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 ***Restricted*** **Plan JBC**	**JBC** **1/1/2022**
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOPM): All eligible copayments and coinsurance apply to OOPM.	
For each member.	$2,000
For each family.	$4,000
PROFESSIONAL SERVICES	
Visit to a physician, physician assistant or nurse practitioner. [1]	
Performed at member's participating physician group (PPG).	$30
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.	$30
Telemedicine services.	$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. Provided for employment, school, camp or sports.	Not covered
Vision examinations for refractive eye exams.	$30
Hearing examinations for hearing loss.	$30
Specialist consultations. Includes OB/GYN self-referral for non-preventive services. For preventive services, refer to periodic health evaluations above. [1]	$30
Podiatry services, includes routine foot care for diabetes.	$30
Routine foot care (cutting/removal of corns, calluses, trimming of nails).	Not covered
Physician visit to member's home (at discretion of physician).	$30
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.	Refer to Pharmacy Benefits
Surgeon/assistant surgeon.	$0
Administration of anesthetics.	$0
X-ray and laboratory procedures, including genetic testing. Preventive x-ray/lab, refer to periodic health evaluations or CVS Minute Clinic preventive care services above. [1]	$0
Complex radiology (CT, SPECT, MRI, MUGA and PET) - Performed in an office or outpatient facility.	$100
Performed in an inpatient facility.	$0
Rehabilitation therapy (outpatient physical, speech, and occupational), including ABA therapy services - Performed in an office or outpatient facility	$30
Cardiac and respiratory therapy - Performed in an office or outpatient facility.	$30
Performed in an inpatient facility.	$0
Habilitation therapy (physical, occupational, speech, respiratory and cardiac therapy). Applied behavioral analysis (ABA) is covered through the mental health benefit.	$30
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.	$30
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 JBC	JBC 1/1/2022
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 or inpatient 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).	$100
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, 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 noninvestigative professional services only).	$0
Chemotherapy or radiation therapy.	$0
Infusion therapy.	
Performed at home.	$0
Performed in an office and outpatient facility.	$30
Renal dialysis.	$0
Home health visit. Includes home health rehabilitation. The copayment is required on and after the 30th calendar day of the treatment plan.	$30 / 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. For newborns, a separate copayment will apply to a newborn requiring admission to a special care unit.	$1,500 per admit
Confinement in a skilled nursing facility (limited to 100 days a calendar year).	$1,500 per admit
Outpatient services.	
Outpatient services other than surgery.	$0
Outpatient surgery at a hospital.	$250 per admit
Outpatient surgery at an ambulatory surgical center.	$100 per admit
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
Emergency room (facility services). [3]	$100
Use of urgent care center.	$50 [4]

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.
4	$50 for medical services; $30 for behavioral health, chemical dependency, or substance use disorders.

CALIFORNIA BENEFIT DESIGN / SCHEDULE OF BENEFITS
MENTAL HEALTH / CHEMICAL DEPENDENCY TREATMENT
MH Plan Code PTE – Effective 1-1-2022

BENEFITS	**Plan Coverage**
Professional Basis for Reimbursement: Non Par Provider	N/A
Institutional Basis for Reimbursement: Non Par Provider	N/A
MAA Default	N/A
Penalty Inpatient Copay	N/A
Penalty Outpatient Other Copay	N/A
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	$2,000
For each family	$4,000
Emergency Services in an Emergency Room (mental health/chemical dependency treatment)	**Plan Coverage**
Professional services	$0
Use of emergency room (facility services)[1]	$100
Ground Ambulance	$100
Air ambulance	$100
Laboratory Services, administered on behalf of Health Net (medical benefit provided by MHN)	**Plan Coverage**
Laboratory services	$0
Mental Health	**Plan Coverage**
Outpatient mental health - consultation	$30
Outpatient mental health - consultation/telemedical services (7)	$0
Outpatient mental health - group therapy session	$15.00
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	$1,500 per admit
Residential treatment centers	$1,500 per admit
Maximum days per calendar year	Unlimited
Inpatient physician visits	$0
Chemical Dependency Rehabilitation & Detoxification	**Plan Coverage**
Outpatient chemical dependency - consultation	$30
Outpatient chemical dependency - consultation/telemedical services (7)	$0
Outpatient chemical dependency - group therapy session	$15.00
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	$1,500 per admit
Residential treatment centers	$1,500 per admit
Maximum days per calendar year	Unlimited
Inpatient physician visits	$0
Detoxification	$1,500 per admit
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.

e 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.

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

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.

Within the family OOPM, there is a per member OOPM accumulation/accrual provision. When an individual family member satisfies the individual OOPM, the ndividual 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.
ncludes deductibles, copayments and coinsurance for covered medical, mental health, and chemical dependency.

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

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.