



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.