



Health Net Health Plan of Oregon, Inc.

BeneFacts: Washington PPO Advantage Plan

Copayment and Coinsurance Schedule WA30-3000-2-9000D/09 PacTr

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 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 Providers 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 Home Health Care, home infusion services, organ and tissue transplant services, and Durable Medical Equipment 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 Usual, Customary and Reasonable (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.

The deductible is waived for preventive care services covered under Article 2.1 and 7.24.

Calendar Year Deductible	For covered services, you are responsible for:	
	PPO Network	Out-of-Network
Annual deductible per person	\$3,000 PPO Network and Out-of-Network combined ^{1,2}	
Annual deductible per family	\$9,000 PPO Network and Out-of-Network combined ^{1,2}	
Physician/Professional/Outpatient Care		
Physician services, office visit ⁴	\$30 per visit ³	40% MAA
Physician services, preventive care ⁴	\$30 per visit ³	40% MAA ³
Physician services, urgent care center ⁴	\$75 per visit ³	\$75 per visit MAA ³
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/mammography/EKG/Ultrasound	20% contract rate ³	40% MAA
Diagnostic laboratory tests, including PAP/PSA test	20% contract rate ³	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 ⁵	20% contract rate	40% MAA
Outpatient or ambulatory care center	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	\$250 per visit ³	\$250 per visit ³
Inpatient admission from emergency room	20% contract rate	40% 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	PPO Network	Out-of-Network
Outpatient mental health ⁶	\$30 per visit ³	40% MAA
Inpatient mental health ⁶	20% contract rate	40% MAA
Outpatient Chemical Dependency ⁶	\$30 per visit ³	40% MAA
Inpatient Chemical Dependency ⁶	20% contract rate	40% MAA
Other Services		
Durable Medical Equipment and external Prosthetic Devices - \$5,000/year max ⁷	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances)	20% contract rate	40% MAA
Diabetes management	\$30 per program ³	40% MAA
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
TMJ services - \$500/lifetime max	50% contract rate ²	50% MAA ²
Home infusion therapy	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 - 130 visit/year max	20% contract rate	40% MAA
Neurodevelopmental therapy, under age 7, inpatient and outpatient combined - \$1,000/year max	20% contract rate	40% MAA
Health education - \$150/year combined max	Any charges over maximum reimbursement of \$50/qualifying class ²	
Spinal and other manipulations (any provider: MD, DO, chiropractor) - 15 manipulations/year max	\$30 per visit ³	40% MAA
Acupuncture Care -15 visits/year max	\$30 per visit ³	40% MAA
Naturopathic Care	\$30 per visit ³	40% MAA
Massage Therapy - 15 visits/year max	\$30 per visit ³	40% MAA
Benefit Maximums		
Annual out-of-pocket maximum per person ⁸	\$9,000	\$18,000
Annual out-of-pocket maximum per family ⁸	\$27,000	\$54,000
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. Covered expenses that satisfy the deductible during the last three months of a Calendar Year may also be used to satisfy the deductible for the following Calendar Year.
- ² Your payments do not apply to the annual out-of-pocket maximum.
- ³ Deductible is waived.
- ⁴ Office visit Copayment includes physician services only. Other services are subject to Copayments and Coinsurance as listed.
- ⁵ The Calendar Year maximum for Outpatient rehabilitation therapy does not apply to services which are billed as Home Health visits.
- ⁶ To Prior Authorize mental health or Chemical Dependency services, call 800-977-8216.
- ⁷ 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.
- ⁸ 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 certificate for details, limitations and exclusions.

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