

<b>Health Net Large Group PPO Plan 38K - Effective 10/1/2002</b>	<b>PPO</b>	<b>OON x</b>
<b>PROFESSIONAL SERVICES</b>		
Visit to a physician, physician assistant or nurse practitioner.	\$10	30%
Preventive care		
Child (through age 16). Includes newborn/well-baby care and <b>immunizations</b> .	\$10	No
Adult (age 17 and older). Refer to introduction pages for list of covered services.	10%	No
Annual routine physical examinations (age 17 and older). Limited to one exam each calendar year and a maximum payment of \$250 for the exam and all related services.	\$10	No
Vision and hearing examinations. Routine preventive exams only for children through age 16.	\$10	No
Adult (age 17 and older).	No	No
Specialist consultations.	\$10	30%
Physician visit to member's home (at discretion of physician).	10%	30%
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).	10%	30%
Immunizations ( <b>including</b> foreign travel/occupational). See child preventive care above.	No	No
Allergy testing.	\$10	30%
Allergy serum.	10%	30%
Allergy injection services (serum not included).	\$10	30%
Injections for treatment of infertility. Deductible required.	10% ♦	30% ♦
All other injections.	\$10	30%
Surgeon/ assistant surgeon. Only specified procedures require certification. Refer to the Introduction pages and the ☞ for additional information.	10%	30%
Administration of anesthetics.	10%	30%
X-ray and laboratory procedures. Through PPO/OON, prior certification only required for MRI, MUGA, PET and SPECT. Refer to the Introduction pages and the ☞ for additional information.	10%	30%
Physical, speech, occupational and respiratory therapy. Visit maximum combined for all therapies.	10%	30%
	Combined limit of 20 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).	10%	30%
<b>CARE FOR CONDITIONS OF PREGNANCY</b>		
Prenatal and postnatal office visit.	GLOBAL FEES REQUIRED	
Normal delivery, Cesarean section. Includes newborn inpatient professional care. ☞	10%	30%
Complications of pregnancy including medically necessary abortions. ☞	10%	30%
Elective abortions.	10%	30%
Genetic testing of fetus.	10%	30%
Circumcision of newborn.	10%	30%
<b>FAMILY PLANNING (professional services only)</b>		
Contraceptive devices - intrauterine device (IUD).	10%	30%
Infertility services (including professional services, inpatient and outpatient care, and treatment by injection). <b>Excludes</b> coverage of artificial insemination. Deductible required.	10% ♦	30% ♦
Sterilization of females.	10%	30%
Sterilization of males.	10%	30%
Reversal of sterilization.	No	No
<b>CARE FOR MENTAL DISORDERS</b>		
<b>Severe Mental Illnesses</b>		
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.	\$10	30%
Inpatient care in a hospital or residential treatment facility for severe mental illness. ☞ ❖	10%	30%
Physician visit to hospital or residential treatment facility for severe mental illness.	10%	30%

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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<b>Other Mental Illnesses (Non-severe mental illnesses)</b>		
Outpatient mental visit for non-severe mental illness.	10% ☐	30% ☐
Inpatient care in a hospital or residential treatment facility for non-severe mental illness. ⌘	10% ☐	30% ☐
Physician visit to hospital or residential treatment facility for non-severe mental illness.	10% ☐	30% ☐
<b>CHEMICAL DEPENDENCY REHABILITATION</b>		
Outpatient consultation (therapy, counseling and/or psychological testing) in an outpatient chemical dependency rehabilitation facility.	10% ☐	30% ☐
Detoxification (acute care for substance abuse). Through PPO and OON combined, the benefit is limited to a maximum of 3 days per calendar year and to a maximum allowable per day of \$250. ⌘	10%	30%
Inpatient rehabilitation for chemical dependency in a hospital or residential chemical dependency facility. ⌘	10% ☐	30% ☐
<b>OTHER SERVICES</b>		
Medical social services.	10%	30%
Patient education for diabetics only.	10%	30%
Air ambulance. ⌘	10%	30%
Ground ambulance.	10%	30%
Durable medical equipment, including corrective footwear. Corrective footwear (includes corrective shoes and inserts) is covered for members who suffer from foot disfigurement, including disfigurement resulting from cerebral palsy, arthritis, polio, spina bifida, diabetes, accidental injury or developmental disability. Prior certification required only when an individual item amount is greater than \$500. ⌘	10%	30%
Diabetic supplies (refer to the Introduction section for additional information).	10%	30%
Hearing aids.	No	No
Prosthesis (replacing body parts). The benefit limit does not apply for breast prosthesis after a mastectomy or to prosthetic devices after a laryngectomy. Prior certification required only when an individual item amount is greater than \$500. ⌘	10%	30%
Acupuncture. Through PPO/OON, the maximum amount payable for each visit is \$25.	\$10	30%
Chiropractic care. Through PPO/OON, the maximum amount payable for each visit is \$25.	\$10	30%
Blood, blood plasma, blood factors and blood derivatives.	10%	10%
Nuclear medicine (professional services only).	10%	30%
Organ and bone marrow transplants (non-experimental and noninvestigative. Professional services only). ⌘	10%	No
Chemotherapy (professional services only).	10%	30%
Renal dialysis (professional services only).	10%	30%
Home health visit. Each day of care is limited to a maximum payment of \$110 (PPO & OON). ⌘	10%	30%
Infusion therapy (home or physician's office). Limited to a maximum allowable amount of \$500 each day through OON. ⌘	10%	30%
Hospice care (elected by member). Limited to a lifetime maximum benefit of \$10,000 through PPO and OON combined. ⌘	10%	30%

<b>x</b>	<b>Out-of-network (OON) services:</b> The member is responsible for the scheduled coinsurance and any charges exceeding Health Net's allowance based on RBRVS.						
⌘	These services require prior certification before being provided or received. If prior certification is not acquired, benefits are reduced to 50%. In addition, for <b>uncertified outpatient services</b> , a \$50 deductible is required for each visit; for <b>uncertified inpatient admissions</b> , a \$250 deductible is required for each inpatient admission. Refer to "Certification," located in the introduction section for additional information. <b>NOTE:</b> Routine care for conditions of pregnancy do not require prior certification. However, notification of pregnancy is requested.						
◆	Infertility services, supplies, injections and medications, are subject to a lifetime deductible of \$500 and limited to a lifetime maximum benefit of \$2000. This maximum is combined through PPO and OON. <b>Note:</b> artificial insemination is not a covered benefit.						
☐	<b>Inpatient (non-severe) Services:</b> Through PPO/OON combined, the total number of days available for inpatient chemical dependency rehabilitation and inpatient mental health care is 30 days combined. The maximum amount allowable for inpatient services is \$250 each day. <b>Outpatient (non-severe) Services:</b> Outpatient mental health care and chemical dependency are limited to a maximum of 30 visits for each member in a calendar year through PPO and OON combined. The maximum amount payable for each visit is \$50.						
⚡	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.						
❖	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%;"><b>Maximum Allowable Each Day</b></td> <td style="width: 50%;"><b>Maximum Allowable Each Day</b></td> </tr> <tr> <td>Inpatient hospital: <b>\$600</b></td> <td>Skilled nursing facility: <b>\$250</b></td> </tr> <tr> <td>Outpatient hospital: <b>50% of billed charges</b></td> <td>Home health care: <b>Customary and reasonable charge</b></td> </tr> </table>	<b>Maximum Allowable Each Day</b>	<b>Maximum Allowable Each Day</b>	Inpatient hospital: <b>\$600</b>	Skilled nursing facility: <b>\$250</b>	Outpatient hospital: <b>50% of billed charges</b>	Home health care: <b>Customary and reasonable charge</b>
<b>Maximum Allowable Each Day</b>	<b>Maximum Allowable Each Day</b>						
Inpatient hospital: <b>\$600</b>	Skilled nursing facility: <b>\$250</b>						
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<b>HOSPITAL AND SKILLED NURSING FACILITY</b>		
Unlimited days of hospital care in a semi-private room or ICU with ancillary services. Excludes care for mental disorders. ⌘ ❖	10%	30%
Confinement for infertility services. ⌘ Deductible required.	10% ◆	30% ◆
Confinement in a skilled nursing facility. ⌘ ❖	10%	30%
	Unlimited days	
Maternity care. Includes routine nursery charges. ⌘ ❖	10%	30%
Outpatient services. Only specified procedures require certification. Refer to the Introduction pages and the ⌘ for additional information. ❖		
Outpatient services other than surgery.	10%	30%
Outpatient surgery at hospital or ambulatory surgical center.	10%	30%
<b>EMERGENCY ROOM / URGENT CARE CENTER</b>		
Note: For all services which meet the criteria for emergency care, the coinsurance will be the percentage shown for PPO, even if the services were received from an OON provider. 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).	10% ⌘	30% ⌘
Use of urgent care center (facility and professional services).	10% ⌘	30% ⌘

<b>x</b> <b>Out-of-network (OON) services:</b> The member is responsible for the scheduled coinsurance and any charges exceeding Health Net's allowance based on RBRVS.						
⌘ 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.						
◆ Infertility services, supplies, injections and medications, are subject to a lifetime deductible of \$500 and limited to a lifetime maximum benefit of \$2000. This maximum is combined through PPO and OON. <b>Note:</b> artificial insemination is not a covered benefit.						
❖ 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%;"><b>Maximum Allowable Each Day</b></td> <td style="width: 50%;"><b>Maximum Allowable Each Day</b></td> </tr> <tr> <td>Inpatient hospital: <b>\$600</b></td> <td>Skilled nursing facility: <b>\$250</b></td> </tr> <tr> <td>Outpatient hospital: <b>50% of billed charges</b></td> <td>Home health care: <b>Customary and reasonable charge</b></td> </tr> </table>	<b>Maximum Allowable Each Day</b>	<b>Maximum Allowable Each Day</b>	Inpatient hospital: <b>\$600</b>	Skilled nursing facility: <b>\$250</b>	Outpatient hospital: <b>50% of billed charges</b>	Home health care: <b>Customary and reasonable charge</b>
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<b>CALENDAR YEAR DEDUCTIBLES</b>	<b>CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOPM)</b>	<b>LIFETIME BENEFIT MAXIMUM</b>
\$250 per member (PPO) \$500 per member (OON)	\$2000 for each member (PPO) \$6000 for each member (OON)	\$5,000,000 for each member (PPO/OON combined)
Three family members must satisfy their individual deductibles to satisfy the family deductible.		Maximum medical and mental health/ substance abuse payments.

# Health Net PPO prescription drug program

Health Net Life is contracted with most major chain pharmacies, including Longs, Rite Aid, Sav-on and Walgreens drugstores, and pharmacies located in the Albertsons, BelAir, Raley's, Ralphs, Safeway, Save Mart and Vons/Pavilions supermarket chains. There are many other neighborhood pharmacies that are also part of our network. For a complete and up-to-date list of participating pharmacies, call Health Net PPO Member Services at the number listed on your ID card.

## Prescriptions By Mail drug program

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period), you have the option of filling it through our convenient Prescriptions By Mail drug program. This program allows you to receive up to a 90-day supply of maintenance medications. For complete information, call Member Services.

## The Health Net PPO Recommended Drug List

The Health Net PPO Recommended Drug List is a comprehensive listing of medications covered for illnesses and conditions. It was developed to identify the safest and most effective medications for Health Net members while attempting to maintain

affordable pharmacy benefits. Some recommended drugs may require prior authorization from Health Net Life. For a copy of the Health Net PPO Recommended Drug List, call Member Services at the number listed on your ID card or visit our web site at [www.healthnet.com](http://www.healthnet.com).

## Outpatient prescription medication

**Level I** \$10 primarily generic drugs listed in the Health Net PPO Recommended Drug List

**Level II** \$15 brand name drugs listed in the Health Net PPO Recommended Drug List when generic equivalent is not commercially available

\$15 plus the difference in cost between the brand name drug and the generic equivalent, if you request a brand name drug listed in the Health Net PPO Recommended Drug List when its generic equivalent is commercially available

**Level III** Drugs not on the Recommended Drug List \$35 or the brand name copayment, whichever is greater, when the drug is not on the Health Net PPO Recommended Drug List and not excluded from coverage

\$35 or the brand name copayment, whichever is greater, plus the difference in cost between the brand name drug and the generic equivalent, if you request a brand name drug when its generic equivalent is commercially available or when the drug is not on the Health Net PPO Recommended Drug List

## What's covered

- Prescription drugs, for up to a 30-day supply per prescription from a Health Net Life-contracted pharmacy, for one copayment
- Mail order for maintenance drugs, for up to a 90-consecutive-day supply. The member is responsible for two applicable copayments.
- Drugs prescribed for treating infertility (subject to a 50% copayment)
- Oral contraceptives (copayments apply)

*(Please turn to back of page)*

- Blood glucose monitoring strips and lancets (copayments apply)
- Insulin needles and syringes (copayments apply)
- Diaphragms and cervical caps (copayments apply)

## What's not covered

### Limitations and exclusions

In addition to the exclusion and limitations listed below, prescription drug benefits are subject to the plan's general exclusions and limitations.

- Drugs prescribed for treating sexual dysfunction
- Allergy serum<sup>2</sup>
- Devices or appliances (except diaphragms or cervical caps), contraceptive foams, abortifacients or menstrual induction drugs
- Cosmetics, health or beauty aids, or drugs prescribed for cosmetic reasons, including drugs prescribed for baldness or to eliminate wrinkles
- Drugs that are appetite suppressants or are indicated for and prescribed for body weight reduction
- Drug products that help you quit smoking (e.g., nicotine patches)
- Drugs or medicines administered by a physician or physician's staff member<sup>3</sup>
- Experimental drugs (those that are labeled "Caution – Limited by the Federal Law to investigational use only")
- Hypodermic needles or syringes, except when dispensed for use with insulin
- Immunizing agents, injections (except for insulin), agents for surgical implantation, biological sera, blood, blood derivatives or blood plasma<sup>3</sup>
- Individual doses of medication dispensed in plastic or foil packages
- Over-the-counter drugs, or a drug where there is a nonprescription equivalent available, except for insulin

- Oxygen<sup>3</sup>
- Replacement of lost, stolen or damaged medications
- Services or supplies for which there is no charge, or for which you are not legally required to pay
- Supply amounts (for any number of days) that exceed the Food and Drug Administration's indicated usage or Health Net Life's recommendations
- Vitamins, nutritional supplements or homeopathic products

<sup>1</sup>Must be approved by Health Net Life.

<sup>2</sup>These items are covered under the medical coverage portion of your plan only if your employer has purchased the coverage.

<sup>3</sup>These items are covered under the medical coverage portion of your plan.

**This is only a summary. Consult your plan or Certificate of Insurance to determine the exact terms and conditions of your coverage.**