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 SmartCare HMO (A) ***Restricted* Plan GIV**	**GIV** **1/1/2020**
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOPM): All eligible copayments and coinsurance apply to OOPM.	
For each member.	$1,500
For each family.	$3,000
PROFESSIONAL SERVICES	
Visit to a physician, physician assistant or nurse practitioner. [1]	
Performed at member's participating physician group (PPG).	$15
Performed at a CVS MinuteClinic for preventive care services. Includes preventive physical examinations, other immunizations and preventive laboratory tests. [1]	$0
Performed at a CVS MinuteClinic for all other non-preventive care services.	$15
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.	$15
Hearing examinations for hearing loss.	$15
Specialist consultations. Includes OB/GYN self-referral for non-preventive services. For preventive services, refer to periodic health evaluations above. [1]	$15
Podiatry services, includes routine foot care for diabetes.	$15
Routine foot care (cutting/removal of corns, calluses, trimming of nails).	Not covered
Physician visit to member's home (at discretion of physician).	$15
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 injectable medications. [1]	$0
Self-administered injectables (up to a 30-day supply for each prescription).	Refer to Pharmacy Benefits 30% up to a max of $250 per Rx
Surgeon/assistant surgeon.	$0
Administration of anesthetics.	$0
X-ray and laboratory procedures, including genetic testing and complex radiology (CT, SPECT, MRI, MUGA and PET). Preventive x-ray/lab, refer to periodic health evaluations or CVS Minute Clinic preventive care services above.[1]	$0
Rehabilitation therapy (outpatient physical, speech, and occupational), including ABA therapy services.	$15
Cardiac and respiratory therapy.	$15
Habilitation therapy (physical, occupational, speech, respiratory and cardiac therapy). Applied behavioral analysis (ABA) is covered through the mental health benefit.	Not covered
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.	$15
Normal delivery, cesarean section and complications of pregnancy. Includes newborn inpatient professional care.	$0
Abortion services.	$0
Genetic testing of fetus.	$0
Circumcision of newborn.	$0

Health Net California Large Group SmartCare HMO *Restricted* Plan GIV	GIV 1/1/2020
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.	
Performed in an office.	$50
Performed in an outpatient facility.	$0
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**	
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 (except footwear, see below).	$0
Diabetic footwear.	$0
Medical supplies. [1]	$0
Hearing aids.	Not covered
Prosthesis (replacing body parts).	$0
Wigs (cranial prosthesis).	Not covered
Blood and blood products.	$0
Blood clotting factors (up to a 30-day supply for each prescription).	Refer to Pharmacy Benefits 30% up to a max of $250 per Rx
Nuclear medicine.	$0
Organ, tissue and stem cell transplants (non-experimental and noninvestigative professional services only).	$0
Chemotherapy or radiation therapy.	$0
Infusion therapy.	
Performed at home.	$15
Performed in an office and outpatient facility.	$0
Renal dialysis.	$0
Home health visit. Includes home health rehabilitation. The copayment starts the 31st calendar day after the first visit.	$15 / 100 visits
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).	$500 per admit
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 room (professional services).	$0
Use of emergency room (facility services). [3]	$50
Use of urgent care center.	$25

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; breast-feeding 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. No benefits are payable for Telemedicine services billed by other providers.
3	The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room.

Health Net

CALIFORNIA BENEFIT DESIGN / SCHEDULE OF BENEFITS
MENTAL HEALTH / CHEMICAL DEPENDENCY TREATMENT
MH PLAN CODE V9V, EFFECTIVE 1/1/2020

BENEFITS	Plan Coverage
Calendar Year Deductible (combined for medical and mental health/chem. dep. plan)	**Plan Coverage**
For each member	N/A
For each family	N/A
Out-of-Pocket Maximum (combined for medical and mental health/chem. dep. plan)	**Plan Coverage**
For each member	$1,500
For each family	$3,000
Emergency Services in an Emergency Room (mental health/chemical dependency treatment)	**Plan Coverage**
Professional services	$0
Use of emergency room (facility services)[1]	$50
Ground Ambulance.	$0
Air ambulance	$0
Laboratory Services, administered on behalf of Health Net (medical benefit provided by MHN)	**Plan Coverage**
Laboratory services	$0
Severe Mental Illnesses [2]	**Plan Coverage**
Outpatient mental health - consultation	$15
Outpatient mental health - consultation/telemedical services[3]	$0
Outpatient mental health - group therapy session	$7.50
Maximum visits per calendar year	Unlimited
Outpatient mental health - other (includes alternate care: partial hospitalization/ day treatment/ intensive outpatient programs)	$0
Inpatient care in a hospital, excluding residential treatment centers	$0
Residential treatment centers	$0
Maximum days per calendar year	Unlimited
Inpatient physician visits	$0
Other Mental Illnesses	**Plan Coverage**
Outpatient mental health - consultation	$15
Outpatient mental health - consultation/telemedical services[3]	$0
Outpatient mental health - group therapy session	$7.50
Maximum visits per calendar year	Unlimited
Outpatient mental health - other (includes alternate care: partial hospitalization/ day treatment/ intensive outpatient programs)	$0
Inpatient care in a hospital, excluding residential treatment centers	$0
Residential treatment centers	$0
Maximum days per calendar year	Unlimited
Inpatient physician visits	$0
Chemical Dependency Rehabilitation & Detoxification	**Plan Coverage**
Outpatient chemical dependency - consultation	$15
Outpatient chemical dependency - consultation/telemedical services[3]	$0
Outpatient chemical dependency - group therapy session	$7.50
Maximum visits per calendar year	Unlimited
Outpatient chemical dependency - other (includes outpatient detoxification and alternate care: partial hospitalization/ day treatment/ intensive outpatient programs)	$0
Inpatient care in a hospital, excluding residential treatment centers	$0
Residential treatment centers	$0
Maximum days per calendar year	Unlimited
Inpatient physician visits	$0
Detoxification	$0
Maximum days per calendar year	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