

# Health Net Seniority Plus Amber II (HMO SNP) offered by Health Net of California, Inc.

## Annual Notice of Changes for 2018

You are currently enrolled as a member of Health Net Seniority Plus Amber II (HMO SNP). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

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### What to do now

#### 1. ASK: Which changes apply to you

- Check the changes to our benefits and costs to see if they affect you.
  - It's important to review your coverage now to make sure it will meet your needs next year.
  - Do the changes affect the services you use?
  - Look in Sections 1.5 and 1.6 for information about benefit and cost changes for our plan.
- Check the changes in the booklet to our prescription drug coverage to see if they affect you.
  - Will your drugs be covered?
  - Are your drugs in a different tier, with different cost sharing?
  - Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
  - Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
  - Review the 2018 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Check to see if your doctors and other providers will be in our network next year.
  - Are your doctors in our network?
  - What about the hospitals or other providers you use?
  - Look in Section 1.3 for information about our Provider Directory.

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- Think about your overall health care costs.
  - How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
  - How much will you spend on your premium and deductibles?
  - How do your total plan costs compare to other Medicare coverage options?
- Think about whether you are happy with our plan.

## 2. **COMPARE:** Learn about other plan choices

- Check coverage and costs of plans in your area.
  - Use the personalized search feature on the Medicare Plan Finder at <https://www.medicare.gov> website. Click “Find health & drug plans.”
  - Review the list in the back of your Medicare & You handbook.
  - Look in Section 3.2 to learn more about your choices.
- Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan’s website.

## 3. **CHOOSE:** Decide whether you want to change your plan

- If you want to **keep** Health Net Seniority Plus Amber II, you don’t need to do anything. You will stay in Health Net Seniority Plus Amber II.
- If you want to **change to a different plan** that may better meet your needs, you can switch plans at any time. Your new coverage will begin on the first day of the following month. Look in section 3.2, page 16 to learn more about your choices.

## **Additional Resources**

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-800-431-9007 for additional information. (TTY users should call 711.) From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, 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.
- We must provide information in a way that works for you (in languages other than English, in audio, in large print, or other alternate formats, etc.).
- **Coverage under this Plan qualifies as minimum essential coverage (MEC)** and satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at <https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families> for more information.

## **About Health Net Seniority Plus Amber II**

- Health Net has a contract with Medicare and the California state Medicaid program to offer HMO-SNP plans. Enrollment in a Health Net Medicare Advantage plan depends on the renewal of these contracts.
  - When this booklet says “we,” “us,” or “our,” it means Health Net of California, Inc. When it says “plan” or “our plan,” it means Health Net Seniority Plus Amber II.
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## Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for Health Net Seniority Plus Amber II in several important areas. **Please note this is only a summary of changes. It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2017 (this year)	2018 (next year)
<p><b>Monthly plan premium*</b></p> <p>* Your premium may be higher or lower than this amount. See Section 1.1 for details.</p>	<p>\$0 - \$36.20</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.</p>	<p>\$0 - \$35.50</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.</p>
<p><b>Doctor office visits</b></p>	<p>Primary care visits: 0% or 20% of the total cost per visit</p> <p>Specialist visits: 0% or 20% of the total cost per visit</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.</p>	<p>Primary care visits: \$0 copay per visit</p> <p>Specialist visits: \$0 copay per visit</p>
<p><b>Inpatient hospital stays</b></p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.</p>	<p>In 2017 the Medicare defined cost-sharing amounts for each benefit period were:</p> <p>\$0 or;</p> <p>Days 1 - 60: \$1,316 deductible</p> <p>Days 61 - 90: \$329 per day</p> <p>Days 91 - 150: \$658 per lifetime reserve day.</p> <p>If you are eligible for</p>	<p>In 2018 the Medicare defined cost-sharing amounts for each benefit period were:</p> <p>\$0 or;</p> <p>Days 1 - 60: \$1,316 deductible</p> <p>Days 61 - 90: \$329 per day</p> <p>Days 91 - 150: \$658 per lifetime reserve day.</p> <p>If you are eligible for</p>

Cost	2017 (this year)	2018 (next year)
	<p>Medicare cost-sharing assistance under Medicaid, you pay \$0.</p>	<p>Medicare cost-sharing assistance under Medicaid, you pay \$0.</p> <p>These amounts may change for 2018</p>
<p><b>Part D prescription drug coverage</b> (See Section 1.6 for details.)</p>	<p>Deductible: \$155 Copayment/Coinsurance as applicable during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> <li>• Drug Tier 1 – Preferred generic drugs: Standard cost-sharing: \$0 copay for a one-month (30-day) supply</li> <li>• Drug Tier 2 – Generic drugs: Standard cost-sharing: \$20 copay for a one-month (30-day) supply</li> <li>• Drug Tier 3 – Preferred brand drugs: Standard cost-sharing: \$47 copay for a one-month (30-day) supply</li> <li>• Drug Tier 4 – Non-preferred brand drugs: Standard cost-sharing: \$100 copay for a one-month (30-day) supply</li> <li>• Drug Tier 5 – Specialty Tier: Standard cost-sharing: 30% coinsurance for a</li> </ul>	<p>Deductible: \$190 Copayment/Coinsurance as applicable during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> <li>• Drug Tier 1: – Preferred generic drugs: Standard cost-sharing: \$0 copay for a one-month (30-day) supply</li> <li>• Drug Tier 2 – Generic drugs: Standard cost-sharing: \$20 copay for a one-month (30-day) supply</li> <li>• Drug Tier 3 – Preferred brand drugs: Standard cost-sharing: \$47 copay for a one-month (30-day) supply</li> <li>• Drug Tier 4 – Non-preferred brand drug: Standard cost-sharing: \$100 copay for a one-month (30-day) supply</li> <li>• Drug Tier 5 – Specialty Tier: Standard cost-sharing: 29% coinsurance for a</li> </ul>

Cost	2017 (this year)	2018 (next year)
	<p>one-month (30-day) supply</p> <ul style="list-style-type: none"> <li>• Drug Tier 6 – Select Care drugs: Standard cost-sharing: \$0 copay for a one-month (30-day) supply</li> </ul>	<p>one-month (30-day) supply</p> <ul style="list-style-type: none"> <li>• Drug Tier 6 – Select Care drugs: Standard cost-sharing: \$0 copay for a one-month (30-day) supply</li> </ul>
<p><b>Maximum out-of-pocket amount</b> This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)</p>	<p>\$4,950</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.</p>	<p>\$4,950</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.</p>

**Annual Notice of Changes for 2018**  
**Table of Contents**

<b>Summary of Important Costs for 2018 .....</b>	<b>1</b>
<b>SECTION 1 Changes to Benefits and Costs for Next Year .....</b>	<b>5</b>
Section 1.1 – Changes to the Monthly Premium .....	5
Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount.....	6
Section 1.3 – Changes to the Provider Network.....	6
Section 1.4 – Changes to the Pharmacy Network.....	7
Section 1.5 – Changes to Benefits and Costs for Medical Services .....	7
Section 1.6 – Changes to Part D Prescription Drug Coverage .....	11
<b>SECTION 2 Administrative Changes .....</b>	<b>14</b>
<b>SECTION 3 Deciding Which Plan to Choose.....</b>	<b>16</b>
Section 3.1 – If you want to stay in Health Net Seniority Plus Amber II.....	16
Section 3.2 – If you want to change plans .....	16
<b>SECTION 4 Deadline for Changing Plans.....</b>	<b>17</b>
<b>SECTION 5 Programs That Offer Free Counseling about Medicare and Medicaid .....</b>	<b>17</b>
<b>SECTION 6 Programs That Help Pay for Prescription Drugs .....</b>	<b>18</b>
<b>SECTION 7 Questions?.....</b>	<b>18</b>
Section 7.1 – Getting Help from Health Net Seniority Plus Amber II .....	18
Section 7.2 – Getting Help from Medicare.....	19
Section 7.3 – Getting Help from Medi-Cal (Medicaid).....	20

## SECTION 1 Changes to Benefits and Costs for Next Year

### Section 1.1 – Changes to the Monthly Premium

Cost	2017 (this year)	2018 (next year)
<b>Monthly premium</b> (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medi-Cal (Medicaid).)	\$0 - \$36.20	\$0 - \$35.50

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as “creditable coverage”) for 63 days or more, if you enroll in Medicare prescription drug coverage in the future.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving “Extra Help” with your prescription drug costs.



## Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay “out-of-pocket” during the year. This limit is called the “maximum out-of-pocket amount.” Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2017 (this year)	2018 (next year)
<p><b>Maximum out-of-pocket amount</b></p> <p><b>Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.</b></p> <p>If you are eligible for Medicaid assistance with Part A and Part B copays, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.</p> <p>Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.</p>	\$4,950	<p>\$4,950</p> <p>Once you have paid \$4,950 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.</p>

## Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at <https://ca.healthnetadvantage.com>. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2018 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.

- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

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## Section 1.4 – Changes to the Pharmacy Network

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Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at <https://ca.healthnetadvantage.com>. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2018 Pharmacy Directory to see which pharmacies are in our network.**

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## Section 1.5 – Changes to Benefits and Costs for Medical Services

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Please note that the *Annual Notice of Changes* only tells you about changes to your Medicare benefits and costs.

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Benefits Chart (what is covered and what you pay)*, in your *2018 Evidence of Coverage*. A copy of the *Evidence of Coverage* was included in this envelope.

Cost	2017 (this year)	2018 (next year)
<b>Inpatient mental healthcare (Psychiatric)</b>	In 2017, the Medicare-defined cost-sharing amounts for each benefit period were:  \$0 copay or;	You pay a \$90 copay each day from days 1 through 15 per benefit period, for Medicare-covered inpatient mental health care.

Cost	2017 (this year)	2018 (next year)
	<p>Days 1-60: \$1,316 deductible</p> <p>Days 61-90: \$329 per day</p> <p>Days 91-150: \$658 per lifetime reserve day.</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0 copayment amount.</p>	<p>You pay a \$0 copay per day from days 16 through 90 per benefit period, for Medicare-covered inpatient mental health care.</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0 copayment amount.</p>
<b>Emergency care</b>	<p>You pay 0% or 20% of the total cost (up to \$75) for each Medicare-covered emergency room visit.</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay 0% of the total cost.</p> <p>You do not pay this amount if you are immediately admitted to the hospital.</p>	<p>You pay 0% or 20% of the total cost (up to \$80) for each Medicare-covered emergency room visit.</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay 0% of the total cost.</p> <p>You do not pay this amount if you are immediately admitted to the hospital.</p>

Cost	2017 (this year)	2018 (next year)
<b>Doctor office visits</b>	<p>You pay 0% or 20% of the total cost for each Medicare-covered primary care physician office visit or medically-necessary surgery services furnished in a physician's office.</p> <p>You pay 0% or 20% of the total cost for each Medicare-covered specialist office visit or medically-necessary surgery services furnished in a specialist's office.</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay 0% of the total cost.</p>	<p>You pay a \$0 copay for each Medicare-covered primary care physician office visit or medically-necessary surgery services furnished in a physician's office.</p> <p>You pay a \$0 copay for each Medicare-covered specialist office visit or medically-necessary surgery services furnished in a specialist's office.</p>
<b>Preventive and Comprehensive Dental Services (Non-Medicare covered)</b>	<p><b>Preventive Dental HMO</b> You pay a \$0 copay for each oral exam, unlimited.</p> <p>You pay a \$0 copay for each cleaning, limited to 2 cleanings every year.</p> <p>You pay a \$0 copay for each fluoride treatment, limited to 1 every year.</p> <p>You pay a \$0 copay for dental x-rays, limited to 1 every year.</p>	<p><b>Preventive Dental HMO</b> You pay a \$0 copay for each oral exam, limited to 2 every year.</p> <p>You pay a \$0 copay for each cleaning, limited to 2 cleanings every year.</p> <p>You pay a \$0 copay for each fluoride treatment, limited to 1 every year.</p> <p>You pay a \$0 copay for dental x-rays, limited to one set of preventive x-rays (up to 4 bitewing x-rays) annually. Full mouth x-rays are limited to once every 24 consecutive months.</p>

Cost	2017 (this year)	2018 (next year)
<b>Preventive and Comprehensive Dental Services (Non-Medicare covered) (con't)</b>	<p><b>Comprehensive Dental HMO</b> You pay 0-20% coinsurance for non-routine service.</p> <p>You pay a \$0 - \$15 copay for diagnostic services</p> <p>You pay \$0 - \$300 copay for restorative services.</p> <p>You pay a \$0 - \$375 copay for endodontics, periodontics, extractions.</p> <p>You pay a \$0 - \$2,250 copay for prosthodontics, other oral/maxillofacial surgery and other services.</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay 0% of the total cost.</p> <p>Please refer to your Evidence of Coverage for plan benefit details.</p>	<p><b>Comprehensive Dental HMO</b> You pay a \$0 copay for non-routine service.</p> <p>You pay a \$0 - \$15 copay for diagnostic services</p> <p>You pay a \$0 - \$300 copay for restorative services.</p> <p>You pay a \$5 - \$275 copay for endodontics.</p> <p>You pay a \$0 - \$375 copay for periodontics.</p> <p>You pay a \$15 - \$150 copay for extractions.</p> <p>You pay a \$0 - \$2,250 copay for prosthodontics, other oral/maxillofacial surgery and other services.</p> <p>Please refer to your Evidence of Coverage for plan benefit details.</p>

Cost	2017 (this year)	2018 (next year)
<b>Vision Care (Non-Medicare covered)</b>	<p>You pay a \$0 copay for 1 set of frames and 1 pair of eyeglass lenses or contact lenses during a 24-month period.</p> <p>You have a \$150 allowance for frames or contact lenses every 24 months.</p> <p>Please refer to your Evidence of Coverage for plan benefit details.</p>	<p>You pay a \$0 copay for 1 set of frames and 1 pair of eyeglass lenses or contact lenses during a 24-month period.</p> <p>You have a \$250 allowance for frames or contact lenses every 24 months.</p> <p>Please refer to your Evidence of Coverage for plan benefit details.</p>
<b>Hospice care</b>	<p>You pay 0% or 20% of the total cost for the one-time only hospice consultation.</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay 0% of the total cost.</p>	<p>You pay a \$0 copay for the one-time only hospice consultation.</p>

## Section 1.6 – Changes to Part D Prescription Drug Coverage

### Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our Drug List is in this envelope.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception to cover the drug.**

- To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Work with your doctor (or prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage*.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Current formulary exceptions will be covered next year unless otherwise indicated on your decision letter.

### Changes to Prescription Drug Costs

*Note:* If you are in a program that helps pay for your drugs (“Extra Help”), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug costs. If you receive “Extra Help” and haven’t received this insert by *September 30, 2017*, please call Member Services and ask for the “LIS Rider.” Phone numbers for Member Services are in Section 7.1 of this booklet.

There are four “drug payment stages.” How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.)

## Changes to the Deductible Stage

Stage	2017 (this year)	2018 (next year)
<p><b>Stage 1: Yearly Deductible Stage</b></p> <p>During this stage, <b>you pay the full cost</b> of your tier 2 (Generic), tier 3 (Preferred Brand), tier 4 (Non-Preferred Brand) and tier 5 (Specialty) drugs until you have reached the yearly deductible.</p>	<p>The deductible is \$155</p> <p>Your deductible amount is either \$0 or \$82, depending on the level of “Extra Help” you receive. (Look at the separate insert, the “LIS Rider,” for your deductible amount.)</p>	<p>The deductible is \$190</p> <p>Your deductible amount is either \$0 or \$83, depending on the level of “Extra Help” you receive. (Look at the separate insert, the “LIS Rider,” for your deductible amount.)</p>

## Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2017 (this year)	2018 (next year)
<p><b>Stage 2: Initial Coverage Stage</b></p> <p>Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and <b>you pay your share of the cost.</b></p> <p>The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply at a network pharmacy or for mail order prescriptions, look in Chapter 6, Section 5 of your <i>Evidence of Coverage</i>.</p> <p>We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</p> <p><b>Drug Tier 1 – Preferred generic drugs:</b> You pay \$0 per prescription.</p> <p><b>Drug Tier 2 – Generic drugs:</b> You pay \$20 per prescription.</p> <p><b>Drug Tier 3 – Preferred brand drugs:</b> You pay \$47 per prescription.</p> <p><b>Drug Tier 4 – Non-preferred brand drugs:</b> You pay \$100 per prescription.</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</p> <p><b>Drug Tier 1 – Preferred generic drugs:</b> You pay \$0 per prescription.</p> <p><b>Drug Tier 2 – Generic drugs:</b> You pay \$20 per prescription.</p> <p><b>Drug Tier 3 – Preferred brand drugs:</b> You pay \$47 per prescription.</p> <p><b>Drug Tier 4 – Non-preferred brand drug:</b> You pay \$100 per prescription.</p>



<p><b>Drug Tier 5 – Specialty Tier:</b> You pay 30% of the total cost.</p> <p><b>Drug Tier 6 – Select Care drugs:</b> You pay \$0 per prescription.</p> <hr/> <p>Once your total drug costs have reached \$3,700, you will move to the next stage (the Coverage Gap Stage). <b>OR</b> you have paid \$4,950 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>	<p><b>Drug Tier 5 – Specialty Tier:</b> You pay 29% of the total cost.</p> <p><b>Drug Tier 6 – Select Care drugs:</b> You pay \$0 per prescription.</p> <hr/> <p>Once your total drug costs have reached \$3,750, you will move to the next stage (the Coverage Gap Stage). <b>OR</b> you have paid \$5,000 out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>
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**Changes to the Coverage Gap and Catastrophic Coverage Stages**

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage.**

For information about your costs in these stages, look at your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

**SECTION 2 Administrative Changes**

Process	2017 (this year)	2018 (next year)
<b>Cardiac and Pulmonary Rehabilitation Services</b>	Referral is <u>not</u> required for Cardiac and Pulmonary Rehabilitation Services.	Referral is <u>required</u> for Cardiac and Pulmonary Rehabilitation Services.

Process	2017 (this year)	2018 (next year)
<b>Transportation Services Verification</b>	All transportation services, including standing orders are subject to verification of eligibility and confirmation of the benefit including any trip limits (if applicable) for this plan.	All transportation services, including standing orders are subject to verification of eligibility and confirmation of the benefit including any trip limits (if applicable) for this plan. The Health Net Transportation Department will call the destination facility to verify the appointment and confirm that it is a covered destination.
<b>Monthly premium/Part D late enrollment penalty payment options</b>	<p>Pay by check or money order.</p> <p>Have payment automatically withdrawn from your bank account.</p> <p>Have payment taken out of your monthly Social Security check.</p> <p>Have payment taken out of your monthly Railroad Retirement Board (RRB) check.</p>	<p>Pay by check or money order.</p> <p>Have payment taken out of your monthly Social Security check.</p> <p>Have payment taken out of your monthly Railroad Retirement Board (RRB) check.</p> <p>Submit payment to: Health Net of California PO Box 748658 Los Angeles, CA 90074-8658</p>

Process	2017 (this year)	2018 (next year)
<b>Mail Order Pharmacy Options</b>	One mail order pharmacy option is available	Two mail order pharmacy options will be available: <ul style="list-style-type: none"> <li>• CVS Caremark</li> <li>• Homescripts</li> </ul> For information about mail order pharmacy options call Member Services.

### **SECTION 3 Deciding Which Plan to Choose**

#### **Section 3.1 – If you want to stay in Health Net Seniority Plus Amber II**

**To stay in our plan you don't need to do anything.** If you do not sign up for a different plan or change to Original Medicare, you will automatically stay enrolled as a member of our plan for 2018.

#### **Section 3.2 – If you want to change plans**

We hope to keep you as a member next year but if you want to change for 2018 follow these steps:

##### **Step 1: Learn about and compare your choices**

- You can join a different Medicare health plan at any time,
- -- OR-- You can change to Original Medicare at any time.

Your new coverage will begin on the first day of the following month. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2018*, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to <https://www.medicare.gov> and click “Find health & drug plans.” **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

## Step 2: Change your coverage

- To change to a **different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Health Net Seniority Plus Amber II.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Health Net Seniority Plus Amber II.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
  - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

## SECTION 4 Deadline for Changing Plans

Because you are eligible for both Medicare and Medi-Cal (Medicaid) you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

## SECTION 5 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In California, the SHIP is called the Health Insurance Counseling & Advocacy Program (HICAP).

The Health Insurance Counseling & Advocacy Program (HICAP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Health Insurance Counseling & Advocacy Program (HICAP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call the Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222, TDD users should call 1-800-735-2929, TTY users should call 711 (National Relay Service). You can learn more about the Health Insurance Counseling & Advocacy Program (HICAP) by visiting their website ([www.aging.ca.gov/hicap](http://www.aging.ca.gov/hicap)).

For questions about your Medi-Cal (Medicaid) benefits, contact Medi-Cal (Medicaid) at 1-800-541-5555, Monday through Friday, 8:00 a.m. to 5:00 p.m., except holidays. TTY users

should call 711 (National Relay Service). Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal (Medicaid) coverage.

## SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **“Extra Help” from Medicare.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don’t even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
  - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the California Office of AIDS – ADAP program. For more information, please go to this website: <https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAmain.aspx>. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-844-421-7050. TTY users should call 711 (National Relay Services).

## SECTION 7 Questions?

### Section 7.1 – Getting Help from Health Net Seniority Plus Amber II

Questions? We’re here to help. Please call Member Services at 1-800-431-9007. (TTY only, call 711.) We are available for phone calls. From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, 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. Calls to these numbers are free.

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**Read your 2018 Evidence of Coverage (it has details about next year's benefits and costs)**

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2018. For details, look in the 2018 *Evidence of Coverage* for Health Net Seniority Plus Amber II. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

**Visit our Website**

You can also visit our website at <https://ca.healthnetadvantage.com>. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

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**Section 7.2 – Getting Help from Medicare**

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To get information directly from Medicare:

**Call 1-800-MEDICARE (1-800-633-4227)**

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

**Visit the Medicare Website**

You can visit the Medicare website (<https://www.medicare.gov>). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to <https://www.medicare.gov> and click on “Find health & drug plans.”)

**Read Medicare & You 2018**

You can read *Medicare & You 2018* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<https://www.medicare.gov>) or 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.

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### **Section 7.3 – Getting Help from Medi-Cal (Medicaid)**

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To get information from, you can call Medi-Cal (Medicaid) at 1-800-541-5555, Monday through Friday, 8:00 a.m. to 5:00 p.m., except holidays. TTY users should call 711 (National Relay Service).