Health Net California Seniority Plus (B) ***Restricted* Group Plan Chart - AY2**	**AY2** **1/1/2020**
PROFESSIONAL SERVICES	
Visit to a physician, physician assistant or nurse practitioner at a PPG.	$20
Periodic health evaluations / Preventive services. [1]	$0
Podiatry services	
Medicare-covered podiatry services. Medically necessary treatment of injuries and diseases of the feet and foot care for members with certain medical conditions.	$20
Routine podiatry services. Cutting/removal of corns or calluses, trimming of nails, preventative maintenance care. Limited to 1 visit each calendar month.	$20
Chiropractic services	
Medicare-covered chiropractic services at a Medicare Advantage PPG. Limited to the Medicare allowed chiropractic benefit.	$20
Welcome to Medicare Physical Exam / Annual Wellness Visit. [2]	$0
Vision services	
Medicare-covered vision examinations - diagnosis and treatment for diseases and conditions of the eye.	$20
Routine vision examinations (refraction).	$20
Glaucoma test (Medicare-covered) including office visit.	$0
Eyewear (Medicare covered only). Limited to one pair of eyeglasses or contact lenses after each cataract surgery.	$0
Hearing examinations	
Medicare-covered hearing examinations (diagnostic hearing exams).	$20
Routine hearing examinations.	$20
Specialist consultations.	$20
Physician visit to member's home (at discretion of physician).	$20
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).	$0
Immunizations	
Medicare-covered immunizations (flu shot, pneumococcal and Hepatitis B).	$0
Other medically necessary immunizations as determined by Medicare, such as, but not limited to rabies and tetanus vaccines.	$0
Immunizations for foreign travel/occupational purposes.	20%
Administration of injected substances (including allergy injections).	$0
Part B drugs. Injected substances provided and administered by a physician.	$0
Immunosuppressive drugs. Covered following a covered transplant in accordance with Medicare guidelines.	20% max cost share $25 per day
Epoetin (EPO).	$0
Osteoporosis drugs.	$0
Oral cancer drugs that are also available as an injectable. Certain self-administered antiemetic drugs are also covered when necessary for the administration and absorption of the oral cancer drug.	$0
Infusion therapy drugs.	$0
Self-injectable medications (non-Part B drugs).	Refer to pharmacy
Allergy testing.	$0
Allergy serum.	$0
Surgeon/assistant surgeon.	$0
Administration of anesthetics.	$0
Diagnostic services (lab/x-ray)	
Laboratory services (both professional and outpatient facility).	$0
X-ray (non-complex) flat film x-rays (both professional and outpatient facility).	$0
Complex procedures: MRIs, CT scans, PET scans and SPECT (both professional and outpatient facility).	$0
Other diagnostic services, including but not limited to; EKG, EEG, nuclear cardiology, etc. (both professional and outpatient facility).	$0
Rehabilitation therapy (outpatient physical, speech, occupational, respiratory and cardiac therapy). Limited to treatment for conditions which are subject to significant improvement through relatively reasonable therapy.	$0
Dental services (Medicare -covered dental services include services by a dentist or oral surgeon that are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation therapy).	$0
OTHER SERVICES	
Medical social services.	$0
Patient education (wellness promotion).	$0
Ambulance (ground and air).	$0
Durable medical equipment (adequately meets the member's medical needs as determined by Medicare Advantage PPG).	$0
Therapeutic shoes for diabetics. One pair per calendar year of therapeutic custom-made shoes (including inserts provided with such shoes) and two additional pairs of inserts or one pair of depth shoes and three pairs of inserts (not including the non-customized inserts provided with such shoes).	$0
Diabetic supplies.	$0
Hearing aids (adequately meets the member's medical needs as determined by Medicare Advantage PPG).	Not covered
Prosthesis (replacing body parts).	$0

Health Net California Seniority Plus - Sutter *Restricted* Group Plan Chart - AY2	AY2 1/1/2020
OTHER SERVICES (continued)	
Blood - Includes storage, administration and coverage of whole blood and packed red cells.	$0
Blood - Clotting factors (Part B; self-injectables for hemophilia).	$0
Organ, tissue and stem cell transplants (nonexperimental and noninvestigative professional services only).	$0
Chemotherapy	
Professional services.	$0
Part B drugs.	$0
Outpatient facility services.	$0
Radiation therapy	
Professional services.	$0
Outpatient facility services.	$0
Renal dialysis (facility or professional services while not hospital confined).	$0
Dialysis supplies and equipment.	$0
Home health intermittent visit.	$0
Infusion therapy administration (home or outpatient).	$0
Hospice care. Hospice services are administered only through the Medicare program. Hospice consultation, refer below.	Not covered
Hospice consultation - initial evaluation only (1 per lifetime).	$20
Respite care (non-hospice benefit pre-authorized by Health Net Medical Management).	Not covered
CHEMICAL DEPENDENCY REHABILITATION and CARE FOR MENTAL DISORDERS	
ADMINISTERED BY MANAGED HEALTH NETWORK (MHN)	
HOSPITAL AND SKILLED NURSING FACILITY SERVICES	
Unlimited days of hospital care in a medically necessary private room, semi-private room or special care unit with ancillary services. Excludes care for mental disorders.	$0
Skilled nursing services. Limited to 100 days per benefit period (spell of illness) in a Medicare certified bed. A benefit period begins when a member receives skilled nursing services and ends when the member has not been inpatient (in a hospital or SNF) for 60 consecutive days.	$0
Outpatient services.	
All other outpatient services. Excludes x-ray and lab services, refer to x-ray benefit under "**Professional Services**".	$20
Outpatient surgery in a hospital.	$20
Outpatient surgery in an Ambulatory Surgical Center (ASC).	$20
Outpatient hospital or Ambulatory Surgical Center facility (ASC) for Colorectal Cancer Screenings.	$0
EMERGENCY SERVICES	
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. Refer to the Introduction pages for more information.	
Use of emergency room (facility and professional services). [3]	$50
Use of urgent care center (facility and professional services).	$20
Worldwide emergency coverage.	$0
OUT-OF-POCKET MAXIMUM (OOPM)	
Calendar year OOPM. Includes medical, mental health and chemical dependency benefits.	$3,400

1	Applies when the only service(s) provided is a Medicare-covered preventive service(s). Abdominal aortic aneurysm screening, bone mass measurement, cardiovascular screening, colorectal cancer screening, diabetes screening, diabetes self-management training, flu shots, Hepatitis B shot, HIV screening, mammograms, medical nutritional therapy services, pap tests/pelvic exam, pneumonia shot, prostate cancer screening, smoking cessation, screening and behavioral counseling interventions in primary care to reduce alcohol misuse, screening for depression in adults, screening for sexually transmitted infections (STI) and high intensity behavioral counseling to prevent STI's, intensive behavioral counseling for cardiovascular disease (bi-annual) and intensive behavioral therapy for obesity.
2	**Welcome to Medicare Physical exam:** The Welcome to Medicare physical exam is limited to one-time within 12 months of obtaining Medicare Part B coverage. **Personalized Preventive Plan Services**; Medicare-covered annual wellness visit, available within the first 12 months of Medicare Part B coverage or 12 months after the Welcome to Medicare Physical exam; one per year.
3	The emergency room 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 UFJ, EFFECTIVE DATE 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	**$3,400**
For each family	**N/A**
Emergency Services in an Emergency Room (mental health/chemical dependency treatment)	
Professional services	**$0**
Use of emergency room (facility services) [1]	**$50**
Ground Ambulance.	**$0**
Air ambulance	**$0**
Laboratory Services (mental health/chemical dependency treatment)	
Laboratory services	**$0**
Physician Visits to Home (mental health/chemical dependency treatment)	
Physician Visits to Home	**$20**
Severe Mental Illnesses [2]	
Outpatient	
Outpatient consultation	**$5** [3]
Group therapy session	**$5** [3]
Maximum visits per calendar year	**Unlimited**
Inpatient	
Inpatient care in a hospital, excluding residential treatment centers	**$0**
Residential treatment centers	**$0**
Maximum days per calendar year (combined with alternate care)	**Unlimited**
Inpatient physician visits	**$0**
Alternate Care	
Partial Hospitalization/Day Treatment/Intensive Outpatient Program	**$0**
Maximum days per calendar year (combined with inpatient care)	**Unlimited**
Other Mental Illnesses	
Outpatient	
Outpatient consultation	**$5**
Group therapy session	**$5**
Maximum visits per calendar year	**Unlimited**
Inpatient	
Inpatient care in a hospital, excluding residential treatment centers	**$0**
Residential treatment centers	**$0**
Maximum days per calendar year (combined with alternate care)	**Unlimited**
Inpatient physician visits	**$0**
Alternate Care	
Partial Hospitalization/Day Treatment/Intensive Outpatient Program	**$0**
Maximum days per calendar year (combined with inpatient care)	**Unlimited**
Chemical Dependency Rehabilitation	
Outpatient	
Outpatient consultation	**$5**
Group therapy session	**$5**
Maximum visits per calendar year	**Unlimited**
Inpatient	
Inpatient care in a hospital, excluding residential treatment centers	**$0**
Residential treatment centers	**$0**
Maximum days per calendar year (combined with alternate care)	**Unlimited**
Inpatient physician visits	**$0**

Alternate Care	
Partial Hospitalization/Day Treatment/Intensive Outpatient Program	**$0**
Maximum days per calendar year (combined with inpatient care)	**Unlimited**
Detoxification	
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] Applied Behavioral Analysis (ABA): ABA is not a covered benefit through the mental health outpatient coverage on Medicare Advantage plans.