Health Net Health Plan of Oregon, Inc.
PPO Single High Deductible Health Plan
Copayment and Coinsurance Schedule HDE26008060/16

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 Contact Center representatives.

PPO Benefits: When you receive covered services from Providers in our PPO network, your expenses include a Calendar Year 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 treating Provider to discuss the other types of 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, infusion services that can be safely administered in the home or in a home infusion suite, organ and tissue transplant services, Durable Medical Equipment, and Prosthetic Devices/Orthotic Devices are covered only if provided by a designated Specialty Care Provider.**

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 Maximum Allowable Amount (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.

	For covered services, you are responsible for:	
Calendar Year Deductible	**PPO Network**	**Out-of-Network**
Annual Deductible: Single coverage	$2,600 [1]	$5,200 [1]
Physician/Professional/Outpatient Care		
Preventive care, women's and men's health care - Pap test, breast exam, pelvic exam, PSA test and digital rectal exam	No charge [2]	40% MAA [2]
Routine mammography	No charge [2]	40% MAA [2]
Physician services, office call	20% contract rate	40% MAA
Physician services, urgent care center	20% contract rate	20% MAA
Physician Hospital visits	20% contract rate	40% MAA
Diagnostic X-ray/EKG/Ultrasound	20% contract rate	40% MAA
Diagnostic laboratory tests	20% contract rate	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 – 30 days/year max [7]	20% contract rate	40% MAA
Outpatient at Ambulatory Surgery Center	15% contract rate	40% MAA
Outpatient at Hospital based facility	20% contract rate	40% MAA
Hospital Care		
Inpatient services [3]	20% contract rate	40% MAA
Inpatient rehabilitation therapy - 30 days/year max [7]	20% contract rate	40% MAA

	For covered services, you are responsible for:	
	PPO Network	**Out-of-Network**
Emergency Services		
Outpatient emergency room services	20% contract rate	20%
Inpatient admission from emergency room	20% contract rate	20%
Emergency ground ambulance transport – 3 trips/year max	20%	20%
Emergency air ambulance transport - 1 trip/year max	20%	20%
Behavioral Health Services – Chemical Dependency and Mental or Nervous Conditions		
Physician services, office call [4]	20% contract rate	40% MAA
Outpatient services [4]	20% contract rate	40% MAA
Inpatient services [4]	20% contract rate	40% MAA
Other Services		
Blood, blood plasma, blood derivatives	20% contract rate	40% MAA
Diabetes management - one initial program	20% contract rate	40% MAA
Durable Medical Equipment and Prosthetic Devices/Orthotic Devices [6]	20% contract rate	40% MAA
Health education	Not covered	Not covered
Home health visits	20% contract rate	40% MAA
Home infusion therapy	20% contract rate	40% MAA
Hospice services	20% contract rate	40% MAA
Medical supplies (including allergy serum and injected substances) [7]	20% contract rate	40% MAA
Outpatient chemotherapy (non-oral anticancer medications and administration)	20% contract rate	40% MAA
Skilled Nursing Facility care – 60 days/year max	20% contract rate	40% MAA
TMJ services - $500/lifetime max	50% contract rate	50% MAA
Benefit Maximums		
Annual Out-of-Pocket Maximum: Single coverage [5] (Combined Medical and Prescription Drugs)	$5,200	$15,600
Lifetime maximum for authorized organ transplant services	Unlimited	Not covered Out-of-Network

Notes

[1] You must meet the specified Deductible each Calendar Year (January 1 through December 31) before Health Net pays any claims.

[2] Deductible is waived.

[3] The above Coinsurance for inpatient Hospital services is applicable for each admission for the hospitalization of an adult, pediatric or newborn patient. If a newborn patient requires admission to an intermediate or intensive care nursery, a separate Coinsurance for inpatient Hospital Services will apply.

[4] For mental health or Chemical Dependency services, call 800-977-8216.

[5] The annual Out-of-Pocket Maximum includes 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.

[6] Corrective shoes and arch supports, including foot orthotics, are excluded unless prescribed in the course of treatment for, or complications from, diabetes.

[7] **Visit/ day limits do not apply to services to treat mental health conditions**.

This Schedule presents general information only. Certain services require Prior Authorization or must be performed by a Specialty Care Provider. Refer to your Agreement for details, limitations and exclusions.
Health Net Health Plan of Oregon, Inc. • 888-802-7001 • www.healthnet.com