OUT-OF-POCKET MAXIMUM - FRONT

health net

Post Office Box 9103 Van Nuys, California 91409-9103

OUT-OF-POCKET MAXIMUM NOTIFICATION

Copayments may be required for certain authorized services as indicated in your Evidence of Coverage booklet (EOC). There is a maximum amount of copayments which you are required to pay each calendar year. This is called Out-of-Pocket Maximum.

Refer to your EOC to determine the Out-of-Pocket Maximum applicable to your type of contract: single-party, two-party or family contract. (If you change contract types during the year, e.g., change from a single to a two-party contract, copayments made under the previous contract will apply toward your maximum under the new contract type.) When determining your Out-of-Pocket Maximum, drug copayments and costs for non-covered services do not apply. Please refer to your EOC for other services which may not be applicable to the Out-of-Pocket Maximum.

An individual member, regardless of the contract type, will only be required to satisfy a single-party copayment maximum per calendar year. No additional copayments are required for a member as of the date he or she satisfies the Member-level Out-of-Pocket Maximum. A Family-level Out-of-Pocket Maximum is satisfied by accumulation of all family members' copayments. These Out-of-Pocket Maximums are illustrated in the examples on the back of this form.

Use the bottom portion of this form to record the copayments you have paid during the year for services delivered to you and members of your family.

It is your responsibility to maintain records to validate when your Out-of-Pocket Maximum is reached. Attach all receipts or copies of cancelled checks for these copayments to this form.

As soon as you reach your maximum for this year, fill out the subscriber information requested below and mail a copy of this form and copies of your proofs of payment to Health Net, Post Office Box 9103, Van Nuys, CA 91409-9103, Attn: Claims.

SUBSCRIBER INFORMATION

SUBSCRIBER ID #	SUBSCRIBER NAME LAST	FIRST	MI
ADDRESS			
CITY		STATE	ZIP

SUBSCRIBER MEDICAL GROUP	CERTIFICATE #	GROUP #

RECORD OF EXPENSES

DATE OF SERVICE	PATIENT NAME / ILLNESS OR DIAGNOSIS	PROVIDER OF SERVICE (Hosp., Doctor, Lab, Ambul., RN, etc.) / DESCRIPTION OF SERVICES RENDERED	COPAYMENT
DATE OF SERVICE	PATIENT NAME / ILLNESS OR DIAGNOSIS	PROVIDER OF SERVICE (Hosp., Doctor, Lab, Ambul., RN, etc.) / DESCRIPTION OF SERVICES RENDERED	COPAYMENT
DATE OF SERVICE	PATIENT NAME / ILLNESS OR DIAGNOSIS	PROVIDER OF SERVICE (Hosp., Doctor, Lab, Ambul., RN, etc.) / DESCRIPTION OF SERVICES RENDERED	COPAYMENT
DATE OF SERVICE	PATIENT NAME / ILLNESS OR DIAGNOSIS	PROVIDER OF SERVICE (Hosp., Doctor, Lab, Ambul., RN, etc.) / DESCRIPTION OF SERVICES RENDERED	COPAYMENT
DATE OF SERVICE	PATIENT NAME / ILLNESS OR DIAGNOSIS	PROVIDER OF SERVICE (Hosp., Doctor, Lab, Ambul., RN, etc.) / DESCRIPTION OF SERVICES RENDERED	COPAYMENT
DATE OF SERVICE	PATIENT NAME / ILLNESS OR DIAGNOSIS	PROVIDER OF SERVICE (Hosp., Doctor, Lab, Ambul., RN, etc.) / DESCRIPTION OF SERVICES RENDERED	COPAYMENT
DATE OF SERVICE	PATIENT NAME / ILLNESS OR DIAGNOSIS	PROVIDER OF SERVICE (Hosp., Doctor, Lab, Ambul., RN, etc.) / DESCRIPTION OF SERVICES RENDERED	COPAYMENT
DATE OF SERVICE	PATIENT NAME / ILLNESS OR DIAGNOSIS	PROVIDER OF SERVICE (Hosp., Doctor, Lab, Ambul., RN, etc.) / DESCRIPTION OF SERVICES RENDERED	COPAYMENT
		TOTAL COPAYMENT	

CLM 114 01/01 (11/93)

SEE REVERSE SIDE FOR EXAMPLES OF MAXIMUM COPAYMENT LIABILITY