Schedule of benefits and coverage

This MATRIX is intended to be used to help you compare coverage benefits and is a summary only. The PLAN CONTRACT AND Evidence of Coverage (EOC) should be consulted for a detailed description of coverage benefits and limitations.

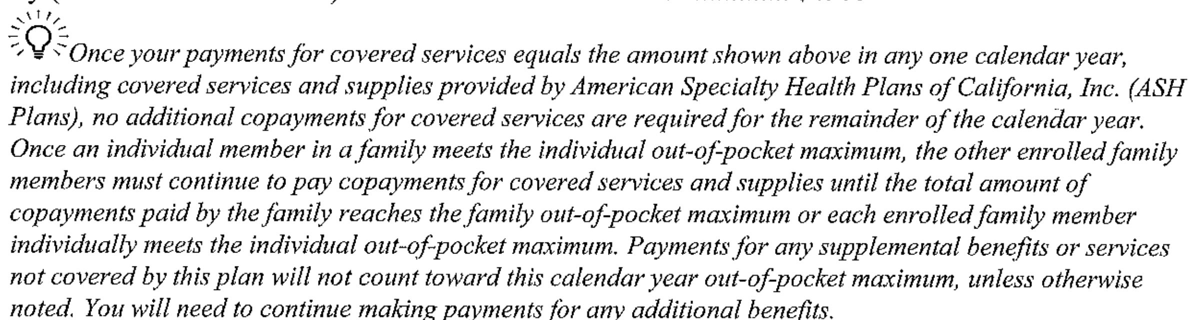
The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments are usually billed after the service is received.

Principal benefits and coverage matrix

Deductibles .... None
Lifetime maximums .... None

Out-of-Pocket maximum

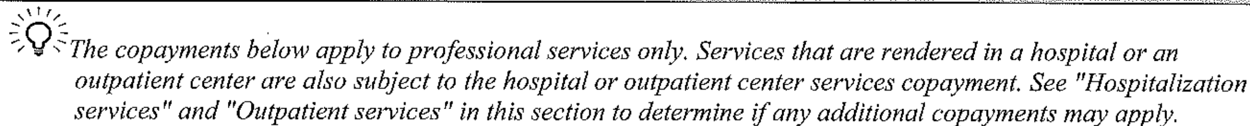
One member $1500
Two members $3000
Family (three members or more) $4500



Once your payments for covered services equals the amount shown above in any one calendar year, including covered services and supplies provided by American Specialty Health Plans of California, Inc. (ASH Plans), no additional copayments for covered services are required for the remainder of the calendar year. Once an individual member in a family meets the individual out-of-pocket maximum, the other enrolled family members must continue to pay copayments for covered services and supplies until the total amount of copayments paid by the family reaches the family out-of-pocket maximum or each enrolled family member individually meets the individual out-of-pocket maximum. Payments for any supplemental benefits or services not covered by this plan will not count toward this calendar year out-of-pocket maximum, unless otherwise noted. You will need to continue making payments for any additional benefits.

Payments for any supplemental benefits, infertility services, deductibles or services not covered by this plan will not count toward this calendar year out-of-pocket maximum, unless otherwise noted. Also, copayments and deductibles for prescription drugs do not apply to the out-of-pocket maximum, unless otherwise noted. You must continue to pay copayments for any services and supplies that do not apply to the out-of-pocket maximum.

Professional services



The copayments below apply to professional services only. Services that are rendered in a hospital or an outpatient center are also subject to the hospital or outpatient center services copayment. See "Hospitalization services" and "Outpatient services" in this section to determine if any additional copayments may apply.

Visit to physician, physician assistant or nurse practitioner, at a contracting physician group $15
Specialist or specialty care consultations ■ $15
Prenatal and postnatal office visits .... Covered in full
Normal delivery, cesarean section, newborn inpatient care .... Covered in full
Treatment of complications of pregnancy .... See note below**

Service	Copayment
Surgeon or assistant surgeon services ▲	Covered in full
Administration of anesthetics	Covered in full
Laboratory procedures and diagnostic imaging (including x-ray) services	Covered in full
Rehabilitative therapy (includes physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)	$15
Organ and stem cell transplants (non-experimental and non-investigational)	Covered in full
Chemotherapy	Covered in full
Radiation therapy	Covered in full
Vision and hearing examinations (for diagnosis or treatment, including refractive eye examinations)	$15

▪ *Self-referrals are allowed for obstetrics and gynecological services including preventive care, pregnancy and gynecological ailments. Copayment requirements may differ depending on the services provided.*

Podiatrist, chiropractor and acupuncturist services may be covered under "Specialist consultation" as authorized by your Physician Group.

▲ *Surgery includes surgical reconstruction of a breast incident to mastectomy (including lumpectomy), including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema. While Health Net and your physician group will determine the most appropriate services, the length of hospital stay will be determined solely by your PCP.*

* *For each pregnancy, the initial prenatal office visit requires a copayment. No copayment is required for subsequent prenatal office visits.*

***Applicable copayment requirements apply to any services and supplies required for the treatment of an illness or condition, including but not limited to, complications of pregnancy. For example, if the complication requires an office visit, then the office visit copayment will apply.*

Preventive care

Service	Copayment
Preventive care services	$15

Preventive care services are covered for children and adults, as directed by your physician, based on the guidelines from the U.S. Preventive Services Task Force Grade A&B recommendations, the Advisory Committee on Immunization Practices that have been adopted by the Center for Disease Control and Prevention, the guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA).

Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA.

Allergy treatment and other injections (except for infertility injections)

Service	Copayment
Allergy testing	Covered in full
Allergy serum	Covered in full
Allergy injection services	$15

Service	Copayment
Surgeon or assistant surgeon services ▲	Covered in full
Administration of anesthetics	Covered in full
Laboratory procedures and diagnostic imaging (including x-ray) services	Covered in full
Rehabilitative therapy (includes physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)	$15
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Allergy treatment and other injections (except for infertility injections)

Service	Copayment
Allergy testing	Covered in full
Allergy serum	Covered in full
Allergy injection services	$15

Immunizations -- To meet foreign travel requirements	20%
Immunizations -- To meet occupational requirements	20%
Injections (except for infertility)	
Injectable drugs administered by a physician (per dose)	$15
Self injectable drugs■	$15

■ *Self-injectable drugs (other than insulin) are considered specialty drugs, which require prior authorization and must be obtained from a contracted specialty pharmacy vendor. Specialty drugs require prior authorization from Health Net. Please refer to the plan's EOC for additional information.*

Injections for the treatment of infertility are described below in the "Infertility services" section.

Outpatient facility services

Outpatient facility services (other than surgery)	$100
Outpatient surgery (surgery performed in a hospital or outpatient surgery center only)	$100

Outpatient care for infertility is described below in the "Infertility services" section.

Hospitalization services

Semi-private hospital room or special care unit with ancillary services, including maternity care (per admission; unlimited days)	$100
Skilled nursing facility stay (per admission; limited to 100 days per calendar year)	Covered in full
Physician visit to hospital or skilled nursing facility	Covered in full

The above inpatient hospitalization copayment is applicable for each admission of hospitalization for an adult, pediatric or newborn patient. If a newborn patient requires admission to a special care unit, a separate copayment for inpatient hospital services for the newborn patient will apply.

Inpatient care for infertility is described below in the "Infertility services" section.

Emergency health coverage

Emergency room (professional and facility charges)	$100
Urgent care center (professional and facility charges)	$50

Copayments for emergency room or urgent care center visits will not apply if the member is admitted as an inpatient directly from the emergency room or urgent care center. A visit to one of the urgent care centers that is owned and operated by the member's physician group will be considered an office visit and the office visit copayment, if any, will apply.

Ambulance services

Ground ambulance .... Covered in full
Air ambulance .... Covered in full

Medical Supplies

Durable medical equipment (including nebulizers, face masks and tubing for the treatment of asthma) .... Covered in full
Orthotics (such as bracing, supports and casts) .... Covered in full
Diabetic Equipment .... Covered in full
Diabetic footwear .... Covered in full
Prostheses .... Covered in full

Diabetic equipment and supplies are covered under the medical benefit (through "Diabetic equipment") and include blood glucose monitors (and monitors designed for the visually impaired) and testing strips, corrective footwear, insulin pumps and related supplies, specific brands of pen delivery systems for the administration of insulin (including pen needles), Ketone test strips, insulin syringes, and lancets and puncture devices when used in monitoring blood glucose levels.

In addition, the following supplies are covered under the medical benefit as specified: visual aids (excluding eyewear) to assist the visually impaired with the proper dosing of insulin are provided through the prostheses benefit; Glucagon is provided through the self-injectable benefit. Self-management training, education and medical nutrition therapy will be covered only when provided by licensed health care professionals with expertise in the management or treatment of diabetes (provided through the patient education benefit).

Your physician must contact the Health Net Pharmacy Department for prior authorization before you can obtain the following covered items upon presentation of your prescription at a contracting Health Net Pharmacy: reusable pen delivery systems, specific brands of disposable insulin needles and syringes, and disposable pen needles.

Mental disorders and chemical dependency benefits

Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services. For definitions of severe mental illness or serious emotional disturbances of a child, please refer to the Behavioral health section of this SB/DF, or call the Customer Contact Center at the number listed on the back cover of this booklet.

Severe Mental Illness and Serious Emotional Disturbances of a Child

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring)* $15

Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing; other outpatient procedures; intensive outpatient care program; day treatment; partial hospitalization; and psychological evaluation or therapeutic session in a home setting for pervasive

Ambulance services

Ground ambulance	Covered in full
Air ambulance	Covered in full

Medical Supplies

Durable medical equipment (including nebulizers, face masks and tubing for the treatment of asthma)	Covered in full
Orthotics (such as bracing, supports and casts)	Covered in full
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<u>Severe Mental Illness and Serious Emotional Disturbances of a Child</u>

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring)*	$15
Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing; other outpatient procedures; intensive outpatient care program; day treatment; partial hospitalization; and psychological evaluation or therapeutic session in a home setting for pervasive	

developmental disorder or autism per provider per day)	Covered in full
Inpatient services	Covered in full
Other Mental Disorders	
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring)*	$15
Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization)	Covered in full
Inpatient services	Covered in full
Chemical Dependency	
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring) *	$15
Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization)	Covered in full
Inpatient services	Covered in full
Acute care detoxification	Covered in full

**Each group therapy session requires only one half of a private office visit copayment. If two or more members in the same family attend the same outpatient treatment session, only one copayment will be applied.*

Home health services

Home health services (copayment starts the 31st calendar day after the 1st visit)	$15

Other services

Sterilizations --Vasectomy	$50
Sterilizations --Tubal ligation	$150
Blood, blood plasma, blood derivatives and blood factors	Covered in full
Renal dialysis	Covered in full
Hospice services	Covered in full

Infertility services and supplies are described below in the "Infertility services" section.

Infertility services

Infertility services and supplies (all covered services that diagnose, evaluate or treat infertility) 50%

Infertility services include professional services, inpatient and outpatient care and treatment by injections.

Infertility services (which include GIFT) and all covered services that prepare the member to receive this procedure, are covered only for the Health Net member.

Chiropractic services

Benefits are administered by American Specialty Health Plans of California, Inc. (ASH Plans).

Office visits *(30-visit maximum per calendar year)* $15

Annual chiropractic appliance allowance $50

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Office visits *(30-visit maximum per calendar year)* $15

Annual chiropractic appliance allowance $50

Limits of coverage

WHAT'S NOT COVERED (EXCLUSIONS AND LIMITATIONS)

- Ambulance and paramedic services that do not result in transportation or that do not meet the criteria for emergency care, unless such services are medically necessary and prior authorization has been obtained.
- Artificial insemination for reasons not related to infertility;
- Biofeedback therapy is limited to medically necessary treatment of certain physical disorders such as incontinence and chronic pain;
- Care for mental health care as a condition of parole or probation, or court-ordered testing for mental disorders, except when such services are medically necessary;
- Conception by medical procedures (IVF and ZIFT);
- Except for podiatric devices to prevent or treat diabetes related complications, corrective footwear is not covered unless medically necessary, custom made for the member and permanently attached to a medically necessary orthotic device that is also a covered benefit under this plan;
- Cosmetic services and supplies;
- Custodial or live-in care;
- Dental services. However, Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures are covered. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
- Disposable supplies for home use;
- Experimental or investigational procedures, except as set out under the "Clinical trials" and "If you have a disagreement with our plan" sections of this SB/DF;
- Genetic testing is not covered except when determined by Health Net to be medically necessary. The prescribing physician must request prior authorization for coverage;
- Hearing aids;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder;
- Non-eligible institutions. This plan only covers services or supplies provided by a legally operated hospital, Medicare-approved skilled nursing facility or other properly licensed facility as specified in the plan's EOC. Any institution that is primarily a place for the aged, a nursing home or similar institution, regardless of how it is designated, is not an eligible institution. Services or supplies provided by such institutions are not covered;
- Orthoptics (eye exercises);
- Orthotics (such as bracing, supports and casts) that are not custom made to fit the member's body. Refer to the "corrective footwear" bullet above for additional foot orthotic limitations;
- Outpatient prescription drugs;
- Personal or comfort items;
- Physician self-treatment;
- Physician treating immediate family members;
- Private rooms when hospitalized, unless medically necessary;
- Private-duty nursing;
- Refractive eye surgery unless medically necessary, recommended by the member's treating physician and authorized by Health Net;
- Reversal of surgical sterilization;

- Routine foot care for treatment of corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes;
- Routine physical examinations (including psychological examinations or drug screening) for insurance, licensing, employment, school, camp or other nonpreventive purposes;
- Services and supplies not authorized by Health Net, the Behavioral Health Administrator or the physician group according to Health Net's procedures;
- Services for a surrogate pregnancy are covered only when the surrogate is a Health Net member. However, when compensation is obtained for the surrogacy, Health Net shall have a lien on such compensation to recover its medical expense;
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the plan's EOC;
- Services related to educational or training, including for employment or professional purposes, except for behavioral health treatment for pervasive developmental disorder or autism;
- State hospital treatment, except as the result of an emergency or urgently needed care;
- Stress, except when rendered in connection with services provided for a treatable mental disorder;
- Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary; and
- Treatment of obesity, weight reduction or weight management, except for treatment of morbid obesity.

The above is a partial list of the principal exclusions and limitations applicable to the medical portion of your Health Net plan. The EOC, which you will receive if you enroll in this plan, will contain the full list.

- Routine foot care for treatment of corns, calluses and cutting of nails, unless prescribed for the treatment of diabetes;
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