PLAN DISCLAIMER

This Schedule of Benefits is a brief list of benefits, with applicable copayments, coinsurance and deductibles information for your health plan. It does not list the exclusions and limitations or other important terms applicable to your 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.

Salud HMO y más California - Large Group *CalPERS* *Restricted* Plan 9VZ - Effective 1/1/2014	**HMO**		
HMO Network: SIMNSA Network providers are located in Mexico. Health Net Salud Network providers are located in select California counties. California members may self-refer to SIMNSA Network providers at any time.	**SIMNSA Network (Mexico members)**	**Health Net Salud Network (California members)**	**SIMNSA Network (Self-referral for California members)**
Visit to a physician, physician assistant or nurse practitioner. [1]			
Performed at member's participating physician group (PPG).	$15	$15	$15
Performed at a CVS MinuteClinic for preventive care services. Includes preventive physical examinations, other immunizations and preventive laboratory tests. [1]	N/A	$0	N/A
Performed at a CVS MinuteClinic for all other non-preventive care services.	N/A	$15	N/A
MD Live telehealth consultation.	$0	$0	$0
Periodic health evaluations. 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	$0	$0
Vision examinations for refractive eye exams.	$0	$0	$0
Hearing examinations for hearing loss.	$0	$0	$0
Specialist consultations. Includes second surgical opinion consultations and OB/GYN self-referral for non-preventive services. For preventive services, refer to periodic health evaluations above. [1]	$15	$15	$15
Physician visit to member's home (at discretion of physician).	Not covered	$15	Not covered
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).	$0	$0	$0
Immunizations (**except** foreign travel/occupational). See below.	$0	$0	$0
Immunizations for foreign travel/occupational purposes.	$0	$0	Not covered
Allergy testing.	$0	$0	$0
Allergy serum.	$0	$0	$0
Allergy injection services (serum not included).	$0	$0	$0
Injections for treatment of infertility.	50%	50%	50%
All other injections.			
Office based injectable medications. [1]	$0	$0	$0
Self-administered injectables.	$5	$30	$5
Surgeon/assistant surgeon.	$0	$0	$0
Transgender surgery. [2]	Not covered	$0	Not covered
Administration of anesthetics.	$0	$0	$0
X-ray and laboratory procedures. Preventive x-ray/lab, refer to periodic health evaluations above.[1]	$0	$0	$0
Rehabilitation therapy (outpatient and home physical, speech, occupation and respiratory therapy). See *PPG Operations Manual*.	$5	$15	$5
Rehabilitation therapy performed in an inpatient setting.	$5	$0	$5
Dental services (when medically necessary to properly monitor, control or treat a severe medical condition when excluded dental services are being performed).	$0	$0	$0
CARE FOR CONDITIONS OF PREGNANCY (professional services only)			
Prenatal and postnatal office visit.	$0	$0	$0
Normal delivery, Cesarean section. Includes newborn inpatient care provided by a member physician.	$0	$0	$0
Complications of pregnancy including medically necessary abortions.	$0	$0	$0
Elective abortions.	Not covered	$0	Not covered
Genetic testing of fetus.	$0	$0	$0
Circumcision of newborn.	$0	$0	$0
FAMILY PLANNING (professional services only)			
Contraceptive methods. Includes intrauterine device (IUD), injectable or implantable contraceptives. [1]	$0	$0	$0
Infertility services (including professional services, inpatient and outpatient care, treatment by injection and prescription drugs, if applicable. See *PPG Operations Manual*).	50%	50%	50%
Sterilization of females. [1]	$0	$0	$0
Sterilization of males.	$0	$0	$0
Reversal of sterilization.	Not covered	Not covered	Not covered

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CARE FOR MENTAL DISORDERS - ***SIMNSA Network: Services must be provided by a SIMNSA provider***			
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 (e.g., 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	Administered by MHN	$15
Inpatient care in a hospital or residential treatment facility for severe mental illness.	$0	Refer members to phone # on Health Net ID card	$0
Physician visit to hospital or residential treatment facility for severe mental illness.	$0		$0
Other Mental Illnesses (Non-severe mental illnesses) - ***SIMNSA Network: Services must be provided by a SIMNSA provider***			
Outpatient mental visit for non-severe mental illness. Includes intensive outpatient care or partial hospitalization / day treatment.	$15	Administered by MHN	$15
Inpatient care in a hospital or residential treatment facility for non-severe mental illness.	$0	Refer members to phone# on ID card	$0
Physician visit to hospital or residential treatment facility for non-severe mental illness.	$0		$0
CARE FOR CHEMICAL DEPENDENCY REHABILITATION - ***SIMNSA Network: Services must be provided by a SIMNSA provider***			
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	Administered by MHN	$15
Detoxification (acute care for substance abuse).	$0	Refer members to phone # on Health Net ID card	$0
Inpatient rehabilitation for chemical dependency in a hospital or residential chemical dependency facility.	$0		$0
OTHER SERVICES			
Medical social services.	$0	$0	$0
Patient education.	$0	$0	$0
Ambulance services (air and ground).	$0	$0	$0
Durable medical equipment. For preventive DME, refer to preventive care. [1]	$0	$0	$0
Orthotics (braces and supports).	$0	$0	$0
Corrective footwear. Custom made shoes and shoe inserts (custom foot orthotics).	Not covered	$0	Not covered
Diabetic supplies, including diabetic footwear.	$0	$0	$0
Hearing aids and ancillary equipment. The benefit maximum applies to devices and ancillary equipment only. Coverage includes repair and maintenance for one year following the provision of a covered hearing aid at no cost and does not apply to benefit maximum.	Not covered	$0 / $1,000 max every 36 month	Not covered
Prosthesis (replacing body parts).	$0	$0	$0
Blood and blood products.	$0	$0	$0
Nuclear medicine.	$0	$0	$0
Organ, tissue and stem cell transplants (non-experimental and noninvestigative professional services only).	$0	$0	$0
Chemotherapy or radiation therapy.	$0	$0	$0
Renal dialysis.	$0	$0	$0
Home health visit.	Not covered	$0	Not covered
Hospice care (elected by member). SIMNSA Network - only covered when services are provided in an acute hospital setting.	$0	$0	$0

1 **Women's preventive care services include the following:** Screening for gestational diabetes; human papillomavirus (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 Transgender surgery and services related to changing a member's physical characteristics to those of the opposite gender are covered when Medically Necessary.

If a member lives 50 miles or more from the nearest Health Net qualified provider in conjunction with the gender transformation treatment, the member is eligible to receive travel expense reimbursement, including clinical work-up, diagnostic testing and preparatory procedures, when necessary for the safety of the member and for the prior approved Transgender surgery. All requests for travel expense reimbursement must be prior approved by Health Net.

Submission of adequate documentation including receipts is required to receive travel expense reimbursement from Health Net.

Transportation for the member to and from the Health Net qualified provider up to $130 per trip for a maximum of four (4) trips (pre-surgical work-up visit, one pre-surgical visit, the initial surgery and one follow-up visit). Transportation for one companion (whether or not an enrolled member) to and from the Health Net qualified provider up to $130 per trip for a maximum of three (3) trips (work-up visit, the initial surgery and one follow-up visit).

Hotel accommodations for the member may not exceed $100 per day for the pre-surgical work-up, pre-surgical visit and the follow-up visit, up to two (2) days per trip or as Medically Necessary. Limited to one room, double occupancy. Hotel accommodations for one companion (whether or not an enrolled member) not to exceed $100 per day, up to four (4) days for the member's pre-surgical work-up and initial surgery stay and up to two (2) days for the follow-up visit. Limited to one room, double occupancy.

Other reasonable expenses not to exceed $25 per day, up to two (2) days per trip for the pre-surgical work-up, pre-surgical visit and follow-up visit and up to four (4) days for the surgery visit.

As a prerequisite to transgender surgery, the candidate is required to undergo twelve (12) months of hormone therapy. This requirement will be waived if such therapy is contraindicated for clinical reasons for the surgery candidate.

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HOSPITAL AND SKILLED NURSING FACILITY SERVICES			
Unlimited days of hospital care with ancillary services in a private room in Mexico. In the U.S., unlimited days of hospital care in a semi-private room or special care unit with ancillary services. Excludes care for chemical dependency/mental disorders.	$0	$0	$0
Confinement for infertility services.	50%	50%	50%
Confinement in a skilled nursing facility (limited to 100 days a calendar year).	$0	$0	$0
Maternity care. Includes routine normal nursery charges.	$0	$0	$0
Outpatient services and surgery.	$0	$0	$0
EMERGENCY SERVICES/URGENTLY NEEDED CARE - Within or outside the Health Net Salud Network or SIMNSA Network.			
Note: Non-emergency care (including urgently needed care) received **within** the Health Net Salud Network in California or SIMNSA HMO Network in Mexico must be performed or authorized by the Health Net Salud provider in California or SIMNSA provider in Mexico. When emergency or urgently needed care is required **outside** the Health Net Salud service area (including care outside of California), authorization is not mandatory in order for services to be covered. When services are provided that meet the criteria for emergency or urgently needed care, whether **within** or **outside** of the Health Net Salud service area (including outside of California), the services are covered, even if the member never contacted the Salud Network provider in California or SIMNSA provider in Mexico. Refer to the Evidence of Coverage (EOC) for more information.			
Use of emergency room (facility and professional services).	$15 [3]	$50 [3]	$15 [3]
Use of an urgent care center (facility and professional services).	$15 [3]	$15 [3]	$15 [3]
OUT-OF-POCKET MAXIMUM (OOPM) - *SIMNSA and Salud Network combined*			
For each member.	$1,500	$1,500	$1,500
For two members or family.	$3,000	$3,000	$3,000
LIFETIME BENEFIT MAXIMUM			
Maximum payments for each member's lifetime.		Unlimited	

3 The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room or urgent care center.