PLAN DISCLAIMER

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

The Certificate of Insurance (COI) for your insurance plan contains the complete terms and conditions of your Health Net Life Insurance Company coverage. It is important for you to thoroughly review the COI for your insurance plan.

Health Net California Large Group PPO ***Restricted* Plan GOG - Effective 1/1/2021**	**PPO**	**OON** Member pays coinsurance and any charges exceeding maximum allowable amount
Deductible Disclaimer: Through PPO, there is no calendar year deductible. Through OON, all services are subject to the deductible, unless otherwise noted.The member must satisfy the calendar-year deductible before benefit payment begins.		
Prior Authorization Disclaimer: Prior authorization is required for some services, refer to the appropriate prior authorization list for specific requirements or to the member's Certificate of Insurance (COI). If prior authorization is not acquired, benefits are reduced to 50%. In addition, for uncertified outpatient services, a $50 copayment is required for each visit; for uncertified inpatient admissions, a $500 copayment is required for each inpatient admission. **Penalties for uncertified services do not apply to OOPM.**		
CALENDAR YEAR DEDUCTIBLE: Through OON, 4th quarter deductible carryover applies.		
For each member.	None	$200
For each family.	None	$600
CALENDAR YEAR OUT-OF-POCKET MAXIMUM: All copayments, coinsurance and deductibles for medical, mental health and chemical dependency, including copayment/coinsurance for uncertified services apply to OOPM. The OON calendar year deductible is included in OOPM. PPO/OON cross-accumulate.		
For each member.	$1,500	
For each family.	$4,500	
PROFESSIONAL SERVICES		
Visit to a physician, physician assistant or nurse practitioner. [1]	$20	40%
Telemedicine services. [2]	$0	Not covered
Preventive care. 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	40%
Annual routine physical examinations. Provided for employment, school, camp or sports. Through PPO/OON, limited to calendar year maximum payment of $250.	$20	40%
Vision examinations for refractive eye exams. Children through age 16.	$20	40%
Adult (age 17 and older).	Not covered	Not covered
Hearing examinations for hearing loss. Children through age 16.	$20	40%
Adult (age 17 and older).	Not covered	Not covered
Specialist consultations (includes second surgical opinions). For podiatry services, refer below. For preventive services, refer to preventive care above. [1]	$20	40%
Podiatry services, includes routine foot care for diabetes.	$20	40%
Routine foot care (cutting/removal of corns, calluses, trimming of nails).	Not covered	Not covered
Physician visit to member's home (at discretion of physician).	20%	40%
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).	20%	40%
Immunizations (**excluding** foreign travel/occupational, see below).	$0	40%
Immunizations for foreign travel/occupational purposes.	Not covered	Not covered
Allergy testing.	$20	40%
Allergy serum.	20%	40%
Allergy injection services (serum not included).	$20	40%
Injections for treatment of infertility.	Not covered	Not covered
All other injections		
Office based injectable medications. [1]	$20	40%
Self-administered injectable medications.	Refer to Pharmacy Benefits	Not covered
Surgeon/ assistant surgeon.	20%	40%
Administration of anesthetics.	20%	40%
X-ray and laboratory procedures, including genetic testing. Preventive x-ray/lab, refer to preventive care above. [1]	20%	40%
Complex radiology (CT scan, PET, MRI, SPECT, MUGA).	20%	40%
Physical, speech, and occupational therapy. includes ABA. Visit maximum combined for all therapies.	20%	40% Combined limit of 20 visits per cal year (PPO/OON) [4]
Cardiac and respiratory therapy. Visit maximum combined for all therapies.	20%	40% Combined limit of 20 visits per cal year (PPO/OON) [4]
Habilitation therapy (physical, occupational, speech, respiratory and cardiac therapy). Applied behavioral analysis (ABA) is covered through the mental health benefit.	20%	40% Combined limit of 20 visits per cal year (PPO/OON) [4]
Dental services (when medically necessary to properly monitor, control or treat a severe medical condition when excluded dental services are being performed).	20%	40%

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CARE FOR CONDITIONS OF PREGNANCY		
Prenatal office visit.	$0	40%
Postnatal office visit.	20%	40%
Normal delivery, complications of pregnancy and Cesarean section. Includes newborn inpatient professional care. [3]	20%	40%
Abortion services.	20%	40%
Genetic testing of fetus.	20%	40%
Circumcision of newborn.	20%	40%
FAMILY PLANNING (professional services only)		
Contraceptive methods. Includes intrauterine device (IUD), injectable or implantable contraceptives. [1]	$0	40%
Infertility services (including professional services, outpatient care and treatment by injection).	Not covered	Not covered
Sterilization of females. [1]	$0	40%
Sterilization of males.	20%	40%
Reversal of sterilization.	Not covered	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**		
OTHER SERVICES		
Medical social services.	20%	40%
Patient education.		
Patient education for diabetes only.	20%	40%
Smoking cessation/weight management.	$0	Not covered
Ambulance services (air and ground)	20%	40%
Durable medical equipment. For preventive DME, refer to preventive care. [1]	20%	40%
Orthotics (braces and supports).	20%	40%
Corrective footwear. Custom made shoes and shoe inserts (custom foot orthotics).	20%	40%
Diabetic supplies.	20%	40%
Hearing aids.	Not covered	Not covered
Medical supplies.[1]	20%	40%
Prosthesis (replacing body parts).	20%	40%
Wigs (cranial prosthesis).	Not covered	Not covered
Acupuncture.	Not covered	Not covered
Chiropractic care. Through PPO, a separate $200 deductible applies each calendar year in addition to the 20% coinsurance. Once the $200 deductible is satisfied, only the 20% coinsurance applies.	20% Combined limit of 15 visits per cal year (PPO/OON)	40%
Blood and blood products, except for blood clotting factors, refer below.	20%	40%
Blood clotting factors.	Refer to Pharmacy Benefits	Not covered
Nuclear medicine.	20%	40%
Organ, tissue and stem cell transplants (non-experimental and noninvestigative. Professional services only.)	20%	Not covered
Travel, lodging and meals expenses (bariatric surgery).	$0	$0 ded waived
Travel, lodging and meals expenses (related to gender reassignment surgical procedures).	20% Combined lifetime maximum of $75,000 (PPO/OON) [5]	40%

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	When provided through preferred vendor; For all other providers, telehealth cost share mirrors in-person cost share based on type of service provided.
3	In accordance with the Affordable Care Act, prenatal obstetrical office visits are covered as a preventive care service without member cost share responsibility on all in-network benefit tiers.
4	Additional visits are payable if precertified as medically necessary following neurological and orthopedic surgery, cerebral cardiovascular accident, third degree burns, head trauma or spinal cord injuries. Medically necessary rehabilitation therapy or habilitative services for treatment of autism or pervasive developmental disorder are not subject to the 20-visit limitation.
5	Gender reassignment surgery must be performed by Health Net-qualified provider in conjunction with gender transformation treatment. Prior authorization is required from Health Net. Reasonable travel, lodging and meal costs, as determined by Health Net Life, for a member to undergo an authorized gender reassignment surgery are subject to a $75,000 lifetime maximum. Travel and lodging are only available for the patient (companion not covered). **Note**: Non-surgical services related to gender reassignment treatment, such as psychotherapy for gender identity disorders and pre & post-surgical hormone therapy are included within the other covered plan benefits, e.g. mental health.

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OTHER SERVICES continued		
Chemotherapy.	20%	40%
Radiation therapy.	20%	40%
Renal dialysis.	20%	40%
Home health visit, including home health rehab.	20%	40%
Infusion therapy (home or physician's office or outpatient).	20%	40%
Hospice care (elected by member).	20%	40%
HOSPITAL AND SKILLED NURSING FACILITY		
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. For newborns, a separate copayment/coinsurance will apply to a newborn requiring admission to a special care unit.	$250 + 20%	$250 + 40%
Confinement in a skilled nursing facility.	$250 + 20%	$250 + 40%
Outpatient services.	$0	40%
EMERGENCY ROOM / URGENT CARE CENTER		
Emergency room (professional services).	20%	20% ded waived
Use of emergency room (facility services).	20%	20% ded waived
Use of urgent care center.	20% [6]	20% ded waived

6 20% for medical services; $20 for behavioral health, chemical dependency, or substance use disorders.