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 (B) ***Restricted* Plan E8Q**	**E8Q** **1/1/2020**
OUT-OF-POCKET MAXIMUM (OOPM): All eligible copayments and coinsurance apply to OOPM.	
For each member.	$2,000
For each family.	$6,000
PROFESSIONAL SERVICES	
Visit to a physician, physician assistant or nurse practitioner at a PPG. [1]	$20
Telemedicine services. [2]	$0 [2]
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. Limited to coverage provided for employment, school, camp or sports.	Not Covered
Vision examinations for refractive eye exams.	$20
Hearing examinations for hearing loss.	$20
Specialist consultations. Includes OB/GYN self-referral for non-preventive services. For preventive services, refer to periodic health evaluations above. [1]	$20
Podiatry services, includes routine foot care for diabetes.	$20
Routine foot care (cutting/removal of corns, calluses, trimming of nails).	Not covered
Physician visit to member's home (at discretion of physician).	$40
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 injectable medications (up to a 30-day supply for each prescription).	Refer to Pharmacy Benefits $0 per prescription
Surgeon/assistant surgeon in hospital or PPG.	$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
Rehabilitation therapy (outpatient physical, speech, occupational, cardiac, and respiratory therapy). Provided as long as significant improvement is expected.	$0
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.	$20
Normal delivery, Cesarean section and complications of pregnancy. 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	
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 *Restricted* Plan E8Q	E8Q 1/1/2020
OTHER SERVICES	
Medical social services.	$0
Patient education. Includes smoking cessation/weight management.	$0
Ground and air ambulance.	$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
Medical supplies.	$0
Hearing aids.	Not covered
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 (up to a 30-day supply for each prescription).	Refer to Pharmacy Benefits $0 per prescription
Nuclear medicine.	$0
Organ, tissue and stem cell transplants. (non-experimental and noninvestigative. Professional services only).	$0
Chemotherapy or radiation therapy.	$0
Renal dialysis.	$0
Home health visit. The copayment starts the 31st calendar day after the first visit.	$20
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. For newborns, a separate copayment will apply to a newborn requiring admission to a special care unit.	$1,000
Confinement in a skilled nursing facility (limited to 100 days a calendar year).	$1,000
Outpatient services.	
Outpatient services other than surgery.	$0
Outpatient surgery at hospital or ambulatory surgical center.	$500
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). [3]	$100
Use of urgent care center.	$50

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	Telemedicine services are covered only when provided through the TELADOC Program. 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 YFE, EFFECTIVE 1/1/2020

BENEFITS	Plan Coverage
Calendar Year Deductible (combined for medical and mental health/chem. dep. plan)	
For each member	N/A
For each family	N/A
Out-of-Pocket Maximum (combined for medical and mental health/chem. dep. plan)	
For each member	$2,000
For each family	$6,000
Emergency Services in an Emergency Room (mental health/chemical dependency treatment)	
Professional services	$0
Use of emergency room (facility services) [1]	$100
Ground Ambulance.	$0
Air ambulance	$0
Laboratory Services, administered on behalf of Health Net (medical benefit provided by MHN)	
Laboratory services	$0
Severe Mental Illnesses [2]	
Outpatient mental health - consultation	$5
Outpatient mental health - consultation/telemedical services[3]	$0
Outpatient mental health - group therapy session	$2.50
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	
Outpatient mental health - consultation	$5
Outpatient mental health - consultation/telemedical services[3]	$0
Outpatient mental health - group therapy session	$2.50
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	
Outpatient chemical dependency - consultation	$5
Outpatient chemical dependency - consultation/telemedical services[3]	$0
Outpatient chemical dependency - group therapy session	$2.50
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 Program