PLAN DISCLAIMER

This Schedule of Benefits is a brief list of benefits, with applicable copayments, coinsurance and deductibles information for your health insurance plan. It does not list the exclusions and limitations or other important terms applicable to your insurance 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 PPO ***Restricted* Plan K3T - Effective 4/1/2023**	**PPO**	**OON** Member pays coinsurance and any charges exceeding maximum allowable amount
Deductible Disclaimer: All services are subject to the deductible, unless otherwise noted. The member must satisfy the calendar-year deductible before benefit payment begins.		
Prior Authorization Disclaimer: Prior authorization is required for some services, refer to the appropriate prior authorization list for specific requirements or to the member's Evidence of Coverage (EOC). If prior authorization is not acquired, benefits are reduced to 50%.		
CALENDAR YEAR DEDUCTIBLES: 4th quarter deductible carryover applies. Deductible is included in the OOPM and PPO/OON cross-accumulate.		
For each member.	$250	$500
For each family.	$750	$1,500
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOPM): All eligible copayments/coinsurance for medical, including uncertified services, apply to OOPM. PPO/OON cross-accumulate.		
For each member.	$3,000	$9,000
For each family.	$9,000	$27,000
PROFESSIONAL SERVICES		
Visit to a physician, physician assistant or nurse practitioner. [1]	$15 ded waived	40%
Telemedicine services.	$0 ded waived [2]	Not covered
Preventive care. 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 ded waived	40%
Annual routine physical examinations provided for employment, school, camp or sports. Through PPO, limited to one exam per year with a maximum payable amount of $250 each calendar year.	$15 ded waived	Not covered
Vision examinations for refractive eye exams. Children through age 16.	$15 ded waived	Not covered
Adult (age 17 and older).	Not covered	Not covered
Hearing examinations for hearing loss. Children through age 16.	$15 ded waived	Not covered
Adult (age 17 and older).	Not covered	Not covered
Specialist consultations (includes second surgical opinions). For preventive services, refer to preventive care above. [1]	$15 ded waived	40%
Podiatry services, includes routine foot care for diabetes.	$15 ded waived	40%
Routine foot care (cutting/removal of corns, calluses, trimming of nails).	Not covered	Not covered
Physician visit to member's home (at discretion of physician).	20%	40%
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).	20%	40%
Immunizations (**except** foreign travel/occupational purposes, refer below).	$0 ded waived	40%
Immunizations for foreign travel/occupational purposes.	Not covered	Not covered
Allergy testing.	$15 ded waived	40%
Allergy serum.	20%	40%
Allergy injection services (serum not included).	$15 ded waived	40%
Injections for treatment of infertility. **Deductible required.**	20% [3]	40% [3]
All other injections.		
Office based injectable medications. [1]	$15 ded waived	40%
Self-administered injectable medications.	Refer to pharmacy benefits	Not covered
Surgeon/assistant surgeon & administration of anesthetics.	20%	40%
Surgeon/assistant surgeon & administration of anesthetics related to bariatric surgery.	20%	Not covered
X-ray and laboratory procedures, including genetic testing. Preventive x-ray/lab, refer to preventive care above. [1]	20%	40%
Complex radiology (CT scan, PET, MRI, SPECT, MUGA).	20%	40%
Rehabilitation therapy (outpatient physical, speech, occupation therapy). Includes ABA therapy.	20%	40% Combined limit of 20 visits per calendar year (PPO/OON) [4]
Cardiac and respiratory therapy.	20%	40% Combined limit of 20 visits per calendar year (PPO/OON) [4]
Habilitation therapy (physical, occupational, speech, respiratory and cardiac therapy). For applied behavioral analysis (ABA), refer to the mental health benefits.	20%	40% Combined limit of 20 visits per calendar year (PPO/OON) [4]
Dental services (when medically necessary to properly monitor, control or treat a severe medical condition when excluded dental services are being performed).	20%	40%

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CARE FOR CONDITIONS OF PREGNANCY		
Prenatal office visit.	20%	40%
Postnatal office visit.	20%	40%
Normal delivery, cesarean section and complications of pregnancy. Includes newborn inpatient professional care.	20%	40%
Abortion services.	$0 ded waived	$0 ded waived
Genetic testing of fetus.	20%	40%
Circumcision of newborn.	20%	40%
FAMILY PLANNING (professional services only)		
Contraceptive methods. Includes intrauterine device (IUD), injectable or implantable contraceptives. [1]	$0 ded waived	40%
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. Deductible required.**	20% [3]	40% [3]
Sterilization of females - performed in an office or outpatient facility. [1]	$0 ded waived	40%
Performed in an inpatient facility.	$0	40%
Sterilization of males.	20%	40%
Reversal of sterilization.	Not covered	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.	20%	40%
Patient education.		
Patient education for diabetes only.	$15 ded waived	40%
Smoking cessation/weight management.	$0 ded waived	40%
All other patient education classes.	$15 ded waived	40%
Ambulance services (air and ground).	20%	20%
Durable medical equipment. For preventive DME, refer to preventive care. [1]	20%	40%
Orthotics (braces and supports).	20%	40%
Corrective footwear. Custom made shoes and shoe inserts (custom foot orthotics).	20%	40%
Diabetic supplies.	20%	40%
Medical supplies.[1]	20%	40%
Hearing aids.	Not covered	Not covered
Prosthesis (replacing body parts).	20%	40%
Wigs (cranial prosthesis).	Not covered	Not covered
Chiropractic care. **Refer to member's EOC.**	**Administered by ASH**	
Acupuncture. **Refer to member's EOC.**	**Administered by ASH**	
Blood and blood products, except for blood clotting factors, refer below.	20%	20%
Blood clotting factors.	**Refer to pharmacy benefits**	Not covered

1	**Women's preventive care services include the following:** Screening for gestational diabetes; human papilloma virus (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	When provided through preferred vendor. For all other providers, telehealth cost share mirrors in-person cost share based on type of services provided.
3	Infertility services require a separate lifetime deductible of $500. The $500 lifetime deductible applies towards the member's OOPM. Also, infertility services, supplies, injections and medications, are limited to a lifetime maximum benefit of $2,000. This maximum is combined through PPO and OON.
4	Additional visits are payable if precertified as medically necessary following neurological and orthopedic surgery, cerebral cardiovascular accident, third degree burns, head trauma or spinal cord injuries. Medically Necessary rehabilitative or habilitative services for autism or pervasive developmental disorder are not subject to the 20 visit limitation.

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OTHER SERVICES - continued		
Nuclear medicine.	20%	40%
Organ, tissue and stem cell transplants (non-experimental and noninvestigative. Professional services only).	20%	Not covered
Chemotherapy.	20%	40%
Radiation therapy.	20%	40%
Renal dialysis.	20%	40%
Home health visit. Includes home health rehabilitation.	20%	40% Combined limit of 100 visits per calendar year (PPO/OON)
Infusion therapy (home, office or outpatient).	20%	40%
Hospice care (elected by member).	20%	40%
HOSPITAL AND SKILLED NURSING FACILITY		
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 coinsurance will apply to a newborn requiring admission to a special care unit.	20%	40%
Confinement for bariatric (weight loss) surgery. Includes surgeon/assistant surgeon, administration of anesthesia and inpatient/outpatient care.	20%	Not covered
Confinement in a skilled nursing facility (limited to 100 days a calendar year).	20%	40% Combined limit of 100 days per calendar year (PPO/OON)
Outpatient services.	20%	40%
EMERGENCY ROOM / URGENT CARE CENTER		
Emergency room (professional services).	20%	20%
Emergency room (facility services). [5]	$100 + 20%	$100 + 20%
Use of urgent care center.	20% [6]	20%

5	An additional $100 emergency room deductible is required if the member is not admitted as an inpatient. The deductible is waived if admitted.
6	20% ded applies for medical services; $15 ded waived for behavioral health, chemical dependency, or substance use disorders.