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 KQC**	**KQC** **1/1/2024**
CALENAR YEAR OUT-OF-POCKET MAXIMUM (OOPM): All eligible copayments and coinsurance apply to OOPM.	
For each member.	$3,000
For each family.	$9,000
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. [1]	$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, laboratory tests and x-rays. [1]	$0
Telemedicine services.	$0 [2]
Annual routine physical examinations. Provided for employment, school, camp or sports.	Not covered
Vision examinations for refractive eye exams.	$30
Hearing examinations for hearing loss.	$30
Specialist consultations. Includes OB/GYN self-referral (excluding well-woman) for non-preventive services. For preventive services, refer to periodic health evaluations above. [1]	$50
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 / $50 [3]
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]	
Office-based injectable medications - Administration.	$0
Office-based injectable medications - Injected Substance. The $125 maximum copayment is per day at physician's office.	20%
Self-administered injectable medications.	**Covered through Pharmacy/ Refer to Pharmacy Benefits**
Surgeon/assistant surgeon in hospital or PPG.	$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, 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.	$30
Normal delivery, cesarean section and complications of pregnancy. Includes newborn inpatient care provided by a member physician.	$0
Abortions services.	$0
Genetic testing of fetus.	$0
Circumcision of newborn.	$0
FAMILY PLANNING (professional services only)	
Contraceptive devices. 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 and SUBSTANCE USE DISORDERS [4]	
Outpatient, office visit/professional consultation (therapy, counseling and/or psychological evaluation), including physician visits to home.	$30
Outpatient services - other (Includes alternate care: partial hospitalization/day treatment/ intensive outpatient care programs).	$0
Inpatient care in a hospital, participating behavioral health facility or residential treatment center.	$500 per admit
Outpatient group therapy session.	$15
Physician visit to hospital, participating behavioral health facility or residential treatment center.	$0
CARE FOR SUBSTANCE USE DISORDERS & DETOXIFICATION	
Outpatient, office visit/professional consultation (therapy, counseling and/or psychological evaluation), including physician visits to home.	$30
Outpatient substance use disorder - other (includes outpatient detoxification and alternate care: partial hospitalization / day treatment/intensive outpatient care programs).	$0
Inpatient care in a hospital, participating behavioral health facility or residential treatment center.	$500 per admit
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.	$500 per admit
OTHER SERVICES	
Medical social services.	$0
Patient education. Includes smoking cessation/weight management.	$0
Ambulance services (air and ground).	$0
Durable medical equipment. [1]	$0
Orthotics (braces and supports).	$0
Corrective footwear. Custom made shoes and shoe inserts (custom foot orthotics).	Not covered
Diabetic supplies, including footwear.	$0
Hearing aids.	Not covered
Medical supplies. [1]	$0
Prosthesis (replacing body parts).	$0
Wigs (cranial prosthesis).	Not covered
Chiropractic care. **Refer to member's EOC.**	**Administered by ASH**
Acupuncture services. **Refer to member's EOC.**	**Administered by ASH**
Blood and blood products, except for blood-clotting factors, refer below.	$0
Blood-clotting factors.	**Covered through Pharmacy/ Refer to Pharmacy Benefits**
Nuclear medicine.	$0
Organ, tissue and stem cell transplants (non-experimental and non-investigative. Professional services only).	$0
Chemotherapy or radiation therapy.	$0
Renal dialysis.	$0
Home health visit. Includes home health rehabilitation. The copayment is required on and after the 31st calendar day of the treatment plan.	$20
Infusion therapy.	
Performed at home.	$20
Performed in an office and outpatient facility. The $125 maximum copayment is per day at physician's office.	20%
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 only when provided through preferred vendor. For all other providers, telehealth cost shares mirrors in-person cost share based on type of services provided.
3	Lower copay applies to office visits to Providers in family practice, pediatrics, internal medicine, geriatrics, general practice, obstetric/gynecology and nurse practitioners. Higher copay applies to office visits to Providers in all other specialties.
4	**Effective 4/1/2024**, The administration of mental health and substance use disorder benefits will be migrating from Managed Health Network (MHN) to HealthNet.

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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. For newborns, a separate copayment will apply to a newborn requiring admission to a special care unit.	$500 per admit
Confinement in a skilled nursing facility (limited to 100 days per calendar year).	$500 per admit
Outpatient services.	
Outpatient surgery at a hospital.	$350 per admit
Outpatient surgery at an ambulatory surgical center.	$350 per admit
Outpatient services other than surgery.	$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). [5]	$250
Use of urgent care center.	$75 [6]

5	The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room.
6	$75 for medical services; $30 for mental health or substance use disorders.