PLAN DISCLAIMER

This Schedule of Benefits is a brief list of benefits, with applicable copayments, coinsurance and deductibles information for your health plan. It does not list the exclusions and limitations or other important terms applicable to your plan.

The Evidence of Coverage (EOC) for your plan contains the complete terms and conditions of your Health Net coverage. It is important for you to thoroughly review the EOC for your plan.

Health Net California Large Group HMO Plan Chart ***Restricted* Plan DWU**	**DWU** **1/1/2017**
OUT-OF-POCKET MAXIMUM: All eligible copayments and coinsurance apply to OOPM.	
For each member.	$1,500
For each family (3 or more members).	$4,500
PROFESSIONAL SERVICES	
Visit to a physician, physician assistant or nurse practitioner at a PPG. [1]	$10
MDLive telehealth consultation. [2]	$0
Periodic health evaluations. Includes annual preventive physical examinations, preventive vision/hearing screenings, well-woman exam and other women's preventive services, preventive laboratory tests and x-rays. [1]	$0
Annual routine physical examinations. Provided for employment, school, camp or sports.	Not covered
Vision and hearing examinations.	$10
Specialist consultations. Includes OB/GYN self-referral. For podiatry services, refer below. For preventive services, refer to periodic health evaluations above. [1]	$10
Podiatry services, includes routine foot care for diabetes.	$10
Routine foot care (cutting/removal of corns, calluses, trimming of nails).	Not covered
Physician visit to member's home (at discretion of physician).	$20
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).	$0
Other immunizations (except foreign travel/occupational - see below).	$0
Immunizations for foreign travel/occupational purposes.	20%
Allergy testing.	$0
Allergy serum.	$0
Allergy injection services (serum not included).	$0
Injections related to infertility services.	50%
All other injections	
Office-based injectables. [1]	$0
Self-administered injectable medications (up to a 30-day supply for each prescription).	Refer to Pharmacy Benefits $0 per prescription
Surgeon/assistant surgeon.	$0
Administration of anesthetics.	$0
X-ray and laboratory procedures, including genetic testing. Preventive x-ray/lab, refer to periodic health evaluations above. [1]	$0
Rehabilitation therapy (outpatient physical, speech, occupational, cardiac and respiratory therapy). Provided as long as significant improvement is expected. For applied behavioral analysis (ABA), refer to the mental health benefits.	$0
Dental services (when medically necessary to properly monitor, control or treat a severe medical condition when excluded dental services are being performed).	$0
CARE FOR CONDITIONS OF PREGNANCY (professional services only)	
Prenatal and postnatal office visit.	$10
Normal delivery, complications of pregnancy and Cesarean section. Includes newborn inpatient care provided by a member physician.	$0
Abortions services	$0
Genetic testing of fetus.	$0
Circumcision of newborn.	$0
FAMILY PLANNING (professional services only)	
Contraceptive methods. Includes intrauterine device (IUD), injectable or implantable contraceptives. [1]	$0
Infertility services. Includes professional services, outpatient care, treatment by injection, prescription drugs if applicable, artificial insemination (AI), IUI and GIFT. **ZIFT and IVF are not covered.**	50%
Sterilization of females. [1]	$0
Sterilization of males.	$50
Reversal of sterilization.	Not covered
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.	$0
Patient education. Includes smoking cessation/weight management.	$0
Ambulance services (ground and air).	$0
Durable medical equipment. For preventive DME, refer to preventive care. [1]	$0
Orthotics (braces and supports).	$0
Corrective footwear. Custom made shoes and shoe inserts (custom foot orthotics).	Not covered
Diabetic supplies.	$0
Hearing aids.	Not covered
Medical supplies.	$0
Prosthesis (replacing body parts).	$0
Wigs (cranial prosthesis).	Not covered
Blood and blood products, except for blood-clotting factors, refer below.	$0
Blood-clotting factors (up to a 30-day supply for each prescription).	Refer to Pharmacy Benefits $0 per prescription
Nuclear medicine.	$0
Organ, tissue and stem cell transplants (non-experimental and noninvestigative. Professional services only).	$0
Gender reassignment travel and lodging.	$0 / $75,000 lifetime max [3]
Chemotherapy or radiation therapy.	$0
Renal dialysis.	$0
Home health visit. The copayment starts the 31st calendar day after the first visit.	$10
Hospice care.	$0
HOSPITAL AND SKILLED NURSING FACILITY SERVICES	
Unlimited days of hospital care (medical, surgical & maternity, including routine normal nursery charges) provided in a medically necessary private room, semi-private room or special care unit with ancillary services. Excludes care for mental disorders.	$0
Confinement in a skilled nursing facility (limited to 100 days a calendar year).	$0
Outpatient services.	$0
EMERGENCY CARE/URGENTLY NEEDED CARE - Within or outside the PPG service area -	
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.	
Emergency professional services.	$0
Use of emergency room (facility services). [4]	$35
Use of urgent care center. [4]	$35

1 Women's preventive care services include the following: Screening for gestational diabetes; human papilloma virus (HPV) DNA testing for women 30 years and older; sexually-transmitted infection counseling; human immunodeficiency virus (HIV) screening and counseling; family planning; FDA-approved contraception methods and contraceptive counseling; breastfeeding support, supplies and counseling; domestic violence screening and counseling; and preventive sterilizations. The applicable cost sharing for preventive care will apply to these services.

2 Telemedicine services are covered only when provided through the MDLive program. No benefit are payable for telehealth services billed by other providers.

3 Medically necessary gender reassignment services, including, but not limited to, psychotherapy, pre-surgical and post-surgical hormone therapy and surgical services (such as genital surgery and mastectomy), for the treatment of gender dysphoria or gender identity disorder are covered. Services not medically necessary for the treatment of gender dysphoria or gender identity disorder are not covered. Surgical services must be performed by a qualified provider in conjunction with gender reassignment surgery or a documented gender reassignment surgery treatment plan.

Reasonable travel, lodging and meal costs, as determined by Health Net Life for a covered member to undergo an authorized gender reassignment surgery are covered, limited to a lifetime maximum of $75,000. Travel and lodging are only available for the patient (companion not covered). Refer to the "Certification Requirement" section of the Plan Benefits" section for more information regarding certification requirements.

If member lives 50 miles or more from the nearest authorized gender reassignment facility, member is eligible to receive travel expense reimbursement, including clinical work-up, diagnostic testing and preparatory procedures, when necessary for the safety of the member and for the prior approved gender reassignment surgery. All requests for travel expense reimbursement must be prior approved by Health Net. Approved travel-related expenses will be reimbursed as follows: 1) Transportation for the member to and from the Health Net qualified facility is provided up to $130 per trip for a maximum of four (4) trips (pre-surgical work-up visit, one pre-surgical visit, the initial surgery and one follow-up visit). 2) Hotel accommodations for the member will not exceed $100 per day for the pre-surgical work-up, pre-surgical visit and the follow-up visit, up to two (2) days per trip or as medically necessary. Accommodations are limited to one room, double occupancy. 3) Other reasonable expenses are not to exceed $25 per day, up to two (2) days per trip for the pre-surgical workup, pre-surgical visit and follow-up visit and up to four (4) days for the surgery visit.
The following items are specifically excluded and will not be reimbursed: expenses for tobacco, alcohol, telephone, television and recreation are specifically excluded. Submission of adequate documentation, including receipts is required to receive travel expense reimbursement.

4 The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room or urgent care center.