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.

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

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OTHER SERVICES	
Medical social services.	$0
Patient education.	$0
Ground ambulance.	$0
Air ambulance.	$0
Durable medical equipment. For preventive DME, refer to preventive care. [1]	$0
Orthotics (braces and supports).	$0
Corrective footwear. Custom made shoes and shoe inserts (custom foot orthotics).	$0
Diabetic supplies, including diabetic footwear.	$0
Hearing aids. 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.	$0 / $1,000 max every 36 months
Prosthesis (replacing body parts).	$0
Blood and blood products.	$0
Nuclear medicine.	$0
Organ, tissue and stem cell transplants (non-experimental and noninvestigative professional services only).	$0
Chemotherapy or radiation therapy.	$0
Renal dialysis.	$0
Home health visit.	$0
Hospice care.	$0
HOSPITAL AND SKILLED NURSING FACILITY SERVICES	
Unlimited days of hospital care in a semi-private room or special care unit with ancillary services. Excluding care for mental disorders.	$0
Confinement for infertility services.	50%
Confinement in a skilled nursing facility.	$0 / 100 days
Maternity care. Includes routine normal nursery charges.	$0
Outpatient services and surgery.	$0
EMERGENCY CARE/URGENTLY NEEDED CARE - Within or outside the PPG service area - (Refer to the Introduction pages for more information)	
NOTE: Non-emergency care (including urgently needed care) received **within** the PPG service area must be performed or authorized by the member's PPG in order for services to be covered. When urgently needed care is provided **outside** the PPG service area, authorization is not mandatory in order for services to be covered. When services are provided that meet the criteria for emergency care, whether **within or outside** the PPG service area, the services are covered, even if the member never contacted the PPG. See the Introduction pages for more information.	
Use of emergency room (facility and professional services). [3]	$50
Use of urgent care center (facility and professional services). [3]	$15
OUT-OF-POCKET MAXIMUM	
For each member.	$1,500
For family (two or more members).	$3,000

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.

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. See the Introduction pages for more information regarding emergency services/urgently needed care.