

Health Net HMO Plan Chart Plan 32K	32K 9/1/2002
PROFESSIONAL SERVICES	
Visit to a physician, physician assistant or nurse practitioner at a PPG.	\$20
Periodic health evaluations. Includes routine, preventive care.	
Birth through 24 months. (Includes newborn care office visit and well-baby care).	\$20
Ages 2 and older.	\$20
Annual routine physical examinations.	No
Vision and hearing examination.	\$20
Specialist consultations. Includes OB/GYN self-referral. Refer to the Introduction pages for additional information.	\$20
Physician visit to member's home (at discretion of physician).	\$35
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).	Yes
Other immunizations (except foreign travel/occupational).	Yes
Immunizations for foreign travel/occupational purposes.	20%
Allergy testing.	Yes
Allergy serum.	Yes
Allergy injection services (serum not included).	Yes
Injections related to infertility services.	50%
All other injections.	Yes
Surgeon/assistant surgeon in hospital or PPG.	Yes
Administration of anesthetics.	Yes
X-ray and laboratory procedures.	Yes
Rehabilitation therapy (inpatient/outpatient physical, speech, occupational and respiratory therapy). Provided as long as significant improvement is expected. See <i>PPG Operations Manual</i> .	Yes
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.	\$20
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>).	50%
Sterilization of females.	\$150
Sterilization of males.	\$50
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
Ambulance.		Yes
Air ambulance.		Yes
Durable medical equipment.		Yes
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.		\$20
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.		Yes
Confinement for infertility services.		50%
Confinement in a skilled nursing facility (limited to 100 days a calendar year).		Yes
Maternity care. Includes routine nursery charges.		Yes
Outpatient services.		Yes
MAXIMUM COPAYMENT LIABILITY		
For each member.		\$1,500
For two-party.		\$3,000
For each family (3 or more members).		\$4,500
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). *		\$100
Use of urgent care center (facility and professional services). *		\$50

* 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.

Plan overview

Standard Behavioral Health

Plan Y1

What member pays for services	Effective 7/1/00
<i>Mental health</i>	
Severe mental illness	
<i>Outpatient</i>	
Outpatient copayment	\$20
Maximum visits per calendar year	unlimited
<i>Inpatient</i>	
Inpatient care for mental health in hospital or skilled nursing facility	no charge
Maximum days per calendar year	unlimited
Physician visit to hospital or skilled nursing facility	no charge
Other mental illnesses	
<i>Outpatient</i>	
Outpatient copayment	\$20
Maximum visits per calendar year	20
<i>Inpatient</i>	
Inpatient care for mental health in hospital or skilled nursing facility	no charge
Maximum days per calendar year	30
Physician visit to hospital or skilled nursing facility	no charge
Chemical dependency rehabilitation	
<i>Outpatient</i>	
Individual therapy session	\$20
Maximum visits per calendar year	20
<i>Detoxification</i>	
	no charge
<i>Inpatient</i>	
Chemical dependency rehabilitation	no charge
Maximum days per calendar year	30

The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa and serious emotional disturbances of children.