2019 Summary *of* Benefits

Health Net Seniority Plus (Employer HMO)

Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara*, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, and Yolo Counties.

Health Net®
MEDICARE PROGRAMS

Benefits effective January 1, 2019
and later (Medical plan FMH)
H0562 Health Net of California, Inc.
H0562_19_9539SB_C

Summary of Benefits

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage" (EOC) or you may access the EOC on our website at www.healthnet.com

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan, such as **Health Net Seniority Plus (Employer HMO)**.

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Health Net Seniority Plus (Employer HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048

Sections in this booklet

This information is available for free in other languages. Please contact our Member Services number at 1-800-539-4072 for additional information. (TTY users should call 711). Hours are 8:00 a.m. to 8:00 p.m., seven days a week. Member Services also has free language interpreter services available for non-English speakers.

This information is also available in a different format, including large print, audio and in non-English formats. Please call Member Services at the number printed on the back cover of this booklet if you need plan information in another format.

Things to Know About Health Net Seniority Plus (Employer HMO)

Hours of Operation

From October 1 through March 31, our plan operates a toll-free call center for both current and prospective members that is staffed seven days a week from 8:00 a.m. to 8:00 p.m. During this time period, current and prospective members are able to speak with a Member Service representative.

However, after March 31, our office hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. On weekends and certain holidays, your call will be handled by our automated phone system. When leaving a message, please include your name, phone number and the time that you called, and a representative will return your call no later than one business day after you leave a message.

Health Net Seniority Plus (Employer HMO) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-800-539-4072 (TTY users should call 711).
- If you are not a member of this plan, call toll-free 1-800-977-6738 or 1-800-596-6565 (TTY users should call 711).
- Our website: www.healthnet.com/uc

Who can join?

To join **Health Net Seniority Plus (Employer HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. You must also meet any additional eligibility requirements of your employer's or union's benefits administrator.

Our service area includes the following counties in California: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara*, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare and Yolo Counties.

*denotes partial county

For partial counties, you must live in one of the following zip codes to join this plan: 93013, 93014, 93067, 93101, 93102, 93103, 93105, 93106, 93107, 93108, 93109, 93110, 93111, 93116, 93117, 93118, 93120, 93121, 93130, 93140, 93150, 93160, 93190, 93199, 93252, 93427, 93436, 93437, 93438, 93440, 93441, 93460, 93463, 93464.

Which doctors, hospitals, and pharmacies can I use?

Health Net Seniority Plus (Employer HMO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered drugs.

You can see our plan's Provider Directory at our website (http://www.healthnet.com).

You can see our plan's Pharmacy Directory at our website (https://www.healthnet.com).

Or, call us and we will send you a copy of the Provider Directory and Pharmacy Directory.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and more.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition to your coverage for Part D drugs, our plan covers some drugs not covered by Part D. These drugs are included on our Formulary (Drug List). The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage.

- You can see the complete Formulary (Drug List) and any restrictions on our website, https://www.healthnet.com/medicare/pharmacy or call us and we will send you a copy of the Formulary (Drug List).

In addition, we cover Part B drugs such as chemotherapy drugs and some drugs administered by your provider.

How will I determine my drug costs?

For Part D drugs and other drugs included in our Formulary (Drug List), our plan groups each medication into one of five "tiers." You will need to use your Formulary (Drug List) to locate what tier your drug is on. Refer to your Evidence of Coverage to determine how much drugs on each tier will cost you. The amount you pay depends on the drug's tier.

To determine your Part B drug cost, refer to your Evidence of Coverage.

This information is not a complete description of benefits, contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payment/co-insurance may change on January 1 of each year.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

SUMMARY OF BENEFITS

Effective January 1, 2019 and later	
Premiums and Benefits	**Health Net Seniority Plus (Employer HMO)**
How much is the monthly premium?	Your coverage is provided through a contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
Is there any limit on how much I will pay for my covered services?	As a member of our plan, the most you will have to pay out-of-pocket for in-network covered services in 2019 is $1500. The amounts you pay for the deductibles (if applicable to your plan), copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for any plan premiums (if applicable to your plan) and/or for your prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount of $1500, you will not have to pay any out-of-pocket costs for the rest of the year for covered services. However, you must continue to pay your plan premium (if applicable) and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

Inpatient hospital care*	**Prior authorization (approval in advance) may be required.* No limit to the number of days covered by the plan each hospital stay. You pay $250 per admission for Medicare-covered hospital stays. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
Outpatient Hospital services, (including services provided at hospital outpatient facilities and ambulatory surgical centers)*	**Prior authorization (approval in advance) may be required.* You pay $100 for each Medicare-covered ambulatory surgical center or outpatient hospital facility visit. There is no copayment for Medicare-covered outpatient services other than surgery in an outpatient hospital facility or ambulatory surgical center.
Physician/practitioner services, including doctor's office visits*	**Prior authorization (approval in advance) may be required.* You pay $20 for each Medicare-covered primary care doctor office visit or medically-necessary surgery services furnished in a physician's office. You pay $20 for each Medicare-covered specialist visit or medically-necessary surgery services furnished in a specialist's office. You pay $20 for each physician visit to your home (at physician's discretion).
Preventive Care*	**Prior authorization (approval in advance) may be required.* There is no coinsurance, copayment, or deductible for beneficiaries eligible for preventive screening. Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • HIV screening • Immunizations • Medical nutrition therapy

	• Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exam • Screening and counseling to reduce alcohol misuse • Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • "Welcome to Medicare" preventive visit • Annual "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency care	You pay $65 for each Medicare-covered emergency room visit. You do not pay this amount if you are immediately admitted to the hospital. Coverage is limited to within the United States.[1] For coverage outside of the United States,[1] please see "Worldwide Emergency/Urgent Coverage" below in this Summary of Benefits. [1]United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.
Urgently Needed Services	You pay $20 for each Medicare-covered urgently needed care visit. You do not pay this amount if you are immediately admitted to the hospital.
Outpatient diagnostic tests and therapeutic services and supplies*	**Prior authorization (approval in advance) may be required.* There is no copayment for Medicare-covered diagnostic procedures and tests. There is no copayment for Medicare-covered x-rays. There is no copayment for Medicare-covered diagnostic radiology services (not including x-rays). There is no copayment for Medicare-covered therapeutic radiology services. There is no copayment for Medicare-covered lab services.

Hearing Services*	**Prior authorization (approval in advance) may be required.* There is no copayment for a maximum of 2 hearing aid devices that adequately meet the member's medical needs every 36. months with a benefit maximum of $2000. You pay $20 for each Medicare-covered hearing test (diagnostic hearing exam). You pay $20 for each supplemental routine (non-Medicare covered) hearing test, up to 1 test every year.
Dental Services*	**Prior authorization (approval in advance) may be required.* There is no copayment for Medicare-covered dental benefits (when medically necessary to properly monitor, control or treat a severe medical condition). In general, routine preventive dental (non- Medicare covered) benefits (such as cleaning) are not covered.
Vision Services*	**Prior authorization (approval in advance) may be required.* You pay $20 for each Medicare-covered eye exam (diagnosis and treatment of diseases and conditions of the eye). You pay $20 for each supplemental routine (non-Medicare covered) eye exam, limited to 1 exam every year. You pay $20 for Medicare-covered diabetic retinopathy screening. There is no copayment for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery). There is no copayment for Medicare-covered glaucoma screening. Limited to one screening every year. Lenses are covered (in full or subject to an eyewear allowance). There is a $100 allowance for frames every 24 months.[1] No referral necessary for eyewear from any Health Net Vision contracting Provider. [1]Amounts you pay for these services do not count toward the maximum out-of-pocket amount. Please refer to the Evidence of Coverage for the complete schedule of services and copayments.
Mental health services: Outpatient mental health care*	**Prior authorization (approval in advance) may be required.* You pay $20 for each Medicare-covered individual therapy visit. You pay $10 for each Medicare-covered group therapy visit. You pay $20 for each Medicare-covered individual therapy visit with a psychiatrist. You pay $10 for each Medicare-covered group therapy visit with a psychiatrist.

Mental health services: Outpatient substance abuse services*	**Prior authorization (approval in advance) may be required.* You pay $20 for each Medicare-covered individual therapy visit. You pay $10 for each Medicare-covered group therapy session.
Mental health services: Partial hospitalization services*	**Prior authorization (approval in advance) may be required.* There is no copayment for Medicare-covered partial hospitalization.
Mental health services: Acute care detoxification*	**Prior authorization (approval in advance) may be required.* You pay $250 per admission for Medicare-covered acute care detoxification services.
Mental health services: Inpatient mental health care*	**Prior authorization (approval in advance) may be required.* No limit to the number of days covered by the plan each hospital stay. You pay $250 per admission for Medicare-covered services in a network hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
Mental health services: Inpatient substance abuse care*	**Prior authorization (approval in advance) may be required.* You pay $250 per admission for Inpatient substance abuse care covered services in a network hospital.
Skilled Nursing Facility (SNF) care*	**Prior authorization (approval in advance) may be required.* Plan covers up to 100 days each benefit period. No prior hospital stay is required. There is no copayment for Medicare-covered services in a Skilled Nursing Facility. You pay all costs for each day after day 100 in the benefit period. A “benefit period” begins the first day you go into a hospital or Skilled Nursing Facility. The benefit period ends when you haven’t received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.
Physical Therapy*	**Prior authorization (approval in advance) may be required.* You pay $20 for each Medicare-covered Physical Therapy visit.
Ambulance services*	**Prior authorization (approval in advance) may be required.* There is no copayment for Medicare-covered ambulance services.
Transportation (non-emergency)	This plan does not cover non-emergency transportation.

How much do I pay for drugs covered under Medicare Part B?*	**Prior authorization (approval in advance) may be required.* You pay the following for Medicare-covered Part B Drugs (including immunosuppressive drugs following discharge after an approved transplant) when obtained or administered at a physician's office: There is no copayment for oral cancer, osteoporosis, Epoetin, and Chemotherapy Medicare-covered Part B Drugs. You pay 20% coinsurance for all other Medicare –covered Part B Drugs with a maximum coinsurance amount of $25 per day. You pay the following for Medicare-covered Part B Drugs (including immunosuppressive drugs following discharge after an approved transplant) obtained at a Pharmacy: There is no copayment for oral cancer, osteoporosis, Epoetin, and Chemotherapy Medicare-covered Part B Drugs. You pay 20% coinsurance for all other Medicare-covered Part B Drugs with a maximum coinsurance amount of $25 per claim for up to a 30-day supply.		
Outpatient Prescription Drugs			
Deductible Stage	You do not pay a deductible for your Part D drugs. There is no deductible for our plan. You begin in the Initial Coverage Stage when you fill your first prescription of the year.		
Initial Coverage Stage	During the Initial Coverage stage, the plan pays its share of the cost of your covered prescription drugs and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription. You stay in the Initial Coverage Stage until the total amount for the Part D prescription drugs you have filled and refilled reaches the $3,820 limit for the Initial Coverage Stage. Cost-sharing may change when you enter another phase of the Part D benefit. For more information about the costs for Long Term Supply, Home Infusion or additional pharmacy-specific cost-sharing and the phases of the benefit, please call Member Services or refer to your Evidence of Coverage.		
Standard Retail Cost-Sharing	**Tier**	**One-month supply** (up to a 30-day supply)	**Three-month supply** (up to a 90-day supply)
	Tier 1 (Preferred generic drugs.)	$5	$15
	Tier 2 (Preferred brand drugs.)	$25	$75
	Tier 3 (Non-preferred brand drugs	$40	$120

	includes non-preferred brand drugs and may include some generic drugs.)		
	Tier 4 Injectable Drugs (includes injectable drugs that do not meet the cost threshold required to be placed on Tier 5.)	$25	$75
	Tier 5 Specialty Tier (includes high cost brand and generic drugs. Drugs in this tier are not eligible for exceptions for payment at a lower tier.)	$25	$75
Standard Mail Order Cost-Sharing	**Tier**	**One-month supply** (up to a 30-day supply)	**Three-month supply** (up to a 90-day supply)
	Tier 1 (Preferred generic drugs.)	$5	$10
	Tier 2 (Preferred brand drugs.)	$25	$50
	Tier 3 (Non-preferred drugs include non-preferred brand and may include some generic drugs.)	$40	$80
	Tier 4 Injectable Drugs (includes injectable drugs that do not meet the (CMS) cost threshold required to be	$25	$50*

	placed on Tier 5.)		
	Tier 5 Specialty Tier (includes high cost brand and generic drugs. Specialty Drugs in this tier are not eligible for exceptions for payment at a lower tier.)	$25	$50*
UC Walk-Up Service	Tier		
	Tier 1 (Preferred generic drugs)	$10	
	Tier 2 (Preferred brand drugs. Drugs on this tier are not eligible for exceptions for payment at a lower tier.)	$50	
	Tier 3 (Non-preferred brand drugs)	$80	
	Tier 4 Injectable Drugs (Includes injectable drugs that do not meet the Centers for Medicare & Medicaid Services (CMS) minimum cost threshold required to be placed on Tier 5 (Specialty Drugs).)	$50*	
	Tier 5 Specialty drugs (High cost drugs. Specialty Drugs are not eligible for exceptions for	$50*	

	payment at a lower tier.)	
	If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You must get your drugs from a network pharmacy. *90-day supply, when available	
Coverage Gap Stage	The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D members who have reached the coverage gap and are not receiving "Extra Help." For brand name drugs, the 70% discount provided by manufacturers excludes any dispensing fee for costs in the gap. Members pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. If you reach the coverage gap, we will automatically apply the discount when your pharmacy submits a claim for your brand name prescription drug and your *Part D Explanation of Benefits* (PART D EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap. In addition to the Medicare coverage gap discount described above, your Employer Group or Benefits Administrator also provides additional coverage. This means that with this brand name discount and the additional coverage, you will pay no more than your copayment or coinsurance for your covered Part D drugs as stated in the Initial Coverage Stage. For all other covered Non-Part D drugs during the Coverage Gap Stage, you continue to pay your copayment or coinsurance as stated in the Initial Coverage Stage. If you have any questions about the availability of a brand name discount for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Member Services (phone numbers are printed on the back cover of this booklet).	
Catastrophic Coverage Stage	You qualify for the Catastrophic Coverage Stage when your Part D out-of-pocket costs have reached the $5,100 limit for the plan year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the plan year. During this stage, the plan will pay most of the cost for your Part D drugs. • **Your share** of the cost for a covered Part D drug will be either coinsurance or a copayment, whichever is the *larger* amount (not to exceed the applicable plan tier copayment as stated in	

	the Initial Coverage Stage): o –either – coinsurance of 5% of the cost of the drug o –or – $3.40 copayment for a generic drug or a drug that is treated like a generic. Or an $8.50 copayment for all other drugs.
Out-of-Pocket Maximum for Outpatient Prescription Drugs	There is a yearly out-of-pocket maximum of $2,000 for covered outpatient prescription drugs. Once your out-of-pocket costs for covered outpatient prescription drugs (excluding Part B drugs and products) reach $2,000 in the calendar year, you will not pay any more copayment/coinsurance for covered outpatient prescription drugs for the rest of the year. All expenses that apply to the $2,000 out-of-pocket maximum will automatically be calculated by Health Net.
Additional Covered Benefits	
Acupuncture	This plan does not cover Acupuncture and other alternative therapies.
Behavioral Health Care Telephonic Clinic Consultations	(Behavioral health care telephonic clinical consultation services are provided by a licensed counselor -1-800-663-9355.) There is no copayment for telephonic clinical consultations, limited to a maximum of 3 consultations per member per calendar year.
Chiropractic services*	**Prior authorization (approval in advance) may be required.* You pay $20 for each Medicare-covered chiropractic visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).
Routine Chiropractic Care	You pay $20 for each Non-Medicare covered (routine) chiropractic visit when using our chiropractic network up to 20 visits every year.* *Amounts you pay for these services do not count toward the maximum out-of pocket amount.
Home health agency care*	**Prior authorization (approval in advance) may be required.* There is no copayment for Medicare-covered home health visits.
Physical exam*	**Prior authorization (approval in advance) may be required.* There is no copayment for each routine physical exam.
Services to treat kidney disease and conditions*	**Prior authorization (approval in advance) may be required.* There is no copayment for Medicare-covered renal dialysis. There is no copayment for Medicare-covered kidney disease education services.
Worldwide Emergency/Urgent Coverage	There is no copayment for worldwide emergency care services received outside of the United States.[1] [1]United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

Hospice Care*	**Prior authorization (approval in advance) may be required.* When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not the plan. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. You pay $20 for a one-time consultation visit before you select hospice.
Rehabilitation services: Outpatient rehabilitation services*	**Prior authorization (approval in advance) may be required.* You pay $20 for each Medicare-covered Occupational Therapy visit. You pay $20 for each Medicare-covered Speech and Language Pathology visit.
Rehabilitation services: Cardiac and pulmonary rehabilitation services*	**Prior authorization (approval in advance) may be required.* You pay $20 for each Medicare-covered cardiac rehabilitation service visit. You pay $20 for each Medicare-covered pulmonary rehabilitation service visit.
Podiatry services	You pay $20 for each Medicare-covered visit. You pay $20 for each supplemental routine (non-Medicare covered) visit, up to 1 visit per calendar month. Medicare-covered podiatry visits are for medically necessary foot care.
Medical equipment/supplies: Durable Medical Equipment and related supplies*	**Prior authorization (approval in advance) may be required.* There is no copayment for Medicare-covered durable medical equipment and related supplies.
Medical equipment/supplies: Prosthetic devices and related supplies*	**Prior authorization (approval in advance) may be required.* There is no copayment for Medicare-covered prosthetic devices and related supplies.
Diabetes self-management training, diabetic services and supplies*	**Prior authorization (approval in advance) may be required.* There is no copayment for Medicare-covered diabetes self-management training. There is no copayment for Medicare-covered diabetes supplies. There is no copayment for Medicare-covered diabetic therapeutic shoes or inserts.

Health and wellness education programs	The plan covers the following supplemental wellness/education programs: • Health Education • Additional smoking and tobacco use cessation visits online and telephonic counseling • Nursing hotline • Health Club Membership/Fitness Classes –Silver&Fit® There is no copayment for health and wellness education programs.
Retail MinuteClinic through CVS Pharmacy	You pay $20 copay for non-preventive services performed at a retail clinic. You pay $0 copay for preventive services performed at a retail clinic. You pay $0 copay for immunizations performed at a retail clinic.
Corrective Footwear*	** Prior authorization (approval in advance) may be required.* There is no copayment for Medicare-covered corrective footwear. Corrective footwear (in addition to coverage for diabetic footwear), includes specialized shoes, arch supports, and inserts, when medically necessary and custom made for the member.
Outpatient transgender surgery/services* (including hysterectomy, oophorectomy and mastectomy)	** Prior authorization (approval in advance) may be required.* You pay $100 for outpatient transgender surgery in a hospital or non-hospital based ambulatory surgical center. There is no copayment for Medicare-covered outpatient transgender services other than transgender surgery in an outpatient hospital facility or ambulatory surgical center. Travel, lodging, meal costs and transgender surgery requires prior authorization. Transgender surgery and related services (including travel, lodging and meal expenses) approved by the plan are subject to no lifetime dollar maximum for each Member. The travel, lodging, meal costs and transgender surgery must be performed by a Health Net qualified provider in conjunction with gender transformation treatment. The treatment plan must conform to Harry Benjamin International Gender Dysphoria Association (HBIGDA) standards. Psychotherapy and hormonal treatment are excluded from the lifetime maximum.

Inpatient hospital transgender surgery/services* (including hysterectomy, oophorectomy and mastectomy)	* *Prior authorization (approval in advance) may be required.* You pay $250 for transgender services. Transgender surgery and related services (including travel, lodging and meal expenses) approved by the plan are subject to no lifetime dollar maximum for each Member. The travel, lodging, meal costs and transgender surgery must be performed by a Health Net qualified provider in conjunction with gender transformation treatment. The treatment plan must conform to Harry Benjamin International Gender Dysphoria Association (HBIGDA) standards. Psychotherapy and hormonal treatment are excluded from the lifetime maximum.
Injection Services*	* *Prior authorization (approval in advance) may be required.* You pay $20 for each Medicare covered service provided by a physician or designee. You pay $20 for hormonal therapy treatment related to Gender Identity Disorder (GID). Injections or injectable substances obtained through a retail pharmacy are subject to the applicable Injectable or Specialty coinsurance.

Notice of Non-Discrimination

Health Net complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, 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 California: 1-800-539-4072 (Health Net Seniority Plus (HMO)) (TTY: 711).

From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available 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 (TTY: 1-800-537-7697).

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

SBID: 90257

For more information please contact

Health Net Seniority Plus (Employer HMO)
Post Office Box 10420
Van Nuys, CA 91410-0420

Current members should call
1-800-539-4072 (TTY:711)

Prospective members should call
1-800-977-6738 (TTY users should call 711)

www.healthnet.com/uc

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Health Net | Health Net is contracted with Medicare for HMO, HMO SNP and PPO plans, and with some state Medicaid programs. Enrollment in Health Net depends on contract renewal.

SBID: 90257