# *2015* Summary *of* Benefits

*Health Net Violet Option 2 (PPO)*

Clackamas, Lane, Multnomah and Washington counties, OR; Clark County, WA

Health Net®
MEDICARE PROGRAMS

Benefits effective January 1, 2015
H5520 Health Net Life Insurance Company
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SECTION I

# INTRODUCTION TO SUMMARY OF BENEFITS

## You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Health Net Violet Option 2 (PPO)**).

## Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Health Net Violet Option 2 (PPO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

### Sections in this booklet

- Things to Know About **Health Net Violet Option 2 (PPO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits
- Optional Benefits (you must pay an extra premium for these benefits)

This document is available in other formats such as Braille and large print.
This document may be available in a non-English language. For additional information, call us at 1-888-445-8913 (TTY users should call 711).

Este documento puede estar disponible en un idioma distinto al inglés. Para obtener información adicional, llamenos al 1-888-445-8913 (Los usuarios de TTY deben llamar al 711).

## Things to Know About Health Net Violet Option 2 (PPO)

### Hours of Operation

You can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Pacific time.

### Health Net Violet Option 2 (PPO) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-888-445-8913 (TTY users should call 711).
- If you are not a member of this plan, call toll-free 1-800-949-6192 (TTY users should call 711).
- Our website: http://www.healthnet.com/medicare

## Who can join?

To join **Health Net Violet Option 2 (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Oregon: Clackamas, Lane, Multnomah, and Washington; Washington: Clark.

## Which doctors, hospitals, and pharmacies can I use?

**Health Net Violet Option 2 (PPO)** has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plan's provider directory at our website (http://www.healthnet.com/medicare).

You can see our plan's pharmacy directory at our website (https://www.healthnet.com/medicare/pharmacy).

Or, call us and we will send you a copy of the provider and pharmacy directories.

## What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, https: //www.healthnet.com/medicare/pharmacy.
- Or, call us and we will send you a copy of the formulary.

## How will I determine my drug costs?

Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

**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

| *Health Net Violet Option 2 (PPO)* | |
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| **MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES** | |
| **How much is the monthly premium?** | $0 per month. In addition, you must keep paying your Medicare Part B premium. |
| **How much is the deductible?** | This plan has deductibles for some hospital and medical services.<br>$250 per year for some in-network and out-of-network services.<br>This plan does not have a deductible for Part D prescription drugs. |
| **Is there any limit on how much I will pay for my covered services?** | Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.<br><br>Your yearly limit(s) in this plan:<br>• $5,100 for services you receive from in-network providers.<br>• $6,600 for services you receive from any provider.<br>Your limit for services received from in-network providers will count toward this limit.<br>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.<br>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. |
| **Is there a limit on how much the plan will pay?** | Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply. |

## COVERED MEDICAL AND HOSPITAL BENEFITS

**NOTE: • SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION.**
**• SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**

| **Outpatient Care and Services** | |
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| Acupuncture and Other Alternative Therapies[1] | There is a limit to how much our plan will pay:<br>• In-network: $20 copay<br>• Out-of-network: $20 copay<br>Combined $250 annual allowance for in and out-of-network routine chiropractic, acupuncture, and naturopathic services. |
| Ambulance[1] | • In-network: $380 copay<br>• Out-of-network: $380 copay |
| Chiropractic Care[1] | Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):<br>• In-network: $20 copay<br>• Out-of-network: $20 copay<br>Routine chiropractic visit (there is a limit to how much our plan will pay):<br>• In-network: $20 copay<br>• Out-of-network: $20 copay<br>Combined $250 annual allowance for in and out-of-network routine chiropractic, acupuncture, and naturopathic services. |
| Dental Services | Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):<br>• In-network: $30 copay<br>• Out-of-network: $50 copay |
| Diabetes Supplies and Services | Diabetes monitoring supplies:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost<br>Diabetes self-management training:<br>• In-network: You pay nothing<br>• Out-of-network: You pay nothing<br>Therapeutic shoes or inserts:<br>• In-network: 15% of the cost<br>• Out-of-network: 20% of the cost |
| Diagnostic Tests, Lab and Radiology Services, and X-Rays[1] | Diagnostic radiology services (such as MRIs, CT scans):<br>• In-network: 15% of the cost<br>• Out-of-network: 20% of the cost<br>Diagnostic tests and procedures:<br>• In-network: 0-15% of the cost, depending on the service<br>• Out-of-network: 0-20% of the cost, depending on the service<br>Lab services:<br>• In-network: $18 copay<br>• Out-of-network: $20 copay |

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| Diagnostic Tests, Lab and Radiology Services, and X-Rays[1] (continued) | Outpatient x-rays:<br>• In-network: $18 copay<br>• Out-of-network: $20 copay<br>Therapeutic radiology services (such as radiation treatment for cancer):<br>• In-network: 15% of the cost<br>• Out-of-network: 20% of the cost |
| Doctor's Office Visits | Primary care physician visit:<br>• In-network: $15 copay<br>• Out-of-network: $30 copay<br>Specialist visit:<br>• In-network: $30 copay<br>• Out-of-network: $50 copay |
| Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1] | • In-network: 15% of the cost<br>• Out-of-network: 20% of the cost |
| Emergency Care | $65 copay<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.<br>$50,000 plan coverage limit for supplemental emergency services outside the U.S. and its territories every year. |
| Foot Care *(podiatry services)* | Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:<br>• In-network: $30 copay<br>• Out-of-network: $50 copay |
| Hearing Services | Exam to diagnose and treat hearing and balance issues:<br>• In-network: $30 copay<br>• Out-of-network: $50 copay |
| Home Health Care[1] | • In-network: You pay nothing<br>• Out-of-network: $15 copay |
| Mental Health Care[1] | Inpatient visit:<br>Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.<br>Our plan covers 90 days for an inpatient hospital stay.<br>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.<br>• In-network:<br>  • $375 copay per day for days 1 through 4<br>  • You pay nothing per day for days 5 through 90 |

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| Mental Health Care[1] (continued) | • Out-of-network:<br>• $500 copay per day for days 1 through 10<br>• You pay nothing per day for days 11 through 190<br>Outpatient group therapy visit:<br>• In-network: $25 copay<br>• Out-of-network: $50 copay<br>Outpatient individual therapy visit:<br>• In-network: $25 copay<br>• Out-of-network: $50 copay |
| Outpatient Rehabilitation[1] | Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks):<br>• In-network: $25 copay<br>• Out-of-network: $35 copay<br>Occupational therapy visit:<br>• In-network: $25 copay<br>• Out-of-network: $35 copay<br>Physical therapy and speech and language therapy visit:<br>• In-network: $25 copay<br>Out-of-network: $35 copay |
| Outpatient Substance Abuse[1] | Group therapy visit:<br>• In-network: $25 copay<br>• Out-of-network: $50 copay<br>Individual therapy visit:<br>• In-network: $25 copay<br>• Out-of-network: $50 copay |
| Outpatient Surgery[1] | Ambulatory surgical center:<br>• In-network: 18% of the cost<br>• Out-of-network: 20% of the cost<br>Outpatient hospital:<br>• In-network: 18% of the cost<br>• Out-of-network: 20% of the cost |
| Over-the-Counter Items | Not Covered |
| Prosthetic Devices *(braces, artificial limbs, etc.)*[1] | Prosthetic devices:<br>• In-network: 15% of the cost<br>• Out-of-network: 20% of the cost<br>Related medical supplies:<br>• In-network: 15% of the cost<br>• Out-of-network: 20% of the cost |
| Renal Dialysis | • In-network: 20% of the cost<br>• Out-of-network: 20% of the cost |
| Transportation | Not covered |
| Urgent Care | $35-50 copay, depending on the service<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care. See the "Inpatient Hospital Care" section of this booklet for other costs. |

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| Vision Services | Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):<br>• In-network: $0-30 copay, depending on the service<br>• Out-of-network: $0-50 copay, depending on the service<br>Eyeglasses or contact lenses after cataract surgery:<br>• In-network: You pay nothing<br>• Out-of-network: 20% of the cost |
| **Preventive Care** | • In-network: You pay nothing<br>• Out-of-network: You pay nothing<br>Our plan covers many preventive services, including:<br>• Abdominal aortic aneurysm screening<br>• Alcohol misuse counseling<br>• Bone mass measurement<br>• Breast cancer screening (mammogram)<br>• Cardiovascular disease (behavioral therapy)<br>• Cardiovascular screenings<br>• Cervical and vaginal cancer screening<br>• Colonoscopy<br>• Colorectal cancer screenings<br>• Depression screening<br>• Diabetes screenings<br>• Fecal occult blood test<br>• Flexible sigmoidoscopy<br>• HIV screening<br>• Medical nutrition therapy services<br>• Obesity screening and counseling<br>• Prostate cancer screenings (PSA)<br>• Sexually transmitted infections screening and counseling<br>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>• Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots<br>• "Welcome to Medicare" preventive visit (one-time)<br>• Yearly "Wellness" visit<br>Any additional preventive services approved by Medicare during the contract year will be covered. |
| **Hospice** | You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. |

| Inpatient Care | |
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| Inpatient Hospital Care[1] | Our plan covers an unlimited number of days for an inpatient hospital stay.<br>• $375 copay per day for days 1 through 4<br>• You pay nothing per day for days 5 through 90<br>• You pay nothing per day for days 91 and beyond<br>• Out-of-network:<br>• $500 copay per day for days 1 through 10<br>• You pay nothing per day for days 11 and beyond |
| Inpatient Mental Health Care | For inpatient mental health care, see the "Mental Health Care" section of this booklet. |
| Skilled Nursing Facility (SNF)[1] | Our plan covers up to 100 days in a SNF.<br>• In-network:<br>• You pay nothing per day for days 1 through 20<br>• $100 copay per day for days 21 through 100<br>• Out-of-network:<br>• You pay nothing per day for days 1 through 20<br>• $150 copay per day for days 21 through 100 |
| **PRESCRIPTION DRUG BENEFITS** | |
| **How much do I pay?** | For Part B drugs such as chemotherapy drugs[1]:<br>• In-network: 15% of the cost<br>• Out-of-network: 20% of the cost<br>Other Part B drugs[1]:<br>• In-network: 15% of the cost<br>• Out-of-network: 20% of the cost |
| **Initial Coverage** | You pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.<br>You may get your drugs at network retail pharmacies and mail order pharmacies. |

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| **Preferred Retail Cost-Sharing** | **Tier** | **One-month supply** | **Two-month supply** | **Three-month supply** |
| | Tier 1 (Preferred Generic) | $5 copay | $10 copay | $15 copay |
| | Tier 2 (Non-Preferred Generic) | $15 copay | $30 copay | $45 copay |
| | Tier 3 (Preferred Brand) | $35 copay | $70 copay | $105 copay |
| | Tier 4 (Non-Preferred Brand) | $85 copay | $170 copay | $255 copay |
| | Tier 5 (Specialty Tier) | 33% of the cost | 33% of the cost | 33% of the cost |
| | Tier 6 (Select Care Drugs) | $0 | $0 | $0 |
| **Standard Retail Cost-Sharing** | **Tier** | **One-month supply** | **Two-month supply** | **Three-month supply** |
| | Tier 1 (Preferred Generic) | $10 copay | $20 copay | $30 copay |
| | Tier 2 (Non-Preferred Generic) | $20 copay | $40 copay | $60 copay |
| | Tier 3 (Preferred Brand) | $45 copay | $90 copay | $135 copay |
| | Tier 4 (Non-Preferred Brand) | $95 copay | $190 copay | $285 copay |
| | Tier 5 (Specialty Tier) | 33% of the cost | 33% of the cost | 33% of the cost |
| | Tier 6 (Select Care Drugs) | $0 | $0 | $0 |

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| **Preferred Mail Order Cost-Sharing** | **Tier** | **One-month supply** | **Two-month supply** | **Three-month supply** |
| | Tier 1 (Preferred Generic) | $5 copay | $10 copay | $10 copay |
| | Tier 2 (Non-Preferred Generic) | $15 copay | $30 copay | $30 copay |
| | Tier 3 (Preferred Brand) | $35 copay | $70 copay | $70 copay |
| | Tier 4 (Non-Preferred Brand) | $85 copay | $170 copay | $213 copay |
| | Tier 5 (Specialty Tier) | 33% of the cost | 33% of the cost | 33% of the cost |
| | Tier 6 (Select Care Drugs) | $0 | $0 | $0 |
| **Standard Mail Order Cost-Sharing** | **Tier** | **One-month supply** | **Two-month supply** | **Three-month supply** |
| | Tier 1 (Preferred Generic) | $10 copay | $20 copay | $30 copay |
| | Tier 2 (Non-Preferred Generic) | $20 copay | $40 copay | $60 copay |
| | Tier 3 (Preferred Brand) | $45 copay | $90 copay | $135 copay |
| | Tier 4 (Non-Preferred Brand) | $95 copay | $190 copay | $285 copay |
| | Tier 5 (Specialty Tier) | 33% of the cost | 33% of the cost | 33% of the cost |
| | Tier 6 (Select Care Drugs) | $0 | $0 | $0 |
| If you reside in a long-term care facility, you pay the same as at a retail pharmacy.<br>You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy. | | | | |
| **Coverage Gap** | Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $2,960.<br>After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap. | | | |

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| **Catastrophic Coverage** | After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of:<br>• 5% of the cost, or<br>• $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs. |
| **OPTIONAL BENEFITS**<br>**(you must pay an extra premium each month for these benefits)** | |
| **Package 1:**<br>**Preventative Dental Plus** | Benefits include:<br>• Preventive Dental<br>• Comprehensive Dental |
| **How much is the monthly premium?** | Additional $31.00 per month. You must keep paying your Medicare Part B premium and your $0 monthly plan premium. |
| **How much is the deductible?** | $35 per year. |
| **Is there any limit on how much I will pay for my covered services?** | Our plan pays up to $1,250 every year. |

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| **Package 2:**<br>**Routine Vision** | Benefits include:<br>• Eye Exams<br>• Eyewear |
| **How much is the monthly premium?** | Additional $6 per month. You must keep paying your Medicare Part B premium and your $0 monthly plan premium. |
| **How much is the deductible?** | This package does not have a deductible. |
| **Is there any limit on how much I will pay for my covered services?** | Our plan pays up to $250 every two years. |

## *For more information please contact*

Health Net Violet Option 1 (PPO)
Post Office Box 10420
Van Nuys, CA 91410-0420

Current members should call
1-888-445-8913 (TTY users should call 711)

Prospective members should call
1-800-949-6192 (TTY users should call 711)

From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, your call will be handled by our automated phone system on weekends and certain holidays.

*www.healthnet.com*

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