



Health Net Health Plan of Oregon, Inc.

Benefacts: Washington PPO Advantage Plan

Copayment and Coinsurance Schedule WPT155V2DX/07 Pacific Trust

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 cardiac services, 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 (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 2.1 and 7.24.

Calendar Year Deductible	For covered services, you are responsible for:	
	PPO Network	Out-of-Network
Annual deductible per person	\$500 PPO Network and Out-of-Network combined ^{1,2}	
Annual deductible per family	\$1,500 PPO Network and Out-of-Network combined ^{1,2}	
Physician/Professional/Outpatient Care		
Physician services, office visit, including preventive care ⁴	\$15 per visit ³	40% UCR <i>plus</i>
Physician services, urgent care center ⁴	\$50 per visit ³	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 ³	40% UCR <i>plus</i>
Diagnostic laboratory tests, including PAP/PSA test	20% contract rate ³	40% UCR <i>plus</i>
CT/MRI/PET/SPECT/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 ⁵	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	\$150 per visit ³	\$150 per visit ³
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)	



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For covered services, you are responsible for:

Behavioral Health Services		PPO Network	Out-of-Network
Outpatient mental health – 12 visits/year max ⁶		\$15 per visit ³	40% UCR <i>plus</i>
Inpatient mental health – 8 days/year max ⁶		20% contract rate	40% UCR <i>plus</i>
Outpatient Chemical Dependency ⁶	\$13,500 combined maximum in a 24-month period	\$15 per visit ³	40% UCR <i>plus</i>
Inpatient Chemical Dependency ⁶		20% contract rate	40% UCR <i>plus</i>
Other Services			
Durable Medical Equipment and external Prosthetic Devices - \$5,000/year max ⁷		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		\$15 per program ³	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 ²	50% UCR <i>plus</i> ²
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>
Neurodevelopmental therapy, under age 7, inpatient and outpatient combined - \$1,000/year max		20% contract rate	40% UCR <i>plus</i>
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		\$15 per visit ³	40% UCR <i>plus</i>
Acupuncture Care - 15 visits/year max		\$15 per visit ³	40% UCR <i>plus</i>
Naturopathic Care		\$15 per visit ³	40% UCR <i>plus</i>
Massage Therapy - 15 visits/year max		\$15 per visit ³	40% UCR <i>plus</i>
Benefit Maximums			
Annual out-of-pocket maximum per person ⁸		\$1,500 PPO Network and Out-of-Network combined	
Annual out-of-pocket maximum per family ⁸		\$4,500 PPO Network and Out-of-Network combined	
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 UCR for Out-of-Network (OON) services. You are still responsible for OON billed charges that exceed UCR.

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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