



2010

HEALTH NET HEALTHY HEART (PPO), HEALTH NET VIOLET OPTION 1 (PPO),
HEALTH NET VIOLET OPTION 2 (PPO), HEALTH NET AQUA (PPO)

SUMMARY OF BENEFITS

Douglas, Jackson, Josephine Counties, OR

Benefits effective January 1, 2010
H5520 Health Net Life Insurance Company



INTRODUCTION TO SUMMARY OF BENEFITS

Thank you for your interest in Health Net Medicare Advantage plans. Our plans are offered by HEALTH NET LIFE INSURANCE COMPANY/Health Net Medicare Advantage, a Medicare Advantage Preferred Provider Organization (PPO). This Summary of Benefits tells you some features of our plans. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Health Net and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like these offered by Health Net. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may be able to join or leave a plan only at certain times. Please call Health Net at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare these Health Net plans and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some

important health benefits. For each benefit, you can see what our plans cover and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE ARE HEALTH NET MEDICARE ADVANTAGE PLANS AVAILABLE?

There is more than one plan listed in the Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call Customer Service for more information.

The service area for these plans includes: Douglas, Jackson, Josephine counties, OR. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN A HEALTH NET MEDICARE ADVANTAGE PLAN?

You can join a Health Net Medicare Advantage plan if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in Health Net Medicare Advantage plans unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

Health Net has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current Provider Directory or for an up-to-date list visit us at www.healthnet.com. Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

You can go to doctors, specialists, or hospitals in or out-of-network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the customer service number at the end of this introduction.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

Health Net Violet Option 1 (PPO), Health Net Violet Option 2 (PPO), and Health Net Healthy Heart (PPO) do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

Health Net Aqua (PPO) does cover Medicare Part B prescription drugs. Health Net Aqua (PPO) does NOT cover Medicare Part D prescription drugs.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

Health Net Violet Option 1 (PPO), Health Net Violet Option 2 (PPO), and Health Net Healthy Heart (PPO) plans only

Health Net has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at <https://www.healthnet.com/formulary.htm>. Our customer service number is listed at the end of this introduction.

Health Net has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower co-pay or co-insurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Health Net Violet Option 1 (PPO), Health Net Violet Option 2 (PPO), and Health Net Healthy Heart (PPO) plans only

Health Net uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our web site at <https://www.healthnet.com/formulary.htm>.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can

get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS?

Health Net Violet Option 1 (PPO), Health Net Violet Option 2 (PPO), and Health Net Healthy Heart (PPO) plans only

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
- Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Health Net you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could

seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, OREGON: Acumentra Health, (800) 344-4354 WASHINGTON: Mountain-Pacific Quality Health, (800) 949-7536.

Health Net Violet Option 1 (PPO), Health Net Violet Option 2 (PPO), and Health Net Healthy Heart (PPO) plans only

As a member of Health Net you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, OREGON: Acumentra Health, (800) 344-4354 WASHINGTON: Mountain-Pacific Quality Health, (800) 949-7536.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

Health Net Violet Option 1 (PPO), Health Net Violet Option 2 (PPO), and Health Net Healthy Heart (PPO) plans only

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Health Net for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Health Net for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.

- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs provided through DME.

PLAN RATINGS

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly at 1-888-445-8913 to obtain a copy of the plan ratings for this plan. TTY users call TTY/TDD 1-800-929-9955.

Please call Health Net for more information about our plans.

Visit us at www.healthnet.com or, call us:

Customer Service Hours: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Pacific

Current members should call toll-free (888)-445-8913 for questions related to the Medicare Advantage or Medicare Part D Prescription Drug programs. (TTY/TDD (800)-929-9955)

Prospective members should call toll-free (800)-822-7698 for questions related to the Medicare Advantage or Medicare Part D Prescription Drug program. (TTY/TDD (800)-929-9955)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227) TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the web.

If you have special needs, this document may be available in other formats.

If you have any questions about this plan's benefits or costs, please contact Health Net Life Insurance Company for details.

SECTION II

SUMMARY OF BENEFITS

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
IMPORTANT INFORMATION		
1. Premium and Other Important Information	<p>In 2009 the monthly Part B Premium was \$96.40 and will change for 2010 and the yearly Part B deductible amount was \$135 and will change for 2010.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2009, this amount was \$85,000 for singles, \$170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p><u>General</u> \$101 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p><u>In-Network</u> \$1,500 out-of-pocket limit.</p> <p>There is no limit on cost sharing for the following services:</p> <p>Medicare Services:</p> <ul style="list-style-type: none"> - Chiropractic Services - Health/Wellness Education <p>This limit includes only Medicare-covered services.</p> <p><u>Out-of-Network</u> \$1,500 out-of-pocket limit.</p> <p>There is no limit on cost sharing for the following services:</p> <p>Medicare Services</p> <ul style="list-style-type: none"> - Chiropractic Services - Health/Wellness Education <p>This limit includes only Medicare-covered services.</p>

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
IMPORTANT INFORMATION		
<u>General</u> \$75 monthly plan premium in addition to your monthly Medicare Part B premium. <u>In-Network</u> \$2,000 out-of-pocket limit. There is no limit on cost sharing for the following services: Medicare Services: - Chiropractic Services - Health/Wellness Education This limit includes only Medicare-covered services. <u>Out-of-Network</u> \$3,000 out-of-pocket limit. There is no limit on cost sharing for the following services: Medicare Services: - Chiropractic Services - Health/Wellness Education This limit includes only Medicare-covered services.	<u>General</u> \$0 monthly plan premium in addition to your monthly Medicare Part B premium. <u>In-Network</u> \$2,500 out-of-pocket limit. There is no limit on cost sharing for the following services: Medicare Services: - Chiropractic Services - Health/Wellness Education This limit includes only Medicare-covered services. <u>Out-of-Network</u> \$3,500 out-of-pocket limit. There is no limit on cost sharing for the following services: Medicare Services: - Chiropractic Services - Health/Wellness Education This limit includes only Medicare-covered services. <u>In and Out-of-Network</u> \$75 yearly deductible. Contact the plan for services that apply.	<u>General</u> \$25 monthly plan premium in addition to your monthly Medicare Part B premium. <u>In-Network</u> \$1,500 out-of-pocket limit. There is no limit on cost sharing for the following services: Medicare Services: - Chiropractic Services - Health/Wellness Education This limit includes only Medicare-covered services. <u>Out-of-Network</u> \$3,000 out-of-pocket limit. There is no limit on cost sharing for the following services: Medicare Services: - Chiropractic Services - Health/Wellness Education This limit includes only Medicare-covered services.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
2. Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist, or hospital that accepts Medicare.	<u>In-Network</u> No referral required for network doctors, specialists, and hospitals.
SUMMARY OF BENEFITS		
INPATIENT CARE		
3. Inpatient Hospital Care (Includes Substance Abuse and Rehabilitation Services)	In 2009 the amounts for each benefit period were: Days 1 - 60: \$1,068 deductible Days 61 - 90: \$267 per day Days 91 - 150: \$534 per lifetime reserve day These amounts will change for 2010. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	<u>In-Network</u> For Medicare-covered hospital stays: Days 1 - 8: \$100 copay per day Days 9 - 90: \$0 copay per day \$0 copay for additional hospital days \$800 out of pocket limit every stay. No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. <u>Out-of-Network</u> For hospital stays: Days 1 - 8: \$100 copay per day Days 9 - 90: \$0 copay per day

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<u>In-Network</u> No referral required for network doctors, specialists, and hospitals.	<u>In-Network</u> No referral required for network doctors, specialists, and hospitals.	<u>In-Network</u> No referral required for network doctors, specialists, and hospitals.
SUMMARY OF BENEFITS		
INPATIENT CARE		
<u>In-Network</u> For Medicare-covered hospital stays: Days 1 - 8: \$150 copay per day Days 9 - 90: \$0 copay per day \$0 copay for additional hospital days \$1,200 out of pocket limit every stay. No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	<u>In-Network</u> For Medicare-covered hospital stays: Days 1 - 8: \$200 copay per day Days 9 - 90: \$0 copay per day \$0 copay for additional hospital days \$1,600 out of pocket limit every stay. No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	<u>In-Network</u> For Medicare-covered hospital stays: Days 1 - 8: \$100 copay per day Days 9 - 90: \$0 copay per day \$0 copay for additional hospital days \$800 out of pocket limit every stay. No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
<u>Out-of-Network</u> For hospital stays: Days 1 - 8: \$200 copay per day Days 9 - 90: \$0 copay per day	<u>Out-of-Network</u> For hospital stays: Days 1 - 8: \$250 copay per day Days 9 - 90: \$0 copay per day	<u>Out-of-Network</u> For hospital stays: Days 1 - 8: \$200 copay per day Days 9 - 90: \$0 copay per day

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
4. Inpatient Mental Health Care	<p>Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above).</p> <p>190 day lifetime limit in a Psychiatric Hospital.</p>	<p><u>In-Network</u> For Medicare-covered hospital stays:</p> <p>Days 1 - 8: \$100 copay per day Days 9 - 90: \$0 copay per day \$800 out of pocket limit every stay.</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p><u>Out-of-Network</u> For hospital stays:</p> <p>Days 1 - 8: \$100 copay per day Days 9 - 190: \$0 copay per day</p>
5. Skilled Nursing Facility (SNF in a Medicare-certified skilled nursing facility)	<p>In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay were:</p> <p>Days 1 - 20: \$0 per day Days 21 - 100: \$133.50 per day</p> <p>These amounts will change for 2010. 100 days for each benefit period.</p> <p>A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> For SNF stays:</p> <p>Days 1 - 8: \$100 copay per day Days 9 - 100: \$0 copay per day \$800 out-of-pocket limit every stay.</p> <p>Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p> <p><u>Out-of-Network</u> For each SNF stay:</p> <p>Days 1 - 8: \$100 copay per SNF day Days 9 - 100: \$0 copay per SNF day</p>

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<u>In-Network</u> For Medicare-covered hospital stays: Days 1 - 8: \$150 copay per day Days 9 - 90: \$0 copay per day \$1,200 out of pocket limit every stay. You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. <u>Out-of-Network</u> For hospital stays: Days 1 - 8: \$200 copay per day Days 9 - 190: \$0 copay per day	<u>In-Network</u> For Medicare-covered hospital stays: Days 1 - 8: \$200 copay per day Days 9 - 90: \$0 copay per day \$1,600 out of pocket limit every stay. You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. <u>Out-of-Network</u> For hospital stays: Days 1 - 8: \$250 copay per day Days 9 - 190: \$0 copay per day	<u>In-Network</u> For Medicare-covered hospital stays: Days 1 - 8: \$100 copay per day Days 9 - 90: \$0 copay per day \$800 out of pocket limit every stay. You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. <u>Out-of-Network</u> For hospital stays: Days 1 - 8: \$200 copay per day Days 9 - 190: \$0 copay per day
<u>General</u> Authorization rules may apply. <u>In-Network</u> For SNF stays: Days 1 - 8: \$150 copay per day Days 9 - 100: \$0 copay per day \$1,200 out-of-pocket limit every stay. Plan covers up to 100 days each benefit period No prior hospital stay is required. <u>Out-of-Network</u> For each SNF stay: Days 1 - 8: \$200 copay per SNF day Days 9 - 100: \$0 copay per SNF day	<u>General</u> Authorization rules may apply. <u>In-Network</u> For SNF stays: Days 1 - 8: \$200 copay per day Days 9 - 100: \$0 copay per day \$1,600 out-of-pocket limit every stay. Plan covers up to 100 days each benefit period No prior hospital stay is required. <u>Out-of-Network</u> For each SNF stay: Days 1 - 8: \$250 copay per SNF day Days 9 - 100: \$0 copay per SNF day	<u>General</u> Authorization rules may apply. <u>In-Network</u> For SNF stays: Days 1 - 8: \$100 copay per day Days 9 - 100: \$0 copay per day \$800 out-of-pocket limit every stay. Plan covers up to 100 days each benefit period No prior hospital stay is required. <u>Out-of-Network</u> For each SNF stay: Days 1 - 8: \$200 copay per SNF day Days 9 - 100: \$0 copay per SNF day

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
6. Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$0 copay for Medicare-covered home health visits. <u>Out-of-Network</u> \$0 copay for home health visits.
7. Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	<u>General</u> You must get care from a Medicare-certified hospice.
OUTPATIENT CARE		
8. Doctor Office Visits	20% coinsurance.	<u>General</u> See "Physical Exams," for more information. <u>In-Network</u> \$10 copay for each primary care doctor visit for Medicare-covered benefits. \$10 to \$25 copay for each in-area, network urgent care Medicare-covered visit. \$10 copay for each specialist visit for Medicare-covered benefits. <u>Out-of-Network</u> \$10 copay for each primary care doctor visit. \$10 copay for each specialist visit.

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<u>General</u> Authorization rules may apply. <u>In-Network</u> \$0 copay for Medicare-covered home health visits. <u>Out-of-Network</u> \$0 copay for home health visits.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$0 copay for Medicare-covered home health visits. <u>Out-of-Network</u> \$0 copay for home health visits.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$0 copay for Medicare-covered home health visits. <u>Out-of-Network</u> \$0 copay for home health visits.
<u>General</u> You must get care from a Medicare-certified hospice.	<u>General</u> You must get care from a Medicare-certified hospice.	<u>General</u> You must get care from a Medicare-certified hospice.
OUTPATIENT CARE		
<u>General</u> See "Physical Exams," for more information. <u>In-Network</u> \$12 copay for each primary care doctor visit for Medicare-covered benefits. \$12 to \$35 copay for each in-area, network urgent care Medicare-covered visit. \$12 copay for each specialist visit for Medicare-covered benefits. <u>Out-of-Network</u> \$20 copay for each primary care doctor visit. \$20 copay for each specialist visit.	<u>General</u> See "Physical Exams," for more information. <u>In-Network</u> \$15 copay for each primary care doctor visit for Medicare-covered benefits. \$15 to \$35 copay for each in-area, network urgent care Medicare-covered visit. \$15 copay for each specialist visit for Medicare-covered benefits. <u>Out-of-Network</u> \$20 copay for each primary care doctor visit. \$20 copay for each specialist visit.	<u>General</u> See "Physical Exams," for more information. <u>In-Network</u> \$10 copay for each primary care doctor visit for Medicare-covered benefits. \$10 to \$25 copay for each in-area, network urgent care Medicare-covered visit. \$10 copay for each specialist visit for Medicare-covered benefits. <u>Out-of-Network</u> \$20 copay for each primary care doctor visit. \$20 copay for each specialist visit.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
9. Chiropractic Services	<p>Routine care not covered.</p> <p>20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$15 copay for each Medicare-covered visit. \$15 copay for each routine visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> <p><u>Out-of-Network</u> \$15 copay for chiropractic benefits.</p>
10. Podiatry Services	<p>Routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p><u>In-Network</u> \$25 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically necessary foot care.</p> <p><u>Out-of-Network</u> \$35 copay for podiatry benefits.</p>
11. Outpatient Mental Health Care	<p>45% coinsurance for most outpatient mental health services.</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$25 copay for each Medicare-covered individual or group therapy visit.</p> <p><u>Out-of-Network</u> \$50 copay for Mental Health benefits. \$50 copay for Mental Health benefits with a psychiatrist.</p>

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$15 copay for each Medicare-covered visit. \$15 copay for each routine 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) if you get it from a chiropractor or other qualified providers.</p> <p><u>Out-of-Network</u> \$15 copay for chiropractic benefits.</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$15 copay for each Medicare-covered visit. \$15 copay for each routine 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) if you get it from a chiropractor or other qualified providers.</p> <p><u>Out-of-Network</u> \$15 copay for chiropractic benefits.</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$15 copay for each Medicare-covered visit. \$15 copay for each routine 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) if you get it from a chiropractor or other qualified providers.</p> <p><u>Out-of-Network</u> \$15 copay for chiropractic benefits.</p>
<p><u>In-Network</u> \$25 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically necessary foot care.</p> <p><u>Out-of-Network</u> \$35 copay for podiatry benefits.</p>	<p><u>In-Network</u> \$25 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically necessary foot care.</p> <p><u>Out-of-Network</u> \$35 copay for podiatry benefits.</p>	<p><u>In-Network</u> \$25 copay for each Medicare-covered visit. \$25 copay for each routine visit Medicare-covered podiatry benefits are for medically necessary foot care.</p> <p><u>Out-of-Network</u> \$35 copay for podiatry benefits.</p>
<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$25 copay for each Medicare-covered individual or group therapy visit.</p> <p><u>Out-of-Network</u> \$50 copay for Mental Health benefits. \$50 copay for Mental Health benefits with a psychiatrist.</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$25 copay for each Medicare-covered individual or group therapy visit.</p> <p><u>Out-of-Network</u> \$50 copay for Mental Health benefits. \$50 copay for Mental Health benefits with a psychiatrist.</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$25 copay for each Medicare-covered individual or group therapy visit.</p> <p><u>Out-of-Network</u> \$50 copay for Mental Health benefits. \$50 copay for Mental Health benefits with a psychiatrist.</p>

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
12. Outpatient Substance Abuse Care	20% coinsurance.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$25 copay for Medicare-covered individual or group visits. <u>Out-of-Network</u> \$50 copay for outpatient substance abuse benefits.
13. Outpatient Services/Surgery	20% coinsurance for the doctor. 20% of outpatient facility charges.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$100 copay for each Medicare-covered ambulatory surgical center visit. \$100 copay for each Medicare-covered outpatient hospital facility visit. <u>Out-of-Network</u> \$100 copay for ambulatory surgical center benefits. \$100 copay for outpatient hospital facility benefits.
14. Ambulance Services (Medically necessary ambulance services)	20% coinsurance.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$75 copay for Medicare-covered ambulance benefits. <u>Out-of-Network</u> \$75 copay for ambulance benefits.
15. Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor. 20% of facility charge, or a set copay per emergency room visit. You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances.	<u>General</u> \$50 copay for Medicare-covered emergency room visits. \$50,000 limit for emergency services outside the U.S. every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<u>General</u> Authorization rules may apply. <u>In-Network</u> \$25 copay for Medicare-covered individual or group visits. <u>Out-of-Network</u> \$50 copay for outpatient substance abuse benefits.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$25 copay for Medicare-covered individual or group visits. <u>Out-of-Network</u> \$50 copay for outpatient substance abuse benefits.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$25 copay for Medicare-covered individual or group visits. <u>Out-of-Network</u> \$50 copay for outpatient substance abuse benefits.
<u>General</u> Authorization rules may apply. <u>In-Network</u> \$150 copay for each Medicare-covered ambulatory surgical center visit. \$150 copay for each Medicare-covered outpatient hospital facility visit. <u>Out-of-Network</u> \$200 copay for ambulatory surgical center benefits. \$200 copay for outpatient hospital facility benefits.	<u>General</u> Authorization rules may apply. <u>In-Network</u> 10% of the cost for each Medicare-covered ambulatory surgical center visit. 10% of the cost for each Medicare-covered outpatient hospital facility visit. <u>Out-of-Network</u> 15% of the cost for ambulatory surgical center benefits. 15% of the cost for outpatient hospital facility benefits.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$100 copay for each Medicare-covered ambulatory surgical center visit. \$100 copay for each Medicare-covered outpatient hospital facility visit. <u>Out-of-Network</u> \$200 copay for ambulatory surgical center benefits. \$200 copay for outpatient hospital facility benefits.
<u>General</u> Authorization rules may apply. <u>In-Network</u> \$150 copay for Medicare-covered ambulance benefits. <u>Out-of-Network</u> \$150 copay for ambulance benefits.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$200 copay for Medicare-covered ambulance benefits. <u>Out-of-Network</u> \$200 copay for ambulance benefits.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$75 copay for Medicare-covered ambulance benefits. <u>Out-of-Network</u> \$75 copay for ambulance benefits.
<u>General</u> \$50 copay for Medicare-covered emergency room visits. \$50,000 limit for emergency services outside the U.S. every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit	<u>General</u> \$50 copay for Medicare-covered emergency room visits. \$50,000 limit for emergency services outside the U.S. every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit	<u>General</u> \$50 copay for Medicare-covered emergency room visits. \$50,000 limit for emergency services outside the U.S. every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
16. Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay. NOT covered outside the U.S. except under limited circumstances.	<u>General</u> \$10 to \$50 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, \$0 for the urgent-care visit.
17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$25 copay for Medicare-covered Occupational Therapy visits. \$25 copay for Medicare-covered Physical and/or Speech/Language Therapy visits. <u>Out-of-Network</u> \$35 copay for Occupational Therapy benefits. \$35 copay for Physical and/or Speech/Language Therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18. Durable Medical Equipment (Includes wheelchairs, oxygen, etc.)	20% coinsurance.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$20 to \$600 copay for Medicare-covered items. <u>Out-of-Network</u> \$30 to \$900 copay for durable medical equipment.
19. Prosthetic Devices (Includes braces, artificial limbs and eyes, etc.)	20% coinsurance.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$20 to \$600 copay for Medicare-covered items. <u>Out-of-Network</u> \$30 to \$900 copay for prosthetic devices.

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<u>General</u> \$20 to \$50 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, \$0 for the urgent-care visit.	<u>General</u> \$20 to \$50 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, \$0 for the urgent-care visit.	<u>General</u> \$20 to \$50 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, \$0 for the urgent-care visit.
<u>General</u> Authorization rules may apply. <u>In-Network</u> \$25 copay for Medicare-covered Occupational Therapy visits. \$25 copay for Medicare-covered Physical and/or Speech/Language Therapy visits. <u>Out-of-Network</u> \$35 copay for Occupational Therapy benefits. \$35 copay for Physical and/or Speech/Language Therapy visits.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$25 copay for Medicare-covered Occupational Therapy visits. \$25 copay for Medicare-covered Physical and/or Speech/Language Therapy visits. <u>Out-of-Network</u> \$35 copay for Occupational Therapy benefits. \$35 copay for Physical and/or Speech/Language Therapy visits.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$25 copay for Medicare-covered Occupational Therapy visits. \$25 copay for Medicare-covered Physical and/or Speech/Language Therapy visits. <u>Out-of-Network</u> \$35 copay for Occupational Therapy benefits. \$35 copay for Physical and/or Speech/Language Therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
<u>General</u> Authorization rules may apply. <u>In-Network</u> \$20 to \$600 copay for Medicare-covered items. <u>Out-of-Network</u> \$30 to \$900 copay for durable medical equipment.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$20 to \$600 copay for Medicare-covered items. <u>Out-of-Network</u> \$30 to \$900 copay for durable medical equipment.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$20 to \$600 copay for Medicare-covered items. <u>Out-of-Network</u> \$30 to \$900 copay for durable medical equipment.
<u>General</u> Authorization rules may apply. <u>In-Network</u> \$20 to \$600 copay for Medicare-covered items. <u>Out-of-Network</u> \$30 to \$900 copay for prosthetic devices.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$20 to \$600 copay for Medicare-covered items. <u>Out-of-Network</u> \$30 to \$900 copay for prosthetic devices.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$20 to \$600 copay for Medicare-covered items. <u>Out-of-Network</u> \$30 to \$900 copay for prosthetic devices.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
<p>20. Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (Includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>20% coinsurance.</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies. Separate Office Visit cost sharing of \$10 copay may apply.</p> <p><u>Out-of-Network</u> \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies.</p>
<p>21. Diagnostic Tests, X-Rays, Lab Services and Radiology Services</p>	<p>20% coinsurance for diagnostic tests and X-rays.</p> <p>\$0 copay for Medicare-covered lab services.</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p><u>General</u> Authorization rules may apply.</p> <p><u>In-Network</u> \$0 copay for Medicare-covered lab services. \$20 to \$600 copay for Medicare-covered diagnostic procedures and tests. \$0 copay for Medicare-covered X-rays. \$20 to \$600 copay for Medicare-covered diagnostic radiology services. \$20 to \$600 copay for Medicare-covered therapeutic radiology services. Separate Office Visit cost sharing of \$10 copay may apply.</p> <p><u>Out-of-Network</u> \$30 to \$900 copay for therapeutic radiology services \$30 to \$900 copay for diagnostic radiology services \$0 copay for outpatient x-rays. \$0 to \$900 copay for diagnostic procedures, tests, and lab services.</p>

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<u>General</u> Authorization rules may apply. <u>In-Network</u> \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies. Separate Office Visit cost sharing of \$12 copay may apply. <u>Out-of-Network</u> \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies. Separate Office Visit cost sharing of \$15 copay may apply. <u>Out-of-Network</u> \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies. Separate Office Visit cost sharing of \$10 copay may apply. <u>Out-of-Network</u> \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies.
<u>General</u> Authorization rules may apply. <u>In-Network</u> \$12 copay for Medicare-covered lab services. \$20 to \$600 copay for Medicare-covered diagnostic procedures and tests. \$12 copay for Medicare-covered X-rays. \$20 to \$600 copay for Medicare-covered diagnostic radiology services. \$20 to \$600 copay for Medicare-covered therapeutic radiology services. Separate Office Visit cost sharing of \$12 copay may apply. <u>Out-of-Network</u> \$20 copay for outpatient x-rays. \$30 to \$900 copay for therapeutic radiology services \$30 to \$900 copay for diagnostic radiology services \$20 to \$900 copay for diagnostic procedures, tests, and lab services.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$15 copay for Medicare-covered lab services. \$20 to \$600 copay for Medicare-covered diagnostic procedures and tests. \$15 copay for Medicare-covered X-rays. \$20 to \$600 copay for Medicare-covered diagnostic radiology services. \$20 to \$600 copay for Medicare-covered therapeutic radiology services. Separate Office Visit cost sharing of \$15 copay may apply. <u>Out-of-Network</u> \$20 copay for outpatient x-rays. \$30 to \$900 copay for therapeutic radiology services \$30 to \$900 copay for diagnostic radiology services \$20 to \$900 copay for diagnostic procedures, tests, and lab services.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$0 copay for Medicare-covered lab services. \$20 to \$600 copay for Medicare-covered diagnostic procedures and tests. \$10 copay for Medicare-covered X-rays. \$20 to \$600 copay for Medicare-covered diagnostic radiology services. \$20 to \$600 copay for Medicare-covered therapeutic radiology services. Separate Office Visit cost sharing of \$10 copay may apply. <u>Out-of-Network</u> \$20 copay for outpatient x-rays. \$30 to \$900 copay for therapeutic radiology services \$30 to \$900 copay for diagnostic radiology services \$0 to \$900 copay for diagnostic procedures, tests, and lab services.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
PREVENTIVE SERVICES		
22. Bone Mass Measurement (For people with Medicare who are at risk)	20% coinsurance. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	<u>In-Network</u> \$0 copay for Medicare-covered bone mass measurement Separate Office Visit cost sharing of \$10 copay may apply. <u>Out-of-Network</u> \$0 copay for Medicare-covered bone mass measurement.
23. Colorectal Screening Exams (For people with Medicare age 50 and over)	20% coinsurance. Covered when you are high risk or when you are age 50 and older.	<u>In-Network</u> \$0 copay for Medicare-covered colorectal screenings. Separate Office Visit cost sharing of \$10 copay may apply. <u>Out-of-Network</u> \$0 copay for colorectal screenings.
24. Immunizations (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)	\$0 copay for Flu and Pneumonia vaccines. 20% coinsurance for Hepatitis B vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	<u>In-Network</u> \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines. <u>Out-of-Network</u> \$0 copay for immunizations.

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
PREVENTIVE SERVICES		
<u>In-Network</u> \$0 copay for Medicare-covered bone mass measurement Separate Office Visit cost sharing of \$12 copay may apply. <u>Out-of-Network</u> \$0 copay for Medicare-covered bone mass measurement.	<u>In-Network</u> \$0 copay for Medicare-covered bone mass measurement Separate Office Visit cost sharing of \$15 copay may apply. <u>Out-of-Network</u> \$0 copay for Medicare-covered bone mass measurement.	<u>In-Network</u> \$0 copay for Medicare-covered bone mass measurement Separate Office Visit cost sharing of \$10 copay may apply. <u>Out-of-Network</u> \$0 copay for Medicare-covered bone mass measurement.
<u>In-Network</u> \$0 copay for Medicare-covered colorectal screenings. Separate Office Visit cost sharing of \$12 copay may apply. <u>Out-of-Network</u> \$0 copay for colorectal screenings.	<u>In-Network</u> \$0 copay for Medicare-covered colorectal screenings. Separate Office Visit cost sharing of \$15 copay may apply. <u>Out-of-Network</u> \$0 copay for colorectal screenings.	<u>In-Network</u> \$0 copay for Medicare-covered colorectal screenings. Separate Office Visit cost sharing of \$10 copay may apply. <u>Out-of-Network</u> \$0 copay for colorectal screenings.
<u>In-Network</u> \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines. <u>Out-of-Network</u> \$0 copay for immunizations.	<u>In-Network</u> \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines. <u>Out-of-Network</u> \$0 copay for immunizations.	<u>In-Network</u> \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines. <u>Out-of-Network</u> \$0 copay for immunizations.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
25. Mammograms (Annual Screening) (For women with Medicare age 40 and older)	20% coinsurance. No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	<u>In-Network</u> \$0 copay for Medicare-covered screening mammograms. Separate Office Visit cost sharing of \$10 copay may apply. <u>Out-of-Network</u> \$0 copay for screening mammograms.
26. Pap Smears and Pelvic Exams (For women with Medicare)	\$0 copay for Pap smears. Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for Pelvic Exams.	<u>In-Network</u> \$0 copay for Medicare-covered pap smears and pelvic exams. - up to 1 additional pap smear(s) and pelvic exam(s) every two years Separate Office Visit cost sharing of \$10 copay may apply. <u>Out-of-Network</u> \$0 copay for pap smears and pelvic exams.
27. Prostate Cancer Screening Exams (For men with Medicare age 50 and older)	20% coinsurance for the digital rectal exam. \$0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.	<u>In-Network</u> \$0 copay for Medicare-covered prostate cancer screening Separate Office Visit cost sharing of \$10 copay may apply. <u>Out-of-Network</u> \$0 copay for prostate cancer screening.
28. End Stage Renal Disease	20% coinsurance for renal dialysis. 20% coinsurance for Nutrition Therapy for End-Stage Renal Disease. Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$20 to \$600 copay for renal dialysis \$0 copay for Nutrition Therapy for End-Stage Renal Disease. <u>Out-of-Network</u> \$30 to \$900 copay for renal dialysis. \$0 copay for Nutrition Therapy for End-Stage Renal Disease.

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<u>In-Network</u> \$0 copay for Medicare-covered screening mammograms. Separate Office Visit cost sharing of \$12 copay may apply. <u>Out-of-Network</u> \$0 copay for screening mammograms.	<u>In-Network</u> \$0 copay for Medicare-covered screening mammograms. Separate Office Visit cost sharing of \$15 copay may apply. <u>Out-of-Network</u> \$0 copay for screening mammograms.	<u>In-Network</u> \$0 copay for Medicare-covered screening mammograms. Separate Office Visit cost sharing of \$10 copay may apply. <u>Out-of-Network</u> \$0 copay for screening mammograms.
<u>In-Network</u> \$0 copay for Medicare-covered pap smears and pelvic exams. - up to 1 additional pap smear(s) and pelvic exam(s) every two years Separate Office Visit cost sharing of \$12 copay may apply. <u>Out-of-Network</u> \$0 copay for pap smears and pelvic exams.	<u>In-Network</u> \$0 copay for Medicare-covered pap smears and pelvic exams. - up to 1 additional pap smear(s) and pelvic exam(s) every two years Separate Office Visit cost sharing of \$15 copay may apply. <u>Out-of-Network</u> \$0 copay for pap smears and pelvic exams.	<u>In-Network</u> \$0 copay for Medicare-covered pap smears and pelvic exams. - up to 1 additional pap smear(s) and pelvic exam(s) every two years Separate Office Visit cost sharing of \$10 copay may apply. <u>Out-of-Network</u> \$0 copay for pap smears and pelvic exams.
<u>In-Network</u> \$0 copay for Medicare-covered prostate cancer screening Separate Office Visit cost sharing of \$12 copay may apply. <u>Out-of-Network</u> \$0 copay for prostate cancer screening.	<u>In-Network</u> \$0 copay for Medicare-covered prostate cancer screening Separate Office Visit cost sharing of \$15 copay may apply. <u>Out-of-Network</u> \$0 copay for prostate cancer screening.	<u>In-Network</u> \$0 copay for Medicare-covered prostate cancer screening Separate Office Visit cost sharing of \$10 copay may apply. <u>Out-of-Network</u> \$0 copay for prostate cancer screening.
<u>General</u> Authorization rules may apply. <u>In-Network</u> \$20 to \$600 copay for renal dialysis \$0 copay for Nutrition Therapy for End-Stage Renal Disease. <u>Out-of-Network</u> \$30 to \$900 copay for renal dialysis. \$0 copay for Nutrition Therapy for End-Stage Renal Disease.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$20 to \$600 copay for renal dialysis \$0 copay for Nutrition Therapy for End-Stage Renal Disease. <u>Out-of-Network</u> \$30 to \$900 copay for renal dialysis. \$0 copay for Nutrition Therapy for End-Stage Renal Disease.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$20 to \$600 copay for renal dialysis \$0 copay for Nutrition Therapy for End-Stage Renal Disease. <u>Out-of-Network</u> \$30 to \$900 copay for renal dialysis. \$0 copay for Nutrition Therapy for End-Stage Renal Disease.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
29. Prescription Drugs	<p>Most drugs are not covered under Original Medicare.</p> <p>You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B</p> <p><u>General</u> \$20 to \$600 copay for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>\$30 to \$900 copay for Part B drugs out-of-network.</p> <p>Drugs covered under Medicare Part D</p> <p><u>General</u> This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at https://www.healthnet.com/formulary.htm on the web. Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service). <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p>

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<p>Drugs covered under Medicare Part B</p> <p><u>General</u> \$20 to \$600 copay for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>\$30 to \$900 copay for Part B drugs out-of-network.</p> <p>Drugs covered under Medicare Part D</p> <p><u>General</u> This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at https://www.healthnet.com/formulary.htm on the web. Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service). <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p>	<p>Drugs covered under Medicare Part B</p> <p><u>General</u> \$20 to \$600 copay for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>\$30 to \$900 copay for Part B drugs out-of-network.</p> <p>Drugs covered under Medicare Part D</p> <p><u>General</u> This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at https://www.healthnet.com/formulary.htm on the web. Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service). <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p>	<p>Drugs covered under Medicare Part B</p> <p><u>General</u> Most drugs not covered.</p> <p>\$20 to \$600 copay for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>\$30 to \$900 copay for Part B drugs out-of-network.</p> <p>Drugs covered under Medicare Part D</p> <p><u>General</u> This plan does not offer prescription drug coverage.</p>

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
Prescription Drugs (continued)		<p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Health Net Healthy Heart (PPO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Health Net Healthy Heart (PPO) approves the exception, you will pay Tier 3 Non-Preferred cost-sharing for that drug.</p> <p><u>In-Network</u> \$0 deductible.</p> <p><u>Initial Coverage</u> You pay the following until total yearly drug costs reach \$2,830:</p>

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Health Net Violet Option 1 (PPO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Health Net Violet Option 1 (PPO) approves the exception, you will pay Tier 3 Non-Preferred cost-sharing for that drug.</p> <p><u>In-Network</u> \$0 deductible.</p> <p><u>Initial Coverage</u> You pay the following until total yearly drug costs reach \$2,830:</p>	<p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Health Net Violet Option 2 (PPO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and Health Net Violet Option 2 (PPO) approves the exception, you will pay Tier 3 Non-Preferred cost-sharing for that drug.</p> <p><u>In-Network</u> \$0 deductible.</p> <p><u>Initial Coverage</u> You pay the following until total yearly drug costs reach \$2,830:</p>	

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
Prescription Drugs (continued)		<p><u>Retail Pharmacy</u></p> <p>Tier 1 Preferred Generic</p> <ul style="list-style-type: none"> - \$5 copay for a one-month (30-day) supply of drugs in this tier - \$15 copay for a three-month (90-day) supply of drugs in this tier - \$10 copay for a 60-day supply of drugs in this tier <p>Tier 2 Preferred Brand</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (30-day) supply of drugs in this tier - \$105 copay for a three-month (90-day) supply of drugs in this tier - \$70 copay for a 60-day supply of drugs in this tier <p>Tier 3 Non-Preferred</p> <ul style="list-style-type: none"> - \$70 copay for a one-month (30-day) supply of drugs in this tier - \$210 copay for a three-month (90-day) supply of drugs in this tier - \$140 copay for a 60-day supply of drugs in this tier <p>Tier 4 Injectable</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (30-day) supply of drugs in this tier <p>Tier 5 Specialty</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (30-day) supply of drugs in this tier

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<u>Retail Pharmacy</u> Tier 1 Preferred Generic - \$6 copay for a one-month (30-day) supply of drugs in this tier - \$18 copay for a three-month (90-day) supply of drugs in this tier - \$12 copay for a 60-day supply of drugs in this tier Tier 2 Preferred Brand - \$38 copay for a one-month (30-day) supply of drugs in this tier - \$114 copay for a three-month (90-day) supply of drugs in this tier - \$76 copay for a 60-day supply of drugs in this tier Tier 3 Non-Preferred - \$76 copay for a one-month (30-day) supply of drugs in this tier - \$228 copay for a three-month (90-day) supply of drugs in this tier - \$152 copay for a 60-day supply of drugs in this tier Tier 4 Injectable - 33% coinsurance for a one-month (30-day) supply of drugs in this tier Tier 5 Specialty - 33% coinsurance for a one-month (30-day) supply of drugs in this tier	<u>Retail Pharmacy</u> Tier 1 Preferred Generic - \$6 copay for a one-month (30-day) supply of drugs in this tier - \$18 copay for a three-month (90-day) supply of drugs in this tier - \$12 copay for a 60-day supply of drugs in this tier Tier 2 Preferred Brand - \$38 copay for a one-month (30-day) supply of drugs in this tier - \$114 copay for a three month (90-day) supply of drugs in this tier - \$76 copay for a 60-day supply of drugs in this tier Tier 3 Non-Preferred - \$76 copay for a one-month (30-day) supply of drugs in this tier - \$228 copay for a three-month (90-day) supply of drugs in this tier - \$152 copay for a 60-day supply of drugs in this tier Tier 4 Injectable - 33% coinsurance for a one-month (30-day) supply of drugs in this tier Tier 5 Specialty - 33% coinsurance for a one-month (30-day) supply of drugs in this tier	

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
Prescription Drugs (continued)		<p><u>Long Term Care Pharmacy</u></p> <p>Tier 1 Preferred Generic</p> <ul style="list-style-type: none"> - \$5 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 2 Preferred Brand</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 3 Non-Preferred</p> <ul style="list-style-type: none"> - \$70 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 4 Injectable</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (34-day) supply of drugs in this tier <p>Tier 5 Specialty</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (34-day) supply of drugs in this tier <p><u>Mail Order</u></p> <p>Tier 1 Preferred Generic</p> <ul style="list-style-type: none"> - \$5 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. - \$10 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. - \$10 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. - \$5 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<p><u>Long Term Care Pharmacy</u></p> <p>Tier 1 Preferred Generic</p> <ul style="list-style-type: none"> - \$6 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 2 Preferred Brand</p> <ul style="list-style-type: none"> - \$38 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 3 Non-Preferred</p> <ul style="list-style-type: none"> - \$76 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 4 Injectable</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (34-day) supply of drugs in this tier <p>Tier 5 Specialty</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (34-day) supply of drugs in this tier <p><u>Mail Order</u></p> <p>Tier 1 Preferred Generic</p> <ul style="list-style-type: none"> - \$6 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. - \$12 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. - \$12 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. - \$6 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. 	<p><u>Long Term Care Pharmacy</u></p> <p>Tier 1 Preferred Generic</p> <ul style="list-style-type: none"> - \$6 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 2 Preferred Brand</p> <ul style="list-style-type: none"> - \$38 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 3 Non-Preferred</p> <ul style="list-style-type: none"> - \$76 copay for a one-month (34-day) supply of drugs in this tier <p>Tier 4 Injectable</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (34-day) supply of drugs in this tier <p>Tier 5 Specialty</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (34-day) supply of drugs in this tier <p><u>Mail Order</u></p> <p>Tier 1 Preferred Generic</p> <ul style="list-style-type: none"> - \$6 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. - \$12 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. - \$12 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. - \$6 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. 	

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
Prescription Drugs (continued)		<ul style="list-style-type: none"> - \$15 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. - \$10 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy. <p>Tier 2 Preferred Brand</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. - \$70 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. - \$70 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. - \$35 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. - \$105 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. - \$70 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy.

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<ul style="list-style-type: none"> - \$18 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. - \$12 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy. <p>Tier 2 Preferred Brand</p> <ul style="list-style-type: none"> - \$38 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. - \$76 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. - \$76 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. - \$38 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. - \$114 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. - \$76 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy. 	<ul style="list-style-type: none"> - \$18 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. - \$12 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy. <p>Tier 2 Preferred Brand</p> <ul style="list-style-type: none"> - \$38 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. - \$76 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. - \$76 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. - \$38 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. - \$114 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. - \$76 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy. 	

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
Prescription Drugs (continued)		<p>Tier 3 Non-Preferred</p> <ul style="list-style-type: none"> - \$70 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. - \$175 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. - \$140 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. - \$70 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. - \$210 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. - \$140 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy. <p>Coverage Gap After your total yearly drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.</p>

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<p>Tier 3 Non-Preferred</p> <ul style="list-style-type: none"> - \$76 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. - \$190 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. - \$152 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. - \$76 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. - \$228 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. - \$152 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy. <p>Coverage Gap After your total yearly drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.</p>	<p>Tier 3 Non-Preferred</p> <ul style="list-style-type: none"> - \$76 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. - \$190 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. - \$152 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. - \$76 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. - \$228 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. - \$152 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy. <p>Coverage Gap After your total yearly drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.</p>	

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
Prescription Drugs (continued)		<p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:</p> <ul style="list-style-type: none">- A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or- 5% coinsurance. <p><u>Out-of-Network</u> Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Health Net Healthy Heart (PPO).</p> <p><u>Out-of-Network Initial Coverage</u> You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,830:</p>

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:</p> <ul style="list-style-type: none"> - A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or - 5% coinsurance. <p><u>Out-of-Network</u> Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Health Net Violet Option 1 (PPO).</p> <p><u>Out-of-Network Initial Coverage</u> You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,830:</p>	<p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:</p> <ul style="list-style-type: none"> - A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or - 5% coinsurance. <p><u>Out-of-Network</u> Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Health Net Violet Option 2 (PPO).</p> <p><u>Out-of-Network Initial Coverage</u> You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,830:</p>	

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
Prescription Drugs (continued)		<p>Tier 1 Preferred Generic - \$5 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 2 Preferred Brand - \$35 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 3 Non-Preferred - \$70 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 4 Injectable - 33% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 5 Specialty - 33% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p><u>Out-of-Network Coverage Gap</u> After your total yearly drug costs reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Health Net Healthy Heart (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Health Net Healthy Heart (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p>

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<p>Tier 1 Preferred Generic - \$6 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 2 Preferred Brand - \$38 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 3 Non-Preferred - \$76 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 4 Injectable - 33% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 5 Specialty - 33% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p><u>Out-of-Network Coverage Gap</u> After your total yearly drug costs reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Health Net Violet Option 1 (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Health Net Violet Option 1 (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p>	<p>Tier 1 Preferred Generic - \$6 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 2 Preferred Brand - \$38 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 3 Non-Preferred - \$76 copay for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 4 Injectable - 33% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p>Tier 5 Specialty - 33% coinsurance for a one-month (30-day) supply of drugs in this tier</p> <p><u>Out-of-Network Coverage Gap</u> After your total yearly drug costs reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Health Net Violet Option 2 (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Health Net Violet Option 2 (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p>	

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
Prescription Drugs (continued)		<p><u>Out-of-Network Catastrophic Coverage</u> After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <ul style="list-style-type: none"> - A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or - 5% coinsurance.
30. Dental Services	Preventive dental services (such as cleaning) not covered.	<p><u>In-Network</u> \$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> - up to 2 oral exam(s) every year - up to 2 cleaning(s) every year - up to 1 dental x-ray(s) every year <p>\$10 to \$50 copay for Medicare-covered dental benefits.</p> <p><u>Out-of-Network</u> 20% of the cost for preventive dental benefits. \$10 to \$50 copay for comprehensive dental benefits.</p> <p><u>In and Out-of-Network</u> \$500 limit for preventive dental benefits every year. This limit applies to both in-network and out-of-network benefits.</p>

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<u>Out-of-Network Catastrophic Coverage</u> After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: <ul style="list-style-type: none"> - A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or - 5% coinsurance. 	<u>Out-of-Network Catastrophic Coverage</u> After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: <ul style="list-style-type: none"> - A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or - 5% coinsurance. 	
<u>In-Network</u> \$0 copay for the following preventive dental benefits: <ul style="list-style-type: none"> - up to 2 oral exam(s) every year - up to 2 cleaning(s) every year - up to 1 dental x-ray(s) every year \$12 to \$50 copay for Medicare-covered dental benefits. <u>Out-of-Network</u> 20% of the cost for preventive dental benefits. \$20 to \$50 copay for comprehensive dental benefits. <u>In and Out-of-Network</u> \$500 limit for preventive dental benefits every year. This limit applies to both in-network and out-of-network benefits.	<u>In-Network</u> In general, preventive dental benefits (such as cleaning) not covered. \$15 to \$50 copay for Medicare-covered dental benefits. <u>Out-of-Network</u> \$20 to \$50 copay for comprehensive dental benefits.	<u>In-Network</u> \$0 copay for the following preventive dental benefits: <ul style="list-style-type: none"> - up to 2 oral exam(s) every year - up to 2 cleaning(s) every year - up to 1 dental x-ray(s) every year \$10 to \$50 copay for Medicare-covered dental benefits. <u>Out-of-Network</u> 20% of the cost for preventive dental benefits. \$20 to \$50 copay for comprehensive dental benefits. <u>In and Out-of-Network</u> \$500 limit for preventive dental benefits every year. This limit applies to both in-network and out-of-network benefits.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
31. Hearing Services	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p><u>In-Network</u> \$0 copay for up to 1 hearing aid(s) every three years. - \$10 copay for Medicare-covered diagnostic hearing exams \$250 limit for hearing aids every three years.</p> <p><u>Out-of-Network</u> \$10 copay for hearing exams. \$0 copay for hearing aids.</p>
32. Vision Services	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p><u>In-Network</u> \$0 copay for: - one pair of eyeglasses or contact lenses after cataract surgery - up to 1 pair(s) of glasses every two years - up to 1 pair(s) of contacts every two years - \$10 copay for exams to diagnose and treat diseases and conditions of the eye. - \$10 copay for up to 1 routine eye exam(s) every year \$100 limit for eye wear every two years.</p> <p><u>Out-of-Network</u> \$10 copay for eye exams. \$0 copay for eye wear.</p>

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<u>In-Network</u> In general, routine hearing exams and hearing aids not covered. - \$12 copay for Medicare-covered diagnostic hearing exams <u>Out-of-Network</u> \$20 copay for hearing exams.	<u>In-Network</u> In general, routine hearing exams and hearing aids not covered. - \$15 copay for Medicare-covered diagnostic hearing exams <u>Out-of-Network</u> \$20 copay for hearing exams.	<u>In-Network</u> In general, routine hearing exams and hearing aids not covered. - \$10 copay for Medicare-covered diagnostic hearing exams <u>Out-of-Network</u> \$20 copay for hearing exams.
<u>In-Network</u> \$0 copay for: - one pair of eyeglasses or contact lenses after cataract surgery - up to 1 pair(s) of glasses every two years - up to 1 pair(s) of contacts every two years - \$12 copay for exams to diagnose and treat diseases and conditions of the eye. - \$10 copay for up to 1 routine eye exam(s) every year \$100 limit for eye wear every two years. <u>Out-of-Network</u> \$20 copay for eye exams. \$0 copay for eye wear.	<u>In-Network</u> \$0 copay for: - one pair of eyeglasses or contact lenses after cataract surgery - \$15 copay for exams to diagnose and treat diseases and conditions of the eye. - \$10 copay for up to 1 routine eye exam(s) every year <u>Out-of-Network</u> \$20 copay for eye exams. 40% of the cost for eye wear.	<u>In-Network</u> \$0 copay for: - one pair of eyeglasses or contact lenses after cataract surgery - up to 1 pair(s) of glasses every two years - up to 1 pair(s) of contacts every two years - \$10 copay for exams to diagnose and treat diseases and conditions of the eye. - \$10 copay for up to 1 routine eye exam(s) every year \$100 limit for eye wear every two years. <u>Out-of-Network</u> \$20 copay for eye exams. \$0 copay for eye wear.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
33. Physical Exams	20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage. When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.	<u>In-Network</u> \$0 copay for routine exams. Limited to 1 exam(s) every year. <u>Out-of-Network</u> \$0 copay for routine exams.
Health/Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.	<u>In-Network</u> The plan covers the following health/wellness education benefits: - Nursing Hotline - Other Wellness Benefits Copays may apply for these benefits. \$10 copay for each Medicare-covered smoking cessation counseling session. <u>Out-of-Network</u> \$15 copay for Health and Wellness services. \$0 copay for Health and Wellness services.
Transportation (Routine)	Not covered.	<u>In-Network</u> This plan does not cover routine transportation.
Acupuncture	Not covered.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$15 copay per visit. <u>Out-of-Network</u> \$15 copay for acupuncture visits.

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
<u>In-Network</u> \$0 copay for routine exams. Limited to 1 exam(s) every year. <u>Out-of-Network</u> \$0 copay for routine exams.	<u>In-Network</u> \$0 copay for routine exams. Limited to 1 exam(s) every year. <u>Out-of-Network</u> \$0 copay for routine exams.	<u>In-Network</u> \$0 copay for routine exams. Limited to 1 exam(s) every year. <u>Out-of-Network</u> \$0 copay for routine exams.
<u>In-Network</u> The plan covers the following health/wellness education benefits: - Nursing Hotline - Other Wellness Benefits Copays may apply for these benefits. \$12 copay for each Medicare-covered smoking cessation counseling session. <u>Out-of-Network</u> \$15 copay for Health and Wellness services. \$0 copay for Health and Wellness services.	<u>In-Network</u> The plan covers the following health/wellness education benefits: - Nursing Hotline - Other Wellness Benefits Copays may apply for these benefits. \$15 copay for each Medicare-covered smoking cessation counseling session. <u>Out-of-Network</u> \$15 copay for Health and Wellness services. \$0 copay for Health and Wellness services.	<u>In-Network</u> The plan covers the following health/wellness education benefits: - Nursing Hotline - Other Wellness Benefits Copays may apply for these benefits. \$10 copay for each Medicare-covered smoking cessation counseling session. <u>Out-of-Network</u> \$15 copay for Health and Wellness services. \$0 copay for Health and Wellness services.
<u>In-Network</u> This plan does not cover routine transportation.	<u>In-Network</u> This plan does not cover routine transportation.	<u>In-Network</u> This plan does not cover routine transportation.
<u>General</u> Authorization rules may apply. <u>In-Network</u> \$15 copay per visit. <u>Out-of-Network</u> \$15 copay for acupuncture visits.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$15 copay per visit. <u>Out-of-Network</u> \$15 copay for acupuncture visits.	<u>General</u> Authorization rules may apply. <u>In-Network</u> \$15 copay per visit. <u>Out-of-Network</u> \$15 copay for acupuncture visits.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
OPTIONAL SUPPLEMENTAL PACKAGE #1		
Premium and Other Important Information		<u>General</u> Package: 1 - Extended Dental and Routine Eyewear Option: \$19 monthly premium, in addition to your \$101 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: - Dental Services - Vision Services \$650 limit for these benefits.
Dental Services		<u>General</u> Plan offers additional comprehensive dental benefits. <u>In-Network</u> \$500 limit for comprehensive dental benefits every year <u>Out-of-Network</u> 0% to 50% of the cost for comprehensive dental services.
Vision Services		<u>In-Network</u> \$150 limit for eye wear every two years. \$0 copay for - up to 1 pair(s) of glasses every two years - up to 1 pair(s) of contacts every two years

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
OPTIONAL SUPPLEMENTAL PACKAGE #1		
<u>General</u> Package: 1 - Extended Dental and Routine Eyewear Option: \$19 monthly premium, in addition to your \$75 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: - Dental Services - Vision Services \$650 limit for these benefits.	<u>General</u> Package: 1 - Extended Dental and Routine Eyewear Option: \$29 monthly premium, in addition to your \$0 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: - Dental Services - Vision Services \$1,250 limit for these benefits.	<u>General</u> Package: 1 - Extended Dental and Routine Eyewear: \$19 monthly premium, in addition to your \$25 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: - Dental Services - Vision Services \$650 limit for these benefits.
<u>General</u> Plan offers additional comprehensive dental benefits. <u>In-Network</u> \$500 limit for comprehensive dental benefits every year <u>Out-of-Network</u> 0% to 50% of the cost for comprehensive dental services.	<u>General</u> Plan offers additional comprehensive dental benefits. <u>In-Network</u> \$1,000 limit for preventive dental benefits every year. \$1,000 limit for comprehensive dental benefits every year. \$0 copay for the following preventive dental benefits: - up to 2 oral exam(s) every year - up to 2 cleaning(s) every year - up to 1 dental x-ray(s) every year <u>Out-of-Network</u> 20% of the cost for preventive dental services. 0% to 50% of the cost for comprehensive dental services.	<u>General</u> Plan offers additional comprehensive dental benefits. <u>In-Network</u> \$500 limit for comprehensive dental benefits every year <u>Out-of-Network</u> 0% to 50% of the cost for comprehensive dental services.
<u>In-Network</u> \$150 limit for eye wear every two years. \$0 copay for - up to 1 pair(s) of glasses every two years - up to 1 pair(s) of contacts every two years	<u>In-Network</u> \$250 limit for eye wear every two years. \$0 copay for - up to 1 pair(s) of glasses every two years - up to 1 pair(s) of contacts every two years	<u>In-Network</u> \$150 limit for eye wear every two years. \$0 copay for - up to 1 pair(s) of glasses every two years - up to 1 pair(s) of contacts every two years

BENEFIT	ORIGINAL MEDICARE	HEALTH NET HEALTHY HEART (PPO)
OPTIONAL SUPPLEMENTAL PACKAGE #2		
Premium and Other Important Information		<u>General</u> Package: 2 - Comprehensive Dental: \$50 monthly premium, in addition to your \$101 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: - Dental Services \$500 limit every year for these benefits.
Dental Services		<u>General</u> Plan offers additional comprehensive dental benefits. <u>In-Network</u> \$1,000 limit for comprehensive dental benefits every year. <u>Out-of-Network</u> 0% to 50% of the cost for comprehensive dental services.

HEALTH NET VIOLET OPTION 1 (PPO)	HEALTH NET VIOLET OPTION 2 (PPO)	HEALTH NET AQUA (PPO)
OPTIONAL SUPPLEMENTAL PACKAGE #2		
<u>General</u> Package: 2 - Comprehensive Dental: \$50 monthly premium, in addition to your \$75 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: - Dental Services \$500 limit every year for these benefits.	<u>General</u> Package: 2 - Comprehensive Dental: \$56 monthly premium, in addition to your \$0 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: - Dental Services \$1,000 limit every year for these benefits.	<u>General</u> Package: 2 - Comprehensive Dental: \$50 monthly premium, in addition to your \$25 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: - Dental Services \$500 limit every year for these benefits.
<u>General</u> Plan offers additional comprehensive dental benefits. <u>In-Network</u> \$1,000 limit for comprehensive dental benefits every year <u>Out-of-Network</u> 0% to 50% of the cost for comprehensive dental services.	<u>General</u> Plan offers additional comprehensive dental benefits. <u>In-Network</u> \$1,000 limit for comprehensive dental benefits every year \$0 copay for the following preventive dental benefits: - up to 2 oral exam(s) every year - up to 2 cleaning(s) every year - up to 1 dental x-ray(s) every year <u>Out-of-Network</u> 0% to 50% of the cost for comprehensive dental services.	<u>General</u> Plan offers additional comprehensive dental benefits. <u>In-Network</u> \$1,000 limit for comprehensive dental benefits every year <u>Out-of-Network</u> 0% to 50% of the cost for comprehensive dental services.

Health Net Medicare Advantage
13221 SW 68th Parkway, Suite 200
Tigard, OR 97223

For more information, please contact us at:

Current members should call
1-888-445-8913 (TTY/TDD 1-800-929-9955 for the hearing and speech impaired)
8:00 a.m. to 8:00 p.m., 7 days a week

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