Health Net®

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.

Value PPO plans 3500 and 6000

Benefits	*Value PPO $3,500 deductible, 100% / 50% coinsurance*		*Value PPO $6,000 deductible, 100% / 50% coinsurance*	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Deductible – per calendar year	$3,500 single / $10,500 family	$7,000 single / $21,000 family	$6,000 single / $18,000 family	$12,000 single / $36,000 family
Maximum lifetime benefits	Unlimited		Unlimited	
Out-of-pocket maximum – excluding deductible and copays	None	$3,500 single / $10,500 family	None	$6,000 single / $18,000 family
Inpatient hospital services – including physician, facility and surgery charges	No charge, subject to deductible	50%, subject to deductible	No charge, subject to deductible	50%, subject to deductible
Outpatient hospital services / ambulatory surgical center services	No charge, subject to deductible	50%, subject to deductible	No charge, subject to deductible	50%, subject to deductible
Office visits Primary care physician	$30 copay/visit	50%, subject to deductible	$30 copay/visit	50%, subject to deductible
Specialist	$60 copay/visit	50%, subject to deductible	$60 copay/visit	50%, subject to deductible
Preventive care – preventive office visits, preventive lab and X-ray, Pap smear and mammogram, prostate screening, immunizations, colorectal cancer screening (including, but not limited to colonoscopy), vision and hearing screenings	$0 copay/visit	50%, subject to deductible	$0 copay/visit	50%, subject to deductible
Outpatient laboratory / X-ray services Performed at a physician's office	No charge	50%, subject to deductible	No charge	50%, subject to deductible
Performed at an independent, nonhospital-affiliated lab facility[1]	No charge	50%, subject to deductible	No charge	50%, subject to deductible
Performed at a hospital	No charge, subject to deductible	50%, subject to deductible	No charge, 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) Performed at a physician's office	$250 CT $400 MRI / MRA / PET / SPECT	50%, subject to deductible	$250 CT $400 MRI / MRA / PET / SPECT	50%, subject to deductible
Performed at an independent, nonhospital-affiliated facility[1]	$250 CT $400 MRI / MRA / PET / SPECT	50%, subject to deductible	$250 CT $400 MRI / MRA / PET / SPECT	50%, subject to deductible
Performed at a hospital	$600 CT $1,000 MRI / MRA / PET / SPECT	50%, subject to deductible	$600 CT $1,000 MRI / MRA / PET / SPECT	50%, subject to deductible

(continued)

[1]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.

Value PPO plans 3500 and 6000

Benefits	*Value PPO $3,500 deductible, 100% / 50% coinsurance*		*Value PPO $6,000 deductible, 100% / 50% coinsurance*	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Prenatal and postpartum care	Not covered		Not covered	
Maternity care	Not covered except for complications of pregnancy		Not covered except for complications of pregnancy	
Outpatient prescription drugs up to a 31-day supply. Quantity limits may apply.	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	50%, subject to deductible	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	50%, subject to deductible
Emergency room services – copay waived if admitted, inpatient benefit will then apply	$450 copay/visit		$450 copay/visit	
Ambulance services – medical emergencies only	No charge, subject to deductible		No charge, subject to deductible	
Urgent care services	$60 copay/visit	50%, subject to deductible	$60 copay/visit	50%, subject to deductible
In-store health care clinic	$30 copay/visit	50%, subject to deductible	$30 copay/visit	50%, subject to deductible
Rehabilitative services – limited to short-term, maximum of 60 days per calendar year, all therapies combined	Inpatient: No charge, subject to deductible Outpatient: No charge, subject to deductible	50%, subject to deductible	Inpatient: No charge, subject to deductible Outpatient: No charge, subject to deductible	50%, subject to deductible
Skilled nursing facility services – limited to 60 days per calendar year	No charge, subject to deductible	50%, subject to deductible	No charge, 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: No charge, subject to deductible	Inpatient: Not covered Outpatient: 50%, subject to deductible	Inpatient: Not covered Outpatient: No charge, subject to deductible	Inpatient: Not covered Outpatient: 50%, subject to deductible
Chiropractic covered – services for spinal manipulations are covered when determined to be medically necessary by Health Net.	$60 copay/visit	50%, subject to deductible	$60 copay/visit	50%, subject to deductible

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

Value PPO plans 7500 and 10000

Benefits	*Value PPO $7,500 deductible, 100% / 50% coinsurance*		*Value PPO $10,000 deductible, 100% / 50% coinsurance*	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Deductible – per calendar year	$7,500 single / $22,500 family	$15,000 single / $45,000 family	$10,000 single / $30,000 family	$20,000 single / $60,000 family
Maximum lifetime benefits	Unlimited		Unlimited	
Out-of-pocket maximum – excluding deductible and copays	None	$7,500 single / $22,500 family	None	$10,000 single / $30,000 family
Inpatient hospital services – including physician, facility and surgery charges	No charge, subject to deductible	50%, subject to deductible	No charge, subject to deductible	50%, subject to deductible
Outpatient hospital services / ambulatory surgical center services	No charge, subject to deductible	50%, subject to deductible	No charge, subject to deductible	50%, subject to deductible
Office visits				
Primary care physician	$30 copay/visit	50%, subject to deductible	$30 copay/visit	50%, subject to deductible
Specialist	$60 copay/visit	50%, subject to deductible	$60 copay/visit	50%, subject to deductible
Preventive care – preventive office visits, preventive lab and X-ray, Pap smear and mammogram, prostate screening, immunizations, colorectal cancer screening (including, but not limited to colonoscopy), vision and hearing screenings	$0 copay/visit	50%, subject to deductible	$0 copay/visit	50%, subject to deductible
Outpatient laboratory / X-ray services				
Performed at a physician's office	No charge	50%, subject to deductible	No charge	50%, subject to deductible
Performed at an independent, nonhospital-affiliated lab facility[1]	No charge	50%, subject to deductible	No charge	50%, subject to deductible
Performed at a hospital	No charge, subject to deductible	50%, subject to deductible	No charge, 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)				
Performed at a physician's office	$250 CT $400 MRI / MRA / PET / SPECT	50%, subject to deductible	$250 CT $400 MRI / MRA / PET / SPECT	50%, subject to deductible
Performed at an independent, nonhospital-affiliated facility[1]	$250 CT $400 MRI / MRA / PET / SPECT	50%, subject to deductible	$250 CT $400 MRI / MRA / PET / SPECT	50%, subject to deductible
Performed at a hospital	$600 CT $1,000 MRI / MRA / PET / SPECT	50%, subject to deductible	$600 CT $1,000 MRI / MRA / PET / SPECT	50%, subject to deductible
Prenatal and postpartum care	Not covered		Not covered	
Maternity care	Not covered except for complications of pregnancy		Not covered except for complications of pregnancy	

(continued)

[1]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.

Value PPO plans 7500 and 10000

Benefits	*Value PPO $7,500 deductible, 100% / 50% coinsurance*		*Value PPO $10,000 deductible, 100% / 50% coinsurance*	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Outpatient prescription drugs up to a 31-day supply. Quantity limits may apply.	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	50%, subject to deductible	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	50%, subject to deductible
Emergency room services – copay waived if admitted, inpatient benefit will then apply	$450 copay/visit		$450 copay/visit	
Ambulance services – medical emergencies only	No charge, subject to deductible		No charge, subject to deductible	
Urgent care services	$60 copay/visit	50%, subject to deductible	$60 copay/visit	50%, subject to deductible
In-store health care clinic	$30 copay/visit	50%, subject to deductible	$30 copay/visit	50%, subject to deductible
Rehabilitative services – limited to short-term, maximum of 60 days per calendar year, all therapies combined	Inpatient: No charge, subject to deductible Outpatient: No charge, subject to deductible	50%, subject to deductible	Inpatient: No charge, subject to deductible Outpatient: No charge, subject to deductible	50%, subject to deductible
Skilled nursing facility services – limited to 60 days per calendar year	No charge, subject to deductible	50%, subject to deductible	No charge, 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: No charge, subject to deductible	Inpatient: Not covered Outpatient: 50%, subject to deductible	Inpatient: Not covered Outpatient: No charge, subject to deductible	Inpatient: Not covered Outpatient: 50%, subject to deductible
Chiropractic covered – services for spinal manipulations are covered when determined to be medically necessary by Health Net.	$60 copay/visit	50%, subject to deductible	$60 copay/visit	50%, subject to deductible

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

Advantage PPO plans

With a wide range of deductibles and copayments, our Advantage plans are ideal if you want more cost flexibility and a lot of choice. Get the health care benefits you need at a price that won't break the bank.

Advantage PPO plans 500 and 1000

Benefits	*Advantage PPO $500 deductible, 80% / 50% coinsurance*		*Advantage PPO $1,000 deductible, 80% / 50% coinsurance*	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Deductible – per calendar year	$500 single / $1,000 family	$1,000 single / $2,000 family	$1,000 single / $2,000 family	$2,000 single / $4,000 family
Maximum lifetime benefits	Unlimited		Unlimited	
Out-of-pocket maximum – excluding deductible and copays	$2,500 single / $5,000 family	$5,000 single / $10,000 family	$3,000 single / $6,000 family	$6,000 single / $12,000 family
Inpatient hospital services – including physician, facility and surgery charges	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Outpatient hospital services / ambulatory surgical center services	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Office visits Primary care physician	$25 copay/visit	50%, subject to deductible	$25 copay/visit	50%, subject to deductible
Specialist	$40 copay/visit	50%, subject to deductible	$40 copay/visit	50%, subject to deductible
Preventive care – preventive office visits, preventive lab and X-ray, Pap smear and mammogram, prostate screening, immunizations, colorectal cancer screening (including, but not limited to colonoscopy), vision and hearing screenings	$0 copay/visit	50%, subject to deductible	$0 copay/visit	50%, subject to deductible
Outpatient laboratory / X-ray services Performed at a physician's office	No charge	50%, subject to deductible	No charge	50%, subject to deductible
Performed at an independent, nonhospital-affiliated lab facility[1]	No charge	50%, subject to deductible	No charge	50%, subject to deductible
Performed at a hospital	20%, 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) Performed at a physician's office	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Performed at an independent, nonhospital-affiliated facility[1]	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Performed at a hospital	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Prenatal and postpartum care	Not covered		Not covered	

(continued)

[1]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.

Advantage PPO plans 500 and 1000

Benefits	*Advantage PPO $500 deductible, 80% / 50% coinsurance*		*Advantage PPO $1,000 deductible, 80% / 50% coinsurance*	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Maternity care	Not covered except for complications of pregnancy		Not covered except for complications of pregnancy	
Outpatient prescription drugs up to a 31-day supply. Quantity limits may apply.	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	50%, subject to deductible	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	50%, subject to deductible
Emergency room services – copay waived if admitted, inpatient benefit will then apply	$300 copay/visit		$300 copay/visit	
Ambulance services – medical emergencies only	20%, subject to deductible		20%, subject to deductible	
Urgent care services	$60 copay/visit	50%, subject to deductible	$60 copay/visit	50%, subject to deductible
In-store health care clinic	$25 copay/visit	50%, subject to deductible	$25 copay/visit	50%, subject to deductible
Rehabilitative services – limited to short-term, maximum of 60 days per calendar year, all therapies combined	Inpatient: 20%, subject to deductible Outpatient: $40 copay/visit	50%, subject to deductible	Inpatient: 20%, subject to deductible Outpatient: $40 copay/visit	50%, subject to deductible
Skilled nursing facility services – limited to 60 days per calendar year	20%, 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: 20%, 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
Chiropractic covered – services for spinal manipulations are covered when determined to be medically necessary by Health Net.	$40 copay/visit	50%, subject to deductible	$40 copay/visit	50%, subject to deductible

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

Advantage PPO plans 2500 and 5000

Benefits	*Advantage PPO $2,500 deductible, 80% / 50% coinsurance*		*Advantage PPO $5,000 deductible, 80% / 50% 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	Unlimited		Unlimited	
Out-of-pocket maximum – excluding deductible and copays	$3,000 single / $6,000 family	$6,000 single / $12,000 family	$3,000 single / $6,000 family	$6,000 single / $12,000 family
Inpatient hospital services – including physician, facility and surgery charges	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Outpatient hospital services / ambulatory surgical center services	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Office visits Primary care physician	$30 copay/visit	50%, subject to deductible	$30 copay/visit	50%, subject to deductible
Specialist	$45 copay/visit	50%, subject to deductible	$45 copay/visit	50%, subject to deductible
Preventive care – preventive office visits, preventive lab and X-ray, Pap smear and mammogram, prostate screening, immunizations, colorectal cancer screening (including, but not limited to colonoscopy), vision and hearing screenings	$0 copay/visit	50%, subject to deductible	$0 copay/visit	50%, subject to deductible
Outpatient laboratory / X-ray services Performed at a physician's office	No charge	50%, subject to deductible	No charge	50%, subject to deductible
Performed at an independent, nonhospital-affiliated lab facility[1]	No charge	50%, subject to deductible	No charge	50%, subject to deductible
Performed at a hospital	20%, 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) Performed at a physician's office	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Performed at an independent, nonhospital-affiliated facility[1]	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Performed at a hospital	20%, subject to deductible	50%, subject to deductible	20%, subject to deductible	50%, subject to deductible
Prenatal and postpartum care	Not covered		Not covered	
Maternity care	Not covered except for complications of pregnancy		Not covered except for complications of pregnancy	

(continued)

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Advantage PPO plans 2500 and 5000

Benefits	*Advantage PPO $2,500 deductible, 80% / 50% coinsurance*		*Advantage PPO $5,000 deductible, 80% / 50% coinsurance*	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Outpatient prescription drugs up to a 31-day supply. Quantity limits may apply.	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	50%, subject to deductible	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	50%, subject to deductible
Emergency room services – copay waived if admitted, inpatient benefit will then apply	$300 copay/visit		$300 copay/visit	
Ambulance services – medical emergencies only	20%, subject to deductible		20%, subject to deductible	
Urgent care services	$60 copay/visit	50%, subject to deductible	$60 copay/visit	50%, subject to deductible
In-store health care clinic	$30 copay/visit	50%, subject to deductible	$30 copay/visit	50%, subject to deductible
Rehabilitative services – limited to short-term, maximum of 60 days per calendar year, all therapies combined	Inpatient: 20%, subject to deductible Outpatient: $45 copay/visit	50%, subject to deductible	Inpatient: 20%, subject to deductible Outpatient: $45 copay/visit	50%, subject to deductible
Skilled nursing facility services – limited to 60 days per calendar year	20%, 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: 20%, 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
Chiropractic covered – services for spinal manipulations are covered when determined to be medically necessary by Health Net.	$45 copay/visit	50%, subject to deductible	$45 copay/visit	50%, subject to deductible

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

SelectChoice PPO plans

With 70% coverage plan designs and deductibles from $2,500 to $10,000, these plans are for those looking for health care benefits with a wide range of deductible options.

SelectChoice PPO plans 2500 and 4000

Benefits	*SelectChoice PPO $2,500 deductible, 70% / 50% coinsurance*		*SelectChoice PPO $4,000 deductible, 70% / 50% 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	$4,000 single / $8,000 family	$8,000 single / $16,000 family
Maximum lifetime benefits	Unlimited		Unlimited	
Out-of-pocket maximum – excluding deductible and copays	$3,000 single / $6,000 family	$6,000 single / $12,000 family	$3,000 single / $6,000 family	$6,000 single / $12,000 family
Inpatient hospital services – including physician, facility and surgery charges	30%, subject to deductible	50%, subject to deductible	30%, subject to deductible	50%, subject to deductible
Outpatient hospital services / ambulatory surgical center services	30%, subject to deductible	50%, subject to deductible	30%, subject to deductible	50%, subject to deductible
Office visits Primary care physician	$30 copay/visit	50%, subject to deductible	$30 copay/visit	50%, subject to deductible
Specialist	$60 copay/visit	50%, subject to deductible	$60 copay/visit	50%, subject to deductible
Preventive care – preventive office visits, preventive lab and X-ray, Pap smear and mammogram, prostate screening, immunizations, colorectal cancer screening (including, but not limited to colonoscopy), vision and hearing screenings	$0 copay/visit	50%, subject to deductible	$0 copay/visit	50%, subject to deductible
Outpatient laboratory / X-ray services Performed at a physician's office	No charge	50%, subject to deductible	No charge	50%, subject to deductible
Performed at an independent, nonhospital-affiliated lab facility[1]	30%, subject to deductible	50%, subject to deductible	30%, subject to deductible	50%, subject to deductible
Performed at a hospital	30%, subject to deductible	50%, subject to deductible	30%, 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) Performed at a physician's office	30%, subject to deductible	50%, subject to deductible	30%, subject to deductible	50%, subject to deductible
Performed at an independent, nonhospital-affiliated facility[1]	30%, subject to deductible	50%, subject to deductible	30%, subject to deductible	50%, subject to deductible
Performed at a hospital	30%, subject to deductible	50%, subject to deductible	30%, subject to deductible	50%, subject to deductible
Prenatal and postpartum care	Not covered		Not covered	
Maternity care	Not covered except for complications of pregnancy		Not covered except for complications of pregnancy	

(continued)

[1]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.

SelectChoice PPO plans 2500 and 4000

Benefits	*SelectChoice PPO $2,500 deductible, 70% / 50% coinsurance*		*SelectChoice PPO $4,000 deductible, 70% / 50% coinsurance*	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Outpatient prescription drugs up to a 31-day supply. Quantity limits may apply.	$500 prescription deductible. 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: $120 copay/ prescription or refill	50%, subject to deductible	$500 prescription deductible. 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: $120 copay/ prescription or refill	50%, subject to deductible
Emergency room services – copay waived if admitted, inpatient benefit will then apply	$450 copay/visit		$450 copay/visit	
Ambulance services – medical emergencies only	30%, subject to deductible		30%, subject to deductible	
Urgent care services	$60 copay/visit	50%, subject to deductible	$60 copay/visit	50%, subject to deductible
In-store health care clinic	$30 copay/visit	50%, subject to deductible	$30 copay/visit	50%, subject to deductible
Rehabilitative services – limited to short-term, maximum of 60 days per calendar year, all therapies combined	Inpatient and outpatient: 30%, subject to deductible	50%, subject to deductible	Inpatient and outpatient: 30%, subject to deductible	50%, subject to deductible
Skilled nursing facility services – limited to 60 days per calendar year	30%, subject to deductible	50%, subject to deductible	30%, 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: 30%, subject to deductible	Inpatient: Not covered Outpatient: 50%, subject to deductible	Inpatient: Not covered Outpatient: 30%, subject to deductible	Inpatient: Not covered Outpatient: 50%, subject to deductible
Chiropractic covered – services for spinal manipulations are covered when determined to be medically necessary by Health Net.	$60 copay/visit	50%, subject to deductible	$60 copay/visit	50%, subject to deductible

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

SelectChoice PPO plans 7000 and 10000

Benefits	*SelectChoice PPO $7,000 deductible, 70% / 50% coinsurance*		*SelectChoice PPO $10,000 deductible, 70% / 50% coinsurance*	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Deductible – per calendar year	$7,000 single / $14,000 family	$14,000 single / $28,000 family	$10,000 single / $20,000 family	$20,000 single / $40,000 family
Maximum lifetime benefits	Unlimited		Unlimited	
Out-of-pocket maximum – excluding deductible and copays	$3,000 single / $6,000 family	$6,000 single / $12,000 family	$3,000 single / $6,000 family	$6,000 single / $12,000 family
Inpatient hospital services – including physician, facility and surgery charges	30%, subject to deductible	50%, subject to deductible	30%, subject to deductible	50%, subject to deductible
Outpatient hospital services / ambulatory surgical center services	30%, subject to deductible	50%, subject to deductible	30%, subject to deductible	50%, subject to deductible
Office visits Primary care physician	$30 copay/visit	50%, subject to deductible	$30 copay/visit	50%, subject to deductible
Specialist	$60 copay/visit	50%, subject to deductible	$60 copay/visit	50%, subject to deductible
Preventive care – preventive office visits, preventive lab and X-ray, Pap smear and mammogram, prostate screening, immunizations, colorectal cancer screening (including, but not limited to colonoscopy), vision and hearing screenings	$0 copay/visit	50%, subject to deductible	$0 copay/visit	50%, subject to deductible
Outpatient laboratory / X-ray services Performed at a physician's office	No charge	50%, subject to deductible	No charge	50%, subject to deductible
Performed at an independent, nonhospital-affiliated lab facility[1]	30%, subject to deductible	50%, subject to deductible	30%, subject to deductible	50%, subject to deductible
Performed at a hospital	30%, subject to deductible	50%, subject to deductible	30%, 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) Performed at a physician's office	30%, subject to deductible	50%, subject to deductible	30%, subject to deductible	50%, subject to deductible
Performed at an independent, nonhospital-affiliated facility[1]	30%, subject to deductible	50%, subject to deductible	30%, subject to deductible	50%, subject to deductible
Performed at a hospital	30%, subject to deductible	50%, subject to deductible	30%, subject to deductible	50%, subject to deductible
Prenatal and postpartum care	Not covered		Not covered	
Maternity care	Not covered except for complications of pregnancy		Not covered except for complications of pregnancy	

(continued)

[1]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.

SelectChoice PPO plans 7000 and 10000

Benefits	*SelectChoice PPO $7,000 deductible, 70% / 50% coinsurance*		*SelectChoice PPO $10,000 deductible, 70% / 50% coinsurance*	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Outpatient prescription drugs up to a 31-day supply. Quantity limits may apply.	$500 prescription deductible. 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: $120 copay/ prescription or refill	50%, subject to deductible	$500 prescription deductible. 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: $120 copay/ prescription or refill	50%, subject to deductible
Emergency room services – copay waived if admitted, inpatient benefit will then apply	$450 copay/visit		$450 copay/visit	
Ambulance services – medical emergencies only	30%, subject to deductible		30%, subject to deductible	
Urgent care services	$60 copay/visit	50%, subject to deductible	$60 copay/visit	50%, subject to deductible
In-store health care clinic	$30 copay/visit	50%, subject to deductible	$30 copay/visit	50%, subject to deductible
Rehabilitative services – limited to short-term, maximum of 60 days per calendar year, all therapies combined	Inpatient and outpatient: 30%, subject to deductible	50%, subject to deductible	Inpatient and outpatient: 30%, subject to deductible	50%, subject to deductible
Skilled nursing facility services – limited to 60 days per calendar year	30%, subject to deductible	50%, subject to deductible	30%, 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: 30%, subject to deductible	Inpatient: Not covered Outpatient: 50%, subject to deductible	Inpatient: Not covered Outpatient: 30%, subject to deductible	Inpatient: Not covered Outpatient: 50%, subject to deductible
Chiropractic covered – services for spinal manipulations are covered when determined to be medically necessary by Health Net.	$60 copay/visit	50%, subject to deductible	$60 copay/visit	50%, subject to deductible

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

Value PPO plan rates effective July 1, 2012

Age	Cochise, Maricopa, Pinal and Santa Cruz counties								Pima County							
	Value PPO $3,500 / 100% / 50%		Value PPO $6,000 / 100% / 50%		Value PPO $7,500 / 100% / 50%		Value PPO $10,000 / 100% / 50%		Value PPO $3,500 / 100% / 50%		Value PPO $6,000 / 100% / 50%		Value PPO $7,500 / 100% / 50%		Value PPO $10,000 / 100% / 50%	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0	580	580	385	385	348	348	299	299	490	490	322	322	291	291	250	250
1	249	249	166	166	149	149	128	128	210	210	138	138	125	125	107	107
2–6	139	139	93	93	86	86	73	73	118	118	76	76	68	68	59	59
7–14	137	137	90	90	81	81	70	70	116	116	75	75	67	67	58	58
15–18	135	154	87	103	77	93	67	78	112	129	73	88	67	79	58	68
19–22	113	183	76	120	68	108	60	94	88	143	60	95	54	85	46	74
23	115	182	75	120	68	108	60	94	89	142	59	95	54	85	46	74
24	116	182	75	121	68	109	60	95	90	142	59	95	53	85	46	74
25	117	182	75	121	68	109	60	95	90	141	59	95	53	84	46	74
26	117	182	75	121	70	109	60	95	91	140	59	94	53	84	46	74
27	118	182	75	121	70	109	58	95	92	140	59	94	52	84	46	74
28	120	183	77	121	71	109	61	95	94	141	60	95	54	85	47	74
29	124	183	79	122	73	110	63	96	97	142	62	96	56	86	48	75
30	126	184	83	122	75	110	64	96	99	143	64	96	58	86	49	75
31	128	184	85	122	77	110	66	96	101	144	65	97	60	88	51	76
32	130	185	87	124	78	111	67	96	104	145	67	98	61	89	52	77
33	137	190	90	126	83	115	71	98	108	149	69	100	64	91	54	78
34	142	195	94	129	86	118	73	100	112	153	73	102	66	93	57	80
35	149	201	97	132	88	120	75	103	116	157	76	105	69	95	59	81
36	154	205	100	136	92	124	78	105	122	161	79	107	73	97	61	83
37	161	211	104	138	95	126	81	107	126	165	82	109	75	99	63	84
38	173	215	113	140	103	128	88	109	136	169	89	111	81	100	69	86
39	188	218	122	143	111	130	95	111	146	172	96	113	88	102	75	88
40	201	222	131	146	120	132	103	113	156	174	102	114	94	104	80	89
41	214	225	141	149	128	135	109	116	165	177	110	116	100	106	85	90
42	227	228	151	151	137	137	117	118	176	180	117	118	107	107	91	92
43	238	250	158	164	142	150	122	128	185	196	123	129	112	116	95	100
44	250	270	164	178	150	162	128	139	194	212	128	140	116	127	100	109
45	260	292	171	192	157	173	134	150	203	228	135	152	122	137	105	117
46	271	313	178	205	162	186	139	160	212	244	140	162	127	146	109	126
47	284	334	186	218	169	199	145	170	221	260	145	173	132	156	113	135
48	303	345	200	226	182	204	157	175	237	269	156	178	142	160	122	138
49	324	355	214	233	194	210	167	182	253	276	168	183	152	165	130	142
50	345	365	227	239	206	217	177	188	269	284	178	188	161	170	139	146
51	366	376	242	247	220	223	189	192	286	292	189	192	171	174	147	149
52	387	387	256	255	231	228	199	198	302	300	201	197	180	179	156	154
53	405	403	268	265	243	238	209	205	317	313	210	206	190	187	163	160
54	424	419	281	275	255	249	220	215	332	325	219	215	199	194	171	168
55	444	435	294	286	266	259	228	223	348	337	228	223	207	203	178	174
56	461	451	306	296	278	268	238	231	363	350	238	232	216	210	186	180
57	481	467	319	307	289	279	249	238	379	363	248	241	225	218	193	188
58	502	477	332	313	301	285	259	244	395	370	258	246	235	222	202	191
59	524	486	346	320	314	290	269	249	412	378	270	250	246	226	210	194
60	546	494	360	326	326	296	280	254	429	385	281	255	255	231	220	199
61	567	503	373	332	338	301	290	258	446	393	292	259	266	235	228	202
62	589	513	387	338	351	307	301	264	463	401	303	265	275	239	237	205
63	611	522	399	345	363	313	312	268	479	409	314	269	286	243	246	209
64	633	531	414	351	376	319	322	273	496	416	326	274	296	248	254	212

Value PPO plan rates effective July 1, 2012

Age	*Other counties*							
	Value PPO $3,500 / 100% / 50%		Value PPO $6,000 / 100% / 50%		Value PPO $7,500 / 100% / 50%		Value PPO $10,000 / 100% / 50%	
	Male	Female	Male	Female	Male	Female	Male	Female
0	691	691	460	460	417	417	359	359
1	296	296	198	198	178	178	153	153
2–6	168	168	109	109	100	100	86	86
7–14	163	163	107	107	97	97	84	84
15–18	161	181	105	125	95	111	81	96
19–22	134	222	90	143	81	131	70	113
23	135	221	89	143	79	131	70	113
24	136	221	89	143	79	131	70	113
25	137	220	89	143	79	131	70	113
26	138	220	88	143	79	131	70	113
27	139	218	88	143	79	131	70	113
28	143	220	92	145	84	132	72	115
29	148	221	95	146	86	132	74	115
30	151	222	97	146	89	134	76	116
31	156	223	100	148	92	134	78	116
32	159	224	104	149	95	135	83	117
33	164	231	108	152	98	138	86	119
34	171	236	113	157	103	141	89	122
35	178	243	118	160	107	145	93	125
36	184	250	124	163	110	149	96	128
37	191	256	128	168	116	152	99	130
38	206	260	138	170	125	154	107	132
39	223	264	149	173	134	157	116	135
40	239	268	159	175	143	159	124	137
41	256	271	169	179	153	161	132	138
42	271	275	179	182	162	163	140	140
43	286	300	189	199	170	179	148	154
44	299	326	198	215	179	194	156	167
45	314	350	206	232	188	209	162	181
46	328	374	216	248	196	225	169	193
47	341	398	226	265	204	239	177	206
48	366	413	241	273	220	247	189	213
49	392	425	257	280	233	255	201	218
50	417	438	273	288	247	262	213	225
51	443	451	289	296	262	269	225	231
52	467	463	305	303	275	276	236	236
53	489	483	320	318	289	288	249	247
54	512	502	334	330	303	299	260	257
55	534	522	351	344	318	312	273	266
56	556	542	365	356	331	323	285	276
57	579	561	381	370	345	334	297	287
58	606	574	397	377	361	341	309	292
59	630	585	416	385	376	348	323	298
60	657	596	433	392	392	354	337	303
61	682	608	450	398	407	361	350	309
62	708	619	467	406	423	367	363	317
63	735	631	484	414	438	373	376	322
64	759	643	501	420	454	381	390	328

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.

Advantage PPO plan rates effective July 1, 2012

Age	Cochise, Maricopa, Pinal and Santa Cruz counties								Pima County							
	Advantage PPO $500 / 80% / 50%		Advantage PPO $1,000 / 80% / 50%		Advantage PPO $2,500 / 80% / 50%		Advantage PPO $5,000 / 80% / 50%		Advantage PPO $500 / 80% / 50%		Advantage PPO $1,000 / 80% / 50%		Advantage PPO $2,500 / 80% / 50%		Advantage PPO $5,000 / 80% / 50%	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0	1,071	1,071	839	839	638	638	433	433	907	907	706	706	537	537	360	360
1	459	459	360	360	273	273	184	184	389	389	303	303	231	231	154	154
2–6	260	260	204	204	154	154	104	104	217	217	171	171	130	130	84	84
7–14	256	256	195	195	150	150	102	102	214	214	165	165	126	126	83	83
15–18	248	287	194	230	147	170	98	116	211	243	165	188	123	144	82	98
19–22	210	341	167	265	125	201	86	136	165	265	128	209	96	157	66	105
23	211	341	167	265	126	200	85	137	167	265	129	208	97	157	66	105
24	213	341	167	263	127	200	85	137	168	265	129	207	99	155	66	105
25	213	339	167	263	128	200	85	137	169	265	130	206	100	154	65	105
26	214	339	167	263	128	200	85	137	169	265	130	205	101	154	65	105
27	215	339	167	263	129	200	85	137	170	265	131	204	102	153	65	105
28	221	341	171	265	131	201	87	137	174	266	135	206	105	154	66	106
29	227	342	177	265	136	201	89	138	178	267	140	207	107	155	68	107
30	233	343	181	266	138	202	92	138	183	268	143	208	109	157	70	107
31	239	344	184	267	140	202	95	138	186	270	146	210	111	158	74	108
32	245	346	190	268	143	203	98	139	190	271	151	211	112	159	75	109
33	256	356	198	275	150	209	102	141	199	279	157	217	118	163	78	111
34	266	365	206	284	156	215	105	145	207	286	162	223	123	168	81	113
35	275	376	216	291	163	221	108	147	215	294	169	230	128	172	84	116
36	285	386	224	299	169	227	114	151	224	300	174	235	132	176	88	120
37	295	397	233	308	177	233	117	153	232	309	180	241	138	181	91	122
38	321	402	252	312	191	236	127	157	251	313	195	244	148	185	99	124
39	346	408	270	318	205	241	138	159	270	318	210	248	160	188	107	126
40	372	414	290	322	220	244	149	163	290	322	225	251	171	191	115	127
41	397	420	308	327	235	247	158	167	310	329	241	254	183	194	123	129
42	423	425	327	332	249	252	169	169	329	333	255	256	193	199	130	131
43	443	463	344	362	262	275	178	184	346	362	269	280	204	216	138	144
44	463	502	360	393	275	298	184	200	362	392	282	304	212	233	144	157
45	486	541	376	423	287	321	193	215	379	420	295	328	223	251	149	168
46	505	579	394	452	299	345	202	231	396	449	309	351	232	269	157	180
47	526	617	411	483	312	369	209	245	413	478	320	375	242	286	163	192
48	566	638	440	498	335	381	224	254	443	494	346	388	259	295	175	199
49	606	657	472	513	359	391	241	260	475	511	369	398	278	304	187	204
50	646	678	502	529	381	403	256	268	505	526	393	411	296	313	200	209
51	685	696	534	544	403	415	271	277	536	542	417	423	314	320	211	215
52	724	716	564	561	426	426	286	284	567	559	441	436	332	330	223	221
53	759	747	591	583	447	445	300	296	592	582	462	454	349	345	234	230
54	795	778	618	607	467	461	316	308	619	605	483	472	366	358	244	240
55	830	808	646	631	488	479	330	320	646	629	504	489	382	371	255	249
56	864	839	673	655	509	498	343	332	671	652	524	507	399	384	266	258
57	899	870	702	679	529	514	358	344	697	675	545	525	416	399	276	269
58	939	886	732	692	553	524	373	351	729	689	569	537	434	408	289	273
59	980	904	763	705	578	535	387	359	759	702	592	547	454	415	301	279
60	1,020	921	793	717	603	544	402	364	791	715	618	558	472	424	314	285
61	1,060	938	824	731	627	554	418	372	822	729	642	568	491	432	327	289
62	1,100	956	856	744	651	564	433	380	854	743	665	580	508	440	338	295
63	1,140	973	886	756	675	574	448	385	884	756	689	589	527	449	351	299
64	1,180	990	917	769	699	584	462	393	916	770	713	601	545	457	363	305

Advantage PPO plan rates effective July 1, 2012

Age	Other counties							
	Advantage PPO $500 / 80% / 50%		Advantage PPO $1,000 / 80% / 50%		Advantage PPO $2,500 / 80% / 50%		Advantage PPO $5,000 / 80% / 50%	
	Male	Female	Male	Female	Male	Female	Male	Female
0	1,286	1,286	1,010	1,010	765	765	513	513
1	552	552	433	433	327	327	220	220
2–6	311	311	245	245	183	183	121	121
7–14	303	303	234	234	179	179	119	119
15–18	292	345	233	269	178	200	117	139
19–22	249	411	196	321	146	244	100	162
23	252	411	198	320	149	243	100	162
24	253	411	200	319	150	243	99	162
25	254	409	200	319	151	242	99	162
26	255	409	201	318	152	242	99	162
27	256	409	202	317	154	241	99	162
28	265	411	206	318	158	242	103	163
29	271	413	211	320	163	243	106	164
30	280	414	216	321	167	244	110	166
31	288	415	222	323	171	245	114	166
32	296	418	227	324	175	246	117	167
33	308	428	238	334	182	254	121	171
34	321	440	247	343	190	260	127	175
35	333	452	258	352	195	268	131	180
36	345	465	268	361	203	275	138	183
37	358	477	279	370	210	282	142	189
38	386	484	302	375	228	286	153	191
39	414	491	324	381	246	291	166	193
40	443	499	348	385	265	295	178	196
41	471	505	371	390	282	299	190	200
42	500	514	395	395	299	303	201	202
43	526	559	414	433	316	331	211	221
44	552	605	434	468	331	359	221	241
45	578	650	452	505	346	386	232	259
46	605	695	472	543	362	413	243	279
47	631	742	491	579	376	440	253	297
48	679	765	527	599	404	455	270	307
49	727	787	564	617	433	470	287	316
50	774	811	600	637	460	483	306	323
51	822	834	637	655	487	498	323	332
52	870	857	673	673	514	512	341	342
53	911	895	707	703	540	532	359	356
54	952	930	740	731	564	554	375	371
55	993	967	774	759	589	576	393	385
56	1,036	1,004	808	787	614	596	411	399
57	1,077	1,041	842	814	639	618	427	414
58	1,126	1,062	877	831	667	630	447	422
59	1,174	1,081	914	845	694	643	466	429
60	1,223	1,102	950	861	723	657	486	438
61	1,271	1,122	987	875	750	669	503	447
62	1,320	1,143	1,023	891	780	682	523	454
63	1,368	1,164	1,058	906	808	695	542	462
64	1,416	1,184	1,095	921	835	707	562	471

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.

SelectChoice PPO plan rates effective July 1, 2012

Age	Cochise, Maricopa, Pinal and Santa Cruz counties								Pima County							
	SelectChoice PPO $2,500 / 70% / 50%		SelectChoice PPO $4,000 / 70% / 50%		SelectChoice PPO $7,000 / 70% / 50%		SelectChoice PPO $10,000 / 70% / 50%		SelectChoice PPO $2,500 / 70% / 50%		SelectChoice PPO $4,000 / 70% / 50%		SelectChoice PPO $7,000 / 70% / 50%		SelectChoice PPO $10,000 / 70% / 50%	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0	567	567	465	465	306	306	252	252	478	478	392	392	256	256	210	210
1	244	244	200	200	131	131	107	107	205	205	169	169	110	110	90	90
2–6	136	136	111	111	76	76	61	61	115	115	95	95	60	60	49	49
7–14	134	134	109	109	71	71	58	58	113	113	93	93	59	59	48	48
15–18	131	151	108	124	68	82	56	66	110	126	90	104	59	69	48	58
19–22	110	179	90	147	61	95	50	78	85	140	70	114	48	75	38	62
23	113	178	92	146	61	95	50	78	86	139	70	113	48	75	38	62
24	114	178	93	146	61	96	50	79	88	139	72	113	47	75	38	62
25	115	178	94	146	61	96	50	79	88	138	72	113	47	75	38	62
26	115	178	94	146	61	96	50	79	89	137	73	112	47	75	38	62
27	116	178	95	146	61	96	50	79	90	137	74	112	46	75	38	62
28	117	179	96	147	62	96	51	79	92	138	75	113	48	75	39	62
29	120	179	99	147	64	97	53	81	95	139	78	113	49	76	41	63
30	122	180	100	148	66	97	54	81	97	140	79	114	51	76	42	63
31	125	180	103	148	68	97	55	81	99	141	81	115	52	77	43	64
32	127	181	104	148	68	98	56	81	101	142	83	116	53	78	44	64
33	134	185	109	152	73	102	60	83	106	146	86	120	57	80	46	65
34	139	191	114	157	76	104	61	84	110	149	90	122	59	82	48	67
35	146	196	119	161	77	106	63	86	113	154	93	126	61	83	49	68
36	151	201	124	164	81	109	66	88	118	158	97	129	64	85	51	70
37	158	206	129	169	84	110	67	89	123	161	100	132	66	88	53	70
38	169	211	139	172	90	113	74	92	132	164	109	135	72	89	59	73
39	183	213	150	174	98	115	79	94	143	168	117	138	77	90	63	74
40	196	216	161	178	106	117	86	95	153	170	125	139	82	91	67	75
41	210	220	171	180	113	118	92	97	161	173	132	142	89	93	72	76
42	222	223	182	183	120	120	98	99	172	176	141	144	94	94	76	77
43	233	245	191	201	126	132	103	107	180	192	147	157	98	102	80	84
44	245	264	201	216	132	142	107	117	190	207	156	170	102	112	84	92
45	255	286	209	234	138	152	113	126	199	223	162	183	107	121	88	98
46	265	306	217	250	142	164	117	135	207	239	170	195	112	129	92	106
47	277	327	227	267	149	174	121	142	216	254	177	208	116	137	95	113
48	297	338	243	276	160	180	131	148	232	263	190	216	125	141	102	115
49	317	348	259	285	171	184	140	153	248	270	203	221	133	145	109	120
50	338	356	276	292	182	191	148	158	263	278	216	227	142	149	116	123
51	358	367	294	301	193	196	159	161	280	286	228	234	151	153	124	126
52	379	379	310	310	203	201	167	166	295	294	241	240	159	158	131	129
53	396	394	324	322	214	210	175	172	310	305	254	250	168	164	138	135
54	414	409	339	335	224	220	184	181	325	317	266	259	175	171	143	141
55	434	425	355	348	234	228	192	188	341	330	279	270	183	178	149	146
56	450	441	369	361	245	236	200	194	354	342	290	280	190	185	156	152
57	470	456	385	373	255	246	210	200	370	354	303	290	199	192	162	158
58	491	466	402	382	265	250	217	205	385	362	316	297	207	195	170	160
59	512	475	419	388	277	255	226	210	402	369	330	302	216	200	176	163
60	534	483	437	395	287	260	235	213	420	377	344	309	224	203	185	167
61	554	492	454	403	297	265	244	217	436	384	357	314	234	207	192	170
62	576	501	471	411	309	270	253	222	453	392	370	321	242	210	199	172
63	597	510	489	417	320	276	263	225	469	399	383	327	252	215	206	176
64	619	519	507	425	331	280	270	228	485	407	397	333	260	218	214	178

SelectChoice PPO plan rates effective July 1, 2012

Age	Other counties							
	SelectChoice PPO $2,500 / 70% / 50%		SelectChoice PPO $4,000 / 70% / 50%		SelectChoice PPO $7,000 / 70% / 50%		SelectChoice PPO $10,000 / 70% / 50%	
	Male	Female	Male	Female	Male	Female	Male	Female
0	675	675	553	553	367	367	301	301
1	289	289	236	236	157	157	129	129
2–6	164	164	135	135	88	88	73	73
7–14	160	160	130	130	85	85	71	71
15–18	158	177	129	145	84	98	67	81
19–22	130	216	107	178	71	116	58	95
23	131	215	108	177	70	116	58	95
24	132	215	108	177	70	116	58	95
25	134	214	109	175	70	116	58	95
26	135	214	110	175	70	116	58	95
27	136	213	111	174	70	116	58	95
28	140	214	115	175	74	117	61	96
29	145	215	118	177	76	117	62	96
30	148	216	121	178	78	117	64	97
31	152	217	125	179	81	117	66	97
32	156	218	127	179	84	118	70	98
33	161	225	131	184	86	121	73	100
34	167	231	137	189	90	125	75	103
35	173	237	142	194	94	127	78	105
36	180	245	148	201	97	131	81	107
37	186	250	152	205	102	134	84	109
38	202	255	166	209	109	136	89	111
39	217	258	179	211	117	138	97	113
40	234	262	192	214	126	140	104	115
41	250	265	205	217	135	141	111	116
42	265	268	217	220	142	143	118	118
43	279	294	228	241	150	158	125	130
44	292	318	239	260	158	171	130	140
45	307	342	252	280	166	183	136	152
46	320	365	263	299	173	199	142	162
47	333	390	273	319	180	211	148	173
48	358	403	294	330	193	217	159	179
49	383	415	313	340	205	224	169	183
50	407	428	333	351	217	231	179	189
51	433	441	354	361	231	237	189	194
52	456	452	373	371	242	243	199	199
53	478	472	391	386	255	254	210	207
54	500	491	409	402	267	263	218	216
55	522	510	427	417	279	275	228	223
56	543	530	445	434	291	285	239	232
57	566	547	463	448	303	295	249	241
58	591	561	484	459	318	300	259	246
59	616	572	504	468	331	306	271	250
60	641	583	525	477	344	311	282	255
61	667	594	545	487	359	318	294	259
62	692	605	567	495	372	323	305	266
63	718	617	588	505	385	328	316	270
64	742	629	607	514	399	335	328	275

Health Net delivers performance as promised.

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 smear, mammography and PSA screenings. For a complete list, see the Evidence of Coverage.

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