Health Net Ruby Select (HMO) offered by Health Net of California, Inc.

Annual Notice of Changes for 2018

You are currently enrolled as a member of Health Net Ruby Select. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

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 Ruby Select, you don't need to do anything. You will stay in Health Net Ruby Select.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2017**

- If you **don't join by December 7, 2017**, you will stay in Health Net Ruby Select.
- If you **join by December 7, 2017**, your new coverage will start on January 1, 2018.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-800-275-4737 for additional information. (TTY users should call 711.) From October 1 to February 14, you can call us 7 days a week from 8 a.m. to 8 p.m. From February 15 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.
- 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 Ruby Select

- Health Net of California, Inc. has a contract with Medicare to offer HMO plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.
- 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 Ruby Select.

Summary of Important Costs for 2018

The table below compares the 2017 costs and 2018 costs for Health Net Ruby Select 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)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$69	$69
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$6,700	$6,700
Doctor office visits	Primary care visits: $10 copay per visit Specialist visits: $25 copay per visit	Primary care visits: $5 copay per visit Specialist visits $20 copay per visit
Inpatient hospital stays 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.	You pay a $345 copay each day from days 1 through 5 per benefit period, for Medicare-covered inpatient hospital care. You pay a $0 copay per day, days 6 and beyond benefit period, for Medicare covered inpatient hospital care.	You pay a $345 copay each day from days 1 through 5 per benefit period, for Medicare-covered inpatient hospital care. You pay a $0 copay per day, days 6 and beyond benefit period, for Medicare covered inpatient hospital care.

Cost	2017 (this year)	2018 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0 Copays/Coinsurance during the Initial Coverage Stage: • Drug Tier 1 – Preferred generic drugs: Standard cost-sharing: $8 copay for a one-month (30-day) supply Preferred cost-sharing: $3 copay for a one-month (30-day) supply • Drug Tier 2 – Generic drugs: Standard cost-sharing: $15 copay for a one-month (30-day) supply Preferred cost-sharing: $10 copay for a one-month (30-day) supply • Drug Tier 3 – Preferred brand drugs: Standard cost-sharing: $47 copay for a one-month (30-day) supply	Deductible: $0 Copays/Coinsurance during the Initial Coverage Stage: • Drug Tier 1 – Preferred generic drugs: Standard cost-sharing: $8 copay for a one-month (30-day) supply Preferred cost-sharing: $3 copay for a one-month (30-day) supply • Drug Tier 2 – Generic drugs: Standard cost-sharing: $15 copay for a one-month (30-day) supply Preferred cost-sharing: $10 copay for a one-month (30-day) supply • Drug Tier 3 – Preferred brand drugs: Standard cost-sharing: $47 copay for a one-month (30-day) supply

Cost	2017 (this year)	2018 (next year)
	Preferred cost-sharing: $37 copay for a one-month (30-day) supply	Preferred cost-sharing: $37 copay for a one-month (30-day) supply
	• Drug Tier 4 – Non-preferred brand drugs: Standard cost-sharing: $100 copay for a one-month (30-day) supply	• Drug Tier 4 – Non-preferred brand drugs: Standard cost-sharing: $100 copay for a one-month (30-day) supply
	Preferred cost-sharing: $90 copay for a one-month (30-day) supply	Preferred cost-sharing: $90 copay for a one-month (30-day) supply
	• Drug Tier 5 – Specialty Tier: Standard cost-sharing: 33% of the total cost for a one-month (30-day) supply	• Drug Tier 5 – Specialty Tier: Standard cost-sharing: 33% of the total cost for a one-month (30-day) supply
	Preferred cost-sharing: 33% of the total cost for a one-month (30-day) supply	Preferred cost-sharing: 33% of the total cost for a one-month (30-day) supply
	• Drug Tier 6 – Select Care drugs: Standard cost-sharing: $0 copay for a one-month (30-day) supply	• Drug Tier 6 – Select Care drugs: Standard cost-sharing: $0 copay for a one-month (30-day) supply

Cost	2017 (this year)	2018 (next year)
	Preferred cost-sharing: $0 copay for a one-month (30-day) supply	Preferred cost-sharing: $0 copay for a one-month (30-day) supply

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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)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$69	$69
Optional supplemental benefits monthly premium		
Buy-Up Package #1: Dental HMO, Eyewear, Chiropractic, Acupuncture and Fitness	$25	Not Available
Buy-Up Package #2: Dental PPO, Eyewear, Chiropractic, Acupuncture and Fitness	$35	Not Available
Buy-Up Package #3: Dental HMO, Chiropractic, Acupuncture and Fitness	Not Available	$13
Buy-Up Package #4: Dental PPO, Chiropractic, Acupuncture and Fitness	Not Available	$23

- 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 services for the rest of the year.

Cost	2017 (this year)	2018 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$6,700	$6,700 Once you have paid $6,700 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year.

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.

Section 1.4 – Changes to the Pharmacy Network

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. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other network pharmacies for some drugs.

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**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

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, *Medical Benefits Chart (what is covered and what you pay)*, in your *2018 Evidence of Coverage.*

Cost	2017 (this year)	2018 (next year)
Emergency care	You pay a $75 copay for each Medicare-covered emergency room visit. You do not pay this amount if you are immediately admitted to the hospital.	You pay a $80 copay for each Medicare-covered emergency room visit. You do not pay this amount if you are immediately admitted to the hospital.

Cost	2017 (this year)	2018 (next year)
Physician/Practitioner services, including doctor's office visits	You pay a $10 copay for each Medicare-covered primary care doctor office visit or medically-necessary surgery services furnished in a physician's office. You pay a $25 copay for each Medicare-covered specialist visit or medically necessary surgery services furnished in a specialist's office.	You pay a $5 copay for each Medicare-covered primary care doctor office visit or medically-necessary surgery services furnished in a physician's office. You pay a $20 copay for each Medicare-covered specialist visit or medically necessary surgery services furnished in a specialist's office.
Ambulance services	You pay a $370 copay per one way trip. One copay per day when there is more than one trip in a single day. Copay is not waived if admitted to the hospital.	You pay a $250 per one way trip. One copay per day when there is more than one trip in a single day. Copay is not waived if admitted to the hospital.
Hospice care	You pay a $25 copay for the one-time only hospice consultation.	You pay a $20 copay for the one-time only hospice consultation.
Vision care (Non-Medicare covered)	You pay a $12 copay for each routine (Non-Medicare covered) eye exam. Routine eyewear is offered as part of an optional supplemental benefit package for 2017. You have a $250 allowance for frames or contact lenses every 24 months. Please refer to your Evidence of Coverage for plan benefit details	You pay a $12 copay for each routine (Non-Medicare covered) eye exam. You pay a $0 copay for 1 set of frames and,1 pair of eyeglass lenses or contact lenses during a 24-month period. You have a $100 allowance for frames or contact lenses every 24 months. Please refer to your Evidence of Coverage for plan benefit details

Cost	2017 (this year)	2018 (next year)
Optional Supplemental Benefits	Optional Supplemental Benefit Package #1, includes coverage for DHMO, routine eyewear, chiropractic care, acupuncture and fitness, is available for an extra premium. Optional Supplemental Benefit Package #2, includes coverage for DPPO, routine eyewear, chiropractic care, acupuncture and fitness, is available for an extra premium. Optional Supplemental Benefit Package #3 and 4 are not available. Please refer to your Evidence of Coverage for plan benefit details.	Optional Supplemental Benefit Package #1 and 2 are not available. Optional Supplemental Benefit Package #3, includes coverage for DHMO, chiropractic care, acupuncture and fitness, is available for an extra premium. Optional Supplemental Benefit Package #4, includes coverage for DPPO, chiropractic care, acupuncture and fitness, is available for an extra premium. Please refer to your Evidence of Coverage for plan benefit details.

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 other 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 at Chapter 6, Sections 6 and 7, in the enclosed *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2017 (this year)	2018 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

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*.

	2017 (this year)	2018 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. 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 *Evidence of Coverage*. 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.	Your cost for a one-month supply at a network pharmacy: **Drug Tier 1 – Preferred generic drugs:** Standard cost-sharing: You pay $8 copay per prescription. Preferred cost-sharing: You pay $3 copay per prescription. **Drug Tier 2 – Generic drugs:** Standard cost-sharing: You pay $15 copay per prescription. Preferred cost-sharing: You pay $10 copay per prescription.	Your cost for a one-month supply at a network pharmacy: **Drug Tier 1 – Preferred generic drugs:** Standard cost-sharing: You pay $8 copay per prescription. Preferred cost-sharing: You pay $3 copay per prescription. **Drug Tier 2 – Generic drugs:** Standard cost-sharing: You pay $15 copay per prescription. Preferred cost-sharing: You pay $10 copay per prescription.

	2017 (this year)	2018 (next year)
	Drug Tier 3 – Preferred brand drugs: Standard cost-sharing: You pay $47 copay per prescription. Preferred cost-sharing: You pay $37 copay per prescription.	**Drug Tier 3 – Preferred brand drugs:** Standard cost-sharing: You pay $47 copay per prescription. Preferred cost-sharing: You pay $37 copay per prescription.
	Drug Tier 4 – Non-preferred brand drugs: Standard cost-sharing: You pay $100 copay per prescription. Preferred cost-sharing: You pay $90 copay per prescription.	**Drug Tier 4 – Non-preferred brand drugs:** Standard cost-sharing: You pay $100 copay per prescription. Preferred cost-sharing: You pay $90 copay per prescription.
	Drug Tier 5 – Specialty Tier: Standard cost-sharing: You pay 33% of the total cost. Preferred cost-sharing: You pay 33% of the total cost.	**Drug Tier 5 – Specialty Tier:** Standard cost-sharing: You pay 33% of the total cost. Preferred cost-sharing: You pay 33% of the total cost.
	Drug Tier 6 – Select Care drugs: Standard cost-sharing: You pay $0 copay per prescription. Preferred cost-sharing: You pay $0 copay per prescription.	**Drug Tier 6 – Select Care drugs:** Standard cost-sharing: You pay $0 copay per prescription. Preferred cost-sharing: You pay $0 copay per prescription.
	_____ Once your total drug costs have reached $3,700, you will move to the next stage (the Coverage Gap Stage). OR you have paid $4,950	_____ Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage). OR you have paid $5,000

	2017 (this year)	2018 (next year)
	out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).	out-of-pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

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

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

SECTION 2 Administrative Changes

Process	2017 (this year)	2018 (next year)
Cardiac and Pulmonary Rehabilitation Services	Referral is not required for Cardiac and Pulmonary Rehabilitation Services	Referral is required for Cardiac and Pulmonary Rehabilitation Services
Monthly premium/Part D late enrollment penalty payment options	Pay by check or money order Have payment automatically withdrawn from your bank account Have payment taken out of your monthly Social Security check Have payment taken out of your monthly Railroad Retirement Board (RRB) check.	Pay by check or money order Have payment taken out of your monthly Social Security check Have payment taken out of your monthly Railroad Retirement Board (RRB) check. Submit payment to: Health Net of California PO Box 748658 Los Angeles, CA 90074-8658

Process	2017 (this year)	2018 (next year)
Mail order pharmacy options	One mail order pharmacy option is available.	Two mail order pharmacy options will be available: • CVS Caremark • Homescripts For information about mail order pharmacy options, call Member Services.
Optional Supplemental Benefits	In 2017, if you were enrolled in Optional Supplemental Benefit Package 1, which includes coverage for DHMO services, routine eyewear, chiropractic care, acupuncture, and fitness, you paid an additional monthly premium of $25. If you were enrolled in Optional Supplemental Benefit Package 2, which includes coverage for DPPO services, routine eyewear, chiropractic care, acupuncture, and fitness, you paid an additional monthly premium of $35.	In 2018, Optional Supplemental Benefit Package 1 is not available. You will be automatically enrolled in Optional Supplemental Benefit Package 3, which includes coverage for DHMO services, chiropractic care, acupuncture, and fitness for an additional monthly premium of $13. Optional Supplemental Benefit Package 2 is not available. You will be automatically enrolled in Optional Supplemental Benefit Package 4, which includes coverage for DPPO services, chiropractic care, acupuncture, and fitness for an additional monthly premium of $23.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Health Net Ruby Select

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 by December 7, 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,
- *OR*-- You can change to Original Medicare. 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 Ruby Select.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Health Net Ruby Select.
- 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.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2018.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2018, and don't like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2018. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

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

Health Insurance Counseling & Advocacy Program 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 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 Health Insurance Counseling & Advocacy Program at 1-800-434-0222. TTY users call 711 (National Relay Service). You can learn more about the Health Insurance Counseling & Advocacy Program by visiting their website (www.aging.ca.gov/hicap).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"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: 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 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 Ruby Select

Questions? We're here to help. Please call Member Services at 1-800-275-4737. (TTY only, call 711). We are available for phone calls. From October 1 to February 14, you can call us 7 days a week from 8 a.m. to 8 p.m. From February 15 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. Calls to these numbers are free.

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 Ruby Select. 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).

Section 7.2 – Getting Help from Medicare

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 the *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.