

HEALTH NET'S ROSETTA STONESM

Confidence starts with having the right information. But in the complicated world of modern health care, it takes something more. Enter **Health Net's Rosetta StoneSM**.

Who is Health Net's Rosetta Stone? She's not a person, but a suite of services designed to help you make confident health care decisions. Just as the original was used to decipher ancient hieroglyphics, our Rosetta Stone services help solve the mystery of modern medicine.

Where can you find Health Net's Rosetta Stone? In the services you'll find when you first log in as a Health Net member, at www.healthnet.com:

Decision PowerSM – Maybe you're facing surgery and want to better understand your options. Or you have found out that your child has asthma, and want to know all that you can do about it. Decision Power helps you take action. Decision Power provides the following complimentary services:

- 24/7 support from specially trained Health Coaches – nurses, dieticians and respiratory therapists
- Video testimonials from those who have faced your upcoming surgery or procedure
- Online medical information and decision support tools
- Chronic condition management guides

SINCE ITS INCEPTION IN JANUARY 2004, OVER 100,000 HEALTH NET, INC. MEMBERS HAVE CALLED DECISION POWER. 80% REPORT THAT TALKING WITH A HEALTH COACH HELPED THEM TO IMPROVE THEIR CONDITION. 95% WOULD RECOMMEND THE SERVICE TO A FRIEND.¹

HealthGate[®] EBM Solutions – An online medical reference of conditions and treatment options. You can search by symptom or diagnosed condition.

Hospital Comparison Report – Not all hospitals provide the same outcomes for the same procedures. The online Hospital Comparison Report lets you compare network hospitals based upon the factors that matter to you.

It's Your LifeSM – Can dealing with child/eldercare, emotional and financial burdens, as well as achieving vitality and wellness, begin with a single step? With It's Your Life, they can. It's Your Life includes:

- *WellRewards* - Savings on massage therapy, chiropractic, acupuncture, vitamins, health club memberships and more;
- Free, confidential support, via phone or Web, for emotional, legal or financial issues and
- Help in finding and researching qualified childcare and eldercare resources.

ADDITIONAL MEMBER PRIVILEGES

Health Net Individual and Family Plan members also can take advantage of the following services:

- Online Doctor Search
- *Direct Information Automated Line (D.I.A.L.)* – Automated assistance on your account 24 hours a day, seven days a week
- *Quick Pay* option that allows your premium to be deducted from your checking or savings account each month
- *Credit card* premium payment option
- Dental and vision coverage available for an additional charge

¹Health Dialog Services Corporation member survey, 2003

A BETTER DECISION STARTS WITH A CLEAR UNDERSTANDING

WHAT IS AN HMO?

With a Health Maintenance Organization (HMO), you select your Primary Care Physician (PCP) from our contracted HMO network. Your PCP oversees all your health care and refers you to any specialty or hospital care you need, excluding emergencies. He or she takes care of any needed authorizations. You also have direct access, without a referral, to an OB-GYN.

HMO advantages include:

- No paperwork or claim forms
- Emergency care coverage worldwide
- Set copayments for office visits and prenatal, postnatal and newborn care
- Little or no charge for X-ray and laboratory services
- Preventive care services
- Prescription coverage

WHAT IS A PPO?

A Preferred Provider Organization (PPO) provides benefit coverage at a significantly reduced expense when you visit physicians or facilities within our extensive PPO network. It is up to you or the provider to confirm that services are covered under your plan. You have the freedom to self refer to specialists and hospitals. You also are eligible for coverage (at a reduced benefit level) when visiting a physician outside the PPO network.

PPO advantages include:

- Freedom to visit any licensed physician at any time, with substantial savings when visiting in-network providers
- No referrals needed to see specialists
- No paperwork or claim forms when using in-network providers
- Lower copayments and coinsurance when you see in-network providers
- Hospital coverage
- Preventive care services
- Prescription coverage
- Access to First Health's national PPO network of physicians and hospitals when traveling²

² Those living in Apache, Navaho, Yavapai and Yuma Counties must always use the First Health network to receive in-network benefits.

ONE FAMILY, MULTIPLE PLANS

Dave and Sylvia have settled into their new dream home. They don't travel much, and have a terrific family care doctor who participates in the Health Net HMO network. "This is a no-brainer," says Sylvia. And Dave agrees. They opt for family coverage under the **\$500 90 HMO** plan, which offers predictable fixed copayments.

Their daughter, Olivia, is a junior at Arizona State. When she's not hitting the books, she's off hitting the slopes, riding the California surf, or she's just off on some other adventure. Dave and Sylvia feel single coverage under the **\$1,000 80/60 PPO** plan is just what Olivia needs (or they need) for peace of mind. This PPO option offers in-network access to a wide national Health Net PPO network and a low annual deductible.

Their son, Dave Jr., is off pursuing his dream to be a novelist. At least he got some of dad's good sense and decides to enroll in the **\$2,500 80/60 PPO** plan. This affordable coverage option protects against unforeseen, "high price tag" medical expenses.



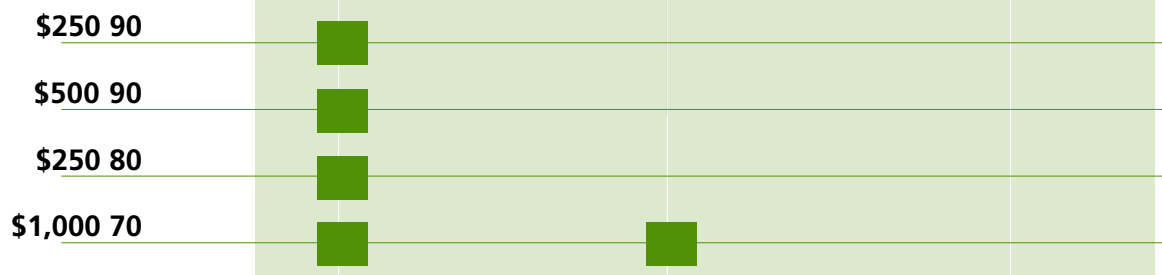
WHICH PLAN IS RIGHT FOR ME?

"I want to pay a set amount for office visits, exams and immunizations."

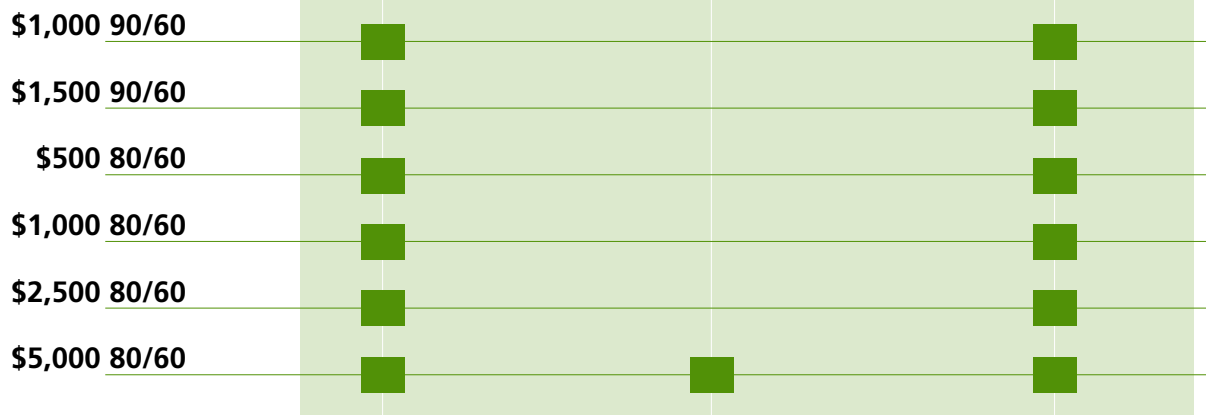
"I want a lower monthly premium. I'll pay a higher deductible, coinsurance or office copay in exchange."

"It's important to me to be able to go to a specialist directly, without having to get a referral first."

HMO PLANS



PPO PLANS



WHAT'S YOUR DECISION?

Overview of Individual & Family coverage options

This benefit chart is a summary only. For benefit details, please see the Schedule of Benefits and Evidence of Coverage for HMO plans or Certificate of Coverage for PPO

Benefits	HMO \$250 Deductible/90% Coinsurance	HMO \$500 Deductible/90% Coinsurance
Deductible (per calendar year)	\$250 single/\$500 family	\$500 single/\$1,000 family
Maximum lifetime benefits	Unlimited	Unlimited
Out of pocket maximum, plus deductible	\$3,000 single/\$6,000 family	\$3,000 single/\$6,000 family
Inpatient hospital services (including physician, facility and surgery charges)	10% (subject to deductible)	10% (subject to deductible)
Outpatient hospital services/ ambulatory surgical center services	10% (subject to deductible)	10% (subject to deductible)
Office visits		
Primary care physician	\$20 per visit	\$25 per visit
Specialist	\$40 per visit	\$50 per visit
Outpatient laboratory and x-ray services (including mammograms)		
Performed at a physician's office	No charge	No charge
Performed at an independent, freestanding lab facility	No charge	No charge
Performed at a hospital lab	\$100 per visit	\$100 per visit
Outpatient imaging and testing services (including but not limited to CT scans, MRIs, MRAs, Stress Tests and PET/SPECT scans)		
Performed at a physician's office	\$25 per visit	\$25 per visit
Performed at an independent, freestanding facility	\$25 per visit	\$25 per visit
Performed at a hospital	\$200 per visit	\$200 per visit
Outpatient Dialysis	\$20 per visit (\$1,000 copayment maximum)	\$20 per visit (\$1,000 copayment maximum)
Outpatient Chemotherapy and Radiation Therapy	\$20 per visit (\$1,000 copayment maximum)	\$20 per visit (\$1,000 copayment maximum)
Preventive care (routine physicals, annual GYN exams, well-baby care, immunizations and vision and hearing screenings) PPO maximum benefit of \$300 per member per calendar year, limit does not apply to ages 0 through 4.	\$20 per primary care physician visit \$40 per specialist physician visit	\$25 per primary care physician visit \$50 per specialist physician visit
Pre and postnatal care (office visit copayment waived after diagnosis of pregnancy is confirmed)	\$20 copayment per primary care physician visit; \$40 copayment per specialist physician visit, 10% (subject to deductible)	\$25 copayment per primary care physician visit; \$50 copayment per specialist physician visit, 10% (subject to deductible)
Maternity care (Normal maternity deliveries are covered if the delivery occurs after the member's contract has been in force for twelve months or longer. Complications of pregnancy are covered regardless of the delivery date.)		
Outpatient prescription drugs (up to a 31 day supply. Quantity limitations may apply)	Tier 1: \$15 copayment per prescription or refill Tier 2: \$35 copayment per prescription or refill Tier 3: \$65 copayment per prescription or refill Tier 4: \$90 copayment per prescription or refill Tier 4: \$90 copayment per prescription or refill	Tier 1: \$15 copayment per prescription or refill Tier 2: \$35 copayment per prescription or refill Tier 3: \$65 copayment per prescription or refill Tier 4: \$90 copayment per prescription or refill Tier 4: \$90 copayment per prescription or refill
Self Injectable drugs (Tier 2 copayment will apply to preferred insulin vials)		
Emergency room services	\$150 copayment per visit (copayment waived if admitted, inpatient hospital benefit will then apply)	\$150 copayment per visit (copayment waived if admitted, inpatient hospital benefit will then apply)
Ambulance services	No charge if a medical emergency	No charge if a medical emergency
Urgent care services	Health Net affiliated facility: \$60 copayment per visit Non-Health Net affiliated facility: \$150 copayment per visit	Health Net affiliated facility: \$60 copayment per visit Non-Health Net affiliated facility: \$150 copayment per visit
Rehabilitative services (limited to short-term, maximum of 60 days per Calendar Year)	Inpatient: 10% (subject to deductible); Outpatient: \$20 copayment per visit	Inpatient: 10% (subject to deductible); Outpatient: \$20 copayment per visit
Skilled nursing facility services (limited to 60 days per Calendar Year)	10% (subject to deductible)	10% (subject to deductible)
Hospice care services	Inpatient: 10% (subject to deductible) Outpatient: No charge	Inpatient: 10% (subject to deductible) Outpatient: No charge
Home health care (limited to part-time and intermittent care)	No charge	No charge
Chiropractic services (Limited to 12 medically necessary visits per Calendar Year. Additional discounts available through the WellRewards Program.)	\$40 copayment per visit	\$50 copayment per visit
Mental health services (outpatient, limited to short term evaluation or crisis intervention. Maximum of 10 visits per calendar year.)	Inpatient: Not covered Outpatient: \$25 copayment per individual /\$12.50 copayment per group visit, limited to short-term evaluation or crisis intervention. (Maximum of 10 visits per calendar year)	Inpatient: Not covered Outpatient: \$25 copayment per individual /\$12.50 copayment per group visit, limited to short-term evaluation or crisis intervention. (Maximum of 10 visits per calendar year)
Substance abuse services (inpatient and outpatient, limited to detoxification only)	Inpatient: 10% (subject to deductible) Outpatient: No charge	Inpatient: 10% (subject to deductible) Outpatient: No charge
Dental and Vision Care Services	See Dental and Vision Brochure for details	See Dental and Vision Brochure for details

D plans.

Benefits	HMO \$250 Deductible/80% Coinsurance	HMO \$1,000 Deductible/70% Coinsurance
Deductible (per calendar year)	\$250 single/\$500 family	\$1,000 single/\$2,000 family
Maximum lifetime benefits	Unlimited	Unlimited
Out of pocket maximum, plus deductible	\$2,500 single/\$5,000 family	\$3,500 single/\$7,000 family
Inpatient hospital services (including physician, facility and surgery charges)	20% (subject to deductible)	30% (subject to deductible)
Outpatient hospital services/ ambulatory surgical center services	20% (subject to deductible)	30% (subject to deductible)
Office visits		
Primary care physician	\$15 per visit	\$25 per visit
Specialist	\$30 per visit	\$50 per visit
Outpatient laboratory and x-ray services (including mammograms)		
Performed at a physician's office	No charge	No charge
Performed at an independent, freestanding lab facility	No charge	No charge
Performed at a hospital lab	\$100 per visit	\$100 per visit
Outpatient imaging and testing services (including but not limited to CT scans, MRIs, MRAs, Stress Tests and PET/SPECT scans)		
Performed at a physician's office	\$25 per visit	\$25 per visit
Performed at an independent, freestanding facility	\$25 per visit	\$25 per visit
Performed at a hospital	\$200 per visit	\$200 per visit
Outpatient Dialysis	\$20 per visit (\$1,000 copayment maximum)	\$20 per visit (\$1,000 copayment maximum)
Outpatient Chemotherapy and Radiation Therapy	\$20 per visit (\$1,000 copayment maximum)	\$20 per visit (\$1,000 copayment maximum)
Preventive care (routine physicals, annual GYN exams, well-baby care, immunizations and vision and hearing screenings) PPO maximum benefit of \$300 per member per calendar year, limit does not apply to ages 0 through 4.	\$15 per primary care physician visit \$30 per specialist physician visit	\$25 per primary care physician visit \$50 per specialist physician visit
Pre and postnatal care (office visit copayment waived after diagnosis of pregnancy is confirmed)	\$15 copayment per primary care physician visit; \$30 copayment per specialist physician visit,	\$25 copayment per primary care physician visit; \$50 copayment per specialist physician visit,
Maternity care (Normal maternity deliveries are covered if the delivery occurs after the member's contract has been in force for twelve months or longer. Complications of pregnancy are covered regardless of the delivery date.)	20% (subject to deductible)	30% (subject to deductible)
Outpatient prescription drugs (up to a 31 day supply. Quantity limitations may apply)	Tier 1: \$15 copayment per prescription or refill Tier 2: \$35 copayment per prescription or refill Tier 3: \$65 copayment per prescription or refill Tier 4: \$90 copayment per prescription or refill	Tier 1: \$15 copayment per prescription or refill Tier 2: \$35 copayment per prescription or refill Tier 3: \$75 copayment per prescription or refill Tier 4: \$100 copayment per prescription or refill
Self Injectable drugs (Tier 2 copayment will apply to preferred insulin vials)	Tier 4: \$90 copayment per prescription or refill	Tier 4: \$100 copayment per prescription or refill
Emergency room services	\$150 copayment per visit (copayment waived if admitted, inpatient hospital benefit will then apply)	\$150 copayment per visit (copayment waived if admitted, inpatient hospital benefit will then apply)
Ambulance services	No charge if a medical emergency	No charge if a medical emergency
Urgent care services	Health Net affiliated facility: \$60 copayment per visit Non-Health Net affiliated facility: \$150 copayment per visit	Health Net affiliated facility: \$60 copayment per visit Non-Health Net affiliated facility: \$150 copayment per visit
Rehabilitative services (limited to short-term, maximum of 60 days per Calendar Year)	Inpatient: 20% (subject to deductible); Outpatient: \$20 copayment per visit	Inpatient: 30% (subject to deductible); Outpatient: \$20 copayment per visit
Skilled nursing facility services (limited to 60 days per Calendar Year)	20% (subject to deductible)	30% (subject to deductible)
Hospice care services	Inpatient: 20% (subject to deductible) Outpatient: No charge	Inpatient: 30% (subject to deductible) Outpatient: No charge
Home health care (limited to part-time and intermittent care)	No charge	No charge
Chiropractic services (Limited to 12 medically necessary visits per Calendar Year. Additional discounts available through the WellRewards Program.)	\$30 copayment per visit	\$50 copayment per visit
Mental health services (outpatient, limited to short term evaluation or crisis intervention. Maximum of 10 visits per calendar year.)	Inpatient: Not covered Outpatient: \$25 copayment per individual /\$12.50 copayment per group visit, limited to short-term evaluation or crisis intervention. (Maximum of 10 visits per calendar year)	Inpatient: Not covered Outpatient: \$25 copayment per individual /\$12.50 copayment per group visit, limited to short-term evaluation or crisis intervention. (Maximum of 10 visits per calendar year)
Substance abuse services (inpatient and outpatient, limited to detoxification only)	Inpatient: 20% (subject to deductible) Outpatient: No charge	Inpatient: 30% (subject to deductible) Outpatient: No charge
Dental and Vision Care Services	See Dental and Vision Brochure for details	See Dental and Vision Brochure for details

Overview of Individual & Family coverage options

This benefit chart is a summary only. For benefit details, please see the Schedule of Benefits and Evidence of Coverage for HMO plans or Certificate of Coverage for PPO

Benefits	PPO \$1,000 Deductible, 90/60% Coinsurance		PPO \$1,500 Deductible, 90/60% Coinsurance	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (per calendar year)	\$1,000 single/\$2,000 family	\$2,000 single/\$4,000 family	\$1,500 single/\$3,000 family	\$3,000 single/\$6,000 family
Maximum lifetime benefits	\$5,000,000		\$5,000,000	
Out of pocket maximum, plus deductible	\$2,000 single/\$4,000 family	\$4,500 single/\$9,000 family	\$2,000 single/\$4,000 family	\$4,500 single/\$9,000 family
Inpatient hospital services (including physician, facility and surgery charges)	10% (subject to deductible)	40% (subject to deductible)	10% (subject to deductible)	40% (subject to deductible)
Outpatient hospital services/ ambulatory surgical center services	10% (subject to deductible)	40% (subject to deductible)	10% (subject to deductible)	40% (subject to deductible)
Office visits				
Primary care physician	\$25	40% (subject to deductible)	\$25	40% (subject to deductible)
Specialist	\$40	40% (subject to deductible)	\$40	40% (subject to deductible)
Outpatient laboratory and x-ray services (including mammograms)				
Performed at a physician's office	No charge	40% (subject to deductible)	No charge	40% (subject to deductible)
Performed at an independent, freestanding lab facility	No charge	40% (subject to deductible)	No charge	40% (subject to deductible)
Performed at a hospital lab	10% (subject to deductible)	40% (subject to deductible)	10% (subject to deductible)	40% (subject to deductible)
Outpatient imaging and testing services (including but not limited to CT scans, MRIs, MRAs, Stress Tests and PET/SPECT scans)				
Performed at a physician's office	10% (subject to deductible)	40% (subject to deductible)	10% (subject to deductible)	40% (subject to deductible)
Performed at an independent, freestanding facility	10% (subject to deductible)	40% (subject to deductible)	10% (subject to deductible)	40% (subject to deductible)
Performed at a hospital	10% (subject to deductible)	40% (subject to deductible)	10% (subject to deductible)	40% (subject to deductible)
Outpatient Dialysis	\$20 copayment per visit (\$1,000 copayment maximum)		\$20 copayment per visit (\$1,000 copayment maximum)	
Outpatient Chemotherapy and Radiation Therapy	\$20 copayment per visit (\$1,000 copayment maximum)		\$20 copayment per visit (\$1,000 copayment maximum)	
Preventive care (routine physicals, annual GYN exams, well-baby care, immunizations and vision and hearing screenings) PPO maximum benefit of \$300 per member per calendar year, limit does not apply to ages 0 through 4.	\$25 copayment per physician visit \$40 copayment per specialist visit	40% (subject to deductible)	\$25 copayment per physician visit \$40 copayment per specialist visit	40% (subject to deductible)
Pre and postnatal care (office visit copayment waived after diagnosis of pregnancy is confirmed)	Not applicable		Not applicable	
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 limitations may apply)	Tier 1: \$15 copayment per prescription or refill Tier 2: \$35 copayment per prescription or refill Tier 3: \$65 copayment per prescription or refill Tier 4: \$90 copayment per prescription or refill		Tier 1: \$15 copayment per prescription or refill Tier 2: \$35 copayment per prescription or refill Tier 3: \$65 copayment per prescription or refill Tier 4: \$90 copayment per prescription or refill	
Self Injectable drugs (Tier 2 copayment will apply to preferred insulin vials)	Tier 4: \$90 copayment per prescription or refill		Tier 4: \$90 copayment per prescription or refill	
Emergency room services	10% (subject to \$150 copayment per emergency room visit)		10% (subject to \$150 copayment per emergency room visit)	
Ambulance services	10% (subject to deductible)		10% (subject to deductible)	
Urgent care services	\$60 copayment per visit	40% (subject to deductible)	\$60 copayment per visit	40% (subject to deductible)
Rehabilitative services (limited to short-term, maximum of 60 days per Calendar Year)	Inpatient: 10% (subject to deductible) Outpatient: \$20	Inpatient: 40% (subject to deductible) Outpatient: 40% (subject to deductible)	Inpatient: 20% (subject to deductible) Outpatient: \$20	Inpatient: 40% (subject to deductible) Outpatient: 40% (subject to deductible)
Skilled nursing facility services (limited to 60 days per Calendar Year)	10% (subject to deductible)	40% (subject to deductible)	10% (subject to deductible)	40% (subject to deductible)
Hospice care services	10% (subject to deductible)	40% (subject to deductible)	10% (subject to deductible)	40% (subject to deductible)
Home health care (limited to part-time and intermittent care)	10% (subject to deductible)	40% (subject to deductible)	10% (subject to deductible)	40% (subject to deductible)
Chiropractic services (Limited to 12 medically necessary visits per Calendar Year. Additional discounts available through the WellRewards Program.)	\$40	40% (subject to deductible)	\$40	40% (subject to deductible)
Mental health services (outpatient, limited to short term evaluation or crisis intervention. Maximum of 10 visits per calendar year.)	10% (subject to deductible)	40% (subject to deductible)	10% (subject to deductible)	40% (subject to deductible)
Substance abuse services (inpatient and outpatient, limited to detoxification only)	10% (subject to deductible)	40% (subject to deductible)	10% (subject to deductible)	40% (subject to deductible)
Dental and Vision Care Services	See Dental and Vision Brochure for details		See Dental and Vision Brochure for details	

D plans.

	PPO \$500 Deductible, 80/60% Coinsurance		PPO \$1,000 Deductible, 80/60% Coinsurance	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Single/\$6,000 family	\$500 single/\$1,000 family	\$1,000 single/\$2,000 family	\$1,000 single/\$2,000 family	\$2,000 single/\$4,000 family
	\$5,000,000		\$5,000,000	
Single/\$9,000 family	\$2,500 single/\$5,000 family	\$5,000 single/\$10,000 family	\$3,000 single/\$6,000 family	\$6,000 single/\$12,000 family
Subject to deductible	20% (subject to deductible)	40% (subject to deductible)	20% (subject to deductible)	40% (subject to deductible)
Subject to deductible	20% (subject to deductible)	40% (subject to deductible)	20% (subject to deductible)	40% (subject to deductible)
Subject to deductible	\$25	40% (subject to deductible)	\$25	40% (subject to deductible)
Subject to deductible	\$40	40% (subject to deductible)	\$40	40% (subject to deductible)
Subject to deductible	No charge	40% (subject to deductible)	No charge	40% (subject to deductible)
Subject to deductible	No charge	40% (subject to deductible)	No charge	40% (subject to deductible)
Subject to deductible	20% (subject to deductible)	40% (subject to deductible)	20% (subject to deductible)	40% (subject to deductible)
Subject to deductible	20% (subject to deductible)	40% (subject to deductible)	20% (subject to deductible)	40% (subject to deductible)
Subject to deductible	20% (subject to deductible)	40% (subject to deductible)	20% (subject to deductible)	40% (subject to deductible)
Outpatient maximum	\$20 copayment per visit (\$1,000 copayment maximum)		\$20 copayment per visit (\$1,000 copayment maximum)	
Outpatient maximum	\$20 copayment per visit (\$1,000 copayment maximum)		\$20 copayment per visit (\$1,000 copayment maximum)	
Subject to deductible	\$25 copayment per physician visit \$40 copayment per specialist visit	40% (subject to deductible)	\$25 copayment per physician visit \$40 copayment per specialist visit	40% (subject to deductible)
	Not applicable		Not applicable	
Of pregnancy	Not covered except for complications of pregnancy		Not covered except for complications of pregnancy	
Prescription or refill	Tier 1: \$15 copayment per prescription or refill		Tier 1: \$15 copayment per prescription or refill	
Prescription or refill	Tier 2: \$35 copayment per prescription or refill		Tier 2: \$35 copayment per prescription or refill	
Prescription or refill	Tier 3: \$65 copayment per prescription or refill		Tier 3: \$65 copayment per prescription or refill	
Prescription or refill	Tier 4: \$90 copayment per prescription or refill		Tier 4: \$90 copayment per prescription or refill	
Emergency room visit	20% (subject to \$150 copayment per emergency room visit)		20% (subject to \$150 copayment per emergency room visit)	
	20% (subject to deductible)		20% (subject to deductible)	
Subject to deductible	\$60 copayment per visit	40% (subject to deductible)	\$60 copayment per visit	40% (subject to deductible)
40% (subject to deductible)	Inpatient: 20% (subject to deductible)	Inpatient: 40% (subject to deductible)	Inpatient: 20% (subject to deductible)	Inpatient: 40% (subject to deductible)
40% (subject to deductible)	Outpatient: \$20	Outpatient: 40% (subject to deductible)	Outpatient: \$20	Outpatient: 40% (subject to deductible)
Subject to deductible	20% (subject to deductible)	40% (subject to deductible)	20% (subject to deductible)	40% (subject to deductible)
Subject to deductible	20% (subject to deductible)	40% (subject to deductible)	20% (subject to deductible)	40% (subject to deductible)
Subject to deductible	20% (subject to deductible)	40% (subject to deductible)	20% (subject to deductible)	40% (subject to deductible)
Subject to deductible	20% (subject to deductible)	40% (subject to deductible)	20% (subject to deductible)	40% (subject to deductible)
Subject to deductible	\$40	40% (subject to deductible)	\$40	40% (subject to deductible)
Subject to deductible	20% (subject to deductible)	40% (subject to deductible)	20% (subject to deductible)	40% (subject to deductible)
Subject to deductible	20% (subject to deductible)	40% (subject to deductible)	20% (subject to deductible)	40% (subject to deductible)
For details	See Dental and Vision Brochure for details		See Dental and Vision Brochure for details	

Overview of Individual & Family coverage options

This benefit chart is a summary only. For benefit details, please see the Schedule of Benefits and Evidence of Coverage for HMO plans or Certificate of Coverage for PPO plans.

Benefits	PPO \$2,500 Deductible, 80/60% Coinsurance		PPO \$5,000 Deductible, 80/60% Coinsurance	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (per calendar year)	\$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	\$5,000,000		\$5,000,000	
Out of pocket maximum, plus deductible	\$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	40% (subject to deductible)	\$30	40% (subject to deductible)
Specialist	\$45	40% (subject to deductible)	\$45	40% (subject to deductible)
Outpatient laboratory and x-ray services (including mammograms)				
Performed at a physician's office	No charge	40% (subject to deductible)	No charge	40% (subject to deductible)
Performed at an independent, freestanding lab facility	No charge	40% (subject to deductible)	No charge	40% (subject to deductible)
Performed at a hospital lab	20% (subject to deductible)	40% (subject to deductible)	2% (subject to deductible)	40% (subject to deductible)
Outpatient imaging and testing services (including but not limited to CT scans, MRIs, MRAs, Stress Tests 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, freestanding 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)
Outpatient Dialysis	\$20 copayment per visit (\$1,000 copayment maximum)		\$20 copayment per visit (\$1,000 copayment maximum)	
Outpatient Chemotherapy and Radiation Therapy	\$20 copayment per visit (\$1,000 copayment maximum)		\$20 copayment per visit (\$1,000 copayment maximum)	
Preventive care (routine physicals, annual GYN exams, well-baby care, immunizations and vision and hearing screenings) PPO maximum benefit of \$300 per member per calendar year, limit does not apply to ages 0 through 4.	\$30 copayment per physician visit \$45 copayment per specialist visit	40% (subject to deductible)	\$30 copayment per physician visit \$45 copayment per specialist visit	40% (subject to deductible)
Pre and postnatal care (office visit copayment waived after diagnosis of pregnancy is confirmed)	Not applicable		Not applicable	
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 limitations may apply)	Tier 1: \$15 copayment per prescription or refill Tier 2: \$40 copayment per prescription or refill Tier 3: \$75 copayment per prescription or refill Tier 4: \$100 copayment per prescription or refill		Tier 1: \$15 copayment per prescription or refill Tier 2: \$40 copayment per prescription or refill Tier 3: \$75 copayment per prescription or refill Tier 4: \$100 copayment per prescription or refill	
Self Injectable drugs (Tier 2 copayment will apply to preferred insulin vials)	Tier 4: \$100 copayment per prescription or refill		Tier 4: \$100 copayment per prescription or refill	
Emergency room services	20% (subject to \$150 copayment per emergency room visit)		10% (subject to \$150 copayment per emergency room visit)	
Ambulance services	20% (subject to deductible)		20% (subject to deductible)	
Urgent care services	\$60 copayment per visit	40% (subject to deductible)	\$60 copayment per visit	40% (subject to deductible)
Rehabilitative services (limited to short-term, maximum of 60 days per Calendar Year)	Inpatient: 20% (subject to deductible) Outpatient: \$20 (subject to deductible)	Inpatient: 40% (subject to deductible) Outpatient: 40% (subject to deductible)	Inpatient: 20% (subject to deductible) Outpatient: \$20 (subject to deductible)	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)
Hospice care services	20% (subject to deductible)	40% (subject to deductible)	20% (subject to deductible)	40% (subject to deductible)
Home health care (limited to part-time and intermittent care)	20% (subject to deductible)	40% (subject to deductible)	20% (subject to deductible)	40% (subject to deductible)
Chiropractic services (Limited to 12 medically necessary visits per Calendar Year. Additional discounts available through the WellRewards Program.)	\$45	40% (subject to deductible)	\$45	40% (subject to deductible)
Mental health services (outpatient, limited to short term evaluation or crisis intervention. Maximum of 10 visits per calendar year.)	20% (subject to deductible)	40% (subject to deductible)	20% (subject to deductible)	40% (subject to deductible)
Substance abuse services (inpatient and outpatient, limited to detoxification only)	20% (subject to deductible)	40% (subject to deductible)	20% (subject to deductible)	40% (subject to deductible)
Dental and Vision Care Services	See Dental and Vision Brochure for details		See Dental and Vision Brochure for details	

COMFORTABLE AND SECURE MEANS INSURING THEIR LIVES

You have big dreams for your children. You want to make sure they are secure regardless of what the future brings. What's your plan to guarantee this?

Health Net Life Insurance Company presents a solid strategy. We offer affordable Individual Term Life Insurance in the following amounts: \$15,000 • \$30,000 • \$50,000.

Terms:

- Term life coverage is available only to individuals 19 years old in order, in conjunction with the purchase of a Health Net Individual and Family Health Plan. If you decide to purchase life coverage, be sure to complete the Beneficiary Information found on the Enrollment Application.
- Coverage can be purchased for both you and your spouse.
- If you wish to purchase life insurance, you must purchase minimum coverage of \$15,000. The maximum life insurance benefit is \$50,000.
- Evidence of Insurability is required for all Individual Term Life Insurance amounts. Coverage will not become effective until approved in writing by Health Net Life Insurance Company.

LIFE INSURANCE MONTHLY RATES

Age of primary insured	Cost per \$1,000	Total monthly cost		
		\$15,000	\$30,000	\$50,000
19-29	\$0.19	\$2.85	\$5.70	\$9.50
30-39	\$0.22	\$3.30	\$6.60	\$11.00
40-49	\$0.50	\$7.50	\$15.00	\$25.00
50-59	\$1.37	\$20.55	\$41.10	\$68.50
60-64	\$2.00	\$30.00	\$60.00	\$100.00

Individual Term Life Insurance is underwritten by Health Net Life Insurance Company.

Since you apply for health insurance with Health Net, there is no additional information required to review your eligibility for Individual Term Life Insurance. Coverage will not become effective until approved in writing by Health Net Life Insurance Company.

ENROLLMENT INFORMATION

ENROLLMENT APPLICATION

Fill out the enrollment application completely. Every question must be answered and all signature areas must be completed before we can process your application. If the application is not completely filled out, signed and dated, it will be returned to you, which will delay processing and could affect the date you are eligible for the plan. A check for the first month's premium (or 1-1/2 months' premium for the 15th of the month effective date) must accompany your application. Except as required by HIPAA, coverage is not guaranteed and will be effective only if approved in writing by Health Net's underwriting department.

PROCESSING YOUR APPLICATION

In reviewing the information on your application, we may contact your health care practitioners. If there are any changes in the health status of the individuals listed on the application, it is very important that you call us immediately at 1-888-463-4875. We recommend that you keep any existing health care coverage you may have until you receive notification from Health Net that your application has been approved, and we receive your first month's payment (or 1-1/2 months' payment for the 15th of the month effective date).

WHEN YOU ARE APPROVED

When you're approved by Health Net and we have received your first month's premium (or 1-1/2 months' premium for the 15th of the month effective date), you will be notified in writing of your effective date with Health Net. You will receive an identification (ID) card and an Evidence of Coverage or Policy, depending on the plan you choose.

ID CARD

Always carry your ID card with you. This is your passport to obtaining health care coverage. You will need to show it to practitioners when you receive medical services or pick up prescriptions. Each family member enrolled in Health Net will receive an ID card.

EVIDENCE OF COVERAGE AND POLICY

These documents are the contract between you and your health care plan. If you enroll in an HMO plan, you will receive an Evidence of Coverage from Health Net of Arizona, Inc. If you enroll in a PPO plan, you will receive a Policy from Health Net Life Insurance Company. If you enroll in the dental and vision plan or the term life insurance plan, you will receive plan documents for those plans separately. Each of these documents stipulates the terms and conditions of your coverage. You will receive the appropriate document(s) in your welcome packet.

PREMIUM PAYMENTS

It is simple to make payments on your health care plan. We will send you a bill based on the payment schedule you prefer. You can elect our Quick Pay option, which allows your premium to be deducted from your checking or savings account each month, have your premiums charged to a credit card, or we can send you a monthly bill for your premium. If we do not receive your payment within our payment timelines, your coverage will be terminated effective as of the last date for which we received your premium.

ENROLLMENT CHECKLIST

- ✓ Review this booklet and the inserts found in the back pocket for important information concerning our HMO and PPO health care plans.
- ✓ Select the plan you want. Refer to the What's Your Decision section found on pages 4 & 5 for a summary of our benefits.
- ✓ Decide if you wish to elect dental and vision coverage and/or term life insurance. Information for these coverage options should be in the back pocket of this brochure. Otherwise, ask your Health Net sales agent for more information.
- ✓ Determine your monthly premium from the monthly premiums booklet located in the back pocket. Find the appropriate category by your age and sex to identify your rate.
- ✓ If you choose an HMO plan, select a physician who is a PCP from the Health Net provider directory on our website at www.healthnet.com > Search Our Doctor Network. You also can call our Customer Contact Center at 1-800-289-2818 for a copy of the directory.
Note: If you choose a PPO plan, you do not need to select a PCP.
- ✓ Fill out the application. Double check to make sure you've answered all questions and signed the application.
- ✓ Send your completed application and first month's premium (or 1-1/2 months' premium for the 15th of the month effective date) in the enclosed self-addressed envelope.
- ✓ Carefully read your Evidence of Coverage or Policy when you receive it. This packet contains summary information only. The actual coverage you receive is conditional on the plan you select and the terms, conditions, limitations and any benefit maximums described in the Evidence of Coverage or the Policy.

If you need assistance or have additional questions, call us at 1-888-463-4875 or (602) 794-1400.

YOUR QUESTIONS MAY ALREADY HAVE BEEN ANSWERED

WHO IS ELIGIBLE FOR INDIVIDUAL & FAMILY HMO AND PPO PLANS?

Any individual who is under 64-1/2 and not eligible for Medicare may apply. However, the primary applicant must be an Arizona resident. There is no minimum age requirement as long as a parent or legal guardian agrees to sign the enrollment application and the Statement of Health. Dependents may be covered under a family contract up to their 25th birthday. Children can be signed up independently (parents don't have to enroll – we call this "child only" coverage). All applicants who wish to enroll in an HMO or PPO plan must go through a medical underwriting process.

WHEN CAN DEPENDENTS BE ENROLLED?

Newborns, children placed for adoption or newly adopted children are automatically covered for 31 days, effective on the first day of the event. You will be charged the premium retroactive to the date of birth, adoption or placement of adoption. To continue coverage past the first 31 days, you must notify Health Net that you want to continue coverage for your dependent, complete an application and pay any required premium. If you don't notify Health Net, coverage for your dependent will be terminated.

WHAT IS A PRIMARY CARE PHYSICIAN (PCP)?

A PCP is the physician who coordinates all medical care for HMO members. PCPs specialize in Family Practice, General Practice, Internal Medicine or Pediatrics. When you need to see your PCP, just call for an appointment. To obtain health care, simply present your ID card and pay the appropriate copayment.

DO I NEED A PCP? IF SO, HOW DO I SELECT ONE?

If you choose an HMO plan, you must choose a PCP. If you enroll in a PPO plan, you do not. However, it is always a good idea to visit a physician on a regular basis to receive your recommended routine and preventive care.

CAN I CHANGE MY PCP?

You can change to another PCP at any time and your change will be effective immediately. To change your PCP, call our Customer Contact Center at 1-800-289-2818.

WHAT IS A DEDUCTIBLE?

The deductible is the amount you pay for covered medical services each year before Health Net pays any benefits.

WHAT IS A COPAYMENT?

A copayment is a fixed dollar amount you pay for certain health care services, such as office visits. Copayments are generally due at the time of the visit/service.

WHAT IS A COINSURANCE?

This is the percentage of covered medical expenses for which you are responsible. For example, if you enroll in a “90/60” (in-network/out-of-network) PPO plan, and you visit an in-network physician, Health Net will pay 90% of covered services, and you will owe the remaining 10%. For out-of-network providers, Health Net pays 60% and you pay 40%.

WHAT IS THE OUT-OF-POCKET MAXIMUM?

This is the most you would have to pay, per calendar year, for covered health care services. Once you reach this amount, Health Net will pay all other care covered under the plan. See the benefits matrix in this guide for details. Deductibles and copayments do not apply toward your out-of-pocket maximum.

WHAT ARE IN-NETWORK BENEFITS VS. OUT-OF-NETWORK BENEFITS?

In-network benefits apply when you see any of Health Net’s PPO contracted practitioners in Arizona. You can also use practitioners contracted with the First Health provider network when traveling outside Arizona and receive in-network benefits.³ When using in-network benefits, your out-of-pocket expenses are lower. Out-of-network benefits apply when you choose to see a practitioner who is not contracted with Health Net or the First Health provider network. When using out-of-network benefits, your out-of-pocket expenses are higher.

DO I NEED PRIOR AUTHORIZATION OR PRECERTIFICATION FOR SERVICES?

If you choose an HMO plan, your PCP or referring practitioner will handle any prior authorization requirements. If you choose a PPO plan, it is your responsibility to make sure you get precertification when required. Precertification is required at least two business days prior to receiving the care, service or supply by calling 1-800-977-7518. Services that require precertification are listed in your Evidence of Coverage or policy. Precertification requirements are subject to change with prior written notice to you.

WHERE CAN I GET MY PRESCRIPTION COVERED UNDER THE PLAN’S PHARMACY PROGRAM?

If you choose an HMO plan, you can use Health Net’s extensive network of independent pharmacies in Arizona. Some of the pharmacies in our network include Albertson’s, Bashas’, Fry’s, Osco, Safeway, Costco, Target and Walgreens. Please refer to the HMO Provider Directory or visit our website at www.healthnet.com for a complete listing of contracted pharmacies. If you choose a PPO plan, you will be able to use most national pharmacy chains.

WHOM DO I CALL WHEN I HAVE QUESTIONS REGARDING MY COVERAGE?

Whenever you have questions about coverage or need an explanation of your plan’s policies and procedures, you can call Health Net’s Customer Contact Center, Monday through Friday (excluding holidays) from 7:00 a.m. to 6:00 p.m. Arizona standard time at 1-800-289-2818, or, for the hearing impaired, our TTY line at 1-800-977-6757.

WHAT IF I NEED TREATMENT WHEN I’M OUT OF TOWN?

If it’s an emergency, call 911 or go to the nearest emergency room. If you choose an HMO plan and it’s urgent but not an emergency, call your PCP for instructions. Your PCP, or his or her designee, will give you instructions on obtaining care. Coverage will be determined based on the care you receive and the terms and conditions of your benefit plan. If you choose a PPO plan, you may receive treatment from any licensed practitioner. Just remember that if you see an out-of-network practitioner, you will have higher out-of-pocket costs. PPO members may use the First Health provider network to receive in-network coverage outside of Arizona.³

WHAT IS MY EFFECTIVE DATE?

Your effective date is determined upon the completion and approval of your application and Statement of Health. You may request a first of the month effective date if your application is received by the 25th day of the month. A check for your first month’s premium must accompany your application.

You may request a 15th of the month effective date if your application is received after the 25th of the month. A check for 1-1/2 months’ premium must accompany your application.

WHAT HAPPENS IF I BECOME ELIGIBLE FOR HEALTH COVERAGE THROUGH MY EMPLOYER?

You may have the option to enroll through your employer’s group plan or you may maintain your own individual plan.

⁴Those living in Apache, Navaho, Yavapai and Yuma Counties must always use the First Health network to receive in-network benefits.

DOES HEALTH NET HAVE HEALTH PLANS AVAILABLE THAT MEET PROVISIONS OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)?

If your group or COBRA health plan (employer-provided health coverage) terminated within the past 63 days, you may be eligible for Individual Portability Coverage. This coverage does not require medical underwriting and there is no pre-existing condition waiting period. In order to qualify for this coverage, you must meet specific criteria. Please contact your Broker or Sales Representative for further information. If you are applying for Individual Portability coverage, you'll also need to complete the Individual Portability Questionnaire.

Note: Not all benefit plans are available for Individual Portability coverage.

WHAT HAPPENS WHEN I TURN 65 OR BECOME ELIGIBLE FOR MEDICARE?

Once you turn age 65 and are Medicare eligible, you may enroll in a Medicare Supplement or Medicare Advantage plan.

LIMITATIONS AND EXCLUSIONS

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.

EXCLUSIONS & LIMITATIONS INCLUDE BUT ARE NOT LIMITED TO:

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.

HMO Plans: Hospital and professional services for a normal delivery are covered only for expectant members who have been enrolled for 12 consecutive months when delivery occurs. Hospital and professional services for members who have been enrolled less than 12 consecutive months are limited to prenatal care and complications of pregnancy, as defined the Evidence of Coverage.

PPO Plans: Coverage for maternity services is limited to complications of pregnancy.

PPO Plans: Precertification is required for certain services. If precertification is not obtained it will result in a reduction of benefits. For a list of services requiring precertification see the certificate of coverage.

The following services and/or procedures are either limited in coverage or excluded from coverage under this health plan. 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.

In Network and Out of Network benefits are subject to deductible, then a percentage of eligible medical expenses.

HMO Plans: With the exception of emergency care and self-referral benefits, all services and items must be provided or arranged by your contracted Primary Care Physician. Selected services require authorization by Health Net.