Schedule of benefits and coverage

This MATRIX is intended to be used to help you compare coverage benefits and is a summary only. The PLAN CONTRACT AND Evidence of Coverage (EOC) should be consulted for a detailed description of coverage benefits and limitations.

The copayment amounts listed below are the fees charged to you for covered services you receive. Copayments can be either a fixed dollar amount or a percentage of Health Net's cost for the service or supply and is agreed to in advance by Health Net and the contracted provider. Fixed dollar copayments are due and payable at the time services are rendered. Percentage copayments are usually billed after the service is received.

Principal benefits and coverage matrix

Deductibles.. None
Lifetime maximums.. None

Out-of-Pocket maximum for medical plans

One member.. $1500
Two members.. $3000
Family (three members or more).. $4500

Once your payments for covered services equals the amount shown above in any one calendar year, including covered services and supplies provided by American Specialty Health Plans of California, Inc. (ASH Plans), no additional copayments for covered services are required for the remainder of the calendar year. Once an individual member in a family meets the individual out-of-pocket maximum, the other enrolled family members must continue to pay copayments for covered services and supplies until the total amount of copayments paid by the family reaches the family out-of-pocket maximum or each enrolled family member individually meets the individual out-of-pocket maximum. Payments for any supplemental benefits or services not covered by this plan will not count toward this calendar year out-of-pocket maximum, unless otherwise noted. You will need to continue making payments for any additional benefits.

Payments for any supplemental benefits, infertility services, deductibles or services not covered by this plan will not count toward this calendar year out-of-pocket maximum, unless otherwise noted. Also, copayments and deductibles for prescription drugs do not apply to the out-of-pocket maximum, unless otherwise noted. You must continue to pay copayments for any services and supplies that do not apply to the out-of-pocket maximum.

Out-of-Pocket maximum for pharmacy plans

One member.. $2000
Family (two members or more).. $4000

Once your payments for prescription drugs equals the amount shown above in any one calendar year, no additional copayments for prescription drugs are required for the remainder of the calendar year. Once an individual member in a family meets the individual out-of-pocket maximum, the other enrolled family members must continue to pay copayments for covered services and supplies until the total amount of copayments paid by the family reaches the family out-of-pocket maximum or each enrolled family member individually meets the individual out-of-pocket maximum. Payments for any other services or supplies will not count toward this calendar year out-of-pocket maximum, unless otherwise noted.

Out-of-pocket costs for prescription drugs exceeding prescription drug benefit coverage and any cost differential between brand/generic medications when dispensing brand name drugs not based on medical necessity will not apply to the OOPM.

Professional services

The copayments below apply to professional services only. Services that are rendered in a hospital or an outpatient center are also subject to the hospital or outpatient center services copayment. See "Hospitalization services" and "Outpatient services" in this section to determine if any additional copayments may apply.

Service	Copayment
Visit to physician, physician assistant or nurse practitioner, at a contracting physician group	$15
Specialist or specialty care consultations ■	$15
Prenatal and postnatal office visits*	$15
Normal delivery, cesarean section, newborn inpatient care	Covered in full
Treatment of complications of pregnancy	See note below**
Surgeon or assistant surgeon services ▲	Covered in full
Administration of anesthetics	Covered in full
Laboratory procedures and diagnostic imaging (including x-ray) services	Covered in full
Rehabilitative therapy (includes physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)	Covered in full
Organ and stem cell transplants (non-experimental and non-investigational)	Covered in full
Chemotherapy	Covered in full
Radiation therapy	Covered in full
Vision and hearing examinations (for diagnosis or treatment, including refractive eye examinations)	$15

■ *Self-referrals are allowed for obstetrics and gynecological services including preventive care, pregnancy and gynecological ailments. Copayment requirements may differ depending on the services provided.*

Podiatrist, chiropractor and acupuncturist services may be covered under "Specialist consultation" as authorized by your Physician Group.

▲ *Surgery includes surgical reconstruction of a breast incident to mastectomy (including lumpectomy), including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema. While Health Net and your physician group will determine the most appropriate services, the length of hospital stay will be determined solely by your PCP.*

**Prenatal, postnatal and newborn care that are preventive care services are covered in full. See copayment listings for preventive care services below. If other non-preventive care services are received during the same office visit, the above copayment will apply for the non-preventive care services.*

***Applicable copayment 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 will apply.*

Preventive care

Preventive care services .... Covered in full

Preventive care services are covered for children and adults, as directed by your physician, based on the guidelines from the U.S. Preventive Services Task Force Grade A&B recommendations, the Advisory Committee on Immunization Practices that have been adopted by the Center for Disease Control and Prevention, the guidelines for infants, children, adolescents and women's preventive health care as supported by the Health Resources and Services Administration (HRSA).

Preventive care services include, but are not limited to, periodic health evaluations, immunizations, diagnostic preventive procedures, including preventive care services for pregnancy, and preventive vision and hearing screening examinations, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA.

One breast pump and the necessary supplies to operate it (as prescribed by your physician) will be covered for each pregnancy at no cost to the member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it. Breast pumps can be obtained by calling the Customer Contact Center at the phone number listed on the back cover of this booklet.

Allergy treatment and other injections (except for infertility injections)

Allergy testing .... Covered in full

Allergy serum .... Covered in full

Allergy injection services .... Covered in full

Immunizations -- To meet foreign travel requirements 20%

Immunizations -- To meet occupational requirements 20%

Injections (except for infertility)

Injectable drugs administered by a physician (per dose) .... Covered in full

Self injectable drugs■ .... Covered in full

■ *Self-injectable drugs (other than insulin) are considered specialty drugs, which require prior authorization and must be obtained from a contracted specialty pharmacy vendor. Specialty drugs require prior authorization from Health Net. Please refer to the plan's EOC for additional information.*

Injections for the treatment of infertility are described below in the "Infertility services" section.

Outpatient facility services

Outpatient facility services (other than surgery) .... Covered in full

Outpatient surgery (surgery performed in a hospital or outpatient surgery center only) .... Covered in full

Outpatient care for infertility is described below in the "Infertility services" section.

Hospitalization services

Semi-private hospital room or special care unit with ancillary services, including

maternity care (per admission; unlimited days) .... Covered in full

Skilled nursing facility stay (per admission; limited to 100 days per calendar year) .... Covered in full

Physician visit to hospital or skilled nursing facility .... Covered in full

The above inpatient hospitalization copayment is applicable for each admission of hospitalization for an adult, pediatric or newborn patient. If a newborn patient requires admission to a special care unit, a separate copayment for inpatient hospital services for the newborn patient will apply.

Inpatient care for infertility is described below in the "Infertility services" section.

Emergency health coverage

Emergency room (professional and facility charges) $50

Urgent care center (professional and facility charges) $50

Copayments for emergency room or urgent care center visits will not apply if the member is admitted as an inpatient directly from the emergency room or urgent care center. A visit to one of the urgent care centers that is owned and operated by the member's physician group will be considered an office visit and the office visit copayment, if any, will apply.

Ambulance services

Ground ambulance .... Covered in full

Air ambulance .... Covered in full

Prescription drug coverage

Please refer to the "Prescription drug program" section of this SB/DF for applicable definitions, benefit descriptions and limitations.

Retail participating pharmacy (up to a 30-day supply)

Level I drugs (primarily generic) $5

Level II drugs (primarily preferred brand name drugs, peak flow meters, inhaler spacers and diabetic supplies, including insulin) ◆ $10

Level III drugs or non-preferred drugs not on the Commercial Formulary ◆ $35

Appetite Suppressants 50%

Lancets .... Covered in full

Preventive drugs, including smoking cessation drugs, and women's contraceptives* .... Covered in full

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

Level I drugs (primarily generic) $10

Level II drugs (primarily preferred brand name drugs, peak flow meters, inhaler

spacers and diabetic supplies, including insulin) ◆ $20

Level III drugs or non-preferred drugs not on the Commercial Formulary ◆ $70

Lancets .... Covered in full

Preventive drugs, including smoking cessation drugs, and women's contraceptives* .... Covered in full

For information about Health Net's Commercial Formulary, please call the Customer Contact Center at the telephone number on the back cover.

Orally administered anti-cancer drugs will have a copayment maximum of $200 for an individual prescription of up to a 30-day supply.

◆ *Generic drugs will be dispensed when a generic drug equivalent is available unless a brand name drug is specifically requested by the physician or the member. When a brand name drug is dispensed and a generic equivalent is commercially available, the member must pay the difference between the generic equivalent and the brand name drug plus the Level I or Level III drug copayment.*

However, if the prescription drug order states "dispense as written," "do not substitute" or words of similar meaning in the physician's handwriting to indicate medical necessity, only the Level II or Level III drug copayment, as appropriate, will be applicable.

* *Preventive drugs, including smoking cessation drugs, and women's contraceptives that are approved by the Food and Drug Administration are covered at no cost to the member. Preventive drugs are prescribed over-the-counter drugs or prescription drugs that are used for preventive health purposes per the U.S. Preventive Services Task Force A and B recommendations.*

If a brand name drug is dispensed, and there is a generic equivalent commercially available, you will be required to pay the difference in cost between the generic and brand name drug. However, if a brand name drug is medically necessary and the physician obtains prior authorization from Health Net, then the brand name drug will be dispensed at no charge.

Percentage copayments will be based on Health Net's contracted pharmacy rate.

If the retail price is less than the applicable copayment, then you will pay the retail price prescription drug covered expenses are the lesser of Health Net's contracted pharmacy rate or the pharmacy's retail price for covered prescription drugs.

This plan uses the Commercial Formulary. The Health Net Commercial Formulary is the approved list of medications covered for illnesses and conditions. It is prepared by Health Net and distributed to Health Net contracted physicians and participating pharmacies. The Commercial Formulary also shows which drugs are Level I, Level II or Level III, so you know which copayment applies to the covered drug. Drugs that are not on the Commercial Formulary (that are not excluded or limited from coverage) are also covered at the Level III drug copayment.

Some drugs require prior authorization from Health Net. Urgent requests from physicians for authorization are processed as soon as possible, not to exceed 24 hours, after Health Net's receipt of the request and any additional information requested by Health Net that is reasonably necessary to make the determination. Routine requests from physicians are processed in a timely fashion, not to exceed 2 business days, as appropriate and medically necessary, for the nature of the member's condition after Health Net's receipt of the information reasonably necessary and requested by Health Net to make the determination. For a copy of the Commercial Formulary, call the Customer Contact Center at the number listed on the back cover of this booklet or visit our website at www.healthnet.com.

Medical Supplies

Durable medical equipment (including nebulizers, face masks and tubing for the treatment of asthma) .... Covered in full

Orthotics (such as bracing, supports and casts) .... Covered in full

Diabetic Equipment See the "Prescription drug program" section of this SB/DF for diabetic supplies benefit information .... Covered in full

Diabetic footwear .... Covered in full

Prostheses .... Covered in full

Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under "Preventive care" in this section.

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 protheses 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).

Mental disorders and chemical dependency benefits

Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services. For definitions of severe mental illness or serious emotional disturbances of a child, please refer to the Behavioral health section of this SB/DF, or call the Customer Contact Center at the number listed on the back cover of this booklet.

Severe Mental Illness and Serious Emotional Disturbances of a Child

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring)* $15

Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing; other outpatient procedures; intensive outpatient care program; day treatment; partial hospitalization; and therapeutic session in a home setting for pervasive developmental disorder or autism per provider per day) .... Covered in full

Participating mental health professional visit to member's home (at the discretions of

the participating mental health professional in accordance with the rules and criteria established by Behavioral Health Administrator) $15

Inpatient services at a hospital, behavioral health facility or residential treatment center .... Covered in full

Other Mental Disorders

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring)* $15

Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization) .... Covered in full

Participating mental health professional visit to member's home (at the discretions of the participating mental health professional in accordance with the rules and criteria established by Behavioral Health Administrator) $15

Inpatient services at a hospital, behavioral health facility or residential treatment center .... Covered in full

Chemical Dependency

Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, including individual and group therapy sessions, medication management and drug therapy monitoring) * $15

Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, intensive outpatient care program, day treatment and partial hospitalization) .... Covered in full

Participating mental health professional visit to member's home (at the discretions of the participating mental health professional in accordance with the rules and criteria established by Behavioral Health Administrator) $15

Service	Copayment
Inpatient services at a hospital, behavioral health facility or residential treatment center	Covered in full
Acute care detoxification at a hospital, behavioral health facility or residential treatment center	Covered in full

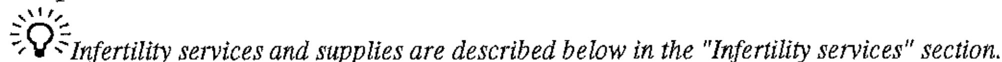
**Each group therapy session requires only one half of a private office visit copayment. If two or more members in the same family attend the same outpatient treatment session, only one copayment will be applied.*

Home health services

Service	Copayment
Home health services (copayment starts the 31st calendar day after the 1st visit)	$15

Other services

Service	Copayment
Sterilizations --Vasectomy	$50
Sterilizations --Tubal ligation	$150
Blood, blood plasma, blood derivatives and blood factors	Covered in full
Renal dialysis	Covered in full
Hospice services	Covered in full

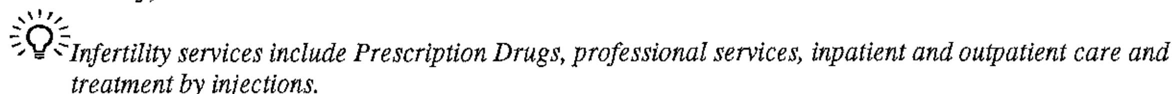


Infertility services and supplies are described below in the "Infertility services" section.

Sterilization of females and women's contraception methods and counseling, as supported by HRSA guidelines, are covered under "Preventive care" in this section.

Infertility services

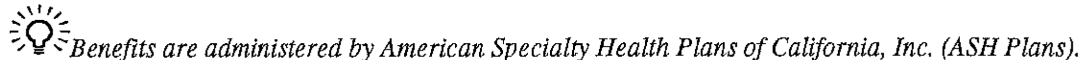
Service	Copayment
Infertility services and supplies (all covered services that diagnose, evaluate or treat infertility)	50%



Infertility services include Prescription Drugs, professional services, inpatient and outpatient care and treatment by injections.

Infertility services (which include GIFT) and all covered services that prepare the member to receive this procedure, are covered only for the Health Net member.

Chiropractic services



Benefits are administered by American Specialty Health Plans of California, Inc. (ASH Plans).

Service	Copayment
Office visits *(30-visit maximum per calendar year)*	$10
Annual chiropractic appliance allowance	*$50*