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 DWV - Effective 1/1/2017	**PPO**	**OON** Member pays coinsurance and any charges exceeding maximum allowable amount
Note: Through PPO, there is no calendar year deductible. Health Net will pay 100% of covered expenses (excluding copayments or coinsurance). Through OON, unless noted otherwise, services are subject to the deductible and the member must satisfy the calendar-year deductible before benefit payment begins.		
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 calender year deductible is included in OOPM. PPO/OON cross-accumulate.		
For each member.	$1,500	
For each family.	$4,500	
LIFETIME BENEFIT MAXIMUM		
For each member or family.	Unlimited	
PROFESSIONAL SERVICES		
Visit to a physician, physician assistant or nurse practitioner. [1]	$20	40%
MDLive telehealth consultation. [2]	$0	Not covered
Preventive care		
Child (through age 16). Includes annual preventive physical examinations, preventive vision/hearing screenings and preventive laboratory tests and x-rays. [1]	$0	40%
Adult (age 17 and older). 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. Only specified medications require certification. [1, 3]	$20	40%
Self-administered injectable medications (up to a 30-day supply for each prescription). Certification required by Health Net Pharmacy. [3]	Refer to Pharmacy Benefits $20 per prescription	Not covered
Surgeon/ assistant surgeon. Only specified procedures require certification. [3]	20%	40%
Administration of anesthetics.	20%	40%
X-ray and laboratory procedures, including genetic testing. Only specified procedures require certification. Preventive x-ray/lab, refer to preventive care above. [1, 3]	20%	40%
Physical, speech, occupational, cardiac and respiratory therapy. Visit maximum combined for all therapies. Only specified procedures require certification. [3]	20%	40% Combined limit of 20 visits (PPO/OON) [4]
Habilitation therapy (physical, occupational, speech, respiratory and cardiac therapy). Applied behavioral analysis (ABA) is covered through the mental health benefit.	Not covered	Not covered
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, 5]	20%	40%
Abortion services.	20%	40%
Genetic testing of fetus. [3]	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
CARE FOR MENTAL DISORDERS		
Severe Mental Illnesses Severe mental illnesses include the following conditions: Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder (e.g., autism), anorexia nervosa, bulimia nervosa, and serious emotional disturbances in children.		
Outpatient mental visit for severe mental illness / physician visit to home.	$20	40%
Outpatient mental health - other (includes alternate care; partial hospitalization / day treatment/intensive outpatient programs).[3]	$0	40%
Inpatient care in a hospital or residential treatment facility for severe mental illness. [3]	$250 + 20%	$250 + 40%
Physician visit to hospital or residential treatment facility for severe mental illness.	20%	40%
Other Mental Illnesses (Non-severe mental illnesses)		
Outpatient mental visit for non-severe mental illness / physician visits to home.	$0	$0 ded waived
Outpatient mental health - other (includes alternate care; partial hospitalization / day treatment/intensive outpatient programs).[3]	$0	$0 ded waived
Inpatient care in a hospital or residential treatment facility for non-severe mental illness. [3]	20%	20% ded waived
Physician visit to hospital or residential treatment facility for non-severe mental illness.	20%	20% ded waived
CHEMICAL DEPENDENCY REHABILITATION		
Outpatient office visit (therapy, counseling and/or psychological testing), including physician visit to home.	$0	$0 ded waived
Outpatient chemical dependency - other (includes alternate care; partial hospitalization / day treatment/intensive outpatient programs).	$0	$0 ded waived
Outpatient detoxification.	20%	20% ded waived
Inpatient detoxification (acute care for substance abuse).[3]	20%	20% ded waived
Inpatient rehabilitation for chemical dependency in a hospital or residential chemical dependency facility. [3]	20%	20% ded waived
Physician chemical dependency visit to hospital.	20%	20% ded waived

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 telemedicine services billed by other providers.
3	These services require prior certification before being provided or received. If prior certification 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. Copayment penalties do not apply to OOPM. Refer to the Certification list for additional information. **NOTE:** Routine care for conditions of pregnancy does not require prior certification, however, notification is requested.
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	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.

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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). [3]	20%	40%
Durable medical equipment. For preventive DME, refer to preventive care. [3]	20%	40%
Orthotics (braces and supports). Custom orthotics require certification.[3]	20%	40%
Corrective footwear. Custom made shoes and shoe inserts (custom foot orthotics). [3]	20%	40%
Diabetic supplies.	20%	40%
Hearing aids.	Not covered	Not covered
Medical supplies.	20%	40%
Prosthesis (replacing body parts). [3]	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.	$200 + 20%	40% Combined limit of 15 visits (PPO/OON)
Blood and blood products, except for blood clotting factors, refer below. Only specified blood products require certification. [3]	20%	40%
Blood clotting factors (up to a 30-day supply for each prescription). [3]	Refer to Pharmacy Benefits $20 per prescription	Not covered
Nuclear medicine.	20%	40%
Organ, tissue and stem cell transplants (non-experimental and noninvestigative. Professional services only.) [3]	20%	Not covered
Gender reassignment travel, lodging and meals.	20%	40% Combined lifetime maximum of $75,000 (PPO/OON) [6]
Chemotherapy.	20%	40%
Radiation therapy. [3]	20%	40%
Renal dialysis.	20%	40%
Home health visit.	20%	40%
Infusion therapy (home or physician's office).	20%	40%
Hospice care (elected by member). [3]	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 coinsurance will apply to a newborn requiring admission to a special care unit. [3]	$250 + 20%	$250 + 40%
Confinement in a skilled nursing facility. [3]	$250 + 20%	$250 + 40%
Outpatient services. Only specified procedures require certification. [3]	$0	40%
EMERGENCY ROOM / URGENT CARE CENTER		
Emergency professional services.	20%	20% ded waived
Use of emergency room (facility services).	20%	20% ded waived
Use of urgent care center.	20%	20% ded waived

3 These services require prior certification before being provided or received. If prior certification 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. Copayment penalties do not apply to OOPM. Refer to the Certification list for additional information. **NOTE:** Routine care for conditions of pregnancy does not require prior certification, however, notification is requested.

6 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.