

**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 Certificate of Insurance (COI) for your insurance plan contains the complete terms and conditions of your Health Net Life Insurance Company coverage. It is important for you to thoroughly review the COI for your insurance plan.

<b>Health Net Large Group PPO (GF) Plan 4YQ - Effective 1/1/2011</b>	<b>PPO</b>	<b>OON</b> <small>Member pays coinsurance and any charges exceeding maximum allowable amount</small>
<b>PROFESSIONAL SERVICES</b>		
Visit to a physician, physician assistant or nurse practitioner.	\$15	40%
Preventive care		
Child (through age 16). Includes annual preventive physical examinations, newborn/well-baby care and <b>immunizations</b> .	\$15	Not covered
Adult (age 17 and older). Includes annual preventive physical examinations. Refer to Introduction pages for list of covered services.	\$15	Not covered
Vision and hearing examinations. Routine preventive exams only for children through age 16.	\$15	Not covered
Adult (age 17 and older). See annual routine physical exams above.	Not covered	Not covered
Specialist consultations (includes second surgical opinions).	\$15	40%
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 ( <b>including</b> foreign travel/occupational). See child preventive care above.	Not covered	Not covered
Allergy testing.	\$15	40%
Allergy serum.	20%	40%
Allergy injection services (serum not included).	20%	40%
Injections for treatment of infertility. Deductible required.	20% ⌘	40% ⌘
All other injections.		
Office based injectable medications.	20%	40%
Self-administered injectable medications (up to a 30-day supply for each prescription). Through PPO, the percentage coinsurance is based on the contracted rate. Only self-injectables require certification by Health Net Pharmacy. Refer to the Introduction pages and the ▲ for additional information.	20% up to a \$100 max copay for each pre- scription	20% up to a \$100 max copay for each prescription
Surgeon/ assistant surgeon. Only specified procedures require certification. Refer to the Introduction pages and the ▲ for additional information.	20%	40%
Administration of anesthetics.	20%	40%
X-ray and laboratory procedures. Only specified procedures require certification. Refer to the Introduction pages and the ▲ for additional information.	20%	40%
Physical, speech, occupational and respiratory therapy. Through OON, the maximum payable for each visit is \$25. Only specified procedures require certification. Refer to the Introduction pages and the ▲ for additional information.	20%	40%
Dental services (when medically necessary to properly monitor, control or treat a severe medical condition when excluded dental services are being performed).	20%	40%
<b>CARE FOR CONDITIONS OF PREGNANCY</b>		
Prenatal and postnatal office visit.	GLOBAL FEES REQUIRED	
Normal delivery, Cesarean section. Includes newborn inpatient professional care. ▲	20%	40%
Complications of pregnancy including medically necessary abortions. ▲	20%	40%
Elective abortions.	20%	40%
Genetic testing of fetus.	20%	40%
Circumcision of newborn.	20%	40%
<b>FAMILY PLANNING (professional services only)</b>		
Contraceptive devices - intrauterine device (IUD).	20%	40%
Infertility services (including professional services, inpatient and outpatient care, and treatment by injection). <b>Excludes</b> coverage of artificial insemination. Deductible required.	20% ⌘	40% ⌘
Sterilization of females.	20%	40%
Sterilization of males.	20%	40%
Reversal of sterilization.	Not covered	Not covered

PPO services to which a copayment applies are not subject to the calendar-year deductible. For these services, Health Net will pay 100% of covered expenses (excluding the copayment), whether or not the calendar-year deductible has been satisfied. Services to which a coinsurance applies are subject to the calendar-year deductible.

## Health Net Large Group PPO - (GF) Plan 4YQ

**PPO**

**OON**

Member pays coinsurance and any charges exceeding maximum allowable amount

### CARE FOR MENTAL DISORDERS

#### Severe Mental Illnesses

Severe mental illnesses include the following conditions: Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder (autism), anorexia nervosa, bulimia nervosa, and serious emotional disturbances in children (under age 18).

Outpatient mental visit for severe mental illness. Includes intensive outpatient care or partial hospitalization / day treatment.	\$15	40%
Inpatient care in a hospital or residential treatment facility for severe mental illness. ▲	20%	40%
Physician visit to hospital or residential treatment facility for severe mental illness.	20%	40%

#### Other Mental Illnesses (Non-severe mental illnesses)

Outpatient mental visit for non-severe mental illness. Includes intensive outpatient care or partial hospitalization / day treatment.	\$15	40%
Inpatient care in a hospital or residential treatment facility for non-severe mental illness. ▲	20%	40%
Physician visit to hospital or residential treatment facility for non-severe mental illness.	20%	40%

### CHEMICAL DEPENDENCY REHABILITATION

Outpatient consultation (therapy, counseling and/or psychological testing) in an outpatient chemical dependency rehabilitation facility. Includes intensive outpatient care or partial hospitalization / day treatment.	\$15	40%
Detoxification (acute care for substance abuse). ▲	20%	40%
Inpatient rehabilitation for chemical dependency in a hospital or residential chemical dependency facility. ▲	20%	40%

### OTHER SERVICES

Medical social services.	20%	40%
Patient education for diabetics only.	20%	40%
Air ambulance. A \$50 deductible is required for each incident in addition to the specified coinsurance. ▲	20%	40%
Ground ambulance. A \$50 deductible is required for each incident in addition to the specified coinsurance.	20%	40%
Durable medical equipment. ▲	20%	40%
	Combined limit of \$5,000 (PPO/OON)	
Orthotics (braces and supports).	20%	40%
Corrective footwear. Custom made shoes and shoe inserts (custom foot orthotics).	20%	40%
Diabetic supplies (refer to the Introduction section for additional information).	20%	40%
Hearing aids.	Not covered	Not covered
Prosthesis (replacing body parts). ▲	20%	40%
Acupuncture. Through OON, the maximum amount payable for each visit is \$25.	20%	40%
	Combined limit of \$1,500 (PPO/OON)	
Chiropractic care. Through OON, the maximum amount payable for each visit is \$25.	\$15	40%
	Combined limit of \$1,500 (PPO/OON)	
Blood and blood products.	20%	20%
Nuclear medicine (professional services only).	20%	40%
Organ and bone marrow transplants (non-experimental and noninvestigative. Professional services only.) ▲	20%	Not covered
Chemotherapy or radiation therapy (professional services only).	20%	40%
Renal dialysis (professional services only). ▲	20%	40%
Home health visit. Each day of care is limited to a maximum payment of \$110 (PPO & OON). ▲	20%	40%
Infusion therapy (home or physician's office). Through OON, limited to a maximum allowable amount of \$500 each day. ▲	20%	40%
Hospice care (elected by member). ▲	20%	40%

▲ These services require prior certification before being provided or received. If prior certification is not acquired, benefits are reduced to 50%. In addition, for **uncertified outpatient services**, a \$100 deductible is required for each visit; for **uncertified inpatient admissions**, a \$500 deductible is required for each inpatient admission. Refer to the Certification lists located in the Introduction section to determine the appropriate list to utilize and for additional information.  
**NOTE:** Routine care for conditions of pregnancy and renal dialysis do not require prior certification. However, notification is requested.

⌘ Infertility services require a separate lifetime deductible of \$500. The \$500 lifetime deductible applies towards the member's OOPM. Once the OOPM is met, the infertility deductible continues to be required. 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. **Note:** Artificial insemination is not a covered benefit.

<b>Health Net Large Group PPO - (GF) Plan 4YQ</b>	<b>PPO</b>	<b>OON</b> Member pays coinsurance and any charges exceeding maximum allowable amount
<b>HOSPITAL AND SKILLED NURSING FACILITY</b>		
Unlimited days of hospital care in a semi-private room or ICU with ancillary services. Excludes care for mental disorders. ▲	20%	40%
Confinement for infertility services. Deductible required.	20% ⌘	40% ⌘
Confinement in a skilled nursing facility. ▲	20%	40%
	Combined limit of 100 days (PPO/OON)	
Maternity care. Includes routine nursery charges. ▲	20%	40%
Outpatient services. Only specified procedures require certification. Refer to the Introduction pages and the ▲ for additional information.		
Outpatient services other than surgery.	20%	40%
Outpatient surgery at hospital or ambulatory surgical center.	20%	40%
<b>EMERGENCY ROOM / URGENT CARE CENTER</b>		
Note: For all services which meet the criteria for emergency care, the coinsurance will be the percentage or copayment shown for PPO, even if the services were received from an OON provider. The member must request certification for inpatient hospital or outpatient emergency room or urgent care center services within 48 hours, or as soon as reasonably possible. Health Net Life will determine whether services meet the criteria for emergency care.		
Use of emergency room (facility and professional services).	20% ✱	40% ✱
Use of urgent care center (facility and professional services).	\$15	40%

✱ An additional \$100 emergency room deductible is required if the member is not admitted as an inpatient. The deductible is waived if admitted.
⌘ Infertility services require a separate lifetime deductible of \$500. The \$500 lifetime deductible applies towards the member's OOPM. Once the OOPM is met, the infertility deductible continues to be required. 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. <b>Note:</b> Artificial insemination is not a covered benefit.
▲ These services require prior certification before being provided or received. If prior certification is not acquired, benefits are reduced to 50%. In addition, for <b>uncertified outpatient services</b> , a \$100 deductible is required for each visit; for <b>uncertified inpatient admissions</b> , a \$500 deductible is required for each inpatient admission. Refer to the Certification lists located in the Introduction section to determine the appropriate list to utilize and for additional information. <b>NOTE:</b> Routine care for conditions of pregnancy and renal dialysis do not require prior certification. However, notification is requested.

<b>CALENDAR YEAR DEDUCTIBLES</b>	<b>CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOPM)</b>	<b>LIFETIME BENEFIT MAXIMUM</b>
\$500 for each member (PPO/OON combined)  Three family members must satisfy their individual deductibles to satisfy the family deductible.	\$3,000 for each member (PPO)  \$6,000 for each member (OON)  Three family members each must satisfy their individual OOPM to satisfy the family OOPM (PPO/OON)  <b>Note:</b> Mental health services (severe, non-severe & chemical dependency rehabilitation) apply to OOPM.	Unlimited  Medical and mental health/substance abuse payments.