2017 Benefit *Highlights*

Health Net MEDICARE PROGRAMS

*Health Net Ruby Select (HMO)**

Alameda County, CA

Plan benefits	*Copays*
Monthly plan premium	$69
Maximum out-of-pocket (MOOP)	$6,700
Doctor office visits • Primary care provider • Specialist	 $10 copay $25 copay
Lab services and X-rays	$0 copay
Complex diagnostic imaging (MRI, MRA, CT, PET, etc.) and radiation therapy	$60 copay
Diabetic supplies	$0 copay
Inpatient hospital care	$345 copay per day, days 1–5 $0 copay per day, days 6 and beyond
Outpatient services/surgery (hospital care)	$345 copay
Outpatient services/surgery (ambulatory care)	$200 copay
Emergency care	$75 copay
Worldwide emergency/urgent coverage – annual limit of $50,000	$0 copay
Urgently needed services	$25 copay
Routine podiatry	$25 copay Up to 12 visits per year
Routine hearing exam	$0 copay
Hearing aids (1 pair every 3 years) [1]	$0 copay $1,000 benefit maximum for 2 hearing aids (for both ears combined) every 3 years
Routine vision exam	$12 copay
Routine eyewear	Optional Supplemental package available
Dental HMO – preventive and comprehensive	Optional Supplemental package available
Dental PPO – preventive and limited comprehensive	Optional Supplemental package available

(Continued)

Prescription drug coverage	*Value Formulary*	
	30-day preferred retail cost-sharing	**30-day standard retail cost-sharing**
Annual Part D deductible	$0	
Tier 1: Preferred generic drugs	$3 copay	$8 copay
Tier 2: Generic drugs	$10 copay	$15 copay
Tier 3: Preferred brand drugs [2]	$37 copay	$47 copay
Tier 4: Non-preferred brand drugs [3]	$90 copay	$100 copay
Tier 5: Specialty tier	33% of the cost	33% of the cost
Tier 6: Select Care drugs	$0 copay	$0 copay
Initial coverage limit (ICL)	$3,700	

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

Once the ICL has been met, you move into the Coverage Gap phase. During the Coverage Gap, you pay 40% of the price for covered brand-name drugs and 51% of the price for covered generic drugs until your costs total $4,950, which is the end of the Coverage Gap. 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. Not everyone will enter the Coverage Gap. After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,950, you will then pay the greater of $3.30 copay or 5% coinsurance for generic drugs and $8.25 copay or 5% coinsurance for all other drugs.

*__This plan uses specific providers only.__ Not all participating Medical Groups and their affiliated primary care providers (PCPs) and facilities are available to you in the service area for this plan. In addition, you may be limited to providers within your PCP's and/or medical group's network. This means that the PCP and/or medical group that you choose may determine the specialists and hospitals you can use. It is important to understand that Health Net offers a variety of plans in each service area; if your provider of choice is not available through this plan, the provider may be available through a different Health Net plan offering.

[1] Benefit allowance once every 3 years. Multi-year benefit may not be available in subsequent years. Members are responsible for any remaining balance over the coverage limit.

[2] This tier includes preferred brand drugs and may include some generic drugs. Brand drugs in this tier are not eligible for exceptions for payment at a lower tier.

[3] This tier includes non-preferred brand drugs and may include some generic drugs.

This information is not a complete description of benefits. Contact the plan for more information. You must continue to pay your Medicare Part B premium. Limitations, copayments and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. The actual complete terms and conditions of the health plan are set forth in the applicable *Evidence of Coverage* document.

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-275-4737 (TTY: 711).

Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-275-4737 (TTY: 711).

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-275-4737 (TTY: 711)**。

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-275-4737 (TTY: 711).

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-275-4737 (TTY: 711).

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-275-4737 (TTY: 711)** 번으로 전화해 주십시오.

Armenian:
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-275-4737 (TTY (հեռատիպ)՝ 711):

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-275-4737 (TTY: 711)** تماس بگیرید.

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-275-4737 (телетайп: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-275-4737 (TTY: 711)**まで、お電話にてご連絡ください。

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-275-4737** (رقم هاتف الصم والبكم: 711).

Punjabi:
ਧਿਆਨ ਦਿਓ1 ਹੈ। ਉਪਲਬਧ ਮੁਫਤ ਲਈ ਤੁਹਾਡੇ ਸੇਵਾ ਸਹਾਇਤਾ ਵਿੱਚ ਭਾਸ਼ਾ ਤਾਂ ,ਹੋ ਬੋਲਦੇ ਪੰਜਾਬੀ ਤੁਸੀਂ ਜੇ :

1-800-275-4737 (TTY: 711)ਕਰੋ। ਕਾਲ ਤੇ'

Cambodian:
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ

1-800-275-4737 (TTY: 711)។

Hmong:
LUS CEEV: Yog tias koj hais lus **Hmoob**, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-800-275-4737 (TTY: 711)**.

Hindi:
ध्यान दें: यदि आप **हदी** बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-800-275-4737 (TTY: 711) पर कॉल करें।

Thai:
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-275-4737 (TTY: 711)**.

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 1-800-275-4737 (TTY: 711), 8:00 a.m. to 8:00 p.m., Pacific Time, seven days a week.

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, (TDD: 1-800–537–7697).

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

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

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