

# Exclusions and Limitations

**HMO & PPO Plans:** The following services and/or procedures are either limited in coverage or excluded from coverage under this health plan:

Comfort/convenience items, hearing aids, cosmetic surgery, court ordered care, custodial care, employment counseling, exercise programs, experimental/investigational procedures and drugs, fraudulent services, gender alterations, household equipment/fixtures, infertility services, inpatient mental health services, long-term rehabilitative services, missed appointments, obesity, paternity testing, radial keratotomy, routine foot care, substance abuse treatment programs, temporomandibular joint disorder, vocational programs, mail order prescription program.

The benefit summaries included in this booklet are only intended to be a brief benefit description. Please refer to your Schedule of Benefits, Evidence of Coverage or Policy for a complete explanation of the benefits, limitations, exclusions and provisions of the plan. In case of conflict, the Evidence of Coverage or Policy will prevail.

**HMO Plans:** With the exception of emergency care and self-referral benefits, all services and items must be provided or arranged by your contracted Primary Care Physician. Selected services require authorization by Health Net.

- ▼ Eligible expenses for covered services delivered by non-contracted providers and facilities will be an amount determined by Health Net based on a percentage of the Health Net fee schedule, which is generally comparable to eligible expenses for covered services delivered by **contracted** providers and facilities. This amount may be adjusted by Health Net from time to time and at any time.
  - ① **HMO & PPO Plans:** The out-of-pocket maximum does not include the deductibles. Expenses you incur for the following cannot be used to satisfy the out-of-pocket maximum:
    - Failure to follow prior authorization/precertification guidelines
    - Mental illness, substance abuse
    - Infertility
    - Use of emergency room for non-emergent care
    - Prescription drugs
    - Copayments
    - Limitations, exclusions
  - ② **HMO Plans:** Hospital and professional services for a normal delivery are covered only for expectant members who have been enrolled for 12 consecutive months when delivery occurs. Hospital and professional services for members who have been enrolled less than 12 consecutive months are limited to prenatal care and complications of pregnancy, as defined in the Evidence of Coverage. Expectant members who met these requirements and were enrolled in this health plan under the automatic eligibility requirements as defined in the Evidence of Coverage do not have to satisfy the maternity waiting period. Please refer to the Evidence of Coverage for a definition of complications of pregnancy.
- PPO Plans:** Inpatient and outpatient are combined benefits.
- ③ **HMO Plans:** Inpatient and outpatient are combined benefits.  
**PPO Plans:** In-Network and Out-of-Network are combined benefits.
  - ④ **HMO & PPO Plans:** All drugs covered by your outpatient prescription benefit are placed in one of four tiers on the Preferred Drug List. The lower the tier, the lower your copayment will be.

- ⑥ **HMO Plans:** Inpatient copayment maximum is \$2,000 per member, per calendar year.

**PPO Plans: Precertification required: Important – reduction of benefits may apply.**

Hospital inpatient admissions (non-emergency, including acute, subacute or rehabilitation); hospital observation stays (less than 24 hours); mental health and substance abuse inpatient admissions; skilled nursing inpatient facility admissions; transplants/transplant services; select outpatient procedures; select rehabilitative programs and therapies; select durable medical equipment; home health (including home infusion therapy); non-emergent ambulance and transportation services; prosthetics; oncology services; podiatry services; sleep studies; oxygen and related breathing equipment; epidural steroid injections; magnetic resonance imaging (MRI); computerized axial tomography (CAT); positron emission tomography (PET) scans; magnetic resonance angiography (MRA); nuclear cardiology; stress echocardiograms; self-injectable medications (except for insulin); select in-office pharmacy injectables.

**Note:** The list of precertification requirements is a condensed list. For a complete list, refer to the Plan Document. In case of conflict, the Plan Document will prevail. Prior authorization and precertification do not guarantee payment. Payment determinations generally are made at the time the claim is received and are based on a variety of factors including eligibility, terms, conditions, limitations and exclusions. If precertification is not obtained when required, or obtained but not followed, the percentage normally payable under your plan will be reduced by 50 percent. Reductions will not apply toward satisfaction of an out-of-pocket maximum.

- ⑥ You may be responsible for the copayment/coinsurance corresponding to the facility where services are rendered.
- ⑦ You may be charged a copayment/coinsurance for services performed at your physician's office and sent to another facility for processing. In such cases, the corresponding facility copayment/coinsurance will apply.
- ⑧ In-Network benefits are subject to deductible, then a percentage of eligible medical expenses. Out-of-Network benefits are subject to deductible, then a percentage of eligible medical expenses.