Health Net®
MEDICARE PROGRAMS

HEALTH NET VIOLET (PPO)

2011 SUMMARY OF BENEFITS

San Diego County, CA

Benefits effective January 1, 2011
H5439 Health Net Life Insurance Company

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INTRODUCTION TO SUMMARY OF BENEFITS

Thank you for your interest in Health Net Violet (PPO). Our plan is offered by HEALTH NET LIFE INSURANCE COMPANY, a Medicare Advantage Preferred Provider Organization (PPO). This Summary of Benefits tells you some features of our plan. 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 Violet (PPO) 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 Health Net Violet (PPO). 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 Violet (PPO) 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 Health Net Violet (PPO) 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 plan covers 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 IS HEALTH NET VIOLET (PPO) AVAILABLE?

The service area for this plan includes the following county: San Diego County, CA. You must live in this area to join the plan.

WHO IS ELIGIBLE TO JOIN HEALTH NET VIOLET (PPO)?

You can join Health Net Violet (PPO) 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 Violet (PPO) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

Health Net Violet (PPO) 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.

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

Health Net Violet (PPO) 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 at https://www.healthnet.com/portal/medicare/content.do?resource=pharmacyDirectory.htm. Our customer service number is listed at the end of this introduction.

Health Net Violet (PPO) 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.

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

Health Net Violet (PPO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Health Net Violet (PPO) 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 OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare 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 and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare & You.

- 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 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Health Net Violet (PPO), 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. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of Health Net Violet (PPO), 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. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we 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 Violet (PPO) 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 Violet (PPO) 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.

WHERE CAN I FIND INFORMATION ON 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 to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call Health Net Life Insurance Company for more information about Health Net Violet (PPO). 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/locally (800)-960-4638 for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug program. (TTY/TDD (800)-929-9955)

Prospective members should call toll-free/locally (800)-935-6565 for questions related to the Medicare Advantage Program and the 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.

This document may be available in a different format or language. For additional information, call customer service at the phone number listed above.

Este documento puede estar disponible en un formato o idioma diferente. Para obtener información adicional, llame a servicio al cliente al número de teléfono indicado anteriormente.

本文件可能備有不同形式或語言。如需額外資訊，請撥打上列會員服務部電話號碼。

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 VIOLET (PPO)
IMPORTANT INFORMATION		
1. Premium and Other Important Information	In 2010 the monthly Part B Premium was $96.40 and may change for 2011 and the yearly Part B deductible amount was $155 and may change for 2011. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples.) For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	<u>General</u> $89 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. This plan covers all Medicare-covered preventive service with zero cost sharing. <u>In-Network</u> $3,400 out-of-pocket limit. There is no limit on cost sharing for the following services. Supplemental Services: • Acupuncture • Health Education/Wellness • Preventive Dental • Comprehensive Dental • Eye Exams • Eye Wear

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (PPO)
IMPORTANT INFORMATION		
Premium and Other Important Information (continued)		In and Out-of-Network $900 yearly deductible. Contact the plan for services that apply. $5,100 out-of-pocket limit. There is no limit on cost sharing for the following services. In-Network: Supplemental Services: • Acupuncture • Health Education/Wellness • Preventive Dental • Comprehensive Dental • Eye Exams • Eye Wear Out-of-Network: Supplemental Services: • Acupuncture • Health Education/Wellness • Preventive Dental • Comprehensive Dental • Eye Exams • Eye Wear
2. Doctor and Hospital Choice (For more information, see Emergency Care – #15 and Urgently Needed Care – #16.)	You may go to any doctor, specialist, or hospital that accepts Medicare.	In-Network No referral required for network doctors, specialists, and hospitals. In and Out-of-Network You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (PPO)
SUMMARY OF BENEFITS		
INPATIENT CARE		
3. Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	In 2010 the amounts for each benefit period were: Days 1–60: $1,100 deductible Days 61–90: $275 per day Days 91–150: $550 per lifetime reserve day These amounts will change for 2011. 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.	In-Network No limit to the number of days covered by the plan each benefit period. $100 copay for each Medicare-covered hospital stay. $0 copay for each additional hospital day. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Out-of-Network $200 copay for each hospital stay.

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4. Inpatient Mental Health Care	Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above). 190 day lifetime limit in a Psychiatric Hospital.	In-Network You get up to 190 days in a Psychiatric Hospital in a lifetime. $100 copay for each Medicare-covered hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Out-of-Network $200 copay for each hospital stay.
5. Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	In 2010 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1–20: $0 per day Days 21–100: $137.50 per day These amounts will change for 2011. 100 days for each benefit period. 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.	General Authorization rules may apply. In-Network Plan covers up to 100 days each benefit period No prior hospital stay is required. $75 copay for each SNF stay. Out-of-Network For each SNF stay: Days 1–100: 10% of the cost per SNF day

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6. Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	$0 copay.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered home health visits. Out-of-Network $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.	General You must get care from a Medicare-certified hospice.
OUTPATIENT CARE		
8. Doctor Office Visits	20% coinsurance	General See "Welcome to Medicare; and Annual Wellness Visit," for more information. In-Network $15 copay for each primary care doctor visit for Medicare-covered benefits. $25 copay for each in-area, network urgent care Medicare-covered visit. $20 copay for each specialist visit for Medicare-covered benefits. Out-of-Network 10% for each primary care doctor visit. 10% for each specialist visit.

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9. Chiropractic Services	Routine care not covered 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.	General Authorization rules may apply. In-Network $20 copay for each Medicare-covered 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. Out-of-Network $50 copay for chiropractic benefits.
10. Podiatry Services	Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	In-Network $25 copay for each Medicare-covered visit. $25 copay for up to 1 routine visit(s). Medicare-covered podiatry benefits are for medically-necessary foot care. Out-of-Network $35 copay for podiatry benefits.
11. Outpatient Mental Health Care	45% coinsurance for most outpatient mental health services.	General Authorization rules may apply. In-Network $25 copay for each Medicare-covered individual or group therapy visit. Out-of-Network $50 copay for Mental Health benefits. $50 copay for Mental Health benefits with a psychiatrist.

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12. Outpatient Substance Abuse Care	20% coinsurance	General Authorization rules may apply. In-Network $25 copay for Medicare-covered individual or group visits. Out-of-Network $50 copay for outpatient substance abuse benefits.
13. Outpatient Services/Surgery	20% coinsurance for the doctor Specified copayment for outpatient hospital facility charges. Copay cannot exceed Part A inpatient hospital deductible. 20% copayment for ambulatory surgical center facility charges.	General Authorization rules may apply. In-Network $50 copay for each Medicare-covered ambulatory surgical center visit. $100 copay for each Medicare-covered outpatient hospital facility visit. Out-of-Network 10% of the cost for ambulatory surgical center benefits. 10% of the cost for outpatient hospital facility benefits.
14. Ambulance Services (medically necessary ambulance services)	20% coinsurance	General Authorization rules may apply. In-Network $200 copay for Medicare-covered ambulance benefits. Out-of-Network $200 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 Specified copayment for outpatient hospital emergency room (ER) facility charge. ER copay cannot exceed Part A inpatient hospital deductible. 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.	General $50 copay for Medicare-covered emergency room visits. This amount applies to your in-network plan deductible. $50,000 plan coverage limit for emergency services outside the U.S. every year. If you are immediately admitted to the hospital, you pay $0 for the emergency room visit.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (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.	General $50 copay for Medicare-covered urgently needed care visits. If you are immediately admitted to the hospital, you pay $0 for the urgently needed care visit.
17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy, Respiratory Therapy Services, Social/ Psychological Services, and more)	20% coinsurance	General Authorization rules may apply. In-Network $25 copay for Medicare-covered Occupational Therapy visits. $25 copay for Medicare-covered Physical and/or Speech and Language Therapy visits. $25 copay for Medicare-covered Cardiac Rehab services. Out-of-Network $35 copay for Occupational Therapy benefits. $35 copay for Physical and/or Speech and Language Therapy visits. $35 copay for Cardiac Rehab services.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18. Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	General Authorization rules may apply. In-Network 10% of the cost for Medicare-covered items. Out-of-Network 20% of the cost for durable medical equipment.
19. Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	General Authorization rules may apply. In-Network 10% of the cost for Medicare-covered items. Out-of-Network 20% of the cost for prosthetic devices.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (PPO)
20. Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes)	20% coinsurance 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.	In-Network $0 copay for Diabetes self-monitoring training. $0 copay for Nutrition Therapy for Diabetes. 10% of the cost for Diabetes supplies. Out-of-Network 10% of the cost for Diabetes self-monitoring training. 10% of the cost for Nutrition Therapy for Diabetes. 20% of the cost for Diabetes supplies.
21. Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and X-rays $0 copay for Medicare-covered lab services 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.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered lab services. $0 copay for Medicare-covered diagnostic procedures and tests. $0 copay for Medicare-covered X-rays. $15 copay for Medicare-covered diagnostic radiology services (not including X-rays). $15 copay for Medicare-covered therapeutic radiology services. Out-of-Network 10% of the cost for diagnostic procedures, tests, and lab services. 10% of the cost for outpatient X-rays. 10% of the cost for diagnostic radiology services. 10% of the cost for therapeutic radiology services.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (PPO)
PREVENTIVE SERVICES		
22. Bone Mass Measurement (for people with Medicare who are at risk)	No coinsurance, copayment or deductible. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions	In-Network $0 copay for Medicare-covered bone mass measurement Out-of-Network 10% of the cost for Medicare-covered bone mass measurement.
23. Colorectal Screening Exams (for people with Medicare age 50 and older)	No coinsurance, copayment or deductible for screening colonoscopy or screening flexible sigmoidoscopy. Covered when you are high risk or when you are age 50 and older.	In-Network $0 copay for Medicare-covered colorectal screenings. Out-of-Network 10% of the cost for colorectal screenings.
24. Immunizations (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)	$0 copay for Flu, Pneumonia and Hepatitis B vaccines You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	In-Network $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and Pneumonia vaccines. Out-of-Network 10% of the cost for immunizations.
25. Mammograms (Annual Screening) (for women with Medicare age 40 and older)	No coinsurance, copayment or deductible 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.	In-Network $0 copay for Medicare-covered screening mammograms. $0 copay for Medicare-covered additional screening mammograms. Out-of-Network 10% of the cost for screening mammograms.

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26. Pap Smears and Pelvic Exams (for women with Medicare)	No coinsurance, copayment or deductible for Pap smears. No coinsurance, copayment or deductible for Pelvic and clinical breast exams Covered once every 2 years. Covered once a year for women with Medicare at high risk.	In-Network $0 copay for Medicare-covered Pap smears and pelvic exams • up to 1 additional Pap smear(s) and pelvic exam(s) every year Out-of-Network 10% of the cost 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.	In-Network $0 copay for • Medicare-covered prostate cancer screening Out-of-Network 10% of the cost 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.	In-Network $15 copay for renal dialysis $0 copay for Nutrition Therapy for End-Stage Renal Disease. Out-of-Network 10% of the cost for Nutrition Therapy for End-Stage Renal Disease. $15 copay for renal dialysis.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (PPO)
29. Prescription Drugs	Most drugs are not covered under Original Medicare. 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.	*Drugs covered under Medicare Part B* <u>General</u> 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs. 20% of the cost for Part B drugs out-of-network. *Drugs covered under Medicare Part D* <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: • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service). 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).

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (PPO)
Prescription Drugs (continued)		Total yearly drug costs are the total drug costs paid by both you and the plan. 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 (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 that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, 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 (PPO) approves the exception, you will pay Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs cost sharing for that drug.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (PPO)
Prescription Drugs (continued)		In-Network $0 deductible. Initial Coverage You pay the following until total yearly drug costs reach $2,840: Retail Pharmacy **Tier 1: Preferred Generic Drugs** • $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 **Tier 2: Preferred Brand Drugs** • $45 copay for a one-month (30-day) supply of drugs in this tier • $135 copay for a three-month (90-day) supply of drugs in this tier • $90 copay for a 60-day supply of drugs in this tier **Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs** • $90 copay for a one-month (30-day) supply of drugs in this tier • $270 copay for a three-month (90-day) supply of drugs in this tier • $180 copay for a 60-day supply of drugs in this tier **Tier 4: Injectable Drugs** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (PPO)
Prescription Drugs (continued)		• 33% coinsurance for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 5: Specialty Tier Drugs** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier • 33% coinsurance for a three-month (90-day) supply of drugs in this tier • 33% coinsurance for a 60-day supply of drugs in this tier Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. <u>Long Term Care Pharmacy</u> **Tier 1: Preferred Generic Drugs** • $5 copay for a one-month (34-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $45 copay for a one-month (34-day) supply of drugs in this tier **Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs** • $90 copay for a one-month (34-day) supply of drugs in this tier **Tier 4: Injectable Drugs** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier **Tier 5: Specialty Tier Drugs** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (PPO)
Prescription Drugs (continued)		Mail Order **Tier 1: Preferred Generic Drugs** • $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. • $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. **Tier 2: Preferred Brand Drugs** • $45 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. • $90 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $90 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (PPO)
Prescription Drugs (continued)		• $45 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • $135 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • $90 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy. **Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs** • $90 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. • $225 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $180 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. • $90 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • $270 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • $180 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (PPO)
Prescription Drugs (continued)		**Tier 4: Injectable Drugs** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. • 33% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • 33% coinsurance for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. • 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • 33% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • 33% coinsurance for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. **Tier 5: Specialty Tier Drugs** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. • 33% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (PPO)
Prescription Drugs (continued)		• 33% coinsurance for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. • 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • 33% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • 33% coinsurance for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy. Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information. <u>Coverage Gap</u> After your total yearly drug costs reach $2,840, you receive a discount on brand name drugs and pay 93% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach $4,550. <u>Catastrophic Coverage</u> After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (PPO)
Prescription Drugs (continued)		<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 (PPO). <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 $2,840: **Tier 1: Preferred Generic Drugs** • $5 copay for a one-month (30-day) supply of drugs in this tier **Tier 2: Preferred Brand Drugs** • $45 copay for a one-month (30-day) supply of drugs in this tier **Tier 3: Non-Preferred Generic and Non-Preferred Brand Drugs** • $90 copay for a one-month (30-day) supply of drugs in this tier **Tier 4: Injectable Drugs** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (PPO)
Prescription Drugs (continued)		**Tier 5: Specialty Tier Drugs** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier <u>Out-of-Network Coverage Gap</u> You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly drug costs reach $4,550. You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly drug costs reach $4,550. <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 your cost share, which is the greater of: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (PPO)
30. Dental Services	Preventive dental services (such as cleaning) not covered.	In-Network In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits"). $15 copay for Medicare-covered dental benefits. Out-of-Network 10% of the cost for comprehensive dental benefits.
31. Hearing Services	Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	In-Network Hearing aids not covered. • $20 copay for Medicare-covered diagnostic hearing exams • $20 copay for up to 1 routine hearing test(s) every year Out-of-Network 10% of the cost for hearing exams.
32. Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	In-Network In general, routine eye wear not covered. However, this plan covers some vision benefits for an extra cost (see "Optional Benefits"). $0 copay for • one pair of eyeglasses or contact lenses after cataract surgery • $0 to $20 copay for exams to diagnose and treat diseases and conditions of the eye. • $20 copay for up to 1 routine eye exam(s) every year Out-of-Network 10% of the cost for eye exams. $0 copay for eye wear.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (PPO)
33. Welcome to Medicare; and Annual Wellness Visit	When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare exam or an Annual Wellness visit. After your first 12 months, you can get one Annual Wellness visit every 12 months. There is no coinsurance, copayment or deductible for either the Welcome to Medicare exam or the Annual Wellness visit. The Welcome to Medicare exam does not include lab tests.	In-Network $0 copay for routine exams. Limited to 1 exam(s) every year. $0 copay for the required Medicare-covered initial preventive physical exam and annual wellness visits. Out-of-Network 10% of the cost for routine exams.
34. 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. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.	In-Network The plan covers the following health/wellness education benefits: • Written health education materials, including Newsletters • Nutritional Training • Additional Smoking Cessation • Nursing Hotline $0 copay for each Medicare-covered smoking cessation counseling session. $0 copay for each Medicare-covered HIV screening. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Out-of-Network $0 copay for Health and Wellness services.
Transportation (Routine)	Not covered.	In-Network This plan does not cover routine transportation.
Acupuncture	Not covered.	In-Network This plan does not cover Acupuncture.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (PPO)
OPTIONAL SUPPLEMENTAL PACKAGE #4		
Premium and Other Important Information		General Package: 4 – DPPO+Eyewear+ Chiropractic/Acupuncture: $25 monthly premium, in addition to your $89 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Chiropractic Services • Acupuncture • Preventive Dental • Comprehensive Dental • Eye Wear
Chiropractic Services		In-Network $15 copay for up to 20 routine visit(s) every year Out-of-Network $15 copay for chiropractic services.
Dental Services		In-Network $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 2 fluoride treatment(s) every year • up to 2 dental X-ray(s) every year In and Out-of-Network $1,000 plan coverage limit for dental benefits every year. This limit applies to both in-network and out-of-network benefits. Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET VIOLET (PPO)
Vision Services		In-Network $0 copay for • up to 1 pair(s) of glasses every two years • up to 1 pair(s) of contacts every two years • up to 1 pair(s) of lenses every two years • up to 1 frame(s) every two years

Health Net Violet (PPO)
Post Office Box 10198
Van Nuys, CA 91410-0198

For more information, please contact us at:

Current members should call
1-800-960-4638 (TTY/TDD 1-800-929-9955)
8:00 a.m. - 8:00 p.m., 7 days a week

Prospective members should call
1-800-935-6565 (TTY/TDD 1-800-929-9955)
8:00 a.m.–8:00 p.m., 7 days a week

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