## 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** (A - COB)<br>***Restricted* Plan GW6** | **GW6**<br>**1/1/2021** |
|---|---|
| **CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOPM):** All eligible copayments and coinsurance apply to OOPM. | |
| For each member. | $1,500 |
| For each family. | $4,500 |
| **PROFESSIONAL SERVICES** | |
| Visit to a physician, physician assistant or nurse practitioner at a PPG. [1] | $10 |
| Performed at member's participating physician group (PPG). | $10 |
| 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. | $10 |
| 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 |
| Telemedicine services. | $0 [2] |
| Annual routine physical examinations. Provided for employment, school, camp or sports. | Not covered |
| Vision examinations for refractive eye exams. | $10 |
| Hearing examinations for hearing loss. | $10 |
| Specialist consultations. Includes OB/GYN self-referral for non-preventive services. For preventive services, refer to periodic health evaluations above.[1] | $10 |
| Podiatry services, includes routine foot care for diabetes. | $10 |
| Routine foot care (cutting/removal of corns, calluses, trimming of nails). | Not covered |
| Physician visit to member's home (at discretion of physician). | $10 |
| 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. | $0 |
| 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. | Refer to Pharmacy Benefits |
| Surgeon/assistant surgeon in hospital or PPG. | $0 |
| Administration of anesthetics. | $0 |
| X-ray and laboratory procedures, including genetic testing and complex radiology (CT, SPECT, MRI and PET). Preventive x-ray/lab, refer to periodic health evaluations/preventive care above. [1] | $0 |
| Rehabilitation therapy (outpatient physical, speech and occupational), including ABA therapy services. | $10 |
| Respiratory therapy and cardiac rehabilitation. | $10 |
| Habilitation therapy (outpatient physical, speech, occupational, cardiac and respiratory therapy). For applied behavioral analysis (ABA), refer to mental health benefits. | $10 |
| 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. | $0 |
| 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. | $0 |
| Reversal of sterilization. | Not covered |

| Health Net California Large Group HMO<br>*Restricted* Plan GW6 | GW6<br>1/1/2021 |
|---|---|
| **ALCOHOL/DRUG REHABILITATION and CARE FOR MENTAL DISORDERS** | |
| **ADMINISTERED BY MANAGED HEALTH NETWORK (MHN)**<br>**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 (air and ground). | $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 |
| Hearing aids. | Not covered |
| Medical supplies. [1] | $0 |
| 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. | Refer to Pharmacy Benefits |
| Nuclear medicine. | $0 |
| Organ, tissue and stem cell transplants (non-experimental and non investigative. Professional services only). | $0 |
| Chemotherapy or radiation therapy. | $0 |
| Renal dialysis. | $0 |
| Home health visit. Includes home health rehabilitation. | $0 |
| Infusion therapy. | |
| Administered in a home. | $10 |
| Administered in office and in an outpatient facility. | $0 |
| 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). | $0 |
| 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. See the Introduction pages for more information. | |
| Emergency room (professional services). | $0 |
| Use of emergency room (facility services). [3] | $25 |
| Use of urgent care center. | $15 for medical services / $10 for behavioral health, chemical dependency, or substance use disorders |

| | |
|---|---|
| 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 when provided through preferred vendor. For all other providers, telehealth cost share mirrors in-person cost share based on type of service provided. |
| 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 VLN EFFECTIVE 01-01-2021***

| **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)** | **Plan Coverage** |
| For each member | $1,500 |
| For each family | $4,500 |
| **Emergency Services in an Emergency Room (mental health/chemical dependency treatment)** | **Plan Coverage** |
| Professional services | $0 |
| Use of emergency room (facility services)[1] | $25 |
| 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 | $5 |
| Outpatient mental health - consultation/telemedical services [8] | $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** | **Plan Coverage** |
| Outpatient mental health - consultation | $5 |
| Outpatient mental health - consultation/telemedical services [8] | $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** | **Plan Coverage** |
| Outpatient chemical dependency - consultation | $5 |
| Outpatient chemical dependency - consultation/telemedical services [8] | $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 | $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] There is no per member deductible accumulation/accrual. It is a single comprehensive family deductible. The family deductible must be met before plan begins to pay for covered services.
All covered benefits are subject to the deductible.

[4] There is no per member OOPM accumulation/accrual. It is a single comprehensive family OOPM.
Includes deductibles, copayments and coinsurance for covered medical, mental health, and chemical

[5] Within the family deductible, there is a per member deductible accumulation/accrual provision. When an individual family member satisfies the individual deductible, the individual member's deductible is satisfied for the calendar year even if the family deductible has not been satisfied. The family deductible is satisfied when two or more members collectively satisfy the family deductible amount.
All covered benefits are subject to the deductible.

[6] Within the family OOPM, there is a per member OOPM accumulation/accrual provision. When an individual family member satisfies the individual OOPM, the individual member's OOPM is satisfied for the calendar year even if the family OOPM has not been satisfied. The family OOPM is satisfied when two or more members collectively satisfy the family OOPM amount.
Includes deductibles, copayments and coinsurance for covered medical, mental health, and chemical dependency.

[7] Order of benefit for services where copay is applicable is copay, then deductible, then coinsurance.

[8] Listed cost share is for services provided through Preferred Vendor; For all other providers, telehealth cost share mirrors in-person cost share based on type of service provided.