Health Net Health Plan of Oregon, Inc.
BeneFacts: Individual and Family
Quick Net Short Term PPO Plan
Coinsurance Schedule QN2500/08

PPO: Two plans, many choices. In health insurance, 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 service representatives.

PPO Benefits: When you receive covered services from providers in our PPO network, your expenses include a Benefit Period 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 from a Provider 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 Birthing Center services, Home Health Care, home infusion services, Durable Medical Equipment, and External Prosthetic Devices/Orthotic Devices are only covered 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 Benefit Period 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 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.

	For covered services, you are responsible for:	
Benefit Period Deductible	**PPO Network**	**Out-of-Network**
Benefit Period deductible per person	$2,500 [1, 2]	$3,000 [1, 2]
Benefit Period deductible per family	$7,500 [1, 2]	$9,000 [1, 2]
Physician/Professional/Outpatient care		
Women's and men's health care - Pap test, breast exam, pelvic exam, PSA test and digital rectal exam	30% contract rate	50% UCR *plus*
Routine mammography	30% contract rate	50% UCR *plus*
Physician services, office call	30% contract rate	50% UCR *plus*
Physician services, urgent care center	30% contract rate	50% UCR *plus*
Physician hospital visits	30% contract rate	50% UCR *plus*
Diagnostic X-ray/EKG/Ultrasound	30% contract rate	50% UCR *plus*
Diagnostic laboratory tests	30% contract rate	50% UCR *plus*
CT/MRI/PET/SPECT/EEG/Holter monitor/Stress test	30% contract rate	50% UCR *plus*
Therapeutic injections	30% contract rate	50% UCR *plus*
Outpatient rehabilitation therapy - $1,250/ max	30% contract rate	50% UCR *plus*
Outpatient or ambulatory care center	30% contract rate	50% UCR *plus*
Hospital care		
Inpatient services	30% contract rate	50% UCR *plus*
Inpatient rehabilitation therapy - 15 days/max	30% contract rate	50% UCR *plus*
Emergency services		
Outpatient emergency room services	30% contract rate	50% UCR *plus*
Inpatient admission from emergency room	30% contract rate	50% UCR *plus*
Emergency ambulance transport - $1,500/max	20% (UCR *plus* applies to Out-of-Network providers)	

BeneFacts: Individual and Family PPO
Quick Net Short Term Plan QN2500/08

	For covered services, you are responsible for:	
Other services		
Durable medical equipment - $2,500/max	30% contract rate	50% UCR *plus*
External Prosthetic Devices/Orthotic Devices	30% contract rate	50% UCR *plus*
Medical supplies (including injected substances)	30% contract rate	50% UCR *plus*
Diabetes management - one initial program per lifetime	30% contract rate	50% UCR *plus*
Blood, blood plasma, blood derivatives	30% contract rate	50% UCR *plus*
Home infusion therapy	30% contract rate	50% UCR *plus*
Skilled nursing facility care - 30 days/max	30% contract rate	50% UCR *plus*
Hospice services	30% contract rate	50% UCR *plus*
Home health visits - $500/max	30% contract rate	50% UCR *plus*
Outpatient neurodevelopmental therapy, under age 7 - $500/year max	30% contract rate	50% UCR *plus*
Benefit maximums		
Out-of-pocket maximum per person [3]	$3,000	$6,000
Out-of-pocket maximum per family [3]	$9,000	$18,000
Lifetime maximum	$1,000,000 PPO Network and Out-of-Network combined	

Notes

[1] You must meet the specified deductible each Benefit Period. Your Benefit Period is stated on your Signature sheet.

[2] Your payments do not apply to the annual out-of-pocket maximum.

[3] The out-of-pocket maximum does not include the deductible. After you reach the out-of-pocket maximum in a Benefit Period, we will pay your covered services during the rest of that Benefit Period 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 contract and other benefit materials for details, limitations and exclusions.

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Health Net Health Plan of Oregon, Inc.
Individual and Family
Quick Net PPO Plan
Prescription Benefits
Supplemental Benefit Schedule QN1K/08 (MAC A)

Article 1 - Purpose and Function of this Schedule

The purpose of this Schedule is to provide prescription benefits. This Schedule is an amending attachment to the Basic Benefit Schedule.

Subject to all terms, conditions, exclusions and definitions in the Medical and Hospital Service Agreement and its attachments, except as expressly amended by the Benefits article of this schedule, you are entitled to receive benefits set forth in this schedule upon payment of the relevant premium and the Copayments.

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. 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 dispensed by a Participating Provider pharmacy, except for Emergency Medical Care rendered outside the Service Area.

2.3 When a generic form of a brand name drug exists, the generic drug will be dispensed and the Tier 1 Copayment shall apply. An approved generic equivalent shall mean a generic drug that 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 must pay an ancillary charge equal to the difference between the cost of the generic drug and the brand name drug in addition to the Tier 2 copayment.

2.4 Copayments shall be as follows for each prescription or refill. Prescription deductibles (if any), Copayments and other amounts you pay for prescription drugs do not apply toward your plan's other deductibles, Copayment maximums, or stop loss maximums.

Benefit Period Deductible for Prescription Benefits: $250 per Member.
Maximum Prescription Benefit: $1000 per Member per Benefit Period.

	In Pharmacy (Per Fill Up to a 30-day Supply)
Tier 1	$15
Tier 2	$30
Tier 3	You pay the full cost of the prescription at Health Net's discounted rate.

Specialty Pharmacy: Certain drugs identified on the PDL are classified as Specialty Pharmacy drugs under your plan. Specialty Pharmacy drugs must be obtained from a designated Specialty Pharmacy Provider. Specialty Pharmacy drugs include, but are not limited to, injectable medications other than insulin that the majority of patients or a caregiver can administer at home after receiving adequate training from a medical professional.

This pharmacy plan does not provide creditable coverage for Medicare Part D.

	Specialty Pharmacy (Per Fill Up to a 30-day Supply)
Specialty Pharmacy	You pay the full cost of the prescription at Health Net's discounted rate.

The Calendar Year Deductible for Prescription Benefits and the Maximum Prescription Benefit include Specialty Pharmacy services.

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 Copayment.

2.6 Reimbursement (minus the Copayment) 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 to us of receipts to Health Net Oregon and sufficient documentation to establish the need for Emergency Medical Care.

2.7 Reimbursement (minus the Copayment) will be made for coverable prescriptions filled by a licensed practitioner at a rural health clinic for an urgent medical condition if there is not a pharmacy within 15 miles of the clinic or if the prescription is dispensed for a patient outside of the normal business hours of any pharmacy within 15 miles of the clinic. For the purposes of 2.7, "urgent medical condition" means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems.

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 treatment of onychomycosis (nail fungus), nocturnal for enuresis (bed wetting), sexual dysfunction, or infertility; drugs used for weight loss, smoking cessation, sexual enhancement, or sexual performance improvement; growth hormone therapy, and 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.

3.12 Diabetic supplies other than blood glucose test strips , lancets, insulin syringes and needles.

3.13 Prescriptions filled through mail order.

Health Net Health Plan of Oregon, Inc.

Quick Net Short Term PPO Plan
Alcohol Treatment Benefits
Supplemental Benefit Schedule ALQN3050/08

Article 1 – Purpose and Function of this Schedule

The purpose of this Schedule is to provide benefits for diagnosis and treatment of alcohol detoxification and alcoholism in addition to basic benefits. This Schedule is an amending attachment to the Basic Benefit Schedule.

Subject to all terms, conditions, exclusions and definitions in the Medical and Hospital Service Agreement and its attachments, except as expressly amended by the Benefits provision of this Schedule, you are entitled to receive benefits set forth in this Schedule upon payment of the relevant premiums and Copayments.

Article 2 – Benefits

		For covered services, you are responsible for:	
Alcohol treatment services		**PPO Network**	**Out-of-Network**
Outpatient	$1,125/ max	30%	50% UCR *plus*
Inpatient		30%	50% UCR *plus*

2.1 Alcohol Treatment Benefits. Benefits for treatment of alcoholism as included in the Diagnostic and Statistical Manual of Disorders are provided up to a maximum of $1,125 in a Benefit Period. In all cases, we shall retain the right to determine the need and alcohol treatment and the modality of treatment that best serves your interest. No coverage shall be provided for educational programs to which drivers are referred by the judicial system or for volunteer mutual support groups. Prior Authorization is required.

2.2 These benefits do not apply to the Out-of-Pocket maximum under the Agreement.

2.3 Deductible is waived for these benefits.

Article 3 – Exclusions and Limitations

3.1 The following benefits, accommodations, care, services, equipment, medications or supplies are expressly excluded or limited from coverage:

a. Treatment for Chemical Dependency other than alcohol detoxification and alcoholism.