under 2	273	273	235	235	192	192
2-6	93	93	80	80	67	67
7-10	91	91	80	80	65	65
11-14	90	90	77	77	63	63
15-17	90	102	75	87	62	72
18-24	98	159	85	136	69	112
25-29	99	158	85	135	69	111
30-34	110	158	95	136	78	112
35-39	140	181	120	154	99	127
40-44	195	198	166	168	137	140
45-49	252	293	217	252	177	208
50-54	344	347	295	297	243	245
55-59	423	416	364	355	299	294
60-64	518	453	445	391	365	320

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.

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