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 GOF**	**GOF** **1/1/2021**
OUT-OF-POCKET MAXIMUM: All eligible copayments and coinsurance apply to OOPM.	
For each member.	$1,500
For each family.	$4,500
PROFESSIONAL SERVICES	
Visit to a physician, physician assistant or nurse practitioner at a PPG. [1]	$10
Performed at **CVS MinuteClinic** for preventive care services includes preventive physical examinations, other immunization and preventive laboratory tests. [1]	$0
Performed at a **CVS MinuteClinic** for all other non- preventive care services.	$10
Telemedicine services. [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 examinations for refractive eye exams.	$10
Hearing examinations for hearing loss.	$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.	Refer to Pharmacy Benefits
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
Complex radiology - CT, PET, MRI, SPECT, MUGA	$0
Rehabilitation therapy (outpatient physical, speech, occupational). Provided as long as significant improvement is expected. For applied behavioral analysis (ABA), refer to the mental health benefits.	$0
Respiratory therapy and cardiac rehabilitation.	$0
Habilitation therapy (physical, occupational, speech, respiratory and cardiac therapy). Applied behavioral analysis (ABA) is covered through the mental health benefit.	$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	

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Health Net California Large Group HMO Plan Chart *Restricted* Plan GOF	GOF 1/1/2021
OUT-OF-POCKET MAXIMUM: All eligible copayments and coinsurance apply to OOPM.	
For each member.	$1,500
For each family.	$4,500
Administered by Managed Health Network (MHN) **Refer members to the MHN telephone number on the back of their Health Net ID card**	

Health Net California Large Group HMO Plan Chart *Restricted* Plan GOF	GOF
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.[1]	$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.	Refer to Pharmacy Benefits
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
Infusion therapy.	
Administered at home.	$10
Administered in the office or outpatient facility.	$0
Home health visit. Includes home health rehab.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.	$35 medical services/ $10 behavioral health, chemical dependency or substance use disorders

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 Teladoc. For all other providers, telehealth cost share mirrors in-person cost share based on type of service provided.
3	Travel and lodging expenses are covered as part of the Transgender Surgery. Prior Authorization required. Health Net's Case Manager will determine and set guidelines for lodging/travel/meal expenses using Health Net's Corporate Travel guidelines. Travel/meal/lodging expenses are only available for the patient (companion not covered), which includes coverage for the following: Pre-op, surgical procedures, post-op visits to Northern California Transgender surgeon only. The maximum meal allowance is $55 per day. Only coach airfare is covered (patient will pay the difference to upgrade) and airport parking limited to long term parking rates for all over night trips in excess of one night. The traveling distance must be more than 50 miles from the provider for Health net to cover travel/lodging/meal expenses. Health Net will not prepay for travel/lodging/meals expenses. Reimbursement will be provided after submission of the claims reimbursement form along with receipts for pre-approved expenses. The authorization number must be indicated on all forms. For use of personal care, member must provide: Purpose of trip, date, location, receipts for tolls and parking (mileage will be reimbursed at federal mileage allowance rates).
4	The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room.