

Health Net HMO Plan Chart Xtra Value Plan Plan 91C		91C 7/1/2007
PROFESSIONAL SERVICES		
Visit to a physician, physician assistant or nurse practitioner at a PPG.		\$30
Periodic health evaluations. Includes routine, preventive, well-woman, and well-baby care.		\$30
Annual routine physical examinations.		No
Vision and hearing examinations.		\$30
Specialist consultations. Includes OB/GYN self-referral (excluding well-woman examinations). Refer to the Introduction pages for additional information.		\$60
Physician visit to member's home.		No
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).		Yes
Other immunizations (except foreign travel/occupational - see below).		Yes
Immunizations for foreign travel/occupational purposes.		No
Allergy testing.		Yes
Allergy serum.		Yes
Allergy injection services (serum not included).		Yes
Injections related to infertility services.		No
All other injections.		
Office based injectable medications		Yes
Self-administered injectables. (up to a 30-day prescription)		30%
Surgeon/assistant surgeon in hospital or PPG.		Yes
Administration of anesthetics.		Yes
X-ray and laboratory procedures.		Yes
Complex radiology (CT, SPECT, MRI, MUGA and PET).		\$200
Rehabilitation therapy (inpatient/outpatient physical, speech, occupational and respiratory therapy). Provided as long as significant improvement is expected. See <i>PPG Operations Manual</i> .		\$30
Dental services (when medically necessary to properly monitor, control, or treat a severe medical condition when excluded dental services are being performed. See <i>PPG Operations Manual</i>).		Yes
CARE FOR CONDITIONS OF PREGNANCY (professional services only)		
Prenatal and postnatal office visit.		\$30
Normal delivery, Cesarean section. Includes newborn inpatient care provided by a member physician.		Yes
Complications of pregnancy including medically necessary abortions.		Yes
Elective abortions.		\$150
Genetic testing of fetus.		Yes
Circumcision of newborn.		Yes
FAMILY PLANNING (professional services only)		
Contraceptive devices.		No
Infertility services (including professional services, inpatient and outpatient care, treatment by injection and prescription drugs, if applicable. See <i>PPG Operations Manual</i>).		No
Sterilization of females.		No
Sterilization of males.		No
Reversal of sterilization.		No
ALCOHOL/DRUG REHABILITATION and CARE FOR MENTAL DISORDERS		
ADMINISTERED BY MANAGED HEALTH NETWORK (MHN) Refer members to the MHN telephone number on the back of their Health Net ID card		

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OTHER SERVICES		
Medical social services.		Yes
Patient education.		Yes
Ground ambulance.		\$200
Air ambulance.		\$200
Durable medical equipment. Limited to a maximum of \$2,000 each calendar year. The benefit limit does not apply for diabetic supplies, nebulizers, face masks and tubing used for the treatment of asthma.		Yes
Orthotics (braces and supports).		Yes
Corrective footwear. Custom made shoes and shoe inserts (custom foot orthotics).		No
Diabetic supplies (refer to the Introduction section for additional information).		Yes
Hearing aids.		No
Prosthesis (replacing body parts).		Yes
Blood, blood plasma, blood factors and blood derivatives.		Yes
Nuclear medicine (professional services only).		Yes
Organ and bone marrow transplants (non-experimental and noninvestigative. Professional services only).		Yes
Chemotherapy (professional services only).		Yes
Renal dialysis (professional services only).		Yes
Home health visit. The copayment starts the 31st calendar day after the first visit (limited to 100 visits each calendar year).		\$30
Hospice care.		Yes
HOSPITAL AND SKILLED NURSING FACILITY SERVICES		
Unlimited days of hospital care in a semi-private room or ICU with ancillary services. Excluding care for mental disorders.		20%
Confinement for infertility services.		No
Confinement in a skilled nursing facility (limited to 100 days a calendar year).		20%
Maternity care. Includes routine nursery charges.		20%
Outpatient services.		20%
OUT-OF-POCKET MAXIMUM		
For each member.		\$3,500
For two-party.		\$7,000
For each family (3 or more members).		\$7,000
EMERGENCY CARE/URGENTLY NEEDED CARE - Within or outside the PPG service area - (Refer to the Introduction pages for more information)		
NOTE: Non-emergency care (including urgently needed care) received within the PPG service area must be performed or authorized by the member's PPG in order for services to be covered. When urgently needed care is provided outside the PPG service area, authorization is not mandatory in order for services to be covered. When services are provided that meet the criteria for emergency care, whether within or outside the PPG service area, the services are covered, even if the member never contacted the PPG. See the Introduction pages for more information.		
Use of emergency room (facility and professional services). *		\$200
Use of urgent care center (facility and professional services). *		\$30
* The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room or urgent care center. See the Introduction pages for more information regarding emergency services/urgently needed care.		

FOR INTERNAL HEALTH NET USE ONLY

Health Net Behavioral Health Benefit Plan		Capitated
Large Group Commercial HMO and POS		Plan XAB
		10/1/2009
Administered by Managed Health Network (MHN) - Authorizations provided by MHN		
MHN Telephone Number: 888-426-0030		
MENTAL HEALTH		
Severe Mental Illnesses		
The following conditions are considered severe mental illnesses: 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).		
<i>Outpatient (severe)</i>		
Outpatient copayment.		\$30
Group therapy session.		\$15
Maximum visits each calendar year.		Unlimited
<i>Inpatient (severe)</i>		
Inpatient care in a hospital or residential treatment facility.		20% per admit
Maximum days each calendar year.		Unlimited
Physician visit to hospital or residential treatment facility.		\$0
Other Non-Severe Mental Illnesses		
<i>Outpatient (non-severe)</i>		
Outpatient copayment.		\$30
Group therapy session.		\$15
Maximum visits each calendar year.		Unlimited
<i>Inpatient (non-severe)</i>		
Inpatient care in a hospital or residential treatment facility.		20% per admit
Maximum days each calendar year.		Unlimited
Physician visit to hospital or residential treatment facility.		\$0
CHEMICAL DEPENDENCY REHABILITATION		
<i>Outpatient</i>		
Individual therapy session.		\$30
Group therapy session.		\$15
Maximum visits each calendar year.		Unlimited
<i>Detoxification</i>		
		20% per admit
<i>Inpatient</i>		
Chemical dependency rehabilitation.		20% per admit
Maximum days each calendar year.		Unlimited

FOR INTERNAL HEALTH NET USE ONLY --- AUTHORIZATIONS PROVIDED BY MHN

Health Net HMO Pharmacy Benefits

Plan Code 21P

The following is a brief description of your Health Net Pharmacy benefits.

RETAIL COPAYMENTS

Drug type	Description	Copayment
Level I – Generic Drugs	Drugs listed on the Health Net Recommended Drug List (primarily generic)	\$10
Level II – Brand, preferred	Drugs and diabetic supplies (including insulin) listed on the Health Net Recommended Drug List (primarily brand name)	\$25
Level III	Drugs not on the Health Net Recommended Drug List	\$50

PRESCRIPTIONS BY MAIL

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period of time), you have the option of filling it through our convenient and cost-saving Prescriptions By Mail Drug Program. Under this program, your copayment is double the retail copayment for up to a 90-day supply: **\$20 level I / \$50 level II / \$100 level III**. For complete information, log on as a Health Net member at www.healthnet.com > *View prescription coverage* > *Get prescriptions by mail* or call Member Services at **1-800-676-6976**.

GENERIC SUBSTITUTIONS

Generic drugs will be dispensed when a Generic Drug equivalent is available, unless the Prescription Drug order states “do not substitute,” “dispense as written,” or words of similar meaning in the Physician’s handwriting in which case the specific drug will be dispensed. However, when a Generic Drug equivalent is available and a Brand Name Drug is dispensed at your request, you must pay the following:

- The Level I Drug Copayment, plus
- The difference between the cost of the Generic Drug and the Brand Name Drug.

However, if the Prescription Drug Order states “do not substitute,” “dispense as written,” or words of similar meaning in the Physician’s handwriting, only the Level II or Level III Drug Copayment, as appropriate, will be applicable.

This is a brief description of your Health Net Pharmacy benefits. Please refer to your Evidence of Coverage to determine the specific benefits, limitations, exclusions and all other terms and conditions of coverage.



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