



Health Net Health Plan of Oregon, Inc.

Benefacts: Individual PPO Crystal High Deductible Health Plan

Coinsurance Schedule IHDHP5000/09

PPO: Two plans, many choices. PPO stands for Preferred Provider Organization. For you, PPO means that you have flexibility and choice in deciding who will provide your health care. That's because this plan lets you receive services from providers in our PPO network or providers out of our network. Who performs the services determines which benefit level applies to covered services and how much you will pay in out-of-pocket expenses. To confirm whether a provider participates in our PPO network and to verify which benefit level will apply to a covered service, please contact one of our Customer Contact Center representatives.

IFP PPO Benefits: When you see providers in our PPO network for most services covered under this plan, you pay our contracted rate for the service until you meet your Calendar Year deductible. Once you meet the deductible, your expenses may include a fixed dollar amount for certain services or a fixed percentage that is applied to our contracted rates with PPO providers.

When you receive covered services from a Provider in our PPO network, you are not responsible for charges that are above our contracted rates. We recommend that you contact your attending Provider to discuss the ancillary Providers that may be used for your services, as Out-of-Network Provider charges will be reimbursed at the Out-of-Network level. **Certain services including but not limited to Birthing Center services, Home Health Care, home infusion services, organ and tissue transplant services, Durable Medical Equipment, and External Prosthetic Devices/Orthotic Devices are covered only if provided by a designated Specialty Care Center. See Article 1.5 of the Basic Benefit Schedule.**

Out-of-Network Benefits: When services are performed by a provider who is not in our PPO network, your expenses include a Calendar Year deductible and a fixed percentage of Maximum Allowable Amount (MAA) rates for other services. We pay Out-of-Network providers based on MAA rates, not on billed amounts. MAA rates may often be less than the amount a provider bills for a service. Out-of-Network providers may therefore hold you responsible for amounts they charge that exceed the MAA rates we pay. Amounts that exceed our MAA rates are not covered and do not apply to your annual out-of-pocket maximum. *Your responsibility for any amounts that exceed our MAA payment is shown on this schedule as MAA.*

Your benefits are subject to deductibles and Coinsurance amounts listed in this schedule.

Calendar Year Deductible	For covered services, you are responsible for:	
	PPO Network	Out-of-Network
Annual deductible: one-person coverage	\$5,000 PPO Network ¹	\$10,000 Out-of-Network ¹
Physician/Professional/Outpatient care		
Women's and men's health care - Pap test, breast exam, pelvic exam, PSA test and digital rectal exam	No charge ²	50% MAA ²
Routine mammography	No charge ²	50% MAA ²
Physician services, office call	No charge	50% MAA
Physician services, urgent care center	No charge	50% MAA
Well Baby care	No charge ²	50% MAA ²
Physician hospital visits	No charge	50% MAA
Diagnostic X-ray/EKG/Ultrasound	No charge	50% MAA
Diagnostic laboratory tests	No charge	50% MAA
CT/MRI/PET/SPECT/EEG/Holter monitor/Stress test	No charge	50% MAA
Allergy and therapeutic injections	No charge	50% MAA
Maternity delivery care (professional services only)	No charge	50% MAA
Outpatient rehabilitation therapy - \$2,500/year max	No charge	50% MAA
Outpatient or ambulatory care center	No charge	50% MAA
Hospital care		
Inpatient services	No charge	50% MAA
Inpatient rehabilitation therapy - 30 days/year max	No charge	50% MAA
Emergency services		
Outpatient emergency room services	No charge	50% MAA
Inpatient admission from emergency room	No charge	No charge MAA
Emergency ambulance transport - \$3,000/year max	No charge (MAA applies to Out-of-Network providers)	



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**BeneFacts: Individual PPO
Crystal High Deductible Health Plan IHDHP5000/09**

For covered services, you are responsible for:

Behavioral health services	PPO Network	Out-of-Network
Mental health - \$1,000/year max ⁴	No charge	50% MAA
Other services		
Durable medical equipment - \$5,000/year max	No charge	50% MAA
External Prosthetic Devices/Orthotic Devices	No charge	50% MAA
Medical supplies (including allergy serums and injected substances)	No charge	50% MAA
Diabetes management program – one initial program per lifetime	No charge	50% MAA
Blood, blood plasma, blood derivatives	No charge	50% MAA
TMJ services - \$500/lifetime max	No charge	50% MAA
Home infusion therapy	No charge	50% MAA
Chemotherapy (non-oral anticancer medications and administration)	No charge	50% MAA
Skilled nursing facility care - 60 days/year max	No charge	50% MAA
Hospice services	No charge	50% MAA
Home health visits -\$1,000/year max	No charge	50% MAA
Health education	Not covered	Not covered

Benefit maximums

Annual out-of-pocket maximum: one-person coverage ⁵	\$5,000	\$20,000
Lifetime maximum for authorized organ transplant services	\$250,000	Not covered Out-of-Network
Lifetime maximum	\$2,000,000 PPO Network and Out-of-Network combined	

Exclusion periods (Refer to Medical and Hospital Service Agreement, Section 8.12)

Allergies & their symptoms, including asthma: 12 months	Mental disorders: 12 months
Elective procedures: 12 months	Organ transplants: 24 months
Pre-existing conditions: 6 months	

Notes

- ¹ The deductible must be met each Calendar Year (January 1 through December 31) before Health Net pays any claims. With this plan, the deductible applies to the annual out-of-pocket maximum.
- ² The deductible is waived.
- ³ Your payments do not apply to the annual out-of-pocket maximum.
- ⁴ To Prior Authorize mental health services, call 800-977-8216.
- ⁵ The deductible applies to the annual out-of-pocket maximum. After you reach the out-of-pocket maximum in a Calendar Year, we will pay your covered services during the rest of that calendar year at 100% of our contract rates for PPO services and at 100% of MAA for Out-of-Network (OON) services. You are still responsible for OON billed charges that exceed MAA.

This schedule presents general information only. Certain services require Prior Authorization or must be performed by a Specialty Care Provider. Refer to your Agreement and other benefit materials for details, limitations and exclusions.

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Health Net Health Plan of Oregon, Inc.

Prescription Benefits

Supplemental Benefit Schedule MASIFPHD100/09 (MAC A)

Article 1 - Purpose and Function of this Schedule

The purpose of this Schedule is to provide prescription benefits. This Schedule is an amending attachment to the Basic Benefit Schedule.

Subject to all terms, conditions, exclusions and definitions in the Medical and Hospital Service Agreement and its attachments, except as expressly amended by the Benefits article of this schedule, You are entitled to receive benefits set forth in this Schedule upon payment of the relevant premium, deductible and Coinsurance.

Article 2 - Benefits

Coverage includes all Medically Necessary legend drugs, compounded medications of which at least one ingredient is a prescription legend drug, orally administered anticancer medications, and any other drug which under law may only be dispensed by written prescription of a duly licensed health care provider, diabetic supplies, and insulin. Coverage is subject to the qualifications, limitations and exclusions below:

- 2.1 The amount of drug to be dispensed per filled prescription shall be for such quantities as directed by the Physician, but in no event shall the quantity exceed a 30-day supply when filled in a pharmacy or a 90-day supply when filled through mail order. Benefits are based on FDA approved dosing guidelines. Some drugs, including but not limited to compounded medications, require Prior Authorization and/or may have a dosage or quantity restriction set by the Plan.
- 2.2 All drugs, including insulin and diabetic supplies, must be prescribed by a Participating Provider or by a Physician under Referral and must be dispensed by a Participating Provider pharmacy, except for Emergency Medical Care rendered outside the Service Area.
- 2.3 When a generic form of a brand name drug exists, the generic drug will be dispensed and the Tier 1 Copayment shall apply. An approved generic equivalent shall mean a generic drug that has been given an "A" therapeutic equivalent code by the Department of Health and Human Services. If a generic equivalent exists but a brand name drug is requested, you must pay an ancillary charge equal to the difference between the cost of the generic drug and the brand name drug in addition to the Tier 2 Copayment.
- 2.4 Coinsurance shall be as follows for each prescription or refill. Deductible and Coinsurance amounts you pay for prescription drugs do apply toward your medical plan deductible and Out-of-Pocket maximum.
- 2.5 You are responsible for accumulating all pharmacy receipts. Once the deductible has been met, send the receipts to Health Net for correct adjudication of your pharmacy services.

Calendar Year Deductible for Prescription Benefits: Refer to your medical plan deductible.

	In Pharmacy (Per Fill Up to a 30-day Supply)	Mail Order (Per Fill Up to a 90-day Supply)
Tier 1	No charge	No charge
Tier 2	No charge	No charge
Tier 3	You pay the full cost of the prescription at Health Net's discounted rate.	You pay the full cost of the prescription at Health Net's discounted rate.

Specialty Pharmacy: Certain drugs identified on the PDL are classified as Specialty Pharmacy drugs under your plan. Specialty Pharmacy drugs are high cost biologic, injectable and oral drugs typically dispensed through a limited network of pharmacies, and having a significantly higher cost than traditional pharmacy benefit drugs.

This pharmacy plan provides creditable coverage for Medicare Part D if you are not currently enrolled in Medicare. If you are currently enrolled in Medicare, please call our Customer Contact Center to find out if your specific plan provides creditable coverage.

	Specialty Pharmacy (Per Fill Up to a 30-day Supply)
Specialty Pharmacy	You pay the full cost of the prescription at Health Net's discounted rate.

Orally Administered Anticancer Medications:

	Orally administered anticancer medications (Per Fill Up to a 30-day Supply)
Anticancer medications	No Copayment

Specialty Pharmacy services and orally administered anticancer medications apply toward your medical plan deductible and Out-of-Pocket maximum.

- 2.6 The level of benefit you receive is based on the Preferred Drug List (PDL) status of the drug at the time your prescription is filled. The PDL may be revised up to four times per Calendar Year based on the recommendations of the Pharmacy and Therapeutics Committee. Any such changes including additions and deletions from the PDL will be communicated to Participating Providers. Compounded medications are subject to the Tier 3 Coinsurance.
- 2.7 Reimbursement (minus the Coinsurance) will be made for prescriptions filled by a pharmacy other than a Participating Provider pharmacy for Emergency Medical Care rendered outside the Service Area, upon presentation of receipts to Health Net Oregon and sufficient documentation to establish the need for Emergency Medical Care.
- 2.8 Reimbursement (minus the Coinsurance) will be made for coverable prescriptions filled by a licensed practitioner at a rural health clinic for an urgent medical condition if there is not a pharmacy within 15 miles of the clinic or if the prescription is dispensed for a patient outside of the normal business hours of any pharmacy within 15 miles of the clinic. For the purposes of this 2.7, "urgent medical condition" means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems.

Article 3 -Exclusions

The following items are excluded from coverage:

- 3.1 Drugs and medicines prescribed or dispensed other than as described in this Schedule.
- 3.2 Early refills other than for changes in directions.
- 3.3 Over-the-counter drugs other than insulin.
- 3.4 Therapeutic or prosthetic devices, orthotics and all supplies, even though they might require a prescription, including but not limited to: hypodermic needles and syringes other than for insulin, appliances, support garments, braces, splints, bandages, dressings and other non-medicinal substances regardless of intended use.
- 3.5 Injectable medications other than those listed as injections on the PDL.
- 3.6 Dental only drugs.
- 3.7 Dietary supplements, food, health and beauty aids, and vitamin preparations other than legend prenatal vitamins and legend vitamins with fluoride.
- 3.8 Drugs for the treatment of onychomycosis (nail fungus), nocturnal enuresis (bed-wetting), sexual dysfunction, or infertility; drugs used for weight loss, smoking cessation, sexual enhancement, or sexual performance improvement; growth hormone therapy; oral nystatin powder.
- 3.9 Any prescription drug for which an over-the-counter therapeutic equivalent is available.
- 3.10 Prescription refills due to loss or theft.
- 3.11 Over-the-counter contraceptive devices and supplies.
- 3.12 Diabetic supplies other than blood glucose test strips, lancets, insulin syringes and needles.

This pharmacy plan provides creditable coverage for Medicare Part D if you are not currently enrolled in Medicare. If you are currently enrolled in Medicare, please call our Customer Contact Center to find out if your specific plan provides creditable coverage.



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Health Net Health Plan of Oregon, Inc. Preventive Care Benefits Supplemental Benefit Schedule

In this Supplemental Benefit Schedule, the terms “we,” “our” and “us” refer to Health Net Health Plan of Oregon, Inc. and the terms “you” and “your” refer to the Subscriber and to each Enrolled Dependent unless otherwise specified.

Article 1 - Purpose and Function of this Schedule

The purpose of this Supplemental Benefit Schedule is to provide coverage for preventive care benefits. This schedule is an amending attachment to the Basic Benefit Schedule. Subject to all terms, conditions, exclusions and definitions in the Medical and Hospital Service Agreement and its attachments, except as expressly amended by the Benefits article of this schedule, you are entitled to receive benefits set forth in this schedule upon payment of the relevant premium and the Copayment or Coinsurance stated in your benefit schedule. The deductible, if any, is waived for preventive care benefits.

Article 2 - Benefits

- 2.1 Routine physical examinations. Scheduled routine physical examinations, including complete blood count (CBC), history and physical, urine analysis (UA), chemical profile, and stool hemocult, are covered.

Physical Examinations do not include stress test, EKG or chest x-ray unless Medically Necessary. Colorectal screening is covered as a medical benefit in Article 7 of the Basic Benefit Schedule.

 - a. Pediatric (under age 19)

Exams are covered according to the American Academy of Pediatrics’ Recommendations for Preventive Pediatric Health Care guidelines for exam frequency.
 - b. Adult (19 and older)

Exams are covered according to the United States Preventive Services Task Force (USPSTF) preventive guidelines for exam frequency.
- 2.2 Immunizations and inoculations. Immunizations and inoculations routinely administered are covered. Immunizations for the purpose of travel are not covered.
- 2.3 Vision Screening Exams. Vision screening to determine the need for vision correction is covered. Eye examinations for refractions are not covered. All types of vision hardware and corrective appliances are excluded except as provided under Durable Medical Equipment and Medical Supplies of the Basic Benefit Schedule.
- 2.4 Circumcisions. Circumcisions for newborn male children are covered.
- 2.5 Benefits for preventive care services covered under this Supplemental Benefit Schedule are payable at benefit levels indicated on your benefit schedule.