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 HMO Plan Chart (NG) Plan 1YC	1YC 10/1/2010
PROFESSIONAL SERVICES	
Visit to a physician, physician assistant or nurse practitioner at a PPG.	$20
Periodic health evaluations. Includes annual preventive physical examinations, preventive vision/hearing screenings, well-woman exam and preventive laboratory tests and x-rays.	$0
Vision examinations for refractive eye exams.	$20
Hearing examinations for hearing loss.	$20
Specialist consultations. Includes OB/GYN self-referral for non-preventive services. For preventive services, refer to periodic health evaluations above.	$20
Physician visit to member's home (at discretion of physician).	$40
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.	20%
Allergy testing.	$0
Allergy serum.	$0
Allergy injection services (serum not included).	$0
Injections related to infertility services.	50%
All other injections.	
Office based injectable medications.	$0
Self-administered injectables (up to a 30-day supply for each prescription). The percentage copayment is based on contracted rate. The member's copayment will not exceed $100 per prescription.	20% up to a $100 max copay per prescription
Surgeon/assistant surgeon in hospital or PPG.	$0
Administration of anesthetics.	$0
X-ray and laboratory procedures. Preventive x-ray/lab, refer to periodic health evaluations above.	$0
Complex radiology (CT, SPECT, MRI, MUGA and PET).	$100
Rehabilitation therapy (outpatient physical, speech, occupational and respiratory therapy). Provided as long as significant improvement is expected. See *PPG Operations Manual*.	$20
Dental services (when medically necessary to properly monitor, control, or treat a severe medical condition when excluded dental services are being performed. See *PPG Operations Manual).*	$0
CARE FOR CONDITIONS OF PREGNANCY (professional services only)	
Prenatal and postnatal office visit.	$20
Normal delivery, Cesarean section. Includes newborn inpatient care provided by a member physician.	$0
Complications of pregnancy including medically necessary abortions.	$0
Elective abortions.	$150
Genetic testing of fetus.	$0
Circumcision of newborn.	$0
FAMILY PLANNING (professional services only)	
Contraceptive devices.	Not covered
Infertility services (including professional services, inpatient and outpatient care, treatment by injection and prescription drugs, if applicable. See *PPG Operations Manual)*.	50%
Sterilization of females.	$150
Sterilization of males.	$50
Reversal of sterilization.	Not covered
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**	

Health Net HMO Plan Chart (NG) Plan 1YC	1YC
OTHER SERVICES	
Medical social services.	$0
Patient education.	$0
Ground ambulance.	$100
Air ambulance.	$100
Durable medical equipment. Limited to a benefit maximum of $5,000 each calendar year. The benefit limit does not apply for orthotics, diabetic supplies, nebulizers, face masks and tubing used for the treatment of asthma.	$0
Orthotics (braces and supports).	$0
Corrective footwear. Custom made shoes and shoe inserts (custom foot orthotics).	Not covered
Diabetic supplies (refer to the Introduction section for additional information).	$0
Hearing aids.	Not covered
Prosthesis (replacing body parts).	$0
Blood and blood products.	$0
Nuclear medicine (professional services only).	$0
Organ and bone marrow transplants (non-experimental and noninvestigative. Professional services only).	$0
Chemotherapy or radiation therapy (professional services only).	$0
Renal dialysis (professional services only).	$0
Home health visit. The copayment starts the 31st calendar day after the first visit.	$20/100 visits
Hospice care.	$0
HOSPITAL AND SKILLED NURSING FACILITY SERVICES	
Unlimited days of hospital care in a semi-private room or ICU with ancillary services. Excluding care for mental disorders.	$250
Confinement for infertility services.	50%
Confinement in a skilled nursing facility (limited to 100 days a calendar year).	
Days 1-10.	$0
Days 11-100	$25 each day
Maternity care. Includes routine nursery charges.	$250
Outpatient services.	
Outpatient services other than surgery.	$0
Outpatient surgery at hospital or ambulatory surgical center.	$250
OUT-OF-POCKET MAXIMUM	
For each member.	$1,500
For two-party.	$3,000
For each family (3 or more members).	$4,500
EMERGENCY CARE/URGENTLY NEEDED CARE - Within or outside the PPG service area - (Refer to the Introduction pages for more information)	
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. See the Introduction pages for more information.	
Use of emergency room (facility and professional services). ❊	$100
Use of urgent care center (facility and professional services). ❊	$20

❊ The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room or urgent care center. See the Introduction pages for more information regarding emergency services/urgently needed care.