



# Health Net Health Plan of Oregon, Inc.

## BeneFacts: PPO Single High Deductible Health Plan Copayment and Coinsurance Schedule HD15008060/09

**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, 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: Single coverage	\$1,500 <sup>1</sup>	\$3,000 <sup>1</sup>

NOTE: The deductible carryover provision in Article 19.27 of the Group Medical and Hospital Service Agreement does not apply.

### Physician/Professional/Outpatient Care

Women's and men's health care - Pap test, breast exam, pelvic exam, PSA test and digital rectal exam	20% contract rate <sup>2</sup>	40% MAA <sup>2</sup>
Routine mammography	20% contract rate <sup>2</sup>	40% MAA <sup>2</sup>
Physician services, office call	20% contract rate	40% MAA
Physician services, urgent care center	20% contract rate	20% MAA
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/EKG/Ultrasound	20% contract rate	40% MAA
Diagnostic laboratory tests	20% contract rate	40% MAA
CT/MRI/PET/SPECT/EEG/Holter monitor/Stress test	20% contract rate	40% MAA
Allergy and therapeutic injections	20% contract rate	40% MAA
Maternity delivery care (professional services only)	20% contract rate	40% MAA
Outpatient rehabilitation therapy - \$2,500/year max	20% contract rate	40% MAA
Outpatient at Ambulatory Surger Center	15% contract rate	40% MAA
Outpatient at Hospital based facility	20% contract rate	40% MAA

### Hospital Care

Inpatient services	20% contract rate	40% MAA
Inpatient rehabilitation therapy - 30 days/year max	20% contract rate	40% MAA

### Emergency Services

Outpatient emergency room services	20% contract rate	20% MAA
Inpatient admission from emergency room	20% contract rate	20% MAA
Emergency ambulance transport - \$3,000/year max	20% (MAA applies to Out-of-Network Providers)	



# BeneFacts: PPO Single High Deductible Health Plan HD15008060/09

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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 <sup>3</sup>	20% contract rate	40% MAA
Outpatient center <sup>3</sup>	20% contract rate	40% MAA
Inpatient services <sup>3</sup>	20% contract rate	40% MAA

### Other Services

Durable Medical Equipment - \$5,000/year max	20% contract rate	40% MAA
External Prosthetic Devices/Orthotic Devices	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% MAA
Diabetes management - one initial program per lifetime	20% contract rate	40% MAA
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
TMJ services - \$500/lifetime max	50% contract rate	50% MAA
Home infusion therapy	20% contract rate	40% MAA
Injectable chemotherapy (anticancer medications and administration)	20% contract rate	40% MAA
Skilled Nursing Facility care - 60 days/year max	20% contract rate	40% MAA
Hospice services	20% contract rate	40% MAA
Home health visits - \$1,000/year max	20% contract rate	40% MAA
Health education	Not covered	Not covered

### Benefit Maximums

Annual out-of-pocket maximum: Single coverage <sup>4</sup>	\$3,000	\$9,000
Lifetime maximum for authorized organ transplant services	\$250,000	Not covered Out-of-Network
Lifetime maximum	Unlimited	\$1,000,000

### Notes

- <sup>1</sup> You must meet the specified deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.
- <sup>2</sup> Deductible is waived.
- <sup>3</sup> For mental health or Chemical Dependency services, call 800-977-8216.
- <sup>4</sup> The annual out-of-pocket maximum includes 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.***

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# Health Net Health Plan of Oregon, Inc. Prescription Benefits

## Supplemental Benefit Schedule NMSAHD80/09 (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, 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. 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 Coinsurance shall be as follows for each prescription or refill. Deductible and coinsurance amounts you pay for prescription drugs apply toward your medical plan deductible and out-of-pocket maximum.
- 2.4 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. Specialty Pharmacy services and orally administered anticancer medications apply toward your medical plan deductible and Out-of-Pocket maximum.

	In Pharmacy (Per Fill Up to a 30-day Supply)	Mail Order (Per Fill Up to a 90-day Supply)
<b>Tier 1</b>	20%	20%
<b>Tier 2</b>	20%	20%
<b>Tier 3</b>	20%	20%
<b>Specialty Pharmacy</b>	20%	Mail order not available
<b>Orally administered anticancer medications</b>	20%	Mail order not available

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.

- 2.5 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.
- 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. Brand name drugs with generic equivalents are subject to the Tier 3 coinsurance as soon as a generic becomes available.
- 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 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.

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. BeneFacts: PPO Family High Deductible Health Plan Copayment and Coinsurance Schedule HD30008060/09

**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, 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: Family coverage	\$3,000 <sup>1</sup>	\$6,000 <sup>1</sup>

NOTE: The deductible carryover provision in Article 19.27 of the Group Medical and Hospital Service Agreement does not apply.

### Physician/Professional/Outpatient Care

Women's and men's health care - Pap test, breast exam, pelvic exam, PSA test and digital rectal exam	20% contract rate <sup>2</sup>	40% MAA <sup>2</sup>
Routine mammography	20% contract rate <sup>2</sup>	40% MAA <sup>2</sup>
Physician services, office call	20% contract rate	40% MAA
Physician services, urgent care center	20% contract rate	20% MAA
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/EKG/Ultrasound	20% contract rate	40% MAA
Diagnostic laboratory tests	20% contract rate	40% MAA
CT/MRI/PET/SPECT/EEG/Holter monitor/Stress test	20% contract rate	40% MAA
Allergy and therapeutic injections	20% contract rate	40% MAA
Maternity delivery care (professional services only)	20% contract rate	40% MAA
Outpatient rehabilitation therapy - \$2,500/year max	20% contract rate	40% MAA
Outpatient at Ambulatory Surgery Center	15% contract rate	40% MAA
Outpatient at Hospital based facility	20% contract rate	40% MAA

### Hospital Care

Inpatient services	20% contract rate	40% MAA
Inpatient rehabilitation therapy - 30 days/year max	20% contract rate	40% MAA

### Emergency Services

Outpatient emergency room services	20% contract rate	20% MAA
Inpatient admission from emergency room	20% contract rate	20% MAA
Emergency ambulance transport - \$3,000/year max	20% (MAA applies to Out-of-Network Providers)	



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**BeneFacts: PPO Family High Deductible Health Plan HD30008060/09**

**For covered services, you are responsible for:**

<b>Behavioral Health Services – Chemical Dependency and Mental or Nervous Conditions</b>	<b>PPO Network</b>	<b>Out-of-Network</b>
Physician services, office call <sup>3</sup>	20% contract rate	40% MAA
Outpatient or ambulatory care center <sup>3</sup>	20% contract rate	40% MAA
Inpatient services <sup>3</sup>	20% contract rate	40% MAA
<b>Other Services</b>		
Durable Medical Equipment - \$5,000/year max	20% contract rate	40% MAA
External Prosthetic Devices/Orthotic Devices	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% MAA
Diabetes management - one initial program per lifetime	20% contract rate	40% MAA
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
TMJ services - \$500/lifetime max	50% contract rate	50% MAA
Home infusion therapy	20% contract rate	40% MAA
Injectable chemotherapy (anticancer medications and administration)	20% contract rate	40% MAA
Skilled Nursing Facility care - 60 days/year max	20% contract rate	40% MAA
Hospice services	20% contract rate	40% MAA
Home health visits - \$1,000/year max	20% contract rate	40% MAA
Health education	Not covered	Not covered
<b>Benefit Maximums</b>		
Annual out-of-pocket maximum: Family coverage <sup>4</sup>	\$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**

- <sup>1</sup> You must meet the specified deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims. Family coverage means the Subscriber and spouse; the Subscriber and child(ren); or the Subscriber, spouse and child(ren). Under family coverage, each Member’s covered expenses count toward the deductible, but the specified family coverage deductible must be met before Health Net pays any claims.
- <sup>2</sup> Deductible is waived.
- <sup>3</sup> For mental health or Chemical Dependency services call 800-977-8216.
- <sup>4</sup> The annual out-of-pocket maximum includes 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.***

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# Health Net Health Plan of Oregon, Inc. Prescription Benefits

## Supplemental Benefit Schedule NMSAHD80/09 (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, 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. 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 Coinsurance shall be as follows for each prescription or refill. Deductible and coinsurance amounts you pay for prescription drugs apply toward your medical plan deductible and out-of-pocket maximum.
- 2.4 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. Specialty Pharmacy services and orally administered anticancer medications apply toward your medical plan deductible and Out-of-Pocket maximum.

	In Pharmacy (Per Fill Up to a 30-day Supply)	Mail Order (Per Fill Up to a 90-day Supply)
<b>Tier 1</b>	20%	20%
<b>Tier 2</b>	20%	20%
<b>Tier 3</b>	20%	20%
<b>Specialty Pharmacy</b>	20%	Mail order not available
<b>Orally administered anticancer medications</b>	20%	Mail order not available

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.

- 2.5 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.
- 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. Brand name drugs with generic equivalents are subject to the Tier 3 coinsurance as soon as a generic becomes available.
- 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 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.

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 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.