Health Net Health Plan of Oregon, Inc.
BeneFacts: Individual and Family
Emerald 40 PPO Plan
Copayment and Coinsurance Schedule IEP4050V9/08

PPO Benefits: When you receive covered services from providers in our PPO network, your expenses may include a Calendar Year deductible, fixed dollar amounts for certain services or a fixed percentage that is applied to our contracted rates with PPO providers. *The percentage of our contracted rate that is your responsibility is shown on this schedule as* **% contract rate**.

When you receive covered services from a Provider in our PPO network, you are not responsible for billed 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 Provider. 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 Usual, Customary and Reasonable (UCR) rates. We pay Out-of-Network providers based on UCR rates, not on billed amounts. UCR 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 UCR rates we pay. Amounts that exceed our UCR rates are not covered and do not apply to your annual out-of-pocket maximum. *Your responsibility for any amounts that exceed our UCR payment is shown on this schedule as* **UCR *plus***.

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

	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual deductible per person	$5,000 PPO Network and Out-of-Network combined [1, 2]	
Annual deductible per family	$15,000 PPO Network and Out-of-Network combined [1, 2]	
Physician/Professional/Outpatient care		
Women's and men's health care - Pap test, breast exam, pelvic exam, PSA test and digital rectal exam	$40 per visit [3]	50% UCR *plus* [3]
Routine mammography	$40 per visit [3]	50% UCR *plus* [3]
Physician services, office call	$40 per visit [3]	50% UCR *plus*
Physician services, urgent care center	$40 per visit	50% UCR *plus* [4]
Well Baby care	$40 per visit [3]	50% UCR *plus* [3]
Physician hospital visits	30% contract rate	50% UCR *plus*
Diagnostic X-ray/EKG/Ultrasound	30% contract rate	50% UCR *plus*
Diagnostic laboratory tests	30% contract rate	50% UCR *plus*
CT/MRI/PET/SPECT/EEG/Holter monitor/Stress test	30% contract rate	50% UCR *plus*
Allergy and therapeutic injections	30% contract rate	50% UCR *plus*
Maternity care	30% contract rate	50% UCR *plus*
Outpatient rehabilitation therapy - $2,500/year max	30% contract rate	50% UCR *plus*
Outpatient or ambulatory care center	30% contract rate	50% UCR *plus*
Hospital care		
Inpatient services	30% contract rate	50% UCR *plus*
Inpatient rehabilitation therapy - 30 days/year max	30% contract rate	50% UCR *plus*
Emergency services		
Outpatient emergency room services	30% contract rate [4]	50% UCR *plus* [4]
Inpatient admission from emergency room	30% contract rate	50% UCR *plus*
Emergency ambulance transport - $3,000/year max	30% (UCR *plus* applies to Out-of-Network providers)	

Health Net

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	For covered services, you are responsible for:	
Behavioral health services	**PPO Network**	**Out-of-Network**
Mental health - $1,000/year max [5]	30% contract rate [2, 3]	50% UCR *plus* [2, 3]
Other services		
Durable Medical Equipment - $5,000/year max	30% contract rate	50% UCR *plus*
External Prosthetic Devices/Orthotic Devices	30% contract rate	50% UCR *plus*
Medical supplies (including allergy serums and injected substances)	30% contract rate	50% UCR *plus*
Diabetes management program - one initial program per lifetime	$40 per visit [3]	50% UCR *plus*
Blood, blood plasma, blood derivatives	30% contract rate	50% UCR *plus*
TMJ services - $500/lifetime max	50% contract rate [2]	50% UCR *plus* [2]
Home infusion therapy	30% contract rate	50% UCR *plus*
Skilled nursing facility care - 60 days/year max	30% contract rate	50% UCR *plus*
Hospice services	30% contract rate	50% UCR *plus*
Home health visits - $1,000/year max	30% contract rate	50% UCR *plus*
Health education - $150/year max for all qualifying classes	Any charges over maximum reimbursement of $50/qualifying class. [2]	
Prescription drugs	Refer to Prescription Drug Schedule for benefits and details. [2]	
Benefit maximums		
Annual out-of-pocket maximum per person [6]	$6,000 PPO Network	$12,000 Out-of-Network
Annual out-of-pocket maximum per family [6]	$18,000 PPO Network	$36,000 Out-of-Network
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] You must meet the specified deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.

[2] Your payments do not apply to the annual out-of-pocket maximum.

[3] Deductible is waived.

[4] Upon approval, the Calendar Year deductible will be waived for an accidental injury. Accidental injury is a physical harm or disability, which is the result of a specific, unexpected or unintentional incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness and must be treated in an Emergency Room (ER) or Urgent Care facility. The Calendar Year deductible will be waived only for that day's treatment in the ER or Urgent Care, the ER or Urgent Care Copay will still apply. A completed accident waiver form must be submitted within 90 days of the accident and is required in order for the claim to be reviewed. Services for which the deductible is waived will not apply toward the annual out-of-pocket maximum.

[5] To Prior Authorize mental health services, call 800-977-8216.

[6] The annual out-of-pocket maximum does not include the annual deductible. 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 UCR for Out-of-Network (OON) services. You are still responsible for OON billed charges that exceed UCR.

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

Health Net Health Plan of Oregon, Inc.
Individual and Family Plan
Prescription Benefits
Supplemental Benefit Schedule PJ2K/08 (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 and the Copayments.

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 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 A covered prescription drug or refill will be provided upon payment of the following Copayment. Prescription deductibles, Copayments and other amounts you pay for prescription drugs do not apply toward your plan's other deductibles, out-of-pocket maximums, Copayment maximums, or maximum amounts subject to Coinsurance.

Calendar Year Deductible for Prescription Benefits: $100 per Member – does not apply to orally administered anticancer medications.

Maximum Prescription Benefit: $2,000 per Member per Calendar Year – does not apply to orally administered anticancer medications.

	In Pharmacy (Per Fill Up to a 30-day Supply)	**Mail Order (Per Fill Up to a 90-day Supply)**
Tier 1	50%	50%
Tier 2	50%	50%
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 must be obtained from a designated Specialty Pharmacy Provider. Specialty Pharmacy drugs include, but are not limited to, injectable medications other than insulin that the majority of patients or a caregiver can administer at home after receiving adequate training from a medical professional.

This pharmacy plan does not provide creditable coverage for Medicare Part D.

	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.

The Calendar Year Deductible for Prescription Benefits and the Maximum Prescription Benefit include Specialty Pharmacy services.

Orally Administered Anticancer Medications:

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

2.5 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 Copayment.

2.6 Reimbursement (minus the Copayment) 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 to us of receipts and sufficient documentation to establish the need for Emergency Medical Care.

2.7 Reimbursement (minus the Copayment) 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 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 treatment of onychomycosis (nail fungus), nocturnal for enuresis (bed wetting), sexual dysfunction, or infertility; drugs used for weight loss, smoking cessation, sexual enhancement, or sexual performance improvement; growth hormone therapy; and 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.

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 according to the following schedule:

a. Pediatric (under age 19)

Infant (under age 2)	Eight well-baby exams in the first 24 months.
Early childhood (3 through 5 years)	One exam every year
Late childhood (6 through 11 years)	One exam every 2 years
Adolescent (12 through 18 years)	One exam every year

b. Adult

19 through 40 years	One exam every 3 years
41 through 60 years	One exam every 2 years
Over 60 years	One exam every year

Physical Examinations do not include stress test, EKG, chest x-ray, or sigmoidoscopy unless Medically Necessary.

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.