Health Net Health Plan of Oregon, Inc.
Individual and Family
Copayment and Coinsurance Schedule
CommunityCare Choice 2T Platinum Plan CC10-300-1-2000DX/14

2T = Two plans in one. When you need health care, this plan lets you receive services from Providers in our CommunityCare network or outside of our CommunityCare network. Who performs the services determines which benefit level applies to covered services and how much you will pay out-of-pocket. To confirm whether a provider participates in one of our networks and to verify which benefit level will apply to a covered service, please contact one of our Customer Contact Center representatives.

CommunityCare (Level 1) Benefits: To receive CommunityCare benefits, you must select a Primary Care Provider (PCP) from our CommunityCare network. Your PCP coordinates all your care. When your PCP refers you to providers in our CommunityCare network, you will receive CommunityCare level benefits. When you receive covered services from Providers in our CommunityCare network, your expenses may include a Calendar Year Deductible, fixed dollar amounts for certain services and a fixed percentage that is applied to our contracted rates with providers in your CommunityCare network. If your PCP refers you to Providers outside of our CommunityCare network, you will receive Level 2 benefits.

Certain services including, but not limited to, Birthing Center services, Home Health Care, infusion services that can be safely administered in the home or in a home infusion suite, organ and tissue transplant services, Durable Medical Equipment, and Prosthetic Devices/Orthotic Devices are covered only if provided by a designated Specialty Care Provider. We recommend that you contact your treating Provider to discuss the other types of Providers that may be used for your services, as Providers outside of the CommunityCare network will be reimbursed at Level 2 benefits.

Other Provider (Level 2) Benefits: When services are performed by a Provider who is not participating in your CommunityCare network, your expenses may include a Calendar Year Deductible, fixed dollar amounts for certain services and a fixed percentage of Maximum Allowable Amount (MAA) rates for other services. Providers outside of your CommunityCare network may or may not be contracted with us. We pay Nonparticipating Providers based on MAA rates, not on billed amounts. MAA rates may often be less than the amount a Provider bills for a service. Nonparticipating Providers may 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 Copayment maximum. *Your responsibility for any amounts that exceed our MAA payment is shown on this Schedule as **MAA**.*

Professional Medical Services and Supplies

Your benefits are subject to Deductibles, Copayments, and Coinsurance amounts listed in this Schedule unless otherwise noted.

	For covered services, you are responsible for:	
Calendar Year Deductible	**CommunityCare (Level 1)**	**Other Provider (Level 2)**
Annual Deductible per person	$300 [1]	$600 [1]
Annual Deductible per family	$600 [1]	$1,200 [1]
Physician/Professional/Outpatient Care		
Preventive 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 visits to Providers in family practice, pediatrics, internal medicine, general practice, obstetrics/gynecology	$10 per visit [2]	50% MAA
Specialty Physician services - office visits to Providers in specialties other than above	$50 per visit [2]	50% MAA
Physician services, urgent care center	$50 per visit [2]	$50 per visit MAA [2]
Physician hospital visits	10% contract rate	50% MAA
Diagnostic X-ray/EKG/Ultrasound	10% contract rate [2]	50% MAA
Diagnostic laboratory tests	10% contract rate [2]	50% MAA
CT/MRI/PET/SPECT/EEG/Holter monitor/Stress test	10% contract rate	50% MAA
Allergy and therapeutic injections	10% contract rate	50% MAA
Maternity delivery care (professional services only)	10% contract rate	50% MAA

Health Net®

Individual and Family
CommunityCare Choice 2T Platinum Plan CC10-300-1-2000DX/14

	For covered services, you are responsible for:	
	CommunityCare (Level 1)	**Other Provider (Level 2)**
Outpatient rehabilitation therapy – 30 visits/year max	10% contract rate	50% MAA
Outpatient habilitation therapy – 30 visits/year max	10% contract rate	50% MAA
Outpatient at Ambulatory Surgery Center	5% contract rate	50% MAA
Outpatient at Hospital-based facility	10% contract rate	50% MAA
Hospital Care		
Inpatient services [6]	10% contract rate	50% MAA
Inpatient rehabilitation therapy - 30 days/year max	10% contract rate	50% MAA
Inpatient habilitation therapy - 30 days/year max	10% contract rate	50% MAA
Emergency Services		
Outpatient emergency room services	$250 per visit, then 10% contract rate [2, 3]	$250 per visit, then 10% [2, 3]
Inpatient admission from emergency room	10% contract rate	50%
Emergency ground ambulance transport	10% at Level 1 or 2	
Emergency air ambulance transport	10% at Level 1 or 2	
Behavioral Health Services – Chemical Dependency and Mental or Nervous Conditions		
Physician services, office call [4]	$10 per visit [2]	50% MAA
Outpatient services [4]	10% contract rate	50% MAA
Inpatient services [4]	10% contract rate	50% MAA
Other Services		
Blood, blood plasma, blood derivatives	10% contract rate	50% MAA
Diabetes management – one initial program	10% contract rate	50% MAA
Durable Medical Equipment and Prosthetic Devices/Orthotic Devices [8]	10% contract rate	50% MAA
Hearing Aids [7]	10% contract rate	50% MAA
Home health visits	10% contract rate	50% MAA
Home infusion therapy	10% contract rate	50% MAA
Hospice services	10% contract rate	50% MAA
Medical supplies (including allergy serums and injected substances)	10% contract rate	50% MAA
Skilled nursing facility care - 60 days/year max	10% contract rate	50% MAA
TMJ services - $500/lifetime max	50% contract rate	50% MAA
Tobacco Use Counseling	No charge [2]	50% MAA
Outpatient chemotherapy (non-oral anticancer medications and administration)	10% contract rate	50% MAA
Benefit Maximums		
Annual Out-of-Pocket Maximum per person [5] (Combined Medical and Prescription Drugs)	$2.000	$4.000
Annual Out-of-Pocket Maximum per family [5] (Combined Medical and Prescription Drugs)	$4,000	$8,000
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered

Notes

[1] You must meet the specified Deductible each calendar year (January 1 through December 31) before Health Net pays any claims.

[2] Deductible is waived.

[3] Copayment is waived if you are admitted.

[4] For mental health or Chemical Dependency services, call 800-977-8216.

[5] The annual Out-of-Pocket Maximum (OOPM) is the maximum dollar amount of Copayment or Coinsurance that you are required to pay each Calendar Year for most covered services and supplies. Each January 1, the accumulation period renews

and a new OOPM requirement begins. The OOPM includes the annual Deductible. After you reach the OOPM in a Calendar Year, we will pay your covered services during the rest of that Calendar Year at 100% of our contract rates for Participating Provider services and at 100% of MAA for Nonparticipating Provider services. You are still responsible for billed charges that exceed MAA.

[6] The above Coinsurance for inpatient Hospital services is applicable for each admission for the hospitalization of an adult, pediatric or newborn patient. If a newborn patient requires admission to an intermediate or intensive care nursery, a separate Coinsurance for inpatient Hospital Services will apply.

[7] Age limits apply. Refer to the "Hearing Aids" section of the Basic Benefit Schedule.

[8] Corrective shoes and arch supports including foot orthotics are excluded unless prescribed in the course of treatments for, or complications from, diabetes.

Outpatient Prescription Drug Benefits

Outpatient prescription drug Deductibles (if any), Copayments and/or Coinsurance and other amounts you pay for outpatient prescription drugs do not apply toward your plan's medical Deductibles.

	In Pharmacy (Per Fill Up to a 30-day Supply)	**Mail Order (Per Fill Up to a 90-day Supply)**
Tier 1	Generic $10	Generic $20
Tier 2	Preferred Brand Drugs $20	Preferred Brand Drugs $40
Tier 3	Non-Preferred Brand Drugs $40	Non-Preferred Brand Drugs $80
Tier 4	Specialty Drugs 50%	Not covered
Preventive Pharmacy and Women's contraceptive drugs and devices	No Copayment and/ or Coinsurance. Deductible waived	No Copayment and/ or Coinsurance. Deductible waived
	(Per Fill Up to a 30-day Supply)	
Specialty Pharmacy	50%	
Orally administered anticancer medications	10%	

Pediatric Vision Benefits

This plan covers routine vision services and supplies for children up to age 19 as described below. To receive maximum benefits, you must utilize Participating Providers. A list of Participating Providers is available at www.healthnet.com or by calling our Customer Contact Center at the phone number at the bottom of this Schedule.

Copayments and/or Coinsurance and other amounts you pay for pediatric vision benefits do not apply toward your plan's medical Deductibles.

Routine eye exam limit: 1 per Calendar Year	$0 Copayment
Lenses limit: 1 pair per Calendar Year, including • Single vision, bifocal, trifocal, lenticular • Glass or Plastic	$0 Copayment
Provider selected frames limit: 1 per Calendar Year	$0 Copayment
Provider selected contact lenses in lieu of eyeglass lenses: **Contact Lens Allowance:** Allowances are one-time use benefits; no remaining balance. • Daily wear / Disposables: Up to 3 month supply of daily disposable, single vision. • Extended wear / Disposables: Up to 6 month supply of monthly or 2 week disposable, single vision. • Conventional: 1 pair from a selection of provider designated contact lenses.	$0 Copayment

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

Health Net Health Plan of Oregon, Inc. • 888-802-7001 • www.healthnet.com