

## 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.

### 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, 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.*

#### 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 .....	\$15
Specialist consultations <sup>■</sup> .....	\$15
Prenatal and postnatal office visits .....	\$15
Normal delivery, cesarean section, newborn inpatient care .....	Covered in full
Treatment of complications of pregnancy, including medically necessary abortions .....	See note below**
Surgeon or assistant surgeon services <sup>▲</sup> .....	Covered in full
Administration of anesthetics .....	Covered in full
Laboratory procedures and diagnostic imaging (including x-ray) services .....	Covered in full
CT, SPECT, MRI, MUGA and PET .....	\$100
Rehabilitative therapy (includes physical, speech, occupational, and respiratory 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) .....	\$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.*
- ▲ *Surgery includes surgical reconstruction of a breast incident to mastectomy, 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.*
- \*\*Applicable copayment or coinsurance 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 or coinsurance will apply.*

#### Preventive care

##### Adult preventive care

Periodic health evaluations, including well-woman exam and annual preventive physical examinations (age 18 and older) .....	Covered in full
Immunizations (age 18 and older) .....	Covered in full

##### Child preventive care

Periodic health evaluations, including newborn, well-baby care, annual preventive physical examinations and immunizations	
birth through 30 days .....	Covered in full
31 days through age 17 .....	Covered in full



*For preventive health purposes, covered services include, but are not limited to, periodic health evaluations, diagnostic preventive procedures and preventive vision and hearing screening examinations, based on recommendations published in the U. S. Preventive Services Task Force. In addition, an annual cervical cancer screening test is covered and includes a Pap test, 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 injection)

Allergy testing .....	Covered in full
Allergy serum .....	Covered in full
Allergy injection services .....	Covered in full
Immunizations -- To meet foreign travel requirements .....	20%
Immunizations -- To meet occupational requirements .....	20%

All other injections (except for infertility injection)  
 Injectable drugs administered by a physician (per dose) ..... Covered in full  
 Self injectable drugs ..... 20%  
*The member's copayment will not exceed* ..... \$100 for each prescription  
 ..... at a pharmacy  
*The member's copayment will not exceed* ..... \$100 per day at a  
 ..... doctor's office

**Outpatient facility services**


Outpatient facility services (other than surgery) ..... Covered in full  
 Outpatient surgery (surgery performed in a hospital or outpatient surgery center only)..... \$500

**Hospitalization services**

Semi-private hospital room or special care unit with ancillary services, including maternity care (per admission; unlimited days) ..... \$500  
 Hospitalization for infertility services ..... 50%  
 Skilled nursing facility stay (limited to 100 days each calendar year)  
 Days 1-10 ..... Covered in full  
 Days 11-100 ..... \$25 per day  
 Physician visit to hospital or skilled nursing facility ..... Covered in full

**Emergency health coverage**

Emergency room (professional and facility charges) ..... \$100  
 Urgent care center (professional and facility charges) ..... \$15

 *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 ..... \$100  
 Air ambulance ..... \$100

## Prescription drug coverage



Please refer to the "Prescription drug program" section of this SB/DF for applicable definitions, benefit descriptions and limitations. Copayments for prescription drugs do not apply to the out-of-pocket maximum, except copayments for peak flow meter and inhaler spacers used for the treatment of asthma, and diabetic supplies.

### Retail participating pharmacy (up to a 30-day supply)

Level I drugs (primarily generic) .....	\$10
Level II drugs (primarily brand name drugs, peak flow meters, inhaler spacers and diabetic supplies, including insulin) ♦ .....	\$25
Level III drugs ♦ .....	\$50
Smoking Cessation Drugs* (covered up to a 12 week course of therapy per calendar year if you are concurrently enrolled in a comprehensive smoking cessation behavioral modification support program.).....	50%
Appetite Suppressants .....	50%
Lancets.....	Covered in full
Contraceptive devices (including diaphragms and cervical caps) .....	\$25

### Mail-order program (up to a 90-day supply of maintenance drugs)

Level I drugs (primarily generic) .....	\$20
Level II drugs (primarily brand name drugs, peak flow meters, inhaler spacers and diabetic supplies, including insulin) ♦ .....	\$50
Level III drugs ♦ .....	\$100
Lancets.....	Covered in full

For information about Health Net's Recommended Drug List, please call the Member Services Department at the telephone number on the back cover.

- ♦ Generic drugs will be dispensed when a generic drug equivalent is available unless a brand name drug is specifically requested by the physician or the member. When a brand name drug is dispensed and a generic equivalent is commercially available, the member must pay the difference between the generic equivalent and the brand name drug plus the Level I or Level III drug copayment.

However, if the prescription drug order states "dispense as written," "do not substitute" or words of similar meaning in the physician's handwriting to indicate medical necessity, only the Level II or Level III drug copayment, as appropriate, will be applicable.

\*Must be approved by Health Net and the member's physician group.



Copayments for prescription drugs do not apply to the out-of-pocket maximum, except copayments for peak flow meters, inhaler spacers used for the treatment of asthma and diabetic supplies.

Percentage copayments will be based on Health Net's contracted pharmacy rate.

If the retail price is less than the applicable copayment, then you will pay the retail price prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.

*This plan uses the Recommended Drug List. The Health Net Recommended Drug List (the "List") is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. The List also shows which drugs are Level I, Level II or Level III, so you know which copayment applies to the covered drug. Drugs that are not on the List (that are not excluded or limited from coverage) are also covered at the Level III drug copayment.*

*Some drugs require prior authorization from Health Net. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 72 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 5 days, as appropriate and medically necessary, for the nature of the member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination. For a copy of the Recommended Drug List, call Member Services at the number listed on the back cover of this booklet or visit our website at [www.healthnet.com](http://www.healthnet.com).*

### 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 See the "Prescription drug program" section of this SB/DF for diabetic supplies benefit information. ....	Covered in full
Diabetic footwear .....	Covered in full
Prostheses .....	Covered in full

▣ *The calendar year maximum does not apply to orthotics or to nebulizers, face masks and tubing used for the treatment of asthma.*



*Diabetic equipment covered under the medical benefit (through "Diabetic Equipment"), includes blood glucose monitors designed for the visually impaired, insulin pumps and related supplies. In addition, the following supplies are covered under the medical benefit as specified: diabetic footwear, 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). Diabetic equipment and supplies covered under the prescription drug benefit include insulin, specific brands of blood glucose monitors and testing strips, Ketone urine testing strips, lancets and lancet puncture devices, specific brands of pen delivery systems for the administration of insulin (including pen needles) and specific brands of insulin syringes.*

### 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 Member Services at the number listed on the back cover of this booklet.*

#### Severe Mental Illness and Serious Emotional Disturbances of a Child

Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting)* .....	\$15
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Inpatient services..... \$500 per admission

### **Other Mental Disorders**

Outpatient professional consultation  
(psychological evaluation or therapeutic  
session in an office setting)\* ..... \$15

Inpatient services..... \$500 per admission

### **Chemical Dependency**

Outpatient professional consultation  
(psychological evaluation or therapeutic  
session in an office setting)\* ..... \$15

Inpatient services..... \$500 per admission

Acute care detoxification..... \$500 per admission

*\*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  
*Calendar year maximum* ..... 100 visits

### **Other services**

Infertility services and supplies (including  
injections related to covered infertility  
services) ..... 50%  
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

### **Chiropractic services**



*Benefits are administered by American Specialty Health Plans of California, Inc. (ASH Plans).  
Copayments for chiropractic services do not apply to the out-of-pocket maximum.*

Office visits (20-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, GIFT and ZIFT);
- Corrective footwear (such as corrective shoes or foot orthotics) that is not incorporated into a cast, splint, brace or strapping of the foot unless medically necessary for the management and treatment of diabetes;
- 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 (except as noted under "Prescription drug program");
- 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 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 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;
- Sex change services;
- 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.