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 ***Restricted* Plan K1G**	**K1G** **1/1/2023**
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (OOPM): All eligible copayments and coinsurance apply to OOPM.	
For each member.	$3,775
For each family	$7,550
PROFESSIONAL SERVICES	
Visit to a physician, physician assistant or nurse practitioner at a PPG. [1]	$30
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.	$30
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
Telemedicine services.	(2)
Annual routine physical examinations provided for employment, school, camp or sports.	Not covered
Vision examinations for refractive eye exams. Birth through age 17.	$0
Ages 18 and older.	Not covered
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]	$30
Podiatry services, includes routine foot care for diabetes.	$30
Routine foot care (cutting/removal of corns, calluses, trimming of nails).	Not covered
Physician visit to member's home (at discretion of physician).	$30
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).	$0
Other immunizations, includes foreign travel/occupational purposes.	$0
Allergy testing.	$0
Allergy serum.	$0
Allergy injection services (serum not included).	$0
All other injections.	
Office based injectable medications.[1]	$0
Self-administered injectable medications.	Refer to ESI pharmacy (877) 620-6730
Surgeon/assistant surgeon.	$0
Administration of anesthetics.	$0
X-ray and laboratory procedures, including genetic testing. Preventive x-ray/lab, refer to periodic health evaluations above. [1]	$0
Complex radiology (CT, SPECT, MRI, PET and MUGA) - performed in an office, freestanding radiology or outpatient facility.	$165
Performed in an inpatient facility.	$0
Rehabilitation therapy (outpatient physical, speech and occupational), including ABA therapy services - performed in an office or outpatient facility.	$30
Cardiac and respiratory therapy - performed in an office or outpatient facility.	$30
Performed in an inpatient facility.	$0
Habilitation therapy (physical, occupational, speech, respiratory and cardiac therapy). For applied behavioral analysis (ABA), refer to the mental health benefits.	$30
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, cesarean section and complications of pregnancy. Includes newborn inpatient professional care.	$0
Abortion services.	$150
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.**	
Basic infertility professional services.	$30
Infertility injections.	$0
Sterilization of females. [1]	$0
Sterilization of males.	$150
Reversal of sterilization.	Not covered

Health Net California Large Group HMO *Restricted* Plan K1G	K1G 1/1/2023
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**	
OTHER SERVICES	
Medical social services.	$0
Patient education. Includes smoking cessation/weight management/diabetes.	$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.	Not covered
Medical supplies. [1]	$0
Prosthesis (replacing body parts).	$0
Wigs (cranial prosthesis).	Not covered
Blood and blood products, except for blood-clotting factors, refer below.	$0
Blood-clotting factors.	Refer to ESI pharmacy (877) 620-6730
Nuclear medicine.	$0
Organ, tissue and stem cell transplants (non-experimental and noninvestigative. Professional services only).	$0
Companion travel.	$0
Non-familial search for organ donors.	$0
Chemotherapy (administration, drugs and supplies).	$0
Radiation therapy.	$0
Renal dialysis.	$0
Home health visit. Includes home health rehabilitation.	$0 / 100 visits
Infusion therapy (home, office or outpatient).	$0
Hospice care.	$0
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. For new-borns, a separate copayment will apply to a newborn requiring admission to a special care unit.	$340 per admit
Confinement in a skilled nursing facility (limited to 100 days a calendar year).	$340 per admit
Outpatient services	
Outpatient services other than surgery.	$30
Outpatient surgery at a hospital or ambulatory surgical center.	$165 per admit
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
Emergency room (facility services). [4]	$245
Use of urgent care center.	$40 [5]

1	**Women's preventive care services include the following:** Screening for gestational diabetes; human papilloma virus (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	Telehealth cost share mirrors in-person cost share based on type of service provided.
4	The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room.
5	$40 for medical services; $30 for behavioral health, chemical dependency, or substance use disorders.