



Summary of Benefits

Health Net of New York, Inc. / Health Net Insurance of New York, Inc.

Charter POS Plan

Advantage Platinum Network

The New School - Charter \$1000 POS Plan

Effective: January 2009

The Health Net Charter POS 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 Charter POS gives you a powerful choice. You can work within the Health Net Advantage Platinum provider network or opt out, choosing a provider not affiliated with the Health Net. Care delivered within the Advantage Platinum network is covered as an HMO plan. Outside the Advantage Platinum network, care is subject to deductible, coinsurance, and claim forms typical of indemnity plans.

All benefits are on a Calendar Year basis. Calendar Year is the 12-month period beginning on January 1st and ending on December 31st of the same year.

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	Unlimited
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	\$20 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, covered for one pap test and two pelvic exams per Year	\$20 Copayment per Visit	Subject to Deductible and Coinsurance
Inpatient Care		
Semi-Private Room and Board	No Cost ^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	No Cost ^a	Subject to Deductible and Coinsurance ^a

Benefits	In Network	Out of Network
Outpatient Care		
Physician Office Visits	\$20 Copayment per Visit	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)	\$0 Copayment per Service ^a	Subject to Deductible and Coinsurance ^a
Physical, Occupational, Cognitive and Speech Therapy, combined maximum, 30 Visits per Year	\$20 Copayment per Visit ^a	Subject to Deductible and Coinsurance ^a
Outpatient Procedures and Surgery	No Cost ^a	Subject to Deductible and Coinsurance ^a
Cardiac Rehabilitation, 36 Visits within 12 Months following myocardial infarction or cardiac surgery	\$20 Copayment per Visit	Subject to Deductible and Coinsurance
Allergy Services	\$20 Copayment per Visit	Subject to Deductible and Coinsurance
Medical Care for injury and illness to the eye	\$20 Copayment per Visit	Subject to Deductible and Coinsurance
Emergency Care		
Urgent Care Center	\$25 Copayment per Visit	\$25 Copayment per Visit
Emergency Room	\$50 Copayment per Visit	\$50 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)	No Cost ^a	Subject to Deductible and Coinsurance ^a
Family Planning and Infertility Services (excludes In Vitro Fertilization, GIFT and ZIFT)	\$20 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	No Cost ^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 , with an additional 20 Visits per Year for Non-Biologically-based mental illness	\$20 Copayment per Visit Outpatient visits may require approval in advance. Please refer to your plan document for details.	Subject to Deductible and Coinsurance ^c Outpatient visits may require approval in advance. Please refer to your plan document for details.
Drug/Alcohol Addiction		
Inpatient Rehabilitative treatment for the abuse of, or addiction to drugs and alcohol, for up to 30 Days per Year	No Cost ^a	Subject to Deductible and Coinsurance ^a
Outpatient Rehabilitative Care for Drug/Alcohol Addiction, 60 Visits per Year; of the 60 Visits, up to 20 may be used for covered family members	\$20 Copayment per Visit ^a	Subject to Deductible and Coinsurance ^c ^a
Inpatient Diagnosis and Medical Treatment for Drug and Alcohol Detoxification, 7 Days per Year	\$0 Copayment per Admission per 90-day benefit period ^d ^a	Subject to Deductible and Coinsurance ^d ^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)	No Cost ^a	Subject to Deductible and Coinsurance ^a
Other Services		
Durable Medical Equipment(certain devices require prior authorization)	No Cost	No Cost
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	\$20 Copayment per Visit	Subject to Deductible and Coinsurance ^c
Acupuncture		
Acupuncture, 20 Visits per Year ^a	\$20 Copayment per Visit	Subject to Deductible and Coinsurance

Benefits	In Network	Out of Network
Diabetic Medications and Supplies		
Diabetic Medications and Supplies at a Plan Pharmacy	\$20 Copayment per each Diabetic Medication and Supply	Covered In Network Only
Routine Eye Care		
Vision Exam and Refraction: \$75 Annual allowance; Appliance: \$175 allowance every 24 Months	You pay and are reimbursed to allowed benefit limit	You pay and are reimbursed to allowed benefit limit
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.		

- a. When medically necessary and approved in advance by a Health Net medical director
- b. Once the visit limit has been exhausted, benefits will ONLY be available for biologically-based mental illness and for children with serious emotional disturbances
- c. For 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.
- d. All 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.

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.

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 and some injectable 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.healthnet.com

Directory by Phone: 1.800.686.9847

Customer Contact Center: 1.800.441.5741

TTD/TTY: 1.888.747.2424 (For the hearing impaired)

In-Network services are underwritten by Health Net of New York, Inc. and Out-of-Network services are underwritten by Health Net Insurance of New York, Inc.