## 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 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**<br>***Restricted* (GF+) Plan M1B** | **M1B**<br>**10/1/2024** |
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| **CALENAR YEAR OUT-OF-POCKET MAXIMUM (OOPM):** All eligible copayments and coinsurance apply to OOPM. | |
| For each member. | $1,500 |
| For each family. | $4,500 |
| **PROFESSIONAL SERVICES** | |
| Visit to a physician, physician assistant or nurse practitioner at a PPG. [1] | $0 |
| Performed at a CVS MinuteClinic for preventive care services. Includes preventive physical examinations, other immunizations and preventive laboratory tests. [1] | $0 |
| Performed at a CVS MinuteClinic for all other non-preventive care services. | $0 |
| Telemedicine services. [2] | $0 |
| Periodic health evaluations. Includes annual preventive physical examinations, preventive vision/hearing screenings, well-woman exam and preventive laboratory tests and x-rays. [1] | $0 |
| Annual routine physical examinations. Provided for employment, school, camp or sports. | Not covered |
| Vision and hearing examinations. | $0 |
| Specialist consultations. Includes OB/GYN self-referral for non-preventive services. For preventive services, refer to periodic health evaluations above. [1] | $0 |
| Podiatry services, includes routine foot care for diabetes. | $0 |
| Routine foot care (cutting/removal of corns, calluses, trimming of nails). | Not covered |
| Physician visit to member's home (at discretion of physician). | $0 |
| Physician visit to hospital or skilled nursing facility (excluding care for mental disorders). | $0 |
| Other immunizations (except foreign travel/occupational - see below). | $0 |
| Immunizations for foreign travel/occupational purposes. | 20% |
| Allergy testing. | $0 |
| Allergy serum. | $0 |
| Allergy injection services (serum not included). | $0 |
| Injections related to infertility services. | 50% |
| All other injections. [1] | $0 |
| Self-administered injectable medications. | $0 |
| Surgeon/assistant surgeon in hospital or PPG. | $0 |
| Administration of anesthetics. | $0 |
| X-ray and laboratory procedures, including genetic testing and complex radiology (CT scan, SPECT, MRI, MUGA, and PET). | $0 |
| Rehabilitation therapy (outpatient physical, speech, and occupational), including ABA therapy services. Provided as long as significant improvement is expected. | $0 |
| Cardiac and respiratory therapy. | $0 |
| Habilitation therapy (physical, occupational, speech, respiratory and cardiac therapy). Applied behavioral analysis (ABA) is covered through the mental health benefit. | $0 |
| Dental services (when medically necessary to properly monitor, control, or treat a severe medical condition when excluded dental services are being performed). | $0 |
| **CARE FOR CONDITIONS OF PREGNANCY (professional services only)** | |
| Prenatal and postnatal office visit. | $0 |
| Normal delivery, complications of pregnancy and cesarean section. Includes newborn inpatient care provided by a member physician. | $0 |
| Abortion services | $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. Includes professional services, outpatient care, treatment by injection, prescription drugs if applicable, artificial insemination (AI), IUI and GIFT. **ZIFT and IVF are not covered.** | 50% |
| Sterilization of females. [1] | $0 |
| Sterilization of males. | $0 |
| Reversal of sterilization. | Not covered |

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| **CARE FOR MENTAL HEALTH** | |
| Outpatient, office visit/professional consultation (Includes psychological evaluation or therapeutic session in an office setting, medication management, drug therapy monitoring, injections, and Methadone) including physician visits to home. | $0 |
| Telemedicine services. [2] | $0 |
| Outpatient Mental Health - Group therapy session. | $0 |
| Outpatient Services - other (Includes Biofeedback, psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care programs, day treatment, partial hospitalization, 23 hour observation, TMS, and therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day, and PT/ST/OT services). | $0 |
| Inpatient care in a hospital, participating behavioral health facility or residential treatment center. | $0 |
| Physician visit to hospital, participating behavioral health facility or residential treatment center. | $0 |
| **CARE FOR SUBSTANCE USE DISORDERS & DETOXIFICATION** | |
| Outpatient, office visit/professional consultation (Includes psychological evaluation or therapeutic session in an office setting, medication management, drug therapy monitoring, injections, and Methadone) including physician visits to home. | $0 |
| Telemedicine services. [2] | $0 |
| Outpatient Substance Use Disorders - Group therapy session. | $0 |
| Outpatient Services - other (Includes alternate care, partial hospitalization, day treatment, intensive outpatient care programs, and 23 hour observation). | $0 |
| Inpatient care in a hospital, participating behavioral health facility or residential treatment center. | $0 |
| Physician visit to hospital, participating behavioral health facility or residential treatment center. | $0 |
| Detoxification in a hospital, participating behavioral health facility or residential treatment center. | $0 |
| **OTHER SERVICES** | |
| Medical social services. | $0 |
| Patient education. Includes smoking cessation/weight management. | $0 |
| Ambulance services (air and ground). | $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). | Not covered |
| Diabetic supplies. | $0 |
| Hearing aids (annual max payable of $5000 every 3 years). | $0 |
| Hearing aid exam (annual max payable of $5000 every 3 years). | $0 |
| Medical supplies.[1] | $0 |
| Prosthesis (replacing body parts). | $0 |
| Wigs (cranial prosthesis). | Not covered |
| Blood, blood products and blood-clotting factors. | $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 includes home health rehab. The copayment is required on and after the 31st calendar day of the treatment plan. | $10 |
| Infusion therapy in home, office or outpatient facility. | $0 |
| Hospice care. | $0 |

1 **Women's preventive care services include the following:** Screening for gestational diabetes; human papillomavirus (HPV) DNA testing; 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 Telemedicine services are covered when provided through preferred vendor. For all other providers, telehealth cost share mirrors in-person cost share based on type of services provided.

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| **HOSPITAL AND SKILLED NURSING FACILITY SERVICES** | |
| Unlimited days of hospital care (medical, surgical & maternity, including routine normal nursery charges) provided in a medically necessary private room, semi-private room or special care unit with ancillary services. Excludes care for mental disorders. | $0 |
| Confinement in a skilled nursing facility (limited to 100 days a calendar year). | $0 |
| Outpatient services. | $0 |
| **EMERGENCY CARE/URGENTLY NEEDED CARE - Within or outside the PPG service area -** | |
| **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. | |
| Emergency room (professional services). | $0 |
| Use of emergency room (facility services). [3] | $35 |
| Use of urgent care center. | $0 [4] |

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| 3 | Copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room. |
| 4 | $0 for medical services; $0 for behavioral health or substance use disorders; |

## GRANDFATHERED HEALTH PLAN DISCLAIMER

Health Net believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at your Group or to Health Net's Customer Contact Center at the phone number on the back of your Health Net ID Card. If you are enrolled in an employer plan that is subject to ERISA, 29 U.S.C. 1001 et seq., you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.