Health Net Health Plan of Oregon, Inc.
BeneFacts: PPO Value Plan
Copayment and Coinsurance Schedule GSP207V3/09

PPO: Two plans, many choices. In health insurance, 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 out-of-pocket. 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.

PPO Benefits: When you receive covered services from Providers in our PPO network, your expenses include a Calendar Year deductible (if any), 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 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, fixed dollar amounts for certain services 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, 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	$750 PPO Network and Out-of-Network combined [1, 2]	
Annual deductible per family	$2,250 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	$20 per visit [3]	50% MAA [3]
Routine mammography	$20 per visit [3]	50% MAA [3]
Physician services, office call	$20 per visit [3]	50% MAA
Physician services, urgent care center	25% contract rate	25% MAA
Physician Hospital visits	25% contract rate	50% MAA
Diagnostic X-ray/EKG/Ultrasound	25% contract rate	50% MAA
Diagnostic laboratory tests	25% contract rate	50% MAA
CT/MRI/PET/SPECT/EEG/Holter monitor/Stress test	25% contract rate	50% MAA
Allergy and therapeutic injections	25% contract rate	50% MAA
Maternity delivery care (professional services only)	25% contract rate	50% MAA
Outpatient rehabilitation therapy - $2,500/year max	25% contract rate [2]	50% MAA [2]
Outpatient at Ambulatory Surgery Center	20% contract rate	50% MAA
Outpatient at Hospital based facility	25% contract rate	50% MAA
Hospital Care		
Inpatient services	25% contract rate	50% MAA
Inpatient rehabilitation therapy - 30 days/year max	25% contract rate	50% MAA
Emergency Services		
Outpatient emergency room services	25% contract rate	25% MAA
Inpatient admission from emergency room	25% contract rate	25% MAA
Emergency ambulance transport - $3,000/year max	20% (MAA applies to Out-of-Network Providers)	

Health Net

BeneFacts: PPO Value Plan GSP207V3/09

For covered services, you are responsible for:

Behavioral Health Services – Chemical Dependency and Mental or Nervous Conditions	**PPO Network**	**Out-of-Network**
Physician services, office call [4]	$20 per visit [3]	50% MAA
Outpatient center [4]	25% contract rate	50% MAA
Inpatient services [4]	25% contract rate	50% MAA
Other Services		
Durable Medical Equipment - $5,000/year max	25% contract rate [2]	50% MAA [2]
External Prosthetic Devices/Orthotic Devices	25% contract rate [2]	50% MAA [2]
Medical supplies (including allergy serum and injected substances)	25% contract rate [2]	50% MAA [2]
Diabetes management - one initial program per lifetime	$20 per program [2, 3]	50% MAA [2]
Blood, blood plasma, blood derivatives	25% contract rate [2]	50% MAA [2]
TMJ services - $500/lifetime max	50% contract rate [2]	50% MAA [2]
Home infusion therapy	25% contract rate	50% MAA
Injectable chemotherapy (anticancer medications and administration)	25% contract rate	50% MAA
Skilled Nursing Facility care - 60 days/year max	25% contract rate [2]	50% MAA [2]
Hospice services	25% contract rate [2]	50% MAA [2]
Home health visits - $1,000/year max	25% contract rate [2]	50% MAA [2]
Health education - $150/year combined max	Any charges over maximum reimbursement of $50/qualifying class [2]	
Benefit Maximums		
Annual out-of-pocket maximum per person [5]	$2,000	$6,000
Annual out-of-pocket maximum per family [5]	$6,000	$18,000
Lifetime maximum for authorized organ transplant services	$250,000	Not covered Out-of-Network
Lifetime maximum	Unlimited	$1,000,000

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

[5] 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 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 contract and other benefit materials for details, limitations and exclusions.

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

Health Net

Health Net Health Plan of Oregon, Inc.
Prescription Benefits
Supplemental Benefit Schedule NMSA15-30%-50%5000M/09 (No MAC S)

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 Schedule is to provide prescription benefits to Subscriber Groups selecting this supplemental benefit in addition to the basic benefits. This Schedule is an amending attachment to the Basic Benefit Schedule.

Subject to all terms, conditions, exclusions and definitions in the Health Net Health Plan of Oregon, Inc. Group Medical and Hospital Service Agreement and its attachments, except the exclusion of prescription drugs in the Exclusions and Limitations section of the Basic Benefit Schedule, You are entitled to receive benefits set forth in this Schedule upon payment of the relevant premium and 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 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. The requirement that drugs must be prescribed by a Participating Provider or by a Physician under Referral does not apply under a Triple Option, PPO, or Flex Net Plan.

2.3 Copayments shall be as follows for each prescription or refill. Prescription deductibles (if any), Copayments and other amounts you pay for prescription drugs do not apply toward your plan's other deductibles, Copayment or out-of-pocket maximums, or stop loss amounts.

Annual out-of-pocket maximum for Prescription Benefits: $5,000 per Member per Calendar Year

	In Pharmacy (Per Fill Up to a 30-day Supply)	**Mail Order (Per Fill Up to a 90-day Supply)**
Tier 1	$15	$30
Tier 2	30%	30%
Tier 3	50%	50%
Specialty Pharmacy	50%	Mail order not available
Orally administered anticancer medications	No Copayment	Mail order not available

2.4 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 provides creditable coverage for Medicare Part D.

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. Brand name drugs with generic equivalents are subject to the Tier 3 Copayment as soon as a generic becomes available.

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 of receipts to Health Net Oregon 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 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 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, 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.

Health Net

Health Net Health Plan of Oregon, Inc.
Well Net
Supplemental Benefit Schedule CAM33 15-1000/09

Article 1 - Purpose and Function of this Schedule

The purpose of this Schedule is to provide coverage for complementary services by Providers of chiropractic, acupuncture, massage therapy, and naturopathic medicine. This Schedule is an amending attachment to the Basic Benefit Schedule.

Subject to all terms, conditions, exclusions and definitions in the Group Medical and Hospital Service Agreement and its attachments, except as expressly amended by the Benefits provision of this Schedule, you are entitled to receive benefits set forth in this Schedule upon payment of the relevant premiums and Copayments specified in this Schedule.

Article 2 – Copayments and Maximums

2.1 The Copayment for chiropractic, acupuncture and naturopathic services is $15 per visit.

2.2 The Copayment for massage therapy services is $25 per visit, with a maximum of 18 visits.

2.3 The maximum combined benefit per Calendar Year is $1,000.

Article 3 - Chiropractic Services

3.1 Chiropractic services are covered as follows:

a. Patients have direct access to ASH Networks contracted chiropractors for their initial visit. A new patient examination is performed by the ASH Networks contracted Provider to determine the nature of the Member's problem and, if covered services appear warranted, a proposed treatment plan of services to be furnished is prepared. A new patient examination is provided for each new patient. A Copayment is required.

b. An established patient examination may be performed by the ASH Networks contracted Provider to assess the need to continue, extend or change a treatment plan approved by ASH Networks. A reevaluation may be performed during a subsequent office visit or separately. If performed separately, a Copayment is required.

c. Subsequent office visits, as set forth in a treatment plan approved by ASH Networks, may involve an adjustment, a brief reexamination and other services, in various combinations. A Copayment is required for each visit to the office.

d. Adjunctive therapy, as set forth in a treatment plan approved by ASH Networks, may involve modalities such as ultrasound, hot packs, cold packs, electrical muscle stimulation and other therapies.

e. X-rays and clinical laboratory tests are payable in full when referred by an ASH Networks contracted chiropractor and approved by ASH Networks. Radiological consultations are a covered benefit when approved by ASH Networks as medically/clinically necessary services and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or Hospital which has contracted with ASH Networks to provide those services.

f. Chiropractic appliances are covered up to a maximum of $50 per year when prescribed by an ASH Networks contracted chiropractor and approved by ASH Networks.

g. All chiropractic services, except for the initial visit, must be Prior Authorized by ASH Networks as medically/clinically necessary for treatment of neuromusculoskeletal conditions.

3.2 Chiropractic Exclusions and Limitations.

a. Services or treatments not approved ASH Networks as medically/clinically necessary, except for a new patient examination and urgent services.

b. Services or treatments not delivered by ASH Networks contracted chiropractors for the delivery of chiropractic care to Members, except for urgent services.

c. Services for examinations and/or treatments from ASH Networks contracted chiropractors for conditions other than those related to neuromusculoskeletal disorders.

d. Hypnotherapy, behavior training, sleep therapy and weight programs.

e. Thermography.

f. Services, lab tests, x-rays and other treatments not documented as medically/clinically necessary and appropriate or classified as Experimental or Investigational and/or as being in the research stage.

g. Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology and any diagnostic radiology other than covered plain film studies.

h. Transportation costs including local ambulance charges.

i. Education programs, non-medical lifestyle or self-help or any self-help physical exercise training or related diagnostic testing.

j. Services or treatments for pre-employment physicals or vocational rehabilitation.

k. Services or treatments caused by or arising out of the course of employment or covered under public liability insurance.

l. Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all chiropractic appliances or Durable Medical Equipment, except as specifically outlined.

m. Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.

n. Services provided by a chiropractor practicing outside the states of Oregon and Washington (state of residency), except for urgent services.

o. Hospitalization, anesthesia, manipulation under anesthesia and other related services.

p. Auxiliary aids and services, including, but not limited to, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

q. Adjunctive therapy not associated with spinal, muscle or joint manipulation.

r. Vitamins, minerals or other similar products.

Article 4 – Acupuncture Services

4.1 Acupuncture services are covered as follows:

a. Patients have direct access to ASH Networks contracted acupuncturists for their initial visit. A new patient examination is performed by the ASH Networks contracted Provider to determine the nature of the Member's problem and, if covered services appear warranted, a treatment plan of services to be furnished is prepared. A new patient examination is provided for each new patient. A Copayment is required.

b. An established patient examination may be performed by the ASH Networks contracted Provider to assess the need to continue, extend or change a treatment plan approved by ASH Networks. A reevaluation may be performed during a subsequent office visit or separately. If performed separately, a Copayment is required.

c. Subsequent office visits, as set forth in a treatment plan approved by ASH Networks, may involve acupuncture treatment, a brief reexamination and other services in various combinations. A Copayment is required for each visit to the office.

d. Adjunctive therapy, as set forth in a treatment plan approved by ASH Networks, may involve modalities such as acupressure, moxibustion, cupping and other therapies.

e. All acupuncture services, except for the initial visit, must be Prior Authorized by ASH Networks as medically/clinically necessary for treatment of nausea, pain syndromes or neuromusculoskeletal conditions.

4.2 Acupuncture exclusions and limitations:

a. Services or treatments not approved by ASH Networks as medically/clinically necessary, except for a new patient examination and urgent services.

b. Services or treatments not delivered by ASH Networks contracted acupuncturists for the delivery of acupuncture care to Members, except for urgent services.

c. Services for examinations and/or treatments from ASH Networks contracted acupuncturists for conditions other than those related to neuromusculoskeletal disorders, nausea or pain syndromes.

d. Hypnotherapy, behavior training, sleep therapy and weight programs.

e. Thermography.

f. Services, lab tests, x-rays and other treatments not documented as medically/clinically necessary and appropriate or classified as Experimental or Investigational and/or as being in the research stage.

g. Radiological x-rays, magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, diagnostic radiology and laboratory services.

h. Transportation costs including local ambulance charges.

i. Education programs, non-medical lifestyle or self-help or self-help physical exercise training or any related diagnostic testing.

j. Services or treatments for pre-employment physicals or vocational rehabilitation.

k. Services or treatments caused by or arising out of the course of employment or covered under public liability insurance.

l. Air conditioners/purifiers, therapeutic mattresses, supplies, Durable Medical Equipment or appliances, or any other similar device.

m. Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.

n. Services provided by an acupuncturist practicing outside the states of Oregon and Washington (state of residency), except for urgent services.

o. Hospitalization, anesthesia, manipulation under anesthesia and other related services.

p. Auxiliary aids and services, including, but not limited to, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

q. Adjunctive therapy not associated with acupuncture.

r. Vitamins, minerals or other similar products.

s. Nutrition supplements which are Native American, South American, European or of any other origin.

t. Nutrition supplements obtained by Member through an acupuncturist, health food store, grocery store or by any other means.

u. Clinical laboratory services or any other type of diagnostic test or service.

Article 5 – Massage Therapy Services

5.1 Massage therapy services are covered as follows:

a. Patients have direct access to ASH Networks contracted massage therapists for up to four visits. All visits beyond the first four visits annually must be Prior Authorized by ASH Networks as medically/clinically necessary for myofascial, neuromusculoskeletal or pain syndromes. A Copayment is required for each massage therapy session/office visit.

b. After the first four visits, the ASH Networks contracted massage therapist will provide therapeutic massage in support of a covered medical condition. The ASH Networks contracted massage therapist develops an applicable treatment plan and submits it to ASH Networks for approval. A Copayment is required for each massage therapy session/office visit.

c. Subsequent sessions include therapeutic massage and possibly a brief reassessment of patient status and progress toward therapy goals. A Copayment is required for each massage therapy session/office visit with the ASH Networks contracted massage therapist. The subsequent session includes all services related to the massage therapy, a brief reassessment if necessary and any consultative support services.

d. Any treatment for a minor under the age of 18 requires parental participation.

5.2 Massage therapy exclusions and limitations:

a. Services or treatments not delivered by ASH Networks contracted Providers for the delivery of massage therapy care to Members.

b. Services beyond the fourth annual visit for treatments of conditions other than those related to myofascial, neuromusculoskeletal or pain syndromes.

c. Massage therapy services beyond the fourth annual visit that are not Prior Authorized by ASH Networks as medically/clinically necessary.

d. Massage services rendered by a Provider of massage therapy services that are not delivered in accordance with the massage benefit plan, including but not limited to limited massage services rendered directly in conjunction with chiropractic, acupuncture or naturopathic services.

e. Hypnotherapy, behavior training, sleep therapy and weight programs.

f. Services and/or treatments not documented as medically/clinically necessary and appropriate or classified as Experimental or Investigational and/or as being in the research stage.

g. Transportation costs including local ambulance charges.

h. Education programs, non-medical lifestyle or self-help or any self-help physical exercise training or any related diagnostic testing.

i. Services or treatments for pre-employment physicals or vocational rehabilitation.

j. Services or treatments caused by or arising out of the course of employment or covered under public liability insurance.

k. Air conditioners/purifiers, therapeutic mattresses, supplies, Durable Medical Equipment or appliances.

l. Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.

m. Services provided outside the scope of a massage therapist's license.

n. Hospitalization.

q. Auxiliary aids and services, including, but not limited to, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

o. Adjunctive therapy whether or not associated with massage therapy.

p. Vitamins, minerals, nutrition supplements or other similar products.

Article 6 – Naturopathic Medicine Services

6.1 Naturopathic medicine services are covered as follows:

a. Patients have direct access to ASH Networks contracted naturopaths for their initial visit. A new patient examination or consultation, including the history and physical examination, is performed by the ASH Networks contracted Provider to determine the nature of the Member's problem and, if covered services appear warranted, a treatment plan of services is prepared and furnished to ASH Networks. One new patient examination is provided for each new patient. A Copayment is required.

b. Subsequent office visits or consultations (including physical examination) are reimbursed as medically/clinically necessary and according to the Member's benefit plan. A Copayment is required.

c. An office visit represents an all-inclusive per diem rate for all services associated with the office visit, including evaluation or reevaluation, any consultative services and any adjunctive services.

d. Adjunctive therapy is limited to that which is allowed by the Provider's state scope of practice and, is also limited to non-invasive modalities such as diathermy, electrical stimulation, hot and cold packs, hydrotherapy, manipulation, massage, range of motion exercises and therapeutic ultrasound. Acupuncture is also covered as allowed by the Provider's state scope of practice. If provided independent of an examination, a Copayment is required.

e. Diagnostic tests are limited to those required for further evaluation of the Member's condition. Medically/clinically necessary x-rays and laboratory studies must be performed either by an appropriately certified naturopathic doctor or staff Member or referred to a facility that has been credentialed to meet ASH

Networks criteria.

f. Covered conditions and services are limited to those the Provider is qualified to treat or perform pursuant to state licensure and scope of practice, excluding obstetrics, surgery, invasive procedures, psychological services and services listed as Limitations and Exclusions.

g. All naturopathy services, except for the initial visit, must be Prior Authorized by ASH Networks as medically/clinically necessary for treatment of a covered condition.

6.2 Naturopathic medicine exclusions and limitations:

a. Services or treatments not approved by ASH Networks as medically/clinically necessary, except for a new patient examination, services allowed under an applicable treatment plan threshold and urgent services.

b. Services or treatments not delivered by ASH Networks contracted Providers for the delivery of naturopathic care to Members, except for urgent services.

c. Services for examinations and/or treatments for conditions that are not listed as a covered condition or listed as an exclusion.

d. Immunizations, vaccinations, injectables and intravenous infusions (does not include venipuncture for the purpose of obtaining blood samples for laboratory studies).

e. Preventive health studies such as PAP smears, PSA studies, mammograms, etc. Are not available under the Naturopathy Benefit. Members seeking such services should consult their primary Physician.

f. Hypnotherapy, behavior training, sleep therapy and weight programs.

g. Thermography

h. Services, lab tests, x-rays and other treatments not documented as clinically/Medically Necessary and appropriate; those classified as Experimental or Investigational; those that are in the research stage; and/or those not specifically referenced as covered diagnostic tests in the naturopathy covered services section above.

i. Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology and diagnostic radiology other than covered plain film studies.

j. Transportation costs including local ambulance charges.

k. Education programs, lifestyle or self-help programs or any self-help physical exercise training or related diagnostic testing.

l. Services or treatments for pre-employment physicals or vocational rehabilitation.

m. Services or treatments caused by or arising out of the course of employment or covered under public liability insurance.

n. Air conditioners/purifiers, therapeutic mattresses, supplies, Durable Medical Equipment or appliances.

o. Prescription drugs or medicines.

p. Hospitalization, anesthesia, manipulation under anesthesia and other related services.

q. Auxiliary aids and services, including, but not limited to, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

r. Adjunctive therapy that is considered by ASH Networks to be invasive or not listed on the payor summaries.

Health Net

Health Net Health Plan of Oregon, Inc.
Preventive Care Benefits
Supplemental Benefit Schedule AY-CP/09

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 Group 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. If your responsibility for services is an office call Copayment rather than a percentage of allowable charges, one immunization/inoculation Copayment equal to the office call Copayment is charged per immunization/inoculation visit. This Copayment is waived if an office call is billed along with the immunization/inoculation charge.

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.