



Health Net®

# Health Net Health Plan of Oregon, Inc. Washington PPO Plans

## 2011 Summary of Significant Group Contract Changes

BENEFIT OR PROVISION	CONTRACT REFERENCE	CHANGES MADE
Specialty Care Providers	Copayment and Coinsurance Schedule	The list of services that require the use of a Specialty Care Provider has been updated to clarify that infusion services includes services that can be safely administered in the home or in a home infusion suite.
Preventive Care	Copayment and Coinsurance Schedule	Preventive care has been added to the Copayment and Coinsurance Schedule. The deductible, if any, is waived for preventive care services.
Outpatient rehabilitation therapy	Copayment and Coinsurance Schedule	The annual maximum for outpatient rehabilitation therapy has been changed to 30 days per year.
Emergency Ground Ambulance Transport	Copayment and Coinsurance Schedule	The Calendar Year benefit maximum has changed to 3 trips per year for emergency ground ambulance transports.
Emergency Air Ambulance Transport	Copayment and Coinsurance Schedule	A new benefit line has been added to the Copayment and Coinsurance Schedule for emergency air ambulance transports. The Calendar Year benefit maximum is \$10,000.
Other Services, Prosthetic Devices/Orthotic Devices	Copayment and Coinsurance Schedule	The reference to "External" has been removed from Prosthetic Devices/Orthotic Devices.
Home health visits	Copayment and Coinsurance Schedule	The annual maximum for home health visits has been removed.
Lifetime maximum for authorized organ transplant services	Copayment and Coinsurance Schedule	The lifetime maximum for authorized organ transplant services has been removed.
Benefit Maximums	Copayment and Coinsurance Schedule	The Lifetime maximum benefit line has been changed to read "Annual Limits" and the annual limit has been changed to 1,250,000 PPO Network and Out-of-Network combined.

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<b>BBS (Basic Benefit Schedule)</b>		
Specialty Care Providers	Article 1.5	The list of services that require the use of a Specialty Care Provider has been updated to clarify that infusion services includes services that can be safely administered in the home or in a home infusion suite.
Physician Services	Article 2.1	Article 2.1 of the Basic Benefit Schedule – Women’s and Men’s Health Care Services is removed. These services are now covered under Preventive Care, as outlined in Article 7.24.
Physician Services	Article 2.9	<p>The following provision regarding the designation of a Primary Care Provider is added to Article 2 of the Basic Benefit Schedule – Physician Services:</p> <p><i>“Health Net allows the designation of a primary care Provider. You have the right to designate any primary care Provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care Provider, and for a list of the participating primary care Providers, you may contact us at:</i></p> <p><i>Health Net Health Plan of Oregon, Inc. 13221 SW 68<sup>th</sup> Parkway Tigard, Oregon 97223</i></p> <p><i>Customer Contact Center Monday - Friday 7:30 a.m. to 5:00 p.m. 888.802.7001 service@healthnet.com</i></p> <p><i>Hearing and Speech Assistance Monday - Friday 7:30 a.m. to 5:00 p.m. TTY 888.802.7122</i></p> <p><i>For children, you may designate a pediatrician as the primary care Provider.”</i></p>

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Physician Services	Article 2.10	<p>The following provision regarding obstetrical and gynecological care is added to Article 2 of the Basic Benefit Schedule – Physician Services:</p> <p><i>“You do not need Prior Authorization from us or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of Participating health care professionals who specialize in obstetrics or gynecology, you may contact us at:</i></p> <p><i>Health Net Health Plan of Oregon, Inc. 13221 SW 68<sup>th</sup> Parkway Tigard, Oregon 97223</i></p> <p><i>Customer Contact Center Monday - Friday 7:30 a.m. to 5:00 p.m. 888.802.7001 service@healthnet.com</i></p> <p><i>Hearing and Speech Assistance Monday - Friday 7:30 a.m. to 5:00 p.m. TTY 888.802.7122</i></p> <p><i>This Agreement will never provide less than the minimum benefits required by state and federal laws.”</i></p>
Other Services, Home Health Care	Article 7.1	Article 7 of the Basic Benefit Schedule is amended to remove the reference of a benefit maximum for Home Health Care.
Other Services, Home Infusion Services	Article 7.2	<p>The Article has been updated to read as follows:</p> <p><i>“Home Infusion Services. Medically Necessary home infusion services that are safely administered in the home or in a home infusion suite are covered when provided in lieu of inpatient/outpatient hospitalization, Physician’s office or Skilled Nursing Facility care. Medically Necessary home injectables except insulin are covered when Prior Authorized. We may utilize a Specialty Care Provider of home infusion services if you live in the Service Area.”</i></p>

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Other Services, Organ and Tissue and Transplants	Article 7.8	<p>The Article has been amended to read as follows:</p> <p><i>“Organ and Tissue Transplants.</i></p> <p><i>Exclusion Period. A 12-month Exclusion Period applies for services related to any organ or tissue transplant. Creditable Coverage applies to this Exclusion Period.</i></p> <p>a. <i>The following organ and tissue transplants are covered when Medically Necessary:</i></p> <ul style="list-style-type: none"> <li>• <i>kidney transplants;</i></li> <li>• <i>pancreas after kidney transplants;</i></li> <li>• <i>cornea transplants;</i></li> <li>• <i>heart transplants;</i></li> <li>• <i>liver transplants;</i></li> <li>• <i>lung transplants;</i></li> <li>• <i>heart-lung transplants;</i></li> <li>• <i>concurrent kidney-pancreas transplants for patients with concomitant Type 1 diabetes and end-stage renal failure;</i></li> <li>• <i>adult autologous stem cell/bone marrow transplants;</i></li> <li>• <i>adult allogeneic stem cell/bone marrow transplants;</i></li> <li>• <i>pediatric autologous stem cell/bone marrow transplants;</i></li> <li>• <i>pediatric allogeneic stem cell/bone marrow transplants; and</i></li> <li>• <i>transplantation of cord blood stem cells</i></li> </ul> <p><i>Transplantations of cord blood stem cells, tandem transplants (also known as sequential or double transplants), and mini-transplants (non-myeloablative allogeneic stem cell transplants) are covered when Medically Necessary.</i></p> <p><i>No other organ or tissue transplants are covered. Organ or bone marrow search, selection, transportation, storage, and eye bank costs are not covered.</i></p> <p>b. <i>We will direct you to a designated Specialty Care Provider in accordance with Article 1.5 of this Basic Benefit Schedule. Services provided by other than the designated Specialty Care Provider will not be covered. Coverage is conditioned upon your acceptance into the transplant program. Coverage may also be subject to approval by a Transplant Evaluation Committee designated by us. The Committee shall have complete discretion in determining whether or not a transplant will be covered and will consider factors such as the treatment’s effectiveness in improving the length and quality of life; the mortality and morbidity associated with the treatment; alternative treatment methods; the current medical and scientific literature; the positions of governmental agencies regarding the treatment; community standards of care; and your physical and mental condition.</i></p>

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Other Services, Organ and Tissue and Transplants, cont.	Article 7.8	<p>c. <i>Prior Authorization is required for transplant evaluation, services, and procedures related to a transplant.</i></p> <p>d. <i>Exclusions and Limitations: All organ and tissue transplants or autologous stem cell rescue not explicitly listed as covered in Article 7.8 of this Basic Benefit Schedule. Services for an organ donor or prospective organ donor when the transplant recipient is not a Member. Organ and bone marrow search, selection, transportation storage, and eye bank costs. Non-human or artificial organs and the related implantation services. Permanent or temporary implantation of artificial or mechanical devices to replace or assist human organ function until the time of organ transplant, except for dialysis to maintain a kidney and artificial pump bridge to approved cardiac transplants. High dose chemotherapy which requires the support of a non-covered bone marrow transplant or autologous stem cell rescue. Transplants disapproved by our Transplant Evaluation Committee. Bone marrow transplantation, stem cell rescue or hematopoietic support for human gene therapy (enzyme deficiencies), autologous stem cell transplantation for acute myocardial infarction (ASTAMI) or heart failure stem cells for spinal fusion. Small bowel and pancreas transplants, and islet cell transplantation. Transplant services not Prior Authorized and/or not provided at the Specialty Care Provider designated by us are not covered."</i></p>
Other Services, Durable Medical Equipment and Prosthetic Devices	Article 7.9	The reference to "External" has been removed from Durable Medical Equipment and Prosthetic Devices.

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Other Services, Preventive Care	New: Article 7.24	<p>The following Article has been added as a core provision to the Basic Benefit Schedule:</p> <p><i>“Preventive Care. When services are received by a Participating Provider, charges for preventive care are covered at no cost share to you. When the primary purpose of the office visit is unrelated to a preventive service, services are payable at benefit levels indicated on your Copayment and Coinsurance Schedule. If you receive services from a Non-participating Provider, benefits are subject to your Non-Participating and/or Out-of-Network cost share amount, as indicated on your Copayment and Coinsurance Schedule. Covered recommended preventive care services include the following:</i></p> <ul style="list-style-type: none"> <li><i>a. United States Preventive Services Task Force (USPSTF) recommended type “A” and “B” services;</i></li> <li><i>b. Immunizations and inoculations as recommended by the Advisory Committee on immunization Practices of the Center for Disease Control (CDC);</i></li> <li><i>c. Pediatric preventive care and screenings, as supported by the Health Resources and Services Administration (HRSA) guidelines;</i></li> <li><i>d. Women’s health care services not included in Article 7.29.a. above, as supported by HRSA guidelines;</i></li> <li><i>e. Other USPSTF recommendations for breast cancer screening, mammography and prevention;</i></li> </ul> <p><i>The deductible, if any, is waived for services covered under this Article which are billed as Preventive Care.</i></p> <p><i>This Agreement will never provide less than the minimum benefits required by state and federal laws.”</i></p>
Other Services, Family Planning	New: Article 7.26	Family planning is removed from the Preventive Care provision. This benefit is subject to the deductibles, Copayments or Coinsurance shown on the Copayment and Coinsurance Schedule.
Other Services, Colorectal screening	Article 7.26 (formerly)	Colorectal screening is removed. These services are now covered under Preventive Care, as outlined in Article 7.24 above.
Other Services, Circumcision	New: Article 7.27	Circumcision is removed from the Preventive Care provision. This benefit is subject to the deductibles, Copayments or Coinsurance shown on the Copayment and Coinsurance Schedule.

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Exclusions and Limitations	Article 9.10	<p>The exclusion has been revised to read as follows:</p> <p><i>“Eye refractions, regardless of diagnosis; routine eye examinations; eye exercises; visual analysis; therapy or training; radial keratoplasty; photo refractive keratotomy and clear lensectomy. Hearing screening and tests except as provided in Article 2.2 of this Basic Benefit Schedule and Preventive Care in Article 7.24 of this Basic Benefit Schedule. Also excluded are eyeglasses and all other types of vision hardware or vision corrective appliances and contact lenses except as provided in Article 7.9 and 7.10.d of this Basic Benefit Schedule.”</i></p>
Exclusions and Limitations	Article 9.18	<p>The exclusion has been revised to read as follows:</p> <p><i>“Weight loss surgery or complications caused by weight loss surgery. Diagnosis, treatment, rehabilitation services and diet supplements for any classification of obesity, including but not limited to morbid obesity, (regardless of co-morbidities), except as covered under Preventive Care, as outlined in Article 7.24.”</i></p>
Exclusions and Limitations	Article 9.39	<p>The following exclusion has been revised to read as follows:</p> <p><i>“Preventive and routine examinations, services, testing, and supplies, except as covered under Preventive Care, as outlined in Article 7.24 of this Basic Benefit Schedule”</i></p>
<b>GMHSA (Group Medical and Hospital Service Agreement)</b>		
Definitions	Article 2.41	<p>“Out-of-Network Providers” has been included in the definition of “Nonparticipating Providers”.</p> <p>This change is a language clarification, not a change to the benefit or benefit administration.</p>
Definitions	Article 2.46	<p>The definition of Pre-existing Condition in Article 2 of the Group Medical and Hospital Service Agreement – Definitions is amended to read as follows:</p> <p><i>“Pre-existing Condition” means a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period preceding the Enrollment date, which means the earlier of the first day of the Subscriber Group’s probationary period or the Member’s Effective Date of coverage. The Enrollment date for a Late Enrollee is the Effective Date of coverage. Pregnancy is not a Pre-existing Condition. Genetic information does not constitute a Pre-existing Condition in the absence of a diagnosis of the condition related to such information. <b>Pre-existing conditions do not apply to a newborn or newly adopted child, nor a Member under the age of 19.”</b></i></p>

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Exclusions and Limitations	Article 8.10.a	<p>The Pre-existing Conditions Exclusion Period provision in the Group Medical and Hospital Service Agreement is amended to read as follows:</p> <p><i>“Pre-existing Conditions Exclusion Period.</i></p> <p>a. <i>“Pre-existing Condition” means a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period preceding the Enrollment date, which means the earlier of the first day of the Subscriber Group’s probationary period or the Member’s Effective Date of coverage. The Enrollment date for a Late Enrollee is the Effective Date of coverage. Pregnancy is not a Pre-existing Condition. Genetic information does not constitute a Pre-existing Condition in the absence of a diagnosis of the condition related to such information. Pre-existing Conditions do not apply to a newborn or newly adopted child, <b>or a Member under the age of 19.</b></i></p>
Termination	Article 9.3	<p><i>The provision regarding rescission of the Agreement for fraud, material misrepresentation or concealment by a Subscriber group of the Group Medical and Hospital Service Agreement – Termination has been amended to read as follows:</i></p> <p><i>“Notwithstanding any provision of Article 9.1 to the contrary, we may rescind an Agreement for fraud, or intentional misrepresentation of material fact by a Subscriber Group and the coverage of a Member may be rescinded for fraud, or intentional misrepresentation of material fact by the Member.”</i></p>
<b>Optional Supplemental Benefit Schedules</b>		
Pharmacy Supplemental Benefit Schedules	Exclusions	<p>The following exclusion has been added:</p> <p><i>“Drugs and medicines used for diagnostic purposes.”</i></p>