



Health Net Health Plan of Oregon, Inc.

Benefacts: PPO Value Plan

Copayment and Coinsurance Schedule NXP201V3/09

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 | \$1,000 PPO Network and Out-of-Network combined ^{1, 2} | |
| Annual deductible per family | \$3,000 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 | \$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 | \$50 per visit ³ | \$50 per visit ³ |
| 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) | |



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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 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 | \$3,000 | \$9,000 |
| Annual out-of-pocket maximum per family ⁵ | \$9,000 | \$27,000 |
| 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.

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Health Net Health Plan of Oregon, Inc.

Prescription Benefits

Supplemental Benefit Schedule NMSS10-50-75/09 (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.

| | In Pharmacy (Per Fill Up to a 30-day Supply) | Mail Order (Per Fill Up to a 90-day Supply) |
|---|---|--|
| Tier 1 | \$10 | \$20 |
| Tier 2 | \$50 | \$100 |
| Tier 3 | \$75 | \$150 |
| Specialty Pharmacy | 20% to a maximum of \$200 | 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.
- 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

This pharmacy plan provides creditable coverage for Medicare Part D.

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 2.6, "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.