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INDIVIDUAL & FAMILY PLAN

HMO BENEFIT PLAN AND RATE OVERVIEW



THE EASY WAY *to pick the health plan that's right for you.*
Effective July 1, 2008

HEALTH MAINTENANCE ORGANIZATION PLANS (HMO)

HMO's are a great choice for individuals and families requiring routine care, with no unusual medical needs that require out-of-network specialists.

Basically, under an HMO, you're required to select a primary care physician who will direct your medical needs through the HMO network. The advantages of an HMO include slightly lower annual premiums, little or no claims filing, and preventive programs.

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

HEALTH NET OF ARIZONA OVERVIEW OF INDIVIDUAL & FAMILY COVERAGE HMO PLANS

This benefit chart is a summary only. For benefit details, please see your Schedule of Benefits and Evidence of Coverage.

BENEFITS	HMO $0 DEDUCTIBLE/70% COINSURANCE	HMO $1,000 DEDUCTIBLE/70% COINSURANCE
Deductible (per calendar year)	None	$1,000 Single/$2,000 Family
Maximum lifetime benefits (in- and out-of-network combined)	Unlimited	Unlimited
Out-of-pocket maximum, excluding deductible and copays for office visits and pharmacy benefits	$7,500 Single/$15,000 Family	$3,500 Single/$7,000 Family
Inpatient hospital services (including physician, facility and surgery charges)	$400 Copay/Admit Plus 30%	30%, Subject to Deductible
Outpatient hospital services/ ambulatory surgical center services	$400 Copay/Visit Plus 30%	30%, Subject to Deductible
Office visits **Primary care physician**	$30 Copay/Visit	$25 Copay/Visit
Specialist	$45 Copay/Visit	$50 Copay/Visit
Preventive care (routine physicals, annual GYN exams, well-baby care, immunizations and vision and hearing screenings)	$30 Copay/PCP Visit $45 Copay/Specialist Visit	$25 Copay/PCP Visit $50 Copay/Specialist Visit
Outpatient laboratory and X-ray services **Performed at a physician's office**	30%	No Charge
Performed at an independent, non-hospital affiliated lab facility*	30%	No Charge
Performed at a hospital	$400 Copay/Visit Plus 30%	$100 Copay/Visit
Outpatient imaging and testing services (including but not limited to CT scans, MRIs, MRAs and PET/SPECT scans) **Performed at a physician's office**	30%	$25 Copay/Visit
Performed at an independent, non-hospital affiliated facility*	30%	$25 Copay/Visit
Performed at a hospital	$400 Copay/Visit Plus 30%	$200 Copay/Visit
Prenatal and postpartum care (office visit copayment waived after diagnosis of pregnancy is confirmed)	$30 Copay/PCP Visit Covered after 12 months of enrollment	$25 Copay/PCP Visit Covered after 12 months of enrollment
Maternity care (normal maternity deliveries are covered if the delivery occurs after the member's contract has been in force for 21 months or longer. Complications of pregnancy are covered regardless of the delivery date.)	$400 Copay/Visit Plus 30%	30%, Subject to Deductible
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:** $10 Copay/Prescription or Refill **Tier 2:** $60 Copay/Prescription or Refill **Tier 3:** $90 Copay/Prescription or Refill **Tier 4:** $120 Copay/Prescription or Refill	**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-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:** $120 Copay/Prescription or Refill	**Tier 4:** $100 Copay/Prescription or Refill
Emergency room services (copayment waived if admitted, inpatient hospital benefit will then apply)	$400 Copay/Visit Plus 30%	$150 Copay/Visit
Ambulance services (medical emergencies only)	30%	No Charge
Urgent care services	30%	$60 Copay/Visit
Rehabilitative services (limited to short-term, maximum of 60 days per calendar year, all therapies combined)	**Inpatient:** $400 Copay/Admit Plus 30% **Outpatient:** 30%	**Inpatient:** 30%, Subject to Deductible **Outpatient:** $50 Copay/Visit
Skilled nursing facility services (limited to 60 days per calendar year)	$400 Copay/Admit Plus 30%	30%, Subject to Deductible
Chiropractic services (limited to 12 medically necessary visits per calendar year.)	$45 Copay/Visit	$50 Copay/Visit
Mental health services (outpatient: limited to short-term evaluation or crisis intervention. Maximum of 10 visits per calendar year.)	**Inpatient:** Not Covered **Outpatient:** $45 Copay/Individual Visit $20 Copay/Group Visit	**Inpatient:** Not Covered **Outpatient:** $25 Copay/Individual Visit $12.50 Copay/Group Visit

*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.

HMO PLAN RATES EFFECTIVE JULY 1, 2008

COCHISE, MARICOPA, PINAL AND SANTA CRUZ COUNTIES

	$0/70%		$1,000/70%	
Age	Male	Female	Male	Female
Under 2	345	345	414	414
2-6	103	103	124	124
7-10	86	86	103	103
11-14	86	86	103	103
15-17	89	93	107	112
18-24	98	238	116	284
25-29	98	276	116	332
30-34	108	284	128	340
35-39	134	286	160	342
40-44	186	291	223	350
45-49	241	299	289	359
50-54	331	333	397	400
55-59	411	423	494	506
60-64	496	438	595	524

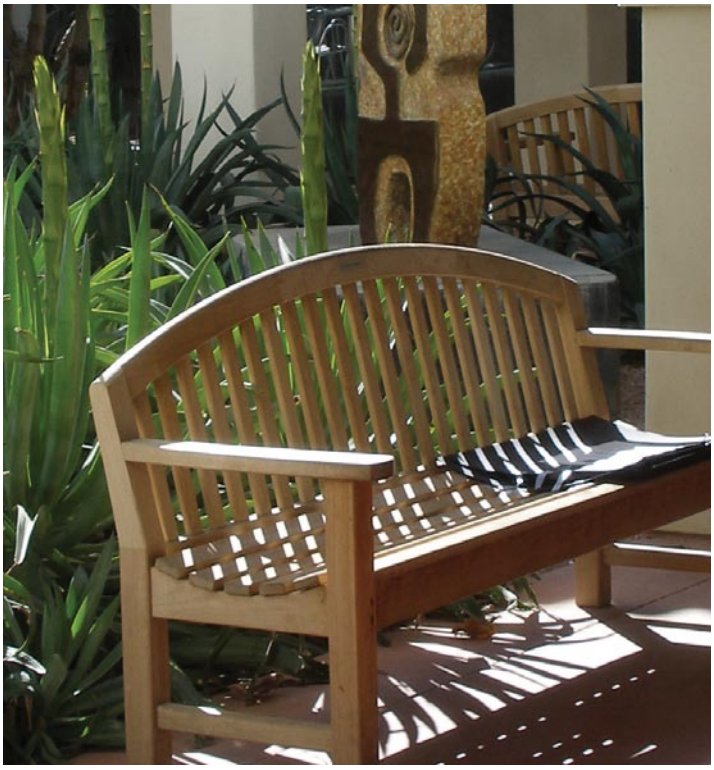
PIMA COUNTY

	$0/70%		$1,000/70%	
Age	Male	Female	Male	Female
Under 2	338	338	404	404
2-6	101	101	121	121
7-10	85	85	102	102
11-14	85	85	102	102
15-17	88	91	106	109
18-24	95	233	113	278
25-29	95	273	113	328
30-34	106	276	127	332
35-39	130	279	156	335
40-44	181	285	216	341
45-49	239	291	286	350
50-54	324	325	389	390
55-59	401	413	482	496
60-64	486	430	584	516

ALL OTHER COUNTIES

	$0/70%		$1,000/70%	
Age	Male	Female	Male	Female
Under 2	536	536	643	643
2-6	163	163	196	196
7-10	136	136	163	163
11-14	136	136	163	163
15-17	139	144	166	174
18-24	150	373	180	446
25-29	151	433	181	520
30-34	164	430	197	516
35-39	208	446	250	535
40-44	290	454	348	545
45-49	378	464	454	558
50-54	518	519	622	623
55-59	641	659	769	790
60-64	774	681	929	818

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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