

**Health Net Large Group PPO
Plan 89H - Effective 7/1/2007**

PPO

OON

Member pays coinsurance and any charges exceeding RBRVS.

PROFESSIONAL SERVICES

Visit to a physician, physician assistant or nurse practitioner.	\$30	40%
Preventive care		
Child (through age 16). Includes newborn/well-baby care and immunizations .	\$30	No
Adult (age 17 and older). Refer to Introduction pages for list of covered services.	20%	No
Annual routine physical examinations.	No	No
Vision and hearing examinations. Routine preventive exams only for children through age 16.	\$30	No
Adult (age 17 and older).	No	No
Specialist consultations.	\$30	40%
Physician visit to member's home (at discretion of physician).	20%	40%
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).	20%	40%
Immunizations (including foreign travel/occupational). See child preventive care above.	No	No
Allergy testing.	\$30	40%
Allergy serum.	20%	40%
Allergy injection services (serum not included).	\$30	40%
Injections for treatment of infertility.	No	No
All other injections. Only self-injectables require certification by Health Net Pharmacy. Refer to the Introduction pages and the ▲ for additional information.	\$30	40%
Surgeon/ assistant surgeon. Only specified procedures require certification. Refer to the Introduction pages and the ▲ for additional information.	20%	40%
Administration of anesthetics.	20%	40%
X-ray and laboratory procedures. Only specified procedures require certification. Refer to the Introduction pages and the ▲ for additional information.	20%	40%
Physical, speech, occupational, and respiratory therapy. Visit maximum combined for all therapies. Through OON the maximum amount payable for each visit is \$25.	20%	40%
	Combined limit of 12 visits (PPO/OON) ◆	
Dental services (when medically necessary to properly monitor, control or treat a severe medical condition when excluded dental services are being performed).	20%	40%

CARE FOR CONDITIONS OF PREGNANCY

Prenatal and postnatal office visit.	GLOBAL FEES REQUIRED	
Normal delivery, Cesarean section. Includes newborn inpatient professional care. ▲	20%	40%
Complications of pregnancy including medically necessary abortions. ▲	20%	40%
Elective abortions.	20%	40%
Genetic testing of fetus.	20%	40%
Circumcision of newborn.	20%	40%

FAMILY PLANNING (professional services only)

Contraceptive devices - intrauterine device (IUD).	20%	40%
Infertility services (including professional services, inpatient and outpatient care, and treatment by injection).	No	No
Sterilization of females.	20%	40%
Sterilization of males.	20%	40%
Reversal of sterilization.	No	No

CARE FOR MENTAL DISORDERS

Severe Mental Illnesses

Severe mental illnesses include the following conditions: Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder (autism), anorexia nervosa, bulimia nervosa, and serious emotional disturbances in children (under age 18).

Outpatient mental visit for severe mental illness.	\$30	40%
Inpatient care in a hospital or residential treatment facility for severe mental illness. Limited to a maximum allowable amount of \$600 each day through OON. ▲	\$250 + 20%	\$250 + 40%
Physician visit to hospital or residential treatment facility for severe mental illness.	20%	40%

PPO services to which a copayment applies are not subject to the calendar-year deductible. For these services, Health Net will pay 100% of covered expenses (excluding the copayment), whether or not the calendar-year deductible has been satisfied. Services to which a coinsurance applies are subject to the calendar-year deductible.

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Other Mental Illnesses (Non-severe mental illnesses)		
Outpatient mental visit for non-severe mental illness.	20% ☐	40% ☐
Inpatient care in a hospital or residential treatment facility for non-severe mental illness. ▲	20% ☐	40% ☐
Physician visit to hospital or residential treatment facility for non-severe mental illness.	20%	40%
CHEMICAL DEPENDENCY REHABILITATION		
Outpatient consultation (therapy, counseling and/or psychological testing) in an outpatient chemical dependency rehabilitation facility.	No	No
Detoxification (acute care for substance abuse). 3 day maximum for each member each calendar year. Limited to a maximum allowable amount of \$600 each day through OON. ▲	\$250 + 20%	\$250 + 40%
Inpatient rehabilitation for chemical dependency in a hospital or residential chemical dependency facility.	No	No
OTHER SERVICES		
Medical social services.	20%	40%
Patient education for diabetics only.	20%	40%
Air ambulance. A \$50 copayment is required for each incident in addition to the specified coinsurance. ▲	\$50 + 20%	\$50 + 40%
Ground ambulance. A \$50 copayment is required for each incident in addition to the specified coinsurance.	\$50 + 20%	\$50 + 40%
Durable medical equipment. ▲	20%	40%
	Combined limit of \$1,000 (PPO/OON)	
Orthotics (braces and supports).	20%	40%
Corrective footwear. Custom made shoes and shoe inserts (custom foot orthotics).	20%	40%
Diabetic supplies (refer to the Introduction section for additional information).	20%	40%
Hearing aids.	No	No
Prosthesis (replacing body parts). ▲	20%	40%
Acupuncture.	No	No
Chiropractic care.	No	No
Blood, blood plasma, blood factors and blood derivatives.	20%	20%
Nuclear medicine (professional services only).	20%	40%
Organ and bone marrow transplants (non-experimental and noninvestigative. Professional services only.) ▲	20%	No
Chemotherapy (professional services only).	20%	40%
Renal dialysis (professional services only). ▲	20%	40%
Home health visit. Each day of care is limited to a maximum payment of \$110 (PPO & OON). ▲ ❖	20%	40%
	Combined limit of 60 visits (PPO/OON)	
Infusion therapy (home or physician's office). Limited to a maximum allowable amount of \$500 each day through OON. ▲	20%	40%
Hospice care (elected by member). Limited to a lifetime maximum benefit of \$5,000 through PPO and OON combined. ▲	20%	40%

▲ These services require prior certification before being provided or received. If prior certification is not acquired, benefits are reduced to 50%. In addition, for uncertified outpatient services , a \$50 deductible is required for each visit; for uncertified inpatient admissions , a \$250 deductible is required for each inpatient admission. Refer to the Certification lists located in the Introduction section to determine the appropriate list to utilize and for additional information. NOTE: Routine care for conditions of pregnancy and renal dialysis do not require prior certification. However, notification is requested						
❖ OON hospital services limited fee schedule: This schedule shows the maximum covered expense allowable for services provided by an OON hospital, home health agency, or a skilled nursing facility. Refer to the Introduction section for additional details: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Maximum Allowable Each Day</td> <td style="width: 50%;">Maximum Allowable Each Day</td> </tr> <tr> <td>Inpatient hospital: \$600</td> <td>Skilled nursing facility: \$250</td> </tr> <tr> <td>Outpatient hospital: 50% of billed charges</td> <td>Home health care: Customary and reasonable charge</td> </tr> </table>	Maximum Allowable Each Day	Maximum Allowable Each Day	Inpatient hospital: \$600	Skilled nursing facility: \$250	Outpatient hospital: 50% of billed charges	Home health care: Customary and reasonable charge
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Inpatient hospital: \$600	Skilled nursing facility: \$250					
Outpatient hospital: 50% of billed charges	Home health care: Customary and reasonable charge					
◆ Additional visits are payable if precertified as medically necessary following neurological and orthopedic surgery, cerebral cardiovascular accident, third degree burns, head trauma or spinal cord injuries.						
☐ Inpatient (non-severe) Services: Inpatient mental health care is limited to a maximum of 30 days for each member in a calendar year through PPO and OON combined. Through OON, the maximum amount allowable each day is \$175. Outpatient (non-severe) Services: Outpatient mental health care is limited to a maximum of 20 visits for each member in a calendar year through PPO and OON combined. Through OON, the maximum amount payable for each visit is \$25.						

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HOSPITAL AND SKILLED NURSING FACILITY		
Unlimited days of hospital care in a semi-private room or ICU with ancillary services. Excludes care for mental disorders. ▲ ❖	\$250 + 20%	\$250 + 40%
Confinement for infertility services.	No	No
Confinement in a skilled nursing facility. ▲ ❖	\$250 + 20%	\$250 + 40%
	Combined limit of 60 days (PPO/OON)	
Maternity care. Includes routine nursery charges. ▲ ❖	\$250 + 20%	\$250 + 40%
Outpatient services. Only specified procedures require certification. Refer to the Introduction pages and the ▲ for additional information. ❖		
Outpatient services other than surgery.	20%	40%
Outpatient surgery at hospital or ambulatory surgical center.	\$250 + 20%	\$250 + 40%
EMERGENCY ROOM / URGENT CARE CENTER		
Note: The member must request certification for inpatient hospital or outpatient emergency room or urgent care center services within 48 hours, or as soon as reasonably possible. Health Net Life will determine whether services meet the criteria for emergency care.		
Use of emergency room (facility and professional services).	20% *	20% *
Use of urgent care center (facility and professional services).	20% *	20% *

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* An additional \$100 emergency room or urgent care deductible is required if the member is not admitted as an inpatient. The deductible is waived if admitted.						

CALENDAR YEAR DEDUCTIBLES	CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOPM)	LIFETIME BENEFIT MAXIMUM
\$500 for each member (PPO/OON combined)	\$4,000 for each member (PPO)	\$5,000,000 for each member (PPO/OON combined)
Three family members must satisfy their individual deductibles to satisfy the family deductible.	\$6,000 for each member (OON)	Maximum medical and detoxification payments.
NOTE: Eligible copayments or coinsurance amounts paid by the member for services provided through PPO will apply towards the OOPM for OON. In addition, the coinsurance paid for services provided through OON will apply towards the OOPM for PPO.		

HEALTH NET PPO PHARMACY BENEFITS

Plan code 209

The following is a brief description of your Health Net PPO Pharmacy benefits.

RETAIL COPAYMENTS

DRUG TYPE	DESCRIPTION	PARTICIPATING PHARMACY COPAYMENT	NON-PARTICIPATING PHARMACY COPAYMENT
Level I – Generic drugs	Drugs listed on the Health Net Recommended Drug List (primarily generic)	\$10	\$10 + 50% AWP ¹
Level II – Brand, preferred	Drugs and diabetic supplies (including insulin) listed on the Health Net Recommended Drug List (primarily brand name)	\$35	\$35 + 50% AWP ¹
Level III	Drugs not on the Health Net Recommended Drug List	\$50	\$50 + 50% AWP ¹

PRESCRIPTIONS BY MAIL

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period of time), you have the option of filling it through our convenient and cost-saving Prescriptions By Mail Drug Program. Under this program, your copayments for up to a 90-day supply are: **\$20 level I / \$70 level II / \$100 level III**. For complete information, log on as a Health Net member at www.healthnet.com > *View prescription coverage* > *Get prescriptions by mail* or call Member Services at **1-800-676-6976**.

GENERIC SUBSTITUTIONS

Generic drugs will be dispensed when a generic drug equivalent is commercially available. If you request a brand name drug when a generic equivalent is commercially available, you must pay the difference between the generic equivalent and the brand name drug in addition to the listed copayments or coinsurance. However, if the prescription drug order states “dispense as written,” “do not substitute” or words of similar meaning in the physician’s handwriting, only the listed drug copayment will be applicable.

This is a brief description of your Health Net PPO Pharmacy benefits. Please refer to your Evidence of Coverage to determine the specific benefits, limitations, exclusions and all other terms and conditions of coverage.

¹When filling prescriptions at non-participating pharmacies, you are required to pay the listed dollar copayment (if applicable), plus 50% of the prescription drug’s Average Wholesale Price (AWP). You are also obligated to pay any amounts the pharmacy charges in excess of the AWP.