

Schedule of benefits and coverage

The services covered and amount you pay depend upon the doctor or hospital you choose when you need health care. The following charts summarize what is covered and what you pay with Health Net Life PPO.

Principal benefits and coverage matrix

Benefit levels	PPO	OON (out-of network)
<i>Features</i>	<p>(Preferred providers) Care provided by doctors and hospitals contracted with our PPO</p>	<p>(All other providers) Care provided by licensed doctors and hospitals not contracted with our PPO</p>
	<ul style="list-style-type: none"> • Lower out-of-pocket costs • Great freedom of choice • Certification from Health Net Life required for certain services • Claim forms usually not required for reimbursement • Must meet annual deductible (and coinsurance, if applicable to this insurance plan) • Coverage for preventive care services available 	<ul style="list-style-type: none"> • Higher out-of-pocket costs • Greatest freedom of choice • Certification from Health Net Life required for certain services • Claim forms required for reimbursement • Must meet annual deductible and coinsurance



For the PPO level of benefits, the percentages that appear in this chart are based on contracted rates with providers. See the "Payment of premiums and charges" section, under "Contracted Rate" for additional details.

For the Out-of-Network level of benefits, the percentages that appear in this chart are based the maximum allowable amount. The covered person is responsible for charges in excess of this amount in addition to the coinsurance shown. See the "Payment of premiums and charges" section, under "Maximum Allowable Amount" for additional details.

Deductibles	PPO	OON (out-of network)
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You must pay this amount for covered services before HNL begins to pay. However, PPO services to which a copayment applies are not subject to the calendar year deductible.

Calendar year deductible

Any amount applied toward the deductible for covered services provided by a PPO provider will apply toward the OON deductible; any amount applied toward the deductible for covered services provided by an OON provider will apply to the PPO deductible.

For each covered person\$500\$500

For a family (the number of covered persons in a family that must satisfy their individual deductible to satisfy the family deductible).....33

Additional deductibles

Infertility services deductible (per lifetime, continues to apply after the OOPM has been met)[Ⓜ].....\$500\$500


Ambulance deductible\$50\$50

Emergency room deductible (waived if admitted to a hospital).....\$100\$100

[Ⓜ] *Combined for PPO and Out-of-Network.*

Insurance Plan maximums	PPO	OON (out-of network)
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Yearly Out-of-pocket maximum (OOPM)

 *Once your payment of copayments or coinsurance (combined for PPO and Out-of-Network) equals the amount shown below in any one calendar year, no additional copayments or coinsurance for covered services are required for the remainder of that year. Payments for services not covered by this insurance plan, or for certain services as specified in the "Payment of premiums and charges" section of this SB, will not be applied to this yearly out-of-pocket maximum. You will need to continue making payments for any additional benefits as described in the "Additional insurance plan benefit information" section of this SB.*

For each covered person\$3000\$6000

For a family33

Type of services, benefit maximums & what you pay

Professional services	PPO	OON
Visit to physician	\$15	40%

Specialist consultations	\$15.....	40%
Prenatal and postnatal office visits	20%	40%
Normal delivery, cesarean section, newborn inpatient professional care*	20%	40%
Treatment of complications of pregnancy, including medically necessary abortions*	See note below**	See note below**
Physician visit to hospital or skilled nursing facility	20%	40%
Surgeon or assistant surgeon ser- vices [▲] *	20%	40%
Administration of anesthetics.....	20%	40%
Rehabilitative therapy (including physical, speech, occupational, cardiac rehabilitation and pulmo- nary rehabilitation therapy)	20%	40%
<i>Maximum payable by HNL for each visit.....</i>	<i>No maximum.....</i>	<i>\$25</i>
Organ and stem cell transplants (nonexperimental and noninvesti- gational) *	20%	Not covered
Chemotherapy	20%	40%
Radiation therapy	20%	40%
Vision and hearing examinations (for diagnosis or treatment) (birth through age 16)	Covered in full.....	Not covered

** *Applicable deductible, 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.*

* *These services require certification for coverage. For a complete listing of services requiring certification please refer to the "Services requiring certification" section of this SB. Routine care for condition of pregnancy does not require prior certification. However notification of pregnancy is requested. If certification is required but not obtained, your benefit reimbursement level will be reduced, both in-network and out-of-network, to 50% of covered expenses. In addition, a \$500 penalty will also be charged for inpatient admissions and a \$100 penalty for outpatient visits.*

▲ *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.*

Allergy treatment and other injections (except for infertility injection)	PPO	OON
Allergy testing	\$15.....	40%
Allergy serum.....	20%	40%
Allergy injection services	20%	40%

All other injections (except for infertility injection)

Injectable drugs administered by a physician	20%	40%
Self-injectable drugs*	20%	20%
<i>Maximum copayment for each prescription (at a pharmacy)</i>	\$100	\$100
<i>Maximum copayment per day (at a doctors office)</i>	\$100	\$100

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Outpatient services	PPO	OON
Outpatient facility services (other than surgery) *	20%	40%
Outpatient surgery (hospital or outpatient surgery center charges only) *	20%	40%

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Hospital services	PPO	OON
Semi-private hospital room or special care unit with ancillary services, including delivery and maternity care (unlimited days) *	20%	40%
Hospitalization for infertility services* •	20%	40%
Skilled nursing facility stay*	20%	40%
<i>Maximum days per calendar year</i> ^a	100	100
Confinement for bariatric (weight loss) surgery	20%	40%


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- *All services and supplies relating to infertility treatment are subject to \$2000 lifetime benefit maximum.*

⌘ *Combined for PPO and Out-of-Network.*

The above coinsurance for inpatient hospital or special care unit services is applicable for each admission for the hospitalization of an adult, pediatric or newborn patient.

Radiological services	PPO	OON
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Laboratory procedures and diagnostic imaging (including x-ray)	20%	40%
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Preventive Care	PPO	OON
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Adult preventive care

Periodic health evaluations, including well-woman exam and annual preventive physical examinations (age 17 and older) [Ⓜ]	Covered in full.....	Not covered
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Child preventive care

Periodic health evaluations, including newborn, well-baby care, annual preventive physical examinations and immunizations (birth through age 16) [Ⓟ]	Covered in full.....	Not covered
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[Ⓜ] *Provided on the basis of age, medical need and health status. Adult preventive care includes: Mammography, cervical cancer screening test/pelvic and breast exams, preventive vision and hearing screening examinations and screening colonoscopy or sigmoidoscopy (refer to the Certificate for frequency and guidelines). However, if during the course of a screening colonoscopy or sigmoidoscopy, a therapeutic (surgical) procedure is performed, then the copayment or coinsurance applicable for outpatient surgery will also be required for the surgical procedure(s) performed. Refer to the "Outpatient Services" section above for the outpatient surgery copayment or coinsurance.*

[Ⓟ] *Limited to evaluation and management of child's physical development for prevention of future medical problems, laboratory tests, x-rays, preventive vision and hearing screening examinations and standard immunizations.*

Emergency health coverage	PPO	OON
Emergency room (facility and professional services).....	20%	40%
Urgent care center (facility and professional services)	\$15	40%


 *The coinsurance shown for PPO emergency health care services will be applied for all emergency care, regardless of whether or not the health care provider is a PPO or noncontracting provider. The coinsurance shown for PPO and Out-of-Network providers are applicable only if non-emergency care is provided at an emergency room or urgent care center.*

Ambulance services	PPO	OON
Ground ambulance	20%	40%
Air ambulance *	20%	40%

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Outpatient prescription drug plan

Prescription drugs	Participating pharmacy	Nonparticipating pharmacy
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 *Please refer to the "Prescription drug program" section of this SB for definitions, benefits and limitations. Copayments for supplemental benefits do not apply to the out-of-pocket maximum.*

Retail pharmacy (up to a 30-day supply)


Level I drugs listed on the Recommended Drug List (primarily generic)	\$10	\$10 plus 50%
Level II drugs listed on the Recommended Drug List (primarily brand name) and diabetic supplies (including insulin) ♦	\$25	\$25 plus 50%
Level III drugs listed on the Recommended Drug List (or drugs not listed on the Recommended Drug List) ♦	\$50	\$50 plus 50%
Contraceptive devices (including diaphragms and cervical caps)	\$25	\$25 plus 50%

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

Level I drugs listed on the Recommended Drug List (primarily generic)	\$20.....	Not Covered
Level II drugs listed on the Recommended Drug List (primarily brand name) and diabetic supplies (including insulin) ♦	\$50.....	Not Covered
Level III drugs listed on the Recommended Drug List (or drugs not listed on the Recommended Drug List) ♦	\$100.....	Not Covered

♦ *Generic drugs will be dispensed when a generic drug equivalent is commercially available. When a brand name drug is dispensed and a generic equivalent is commercially available, the covered person must pay the difference between the generic equivalent and the brand name drug in addition to the listed copayments or coinsurance. However, if the prescription drug order states "dispense as written," "do not substitute" or words of similar meaning in the physician's handwriting, only the listed drug copayment will be applicable.*

Medical supplies	PPO	OON
Durable medical equipment *	20%	40%
<i>Calendar year maximum payable by HNL</i> ²	\$5000.....	\$5000
Diabetes education.....	20%	40%
Orthotics (such as bracing, supports and casts) *	20%	40%
Corrective footwear*	20%	40%
Diabetic equipment (See the "Prescription Drug Program" section of this SB for diabetic supplies benefit information)	20%	40%
Diabetic footwear	20%	40%
Prostheses*	20%	40%

 *Durable Medical Equipment is covered when medically necessary and acquired or supplied by an HNL designated contracted vendor for Durable Medical Equipment. Preferred Providers that are not designated by HNL as a contracted vendor for Durable Medical Equipment are considered Out-of-Network Providers for purposes of determining coverage and benefits. For information about HNL's designated contracted vendors for Durable Medical Equipment, please contact the Member Services Department at the telephone number on the back cover.*



Diabetic equipment covered under the medical benefit (through "Diabetic equipment") includes blood glucose monitors designed for the visually impaired, insulin pumps and related supplies, and corrective footwear. 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 insulin syringes.

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 prosthesis 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).

☞ Combined for PPO and Out-of-Network.

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Mental disorders and chemical dependency benefits

PPO

OON



Severe mental illness includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition the Diagnostic and Statistical Manual for Mental Disorders), autism, anorexia nervosa and bulimia nervosa.

Serious emotional disturbances of a child is when a child under the age of 18 has one or more mental disorders identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary chemical dependency disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one of the following: (a) as a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self care, school functioning, family relationships or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home or (ii) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year; (b) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; and/or (c) the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Severe Mental Illness and Serious Emotional Disturbances of a Child

Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting) ♦	\$15	40%
Inpatient services*	20%	40%

Other Mental Disorders

Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting) ♦	\$15	40%
Inpatient services*	20%	40%

Chemical Dependency

Outpatient professional consultation (psychological evaluation or therapeutic session in an office setting) ♦	\$15	40%
Inpatient services*	20%	40%
Acute detoxification*	20%	40%

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

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Home Health Services	PPO	OON
Home health visits*	20%	40%
Maximum amount allowable by HNL per day	\$110	\$110

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Other services	PPO	OON
Infertility services and supplies (including injections related to covered infertility services)	20%	40%
Lifetime maximum [Ⓜ]	\$2000	\$2000
Sterilization - Vasectomy	20%	40%
Sterilization - Tubal ligation	20%	40%

Blood, blood plasma, blood derivatives and blood factors	20%	20%
Renal dialysis.....	20%	40%
Hospice services*	20%	40%
Infusion Therapy (home or physician's office) *	20%	40%
<i>Number of days for each supply of injectable prescription drugs and other substances, for each delivery.....</i>		
	14	14
<i>Maximum amount allowable by HNL per day.....</i>		
	No Maximum	\$500

☞ Combined for PPO and Out-of-Network.

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Chiropractic care	PPO	OON
Office visits.....	\$15	40%
<i>Maximum amount payable by HNL per visit</i>		
	No maximum.....	\$25
<i>Calendar year maximum[☞].....</i>		
	\$1500	\$1500

☞ Combined for PPO and Out-of-Network.

Acupuncture care	PPO	OON
Office visits.....	20%	40%
<i>Maximum amount payable by HNL per visit</i>		
	No maximum.....	\$25
<i>Calendar year maximum[☞].....</i>		
	\$1500	\$1500

☞ Combined for PPO and Out-of-Network.

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 medically necessary and prior authorization has been obtained.
- Artificial insemination;
- Care for mental health care as a condition of parole or probation, or court-ordered treatment and testing for mental disorders, except when such services are medically necessary;
- Charges in excess of rate negotiated between any organization and the physician, hospital or other provider;
- Conception by medical procedures (IVF, GIFT and ZIFT);
- Conditions resulting from the release of nuclear energy when government funds are available;
- Cosmetic services or 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 insurance plan" sections of this SB;
- Genetic testing is not covered except when determined by Health Net Life to be medically necessary. The prescribing physician must request prior authorization for coverage;
- Hearing aids;
- Hearing examination (age 17 and older);
- Hypnosis;
- Immunization (age 17 and older);
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder;
- Non-eligible institutions. This insurance 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 *Certificate*. Any institution, regardless of how it is designated, is not an eligible institution. Services or supplies provided by such institutions are not covered;
- Nontreatable disorders;
- Orthoptics (eye exercises);
- Orthotics (such as bracing, supports and casts) that are not custom made to fit the covered person's body;
- Outpatient prescriptions drugs or medications (except as noted under "Prescription drug program");
- Personal or comfort items;
- Physician self-treatment;
- Physician treating immediate family members;
- Pre-existing conditions that occur during the first six months of your coverage, except as stated elsewhere;
- Private rooms when hospitalized, unless medically necessary;
- Private-duty nursing;

- Refractive eye surgery unless medically necessary, recommended by the covered person's treating physician and authorized by Health Net Life;
- 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 determined not to be medically necessary as defined in the *Certificate*;
- Services and supplies not specifically listed in the plan's *Certificate* as covered expenses;
- Services and supplies that do not require payment in the absence of insurance;
- Services for an injury incurred in the commission (or attempted commission) of a crime unless the condition was an injury resulting from an act of domestic violence or an injury resulting from a medical condition;
- Services for a surrogate pregnancy are covered. However, when compensation is obtained for the surrogacy, Health Net Life shall have a lien on such compensation to recover its medical expense;
- Services not related to a covered illness or injury, except as provided under preventive care and annual routine exams;
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the plan's *Certificate*;
- Services related to educational and 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;
- Treatment of obesity, weight reduction or weight management, except for treatment of morbid obesity;
- Vision examination (age 17 and older).

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