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 Plan GX3	GX3 1/1/2021
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]	$20/$40 [4]
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.	$20
Telemedicine services.	$0 [3]
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
Annual routine physical examinations. Provided for employment, school, camp or sports.	Not covered
Vision examinations for refractive eye exams.	$20/$40 [4]
Hearing examinations for hearing loss.	$20/$40 [4]
Specialist consultations. Includes OB/GYN self-referral (excluding well-woman) for non-preventive services. For preventive services, refer to periodic health evaluations above. [1]	$20/$40 [4]
Podiatry services, includes routine foot care for diabetes.	$20
Routine foot care (cutting/removal of corns, calluses, trimming of nails).	Not covered
Physician visit to member's home (at discretion of physician).	$20/$40 [4]
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 services.	Not covered
Allergy testing.	$20
Allergy serum.	$0
Allergy injection services (serum not included).	$20
Injections related to infertility services.	50%
All other injections.	
Office based injectable medications. [1]	$0
Self-administered injectables.	Refer to Pharmacy Benefits
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, MUGA and PET).	$100
Rehabilitation therapy (outpatient physical, speech and occupational), including ABA therapy services.	$20
Respiratory therapy and cardiac rehabilitation.	$20
Habilitation therapy (physical, occupational, speech, respiratory and cardiac therapy). Applied behavioral analysis (ABA) is covered through the mental health benefit.	$20
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.[1]	$20
Normal delivery, complications of pregnancy and Cesarean section. 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 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. Lifetime infertility max benefit payable is $8,500.**	50%
Sterilization of females. [1]	$0
Sterilization of males performed in an office or outpatient facility.	$50
Performed in an inpatient facility.	$0
Reversal of sterilization.	Not covered

Health Net California Large Group HMO Plan GX3	GX3 1/1/2021
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.	$0
Ambulance services (air and ground).	$100
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 Pharmacy Benefits
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 rehabilitation. The copayment starts the 31st calendar day after the first visit.	$20/100 visits
Infusion therapy.	
Home	$20
Office and 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 newborns, a separate copayment will apply to a newborn requiring admission to a special care unit.	$500
Confinement in a skilled nursing facility (limited to 100 days a calendar year).	
Days 1-10.	$0 per day
Days 11-100	$25 each day
Outpatient services.	
Outpatient services other than surgery.	$0
Outpatient surgery at hospital.	$500
Outpatient surgery at an ambulatory surgical center.	$200
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.	
Use of emergency room (professional services).	$0
Use of emergency room (facility). [2]	$100
Use of urgent care center.	$40 for medical services; $20 for behavioral health, chemical dependency, or substance use disorders

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	The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room.
3	Telemedicine services are covered only when provided through preferred vendor; For all other providers, telehealth cost share mirrors in-person cost share based on type of service provided
4	The lower copayment applies to office visits to providers in family practice, pediatrics, internal medicine, geriatrics, general practice, optometrist, audiologist, OB/GYN and nurse practitioners. The higher copayment applies to office visits to providers in all other specialties.

Health Net of California, Inc. (Health Net)

LARGE GROUP

Health Net Pharmacy Benefits

$100 DEDUCTIBLE ($10/$30/$50)

PLANS APPLY TO THE FOLLOWING NETWORKS: FULL NETWORK HMO, EXCELCARE HMO, SMARTCARE HMO

The following is a brief description of your Health Net Pharmacy benefits.

Benefits and coverage	Description	Copayment[1]
Tier 1 – Generic	Drugs listed on the Health Net Recommended Drug List (RDL) (primarily generic)	$10
Tier 2 – Brand, preferred	Drugs and diabetic supplies (including insulin) listed on the Health Net RDL (primarily brand name)	$30
Tier 3 –Non-formulary	Drugs not on the Health Net RDL	$50
Specialty Tier	High-cost drugs used to treat complex medical conditions	30% ($250 max)
Deductible	Brand Deductible	$100
Out-of-pocket maximum	Per calendar year, combined with the Medical out-of-pocket maximum	

For complete information, log on as a Health Net member at www.healthnet.com > *My Pharmacy Benefits > Mail Order Pharmacy* or call Member Services at 1-800-676-6976.

Mail order convenience

If your prescription is for a maintenance medication (a drug that you will be taking for an extended period of time), you have the option of filling it through our convenient and cost-saving mail order pharmacy program. Under this program, your copayments for up to a 90-day supply are:

Benefit level	Copayment[1]
Tier 1 – Generic	$20
Tier 2 – Brand, preferred	$75
Tier 3 –Non-formulary	$125

Generic substitutions

Generic drugs will be dispensed when a generic drug equivalent is available. Health Net will cover brand-name drugs that have generic equivalents only when the brand-name drug is medically necessary and the physician obtains prior authorization from Health Net, subject to copayment requirements described in the member's Schedule of Benefits.

[1]Plans will cover most female prescription contraceptives at $0 cost share. Coverage on some drugs may not follow the generic and brand tier system. Please refer to your plan documents and Health Net's Recommended Drug List (RDL) for coverage, cost share and tier information.

This is merely a brief summary of benefits. It does not include all covered services, limitations or exclusions. Please refer to the *Evidence of Coverage* for all terms and conditions of coverage.

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Nondiscrimination Notice

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), Health Net of California, Inc. and Health Net Life Insurance Company (Health Net) comply with applicable federal civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

HEALTH NET:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at **1-800-522-0088 (TTY: 711)**

If you believe that Health Net has failed to provide these services or discriminated in another way based on one of the characteristics listed above, you can file a grievance by calling Health Net's Customer Contact Center at the number above and telling them you need help filing a grievance. Health Net's Customer Contact Center is available to help you file a grievance. You can also file a grievance by mail, fax or email at:

Health Net of California, Inc./Health Net Life Insurance Company Appeals & Grievances PO Box 10348, Van Nuys, CA 91410-0348

Fax: 1-877-831-6019

Email: Member.Discrimination.Complaints@healthnet.com (Members) or Non-Member.Discrimination.Complaints@healthnet.com (Applicants)

For HMO, HSP, EOA, and POS plans offered through Health Net of California, Inc.: If your health problem is urgent, if you already filed a complaint with Health Net of California, Inc. and are not satisfied with the decision or it has been more than 30 days since you filed a complaint with Health Net of California, Inc., you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

For PPO and EPO plans underwritten by Health Net Life Insurance Company: You may submit a complaint by calling the California Department of Insurance at 1-800-927-4357 or online at https://www.insurance.ca.gov/ 01-consumers/101-help/ index.cfm.

If you believe you have been discriminated against because of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, at https://ocrportal.hhs.gov/ocr/portal/ lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.