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 (A) ***Restricted* Plan FOH - Effective 1/1/2020**	**PPO**	**OON** Member pays coinsurance and any charges exceeding maximum allowable amount
Deductible disclaimer All services are subject to the deductible, unless noted otherwise. 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 by 20%. **Penalties for uncertified services do apply to OOPM.**		
CALENDAR YEAR DEDUCTIBLES: 4th quarter deductible carryover applies. Deductible is included in the OOPM and PPO/OON cross-accumulate.		
For each member.	$250	
For each family.	Three family members must satisfy their individual deductibles to satisfy the family deductible.	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOPM): All eligible copayments/coinsurance for medical, mental health and chemical dependency, including uncertified services, apply to OOPM. PPO/OON cross-accumulate.		
For each member.	$1,500	$5,000
For each family.	$3,000	$10,000
LIFETIME MAXIMUM BENEFIT		
For each member.	Unlimited	
PROFESSIONAL SERVICES		
Visit to a physician, physician assistant or nurse practitioner. [1]	$10 ded waived	30%
Preventive care. Includes annual preventive physical examinations, preventive vision/hearing screenings, well-woman exam and preventive laboratory tests and x-rays. [1]	$0 ded waived	Not covered
Annual routine physical examinations. Provided for employment, school, camp or sports.	Not covered	Not covered
Vision examinations for refractive eye exams. Child (newborn until age 2).	$0 ded waived	Not covered
Child (age 2 through age 16).	$10 ded waived	Not covered
Adult (age 17 and older).	Not covered	Not covered
Hearing examinations for hearing loss. Child (newborn until age 2).	$0 ded waived	Not covered
Child (age 2 through age 16).	$10 ded waived	Not covered
Adult (age 17 and older).	Not covered	Not covered
Specialist consultations (includes second surgical opinions). For preventive services, refer to preventive care above. [1]	$10 ded waived	30%
Podiatry services, includes routine foot care for diabetes.	$10 ded waived	30%
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).	10%	30%
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).	10%	30%
Immunizations (**except** foreign travel/occupational purposes, refer below).	$0 ded waived	Not covered
Immunizations for foreign travel/occupational purposes.	Not covered	Not covered
Allergy testing.	50%	50%
Allergy serum.	50%	50%
Allergy injection services (serum not included).	10%	30%
Injections for treatment of infertility. **Deductible required.**	50% [2]	50% [2]
All other injections		
Office based injectable medications. [1]	10%	30%
Self-administered injectable medications (up to a 30-day supply for each prescription).	Refer to pharmacy benefits 10% up to $250 max per Rx	Not covered
Surgeon/ assistant surgeon.	10%	30%
Administration of anesthetics.	10%	30%
X-ray and laboratory procedures, including genetic testing. Preventive x-ray/lab, refer to preventive care above. [1]	10%	30%
Rehabilitation therapy (outpatient physical, speech, and occupational), including ABA therapy services.	10%	30%
Cardiac and respiratory therapy.	10%	30%
Habilitation therapy (physical, occupational, speech, respiratory and cardiac therapy). For applied behavioral analysis (ABA), refer to the mental health benefits.	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).	10%	30%
CARE FOR CONDITIONS OF PREGNANCY		
Prenatal office visit.	$0 ded waived	30%
Postnatal office visit.	10%	30%
Normal delivery, cesarean section and complications of pregnancy. Includes newborn inpatient care provided by a member physician. [3]	10%	30%
Abortions services.	10%	30%
Genetic testing of fetus.	10%	30%
Circumcision of newborn.	10%	30%

Health Net Large Group PPO - Plan FOH	PPO	OON Member pays coinsurance and any charges exceeding maximum allowable amount
Deductible disclaimer All services are subject to the deductible, unless noted otherwise. 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 by 20%. **Penalties for uncertified services do apply to OOPM.**		
FAMILY PLANNING (professional services only)		
Contraceptive methods. Includes intrauterine device (IUD), injectable or implantable contraceptives. [1]	$0 ded waived	Not covered
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. Deductible required.**	50% [2]	50% [2]
Sterilization of females.[1]	$0 ded waived	30%
Sterilization of males.	10%	30%
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.	10%	30%
Patient education.		
Patient education for diabetes only.	10%	30%
Smoking cessation/weight management.	$0 ded waived	Not covered
Ambulance services (air and ground).	10%	10%
Durable medical equipment. For preventive DME, refer to preventive care. [1]	50%	50%
Orthotics (braces and supports).	10%	30%
Corrective footwear. Custom made shoes and shoe inserts (custom foot orthotics).	10%	30%
Diabetic supplies (except footwear, see below).	20%	50%
Diabetic footwear.	10%	30%
Medical supplies.[1]	10%	30%
Hearing aids.	Not covered	Not covered
Prosthesis (replacing body parts).	10%	30%
Wigs (cranial prosthesis).	Not covered	Not covered
Acupuncture.	20%	20%
Chiropractic care.	Not covered	Not covered
Blood and blood products, except for blood clotting factors, refer below.	10%	10%
Blood clotting factors (up to a 30-day supply for each prescription).	Refer to pharmacy benefits 10% up to $250 max per Rx	Not covered

1 **Women's preventive care services include the following:** Screening for gestational diabetes; human papillomavirus (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 Infertility services require a separate lifetime deductible of $500. The $500 lifetime deductible applies towards the member's OOPM. Also, infertility services, supplies, injections and medications, are limited to a maximum benefit of $2,500 per calendar year and a lifetime maximum benefit of $10,000. This maximum is combined through PPO and OON.

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.

Health Net Large Group PPO - Plan FOH	PPO	OON Member pays coinsurance and any charges exceeding maximum allowable amount
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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 by 20%. **Penalties for uncertified services do apply to OOPM.**		
OTHER SERVICES (continued)		
Nuclear medicine.	10%	30%
Organ, tissue and stem cell transplants (non-experimental and noninvestigative. Professional services only).	10%	30%
Chemotherapy.	10%	30%
Radiation therapy.	10%	30%
Renal dialysis.	10%	30%
Home health visit. Includes home health rehab.	20%	20% Combined limit of 100 visits (PPO/OON)
Infusion therapy (home, outpatient or physician's office).	20%	20%
Hospice care (elected by member).	20%	20%
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.	10%	30%
Confinement in a skilled nursing facility.	20%	20% Combined limit of 100 days per year (PPO/OON)
Outpatient services.	10%	30%
EMERGENCY ROOM / URGENT CARE CENTER		
Emergency professional services	10%	10%
Use of emergency room (facility services).	10% [4]	10% [4]
Use of urgent care center.	10% [4]	10% [4]

4 An additional $50 emergency room or urgent care deductible is required if the member is not admitted as an inpatient. The emergency room deductible is waived if admitted.

Health Net

CALIFORNIA BENEFIT DESIGN / SCHEDULE OF BENEFITS
MENTAL HEALTH / CHEMICAL DEPENDENCY TREATMENT
MH PLAN CODE YYI, EFFECTIVE 1/1/2020

BENEFITS	Plan Coverage	
Calendar Year Deductible (combined for medical and mental health/chem. dep. plan)	In-Network	Out -of Network
For each member	$250	
For each family	3 per family	
Out-of-Pocket Maximum (combined for medical and mental health/chem. dep. plan)		
For each member	$1,500	$5,000
For each family	$3,000	$10,000
Emergency Services in an Emergency Room (mental health/chemical dependency treatment)		
Professional services	10% [deduct applies]	10% [deduct applies]
Use of emergency room (facility services) [1]	$50 + 10% [deduct applies]	$50 + 10% [deduct applies]
Ground Ambulance.	10% [deduct applies]	10% [deduct applies]
Air ambulance	10% [deduct applies]	10% [deduct applies]
Non-Emergency Services		
Professional Basis for Reimbursement: Non Par Provider	Negotiated Rate	Maximum Allowable Amount (100% of Medicare Allowable Amount)
Institutional Basis for Reimbursement: Non Par Provider	Negotiated Rate	Maximum Allowable Amount (150% of Medicare Allowable Amount)
MAA Default	Negotiated Rate	75% Billed Charges
Penalty Inpatient Copay	N/A	
Penalty outpatient Copay	N/A	
Reduce Coinsurance by:	20%	20%
Laboratory Services, administered on behalf of Health Net (medical benefit provided by MHN)		
Laboratory services	10% [deduct applies]	30% [deduct applies]
Severe Mental Illnesses [2]		
Outpatient mental health - consultation	$10 [deduct waived]	30% [deduct applies]
Outpatient mental health - group therapy session	$10 [deduct waived]	30% [deduct applies]
Outpatient mental health - telemedical services [3]	Not Covered	Not Covered
Maximum visits per calendar year	Unlimited	Unlimited
Outpatient mental health - other (includes alternate care: partial hospitalization/ day treatment/ intensive outpatient programs)	$0 [deduct waived]	30% [deduct applies]
Inpatient care in a hospital, excluding residential treatment centers	10% [deduct applies]	30% [deduct applies]
Residential treatment centers	10% [deduct applies]	30% [deduct applies]
Maximum days per calendar year	Unlimited	Unlimited
Inpatient physician visits	10% [deduct applies]	30% [deduct applies]
Other Mental Illnesses		
Outpatient mental health - consultation	$10 [deduct waived]	30% [deduct applies]
Outpatient mental health - group therapy session	$10 [deduct waived]	30% [deduct applies]
Outpatient mental health - telemedical services [3]	Not Covered	Not Covered
Maximum visits per calendar year	Unlimited	Unlimited
Outpatient mental health - other (includes alternate care: partial hospitalization/ day treatment/ intensive outpatient programs)	$0 [deduct waived]	30% [deduct applies]
Inpatient care in a hospital, excluding residential treatment centers	10% [deduct applies]	30% [deduct applies]
Residential treatment centers	10% [deduct applies]	30% [deduct applies]
Maximum days per calendar year	Unlimited	Unlimited
Inpatient physician visits	10% [deduct applies]	30% [deduct applies]
Chemical Dependency Rehabilitation & Detoxification		
Outpatient chemical dependency - consultation	$10 [deduct waived]	30% [deduct applies]
Outpatient chemical dependency - group therapy session	$10 [deduct waived]	30% [deduct applies]
Outpatient chemical dependency - telemedical services [3]	Not Covered	Not Covered
Maximum visits per calendar year	Unlimited	Unlimited
Outpatient chemical dependency - other (includes outpatient detoxification and alternate care: partial hospitalization/ day treatment/ intensive outpatient programs)	$0 [deduct waived]	30% [deduct applies]
Inpatient care in a hospital, excluding residential treatment centers	10% [deduct applies]	30% [deduct applies]
Residential treatment centers	10% [deduct applies]	30% [deduct applies]
Maximum days per calendar year	Unlimited	Unlimited
Inpatient physician visits	10% [deduct applies]	30% [deduct applies]
Detoxification	10% [deduct applies]	30% [ded applies]
Maximum days per calendar year	Unlimited	Unlimited

[1] The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room.

[2] The following conditions are considered severe mental illnesses: Anorexia nervosa, bulimia nervosa, bipolar disorder, major depressive disorders, pervasive developmental disorder (e.g., autism), panic disorder, schizophrenia, schizo affective disorder and serious emotional disturbances of children.

[3] Telemedicine Services only covered thru TELADOC Program.