



Health Net Health Plan of Oregon, Inc.
BeneFacts: Individual and Family
Pearl 25 HMO Plan
Copayment Schedule IH2540/06

HMO: Convenient access to care

This Health Maintenance Organization (HMO) plan gives you access to one of the region’s largest networks of physicians, hospitals and other health care professionals and facilities. For most services covered under this plan, your out-of-pocket expenses are limited to a fixed dollar amount. When you receive covered services in our HMO network, you are not responsible for any charges that exceed our contracted rates with our HMO providers.

The plan requires that you first select a Primary Care Provider (PCP) from our HMO network. Your PCP coordinates all your health care, including referrals. **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 1.6 of the Basic Benefit Schedule.**

To confirm whether a provider participates in our HMO network, refer to our provider directory, use the regularly updated DocSearch feature on our web site, or get in touch with a Customer Contact representative by using the contact information on the other side of this sheet.

You do not have to pay a deductible with this plan.
Your benefits are subject to Copayments listed in this schedule.

Physician/Professional/Outpatient care	For covered services, you are responsible for:
Women’s and Men’s health care - Pap test, breast exam, pelvic exam, PSA test and digital rectal exam	\$25 per visit
Routine mammography	\$25 per visit
Physician services, office call	\$25 per visit
Physician services, urgent care center	\$50 per visit
Physician hospital visits	No charge
Diagnostic X-ray/EKG/Ultrasound	\$25 per visit
Diagnostic laboratory tests	\$25 per visit
CT/MRI/PET/SPECT/EEG/Holter monitor/Stress test	\$100
Allergy and therapeutic injections	No charge
Maternity delivery care (professional services only)	\$250 per pregnancy
Outpatient rehabilitation therapy - \$2,500/year max	\$10 per visit
Outpatient or ambulatory care center	\$250 per visit
Hospital care	
Inpatient services	\$400 per day
Inpatient rehabilitation therapy - 30 days/year max	\$400 per day
Emergency services	
Outpatient emergency room services	\$100 per visit ¹
Inpatient admission from emergency room	\$400 per day
Emergency ambulance transport - \$3,000/year max	20% (UCR <i>plus</i> applies to Out-of-Network providers) ²
Behavioral health services	
Outpatient Mental health ³	\$25 per visit ⁴
Inpatient Mental Health ³ ----- \$1,000/year max	\$400 per day ⁴



Other services	For covered services, you are responsible for:
Durable medical equipment and external Prosthetic Devices - \$5,000/year max	20% contract rate
Medical supplies (including allergy serums and injected substances)	20% contract rate
Diabetes management - one initial program per lifetime	\$25 per visit
Blood, blood plasma, blood derivatives	No charge
TMJ services - \$500/lifetime max	50% contract rate ⁴
Home infusion therapy	No charge
Skilled nursing facility care - 60 days/year max	No charge
Hospice services	No charge
Home health visits - \$1,000/year max	No charge
Outpatient neurodevelopmental therapy, under age 7 - \$1,000/year max	\$10 per visit
Health education \$150/year max for all qualifying classes	Any charges over maximum reimbursement of \$50/qualifying class. ⁴

Benefit maximums	
Annual Copayment maximum per person ⁵	\$4,000 per person / \$12,000 per family
Lifetime maximum for authorized organ transplant services	\$250,000
Lifetime maximum	Unlimited

Exclusion periods (Refer to Medical and Hospital Service Agreement, Section 8.12)	
Allergies & their symptoms, including asthma: 12 months	Pre-existing conditions: 6 months
Elective procedures: 12 months	Organ transplants: 24 months
Mental disorders: 12 months	

Notes

- ¹ Copayment is waived if you are admitted.
- ² UCR *plus* means Out-of-Network providers may hold you responsible for any billed charges that exceed the Usual, Customary and Reasonable (UCR) amount we pay. You are responsible for the listed percentage of the UCR amount *plus* any additional billed amount over UCR.
- ³ To Prior Authorize mental health or Chemical Dependency services, call 800-977-8216.
- ⁴ Your payments do not apply to the annual Copayment maximum.
- ⁵ After you reach the Copayment maximum in a Calendar Year, we will pay your covered HMO services during the rest of that Calendar Year at 100% of our HMO contract rates.

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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