



Health Net Health Plan of Oregon, Inc.

BeneFacts: PPO Single High Deductible Health Plan

Copayment and Coinsurance Schedule WT1HD25008060/07 AGC

PPO: Two plans, many choices. In health coverage, 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 choose Providers in our PPO network or Providers out of our network. Your choice of Provider 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 in our PPO network, you are not responsible for charges that are above our contracted rates. **Certain services 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 you see 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 Usual, Customary and Reasonable (UCR) rates for other services. We pay Out-of-Network Providers based on UCR rates, not on billed amounts. UCR 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 UCR rates we pay. Amounts that exceed our UCR rates are not covered and do not apply to your annual out-of-pocket maximum. *Your responsibility for any amounts that exceed our UCR payment is shown on this schedule as UCR plus.*

Your benefits are subject to deductibles, Copayments and Coinsurance amounts listed in this schedule.

The deductible is waived for preventive care services covered under Article 7.24.

Calendar Year Deductible	For covered services, you are responsible for:	
	PPO Network	Out-of-Network
Annual deductible: Single coverage	\$2,500 ¹	\$5,000 ¹
NOTE: The deductible carryover provision in Article 17.27 of the Group Medical and Hospital Service Agreement does not apply.		
Physician/Professional/Outpatient Care		
Physician services, office visit, including preventive care ²	20% contract rate	40% UCR <i>plus</i>
Physician services, urgent care center ²	20% contract rate	40% UCR <i>plus</i>
Physician Hospital visits	20% contract rate	40% UCR <i>plus</i>
Diagnostic X-ray/mammography/EKG/Ultrasound	20% contract rate	40% UCR <i>plus</i>
Diagnostic laboratory tests, including PAP test	20% contract rate	40% UCR <i>plus</i>
CT/MRI/EEG/Holter monitor/Stress test	20% contract rate	40% UCR <i>plus</i>
Allergy and therapeutic injections	20% contract rate	40% UCR <i>plus</i>
Maternity delivery care (professional services only)	20% contract rate	40% UCR <i>plus</i>
Outpatient rehabilitation therapy - \$2,500/year max ³	20% contract rate	40% UCR <i>plus</i>
Outpatient or ambulatory care center	20% contract rate	40% UCR <i>plus</i>
Hospital Care		
Inpatient services	20% contract rate	40% UCR <i>plus</i>
Inpatient rehabilitation therapy - 30 days/year max	20% contract rate	40% UCR <i>plus</i>
Emergency Services		
Outpatient emergency room services	20% contract rate	20%
Inpatient admission from emergency room	20% contract rate	40% UCR <i>plus</i>
Emergency ambulance transport - \$3,000/year max	20% (UCR <i>plus</i> applies to Out-of-Network Providers)	

This schedule presents general information only. Refer to your certificate for details, limitations and exclusions.

**BeneFacts: PPO Single High Deductible Health Plan WT1HD25008060/07 AGC****Health Net****For covered services, you are responsible for:**

Behavioral Health Services	PPO Network	Out-of-Network
Inpatient mental health – 8 days/year max	20% contract rate	40% UCR <i>plus</i>
Outpatient mental health – 12 visits/year max	20% contract rate	40% UCR <i>plus</i>
Inpatient Chemical Dependency	\$13,000 combined maximum in a 24-month period	20% contract rate
Outpatient Chemical Dependency		40% UCR <i>plus</i>
Other Services		
Durable Medical Equipment and external Prosthetic Devices - \$5,000/year max ⁴	20% contract rate	40% UCR <i>plus</i>
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% UCR <i>plus</i>
Diabetes management	20% contract rate	40% UCR <i>plus</i>
Blood, blood plasma, blood derivatives	20% contract rate	40% UCR <i>plus</i>
TMJ services - \$500/lifetime max	50% contract rate	50% UCR <i>plus</i>
Home infusion therapy	20% contract rate	40% UCR <i>plus</i>
Skilled Nursing Facility care - 60 days/year max	20% contract rate	40% UCR <i>plus</i>
Hospice services	20% contract rate	40% UCR <i>plus</i>
Home health visits – 130 visits/year max	20% contract rate	40% UCR <i>plus</i>
Outpatient neurodevelopmental therapy, under age 7, inpatient and outpatient combined - \$1,000/year max	20% contract rate	40% UCR <i>plus</i>
Spinal and other manipulations (any provider: MD, DO, chiropractor) - 15 manipulations/year max	20% contract rate	40% UCR <i>plus</i>
Acupuncture Care - 15 visits/year max	20% contract rate	40% UCR <i>plus</i>
Naturopathic Care	20% contract rate	40% UCR <i>plus</i>
Massage Therapy - 15 visits/year max	20% contract rate	40% UCR <i>plus</i>
Benefit Maximums		
Annual out-of-pocket maximum: Single coverage ⁵	\$5,000	\$10,000
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 Office visit includes physician services only. Other services are subject to Copayments and Coinsurance as listed.
- ³ The Calendar Year maximum for Outpatient rehabilitation therapy does not apply to services which are billed as Home Health visits.
- ⁴ The Calendar Year maximum for Durable Medical Equipment does not apply to rental charges for Durable Medical Equipment for Home Health Care or Hospice care, or when Home Health Care or Hospice care are being provided under case management in lieu of Hospitalization.
- ⁵ 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 UCR for Out-of-Network (OON) services. You are still responsible for OON billed charges that exceed UCR.

This schedule presents general information only. Refer to your certificate 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

WA Supplemental Benefit Schedule WHD80/07 (No MAC) AGC

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, 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.
- 2.3 Coinsurance shall be as follows for each prescription or refill. Deductible and Coinsurance amounts you pay for prescription drugs do 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.

	In Pharmacy (Per Fill Up to a 30-day Supply)	Mail Order (Per Fill Up to a 90-day Supply)
Tier 1	20%	20%
Tier 2	20%	20%
Tier 3	20%	20%

- 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 Coinsurance. Brand name drugs with generic equivalents are subject to the Tier 3 Coinsurance as soon as a generic becomes available.
- 2.6 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.

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 as injections 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, smoking cessation, 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 Non-hormonal contraceptive devices, IUDs, contraceptive implants, and contraceptive injectables other than Depo Provera 150mg injection are excluded under this Supplemental Prescription Benefits Schedule. Diaphragms and non-hormonal contraceptive devices, IUDs, contraceptive implants, contraceptive injectables, and Norplant are covered under the Basic Benefit Schedule when provided in the doctor's office.
- 3.12 Diabetic supplies other than blood glucose test strips, lancets, insulin syringes and needles.



Health Net Health Plan of Oregon, Inc.

Prescription Benefits

YOUR RIGHT TO SAFE AND EFFECTIVE PHARMACY SERVICES

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you would like more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please contact Health Net at 1-888-802-7001.

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health Washington State Board of Pharmacy at 360-236-4825.

"Does this plan limit or exclude certain drugs my health care provider may prescribe, or encourage substitutions for some drugs?"

The Plan formulary is called the Preferred Drug List (PDL) and is maintained by the Health Net Pharmacy and Therapeutics Committee. The Pharmacy and Therapeutics Committee includes local and national practicing physicians and pharmacists who review FDA approval information and clinical research studies to make formulary recommendations and decisions. A copy of the current PDL is available through the Customer Contact Center at (888) 802-7001 or visit our website at www.healthnet.com.

Formulary and drug product decisions are based on the following:

- Proven safety and effectiveness
- Accepted for use by the medical community
- Economical efficiency

The term "Medically Necessary" as used in the Prescription Benefits Supplemental Benefit Schedule follows the same definition as indicated in your plan contract.

An approved generic equivalent shall mean a generic drug has been given an "A" therapeutic equivalent code by the Department of Health and Human Services.

If a generic equivalent exists, but a brand name drug is requested you may pay either:

The difference in price between the brand-name drug and the generic, plus the Tier 2 copayment.

OR

The applicable Tier 3 copayment.

Your out-of-pocket expense will not exceed the pharmacy's retail price for the drug.

Please refer to your Prescription Benefits Supplemental Benefit Schedule for specific information regarding limitations, exclusions, and substitutions for drugs.

When can my plan change the approved drug list (formulary)? If a change occurs, will I have to pay more to use a drug I had been using?"

The PDL (formulary) is reviewed and updated on an ongoing basis, and it may be revised up to four times per year based on the recommendations of the Pharmacy and Therapeutics Committee. Most changes involve the addition of new drugs to the formulary. Changes to existing formulary drugs may impact a drug you are using and may require a higher copayment.

"What should I do if I want a change from limitations, exclusions, substitutions or cost increases for drugs specified in this plan?"

If you receive a denial or partial denial of an authorization request you may contact a Pharmacy Services representative to discuss the determination. If additional information is presented or may be obtained from your physician for consideration against the prior authorization criteria, a second review may be requested. You may contact a Pharmacy Services representative at (888) 802-7001 between the hours of 9:00-12:00 and 1:00-5:00 Monday through Friday, excluding holidays. You have the right to appeal the denial or partial denial of an authorization request. The appeal must be submitted either orally or in writing within 180 days of the date of the denial notice. We will resolve and respond in writing to appeals within 30 days (14 days for Washington plan members). If a delay could seriously jeopardize your life or health you may request an expedited review in writing or over the phone by contacting a Pharmacy Service representative. Expedited reviews are completed not later than 72 hours following receipt. Send written appeals to:

Health Net Health Plan of Oregon

Attention: Grievances and Appeals

13221 SW 68th Parkway

Tigard, OR 97223-8328

"How much do I have to pay to get a prescription filled?"

- Tier 1 is the lowest Copayment/Coinsurance level. This level includes but is not limited to most generic drugs.
- Tier 2 is the intermediate Copayment/Coinsurance level. This level includes but is not limited to preferred brand name drugs that have no generic equivalent.
- Tier 3 is the highest Copayment/Coinsurance level. This level includes but is not limited to generic and brand name drugs that are not listed in Tier 1 or Tier 2. In most cases there are alternatives in Tier 1 or 2 for drugs found in this highest tier.

Please refer to your Prescription Benefits Supplemental Benefit Schedule for specific information on your prescription drug costs.

"Do I have to use certain pharmacies to pay the least out of my own pocket under this health plan?"

Prescriptions must be purchased at a Participating Pharmacy in order to be covered under the prescription benefit. Most major pharmacy chains are part of the Health Net Network. There are approximately 1,200 independent and chain pharmacies in the state of Washington that are participating with Health Net. If you need to verify that a specific pharmacy is participating with Health Net, please call the Customer Contact Center at (888) 802-7001 or visit our website at www.healthnet.com.

"How many days' supply of most medications can I get without paying another co-pay or other repeating charge?"

You may receive up to a 30-day supply when ordered in a participating retail pharmacy.

You may receive up to a 90-day supply when ordered through our contracted mail order pharmacy.

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.

If your physician has increased your dose, he needs to notify your pharmacy of the change in directions. Your pharmacy may contact us for an override if this change will result in an early refill request.

Please refer to your Prescription Benefits Supplemental Benefit Schedule for information on the days' supply available under your benefit.

"What other pharmacy services does my health plan cover?"

There are no additional pharmacy services covered under the Policy.