



Summary of Benefits
Health Net Insurance of New York, Inc.
Outlook POS-I Split Copay Plan
Advantage Platinum Network
New York County Dental Society
Effective: June 2009

The Health Net Outlook POS-I plan is an open access plan that offers you the opportunity to use either Health Net Advantage Platinum network or non-network health care providers each time you seek medical care, and still receive benefits for covered services. Health Net Outlook POS-I gives you a powerful choice. You can work within the Health Net Advantage Platinum network provider network or opt out, choosing a provider not affiliated with the Health Net.

To be eligible for the reduced copay under this Health Net Split Copay plan, the member must receive services from an Advantage Platinum network PCP. The reduced copay also applies to female members when accessing an OB/Gyn.

Benefits	In Network	Out of Network
Financial		
Deductible	N/A	\$1,000 Single, \$2,000 Family
Coinsurance Level	N/A	30%
Maximum Out-of-Pocket Cost (does not include charges in excess of allowed amount or non-covered benefits)	N/A	\$4,000 Single, \$8,000 Family
Maximum Lifetime Benefit Per Member	Unlimited	\$5,000,000
Prescription Drugs		
Retail Prescription Coverage, for up to 30-day supply Mail Order Prescription Coverage, for up to a 90-day supply, the mail order copayment is two times the retail copayment Please be aware that this benefit plan includes Step Therapy, which means that you may be required to try one or more "prerequisite" drugs before a tier three medication will be covered. This process typically helps you control out of pocket costs, while still using FDA-approved drugs, as tier one and tier two drugs require a smaller copayment than tier three drugs. All Step Therapy drugs require Prior Authorization. Please refer to your Evidence of Coverage (EOC) for further information.	\$10 Copayment for generic drugs \$30 Copayment for brand name drugs on the Preferred Drug List without a generic equivalent \$50 Copayment for brand name drugs on the Preferred Drug List with a generic equivalent or brand name drugs not on the Preferred Drug List Unlimited Maximum per Calendar Year	Covered at participating pharmacies only
Preventive Care		
Physical Examination, for children through age 18 in accordance with Health Net's schedule of covered well exams	No Cost	No Cost
Physical Examination, for adults age 19 and over in accordance with Health Net's schedule of well exams	\$30 Copayment per Visit	Subject to Deductible and Coinsurance
Preventive Immunizations, for children through age 18	No Cost	No Cost
Preventive Immunizations, for adults age 19 and over	No Cost	Subject to Deductible and Coinsurance
Mammogram	No Cost	Subject to Deductible and Coinsurance
Routine Gynecological Care, one pap test and two pelvic exams per Year	\$30 Copayment per Visit	Subject to Deductible and Coinsurance
Inpatient Care		
Semi-Private Room and Board	\$750 Copayment per Admission per 90-day benefit period ^a	Subject to Deductible and Coinsurance ^a
Physicians', Surgeons' and Nursing Services and Medications	No Cost ^a	Subject to Deductible and Coinsurance ^a
Inpatient Skilled Services such as Physical, Occupational Therapy, and Skilled Nursing Care, combined maximum, 90 Days per Year	\$750 Copayment per Admission per 90-day benefit period ^a	Subject to Deductible and Coinsurance ^a

Benefits	In Network	Out of Network
Outpatient Care		
Physician Office Visits	\$30 Copayment per Visit when rendered by a PCP or OB/Gyn \$50 Copayment per Visit when rendered by a specialist	Subject to Deductible and Coinsurance
Laboratory and Imaging Services	No Cost	Subject to Deductible and Coinsurance
Comprehensive Imaging Services (MRI, MRA, CT Scan, PET Scan, SPECT Scan, Nuclear Cardiology (MUGA), and Bone Densitometry)	No Cost ^a	Subject to Deductible and Coinsurance ^a
Physical, Occupational, Speech and Cognitive Therapy, combined maximum, 30 Visits per Year	\$50 Copayment per Visit ^a	Subject to Deductible and Coinsurance ^a
Outpatient Procedures and Surgery	\$250 Copayment per Visit ^a	Subject to Deductible and Coinsurance ^a
Cardiac Rehabilitation, 36 Visits within 12 Months following myocardial infarction or cardiac surgery	\$50 Copayment per Visit	Subject to Deductible and Coinsurance
Allergy Services	\$50 Copayment per Visit	Subject to Deductible and Coinsurance
Medical Care for injury and illness to the eye	\$30 Copayment per Visit when rendered by a PCP \$50 Copayment per Visit when rendered by a specialist	Subject to Deductible and Coinsurance
Emergency Care		
Urgent Care Center	\$50 Copayment per Visit	Subject to Deductible and Coinsurance
Emergency Room	\$75 Copayment per Visit	\$75 Copayment per Visit
Maternity Care		
Pre-Natal and Post-Natal (from effective date of Health Net coverage)	No Cost	Subject to Deductible and Coinsurance
Hospital Services for Mother and Child (includes all newborn costs even if newborn requires continued hospitalization after mother is discharged)	\$750 Copayment per Admission per 90-day benefit period ^a	Subject to Deductible and Coinsurance ^a
Family Planning and Infertility Services (excludes In Vitro Fertilization, GIFT and ZIFT)	\$50 Copayment per Visit	Subject to Deductible and Coinsurance
Mental Health Care		
Inpatient Mental Health Care, for the combined diagnoses of Biologically- and Non-Biologically-based Mental Illness and for Children with Serious Emotional Disturbances, 30 Inpatient Days, exchangeable with 60 Partial Hospitalization Sessions per Year ^b	\$750 Copayment per Admission per 90-day benefit period \$250 Copayment for the first day in a partial day program ^a	Subject to Deductible and Coinsurance ^a
Outpatient Mental Health Care, for the combined diagnoses of Biologically- and Non-Biologically-based Mental Illness and for Children with Serious Emotional Disturbances, 20 Visits per Year ^b	\$50 Copayment per Visit ^a	Subject to Deductible and Coinsurance ^{ac}
Drug/Alcohol Addiction		
Inpatient Rehabilitative treatment for the abuse of, or addiction to drugs and alcohol, 30 Days per Year	\$750 Copayment per Admission per 90-day benefit period ^a	Subject to Deductible and Coinsurance ^a
Outpatient Rehabilitative Care for Drug/Alcohol Addiction, 60 Visits per Year; of the 60 Visits, 20 may be used for covered family members	Subject to 50% Coinsurance ^a	Subject to Deductible and 50% Coinsurance ^{ac}
Inpatient Diagnosis and Medical Treatment for Drug and Alcohol Detoxification, 7 Days per Year ^d	\$750 Copayment per Admission per 90-day benefit period ^a	Subject to Deductible and Coinsurance ^a
Home Health Or Hospice Care		
Home Health Care, 40 Visits per Year	No Cost ^a	Subject to \$50 Deductible and 25% Coinsurance ^a
Hospice Care in the home, benefit limitation of 210 Visits (combined with Inpatient Hospice Care)	No Cost ^a	Subject to Deductible and Coinsurance ^a
Inpatient Hospice Care, benefit limitation of 210 Visits (combined with Hospice Care in the home)	\$750 Copayment per Admission per 90-day benefit period ^a	Subject to Deductible and Coinsurance ^a
Other Services		
Durable Medical Equipment, \$1,500 per Year (certain devices require prior authorization)	50% of the cost of covered item(s)	50% of the cost of covered item(s) after Deductible
Orthotics, \$1,500 per Year (excludes foot orthotics)	50% of the cost of covered item(s)	50% of the cost of covered item(s) after Deductible
Chiropractic Care	\$50 Copayment per Visit	Subject to Deductible and Coinsurance ^c
Diabetic Medications and Supplies		
Diabetic Medications and Supplies at a Plan Pharmacy	\$30 Copayment per each Diabetic Medication and Supply	Subject to Deductible and Coinsurance

Benefits	In Network	Out of Network
Limiting Age		
Dependents are covered to the end of the month in which the eligible dependent reaches age 19. If the eligible dependent is 19 or over, and is a full-time student, coverage will extend to the earlier of the end of the month in which the eligible dependent graduates, ceases to be a full-time student, or reaches age 25.		
Eligible Dependent Coverage		
Plan offers coverage to the subscriber's eligible dependents, which may include the following: subscriber's legal spouse, domestic partner, eligible dependent children. Please refer to your employer's benefits office for qualifying criteria.		

^aWhen medically necessary and approved in advance by a Health Net medical director

^bOnce the visit limit has been exhausted, benefits will ONLY be available for biologically-based mental illness and for children with serious emotional disturbances

^cFor Out-Of-Network outpatient mental health, rehabilitative treatment for the abuse of or addiction to drugs and alcohol, and chiropractic care, the allowed amount is determined by the vendor's fee schedule.

^dAll In-Network and Out-of-Network benefits accrue to a combined visit limit

In-Network services are services and benefits provided or arranged by a Health Net Advantage Platinum network provider.

Pre-Existing Conditions Limitation

This plan is subject to a pre-existing conditions limitation - a plan provision that excludes coverage for certain medical conditions for a set period of time. This typically applies if you had no coverage at all or a break in coverage prior to your enrollment with us. Please contact your Benefits Administrator, or refer to your Evidence of Coverage, for more information.

Conditions and Limitations

You are covered for emergencies anywhere in the world. If the situation is life-threatening, go straight to the nearest hospital's emergency room or call 911. If at all possible, try to reach your Health Net Advantage Platinum network primary care physician. Please be sure it is a true emergency. Many people go to the emergency room for things like colds, sore throats, coughs and routine fevers because it is convenient. While none of these problems constitutes an emergency, you are covered for all of them through a visit to your physician's office. You will be responsible for any emergency room charges when it is not an emergency.

Hospital Copayment Maximum

All of your in network inpatient hospital/facility copayments will be applied to the annual hospital copayment maximum of \$750 per member or \$1,500 per family per calendar year.

Out of Network Benefits

When using Out of Network benefit, prior authorization is required for all inpatient and outpatient hospital admissions, all elective ambulatory surgical procedures, and most diagnostic procedures performed in a non-plan Advantage Platinum network hospital or free-standing surgical center. To obtain prior authorization, please contact Health Net's Customer Contact Center at 1-800-441-5741. A penalty is applied to Out of Network reimbursement when the member does not complete the prior authorization process.

General Exclusions

You are not covered for physical exams for employment, insurance, school, premarital requirement or summer camp (unless substituted for a normal physical exam); prescription drugs, self-administered injectable or oral medication dispensed by a physician in his or her office; prescription drugs prescribed for a non-covered service; dental services unless provided by a rider to the Health Net Evidence of Coverage; eyeglasses or contact lenses unless provided by a rider to the Health Net Evidence of Coverage; hearing aids; routine foot care; foot orthotics; some transplant procedures; cosmetic or reconstructive surgery, unless medically necessary; custodial services; weight-reduction programs; marriage counseling; or long-term psychiatric treatment.

Health Net will not duplicate any benefits for which members are entitled under worker's compensation, No-Fault, Medicare, or other group health insurance coverage.

The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Health Net Evidence of Coverage is the final arbiter of coverage under Health Net. If you have any questions, please call the Health Net Customer Contact Center at 1-800-441-5741.

Directory by Web: www.Health.Net

Directory by Phone: 1.800.686.9847

Customer Contact Center: 1.800.441.5741

TTD/TTY: 1.888.747.2424 (For the hearing impaired)

Services are underwritten by Health Net Insurance of New York, Inc.