2016 Summary *of* Benefits

Health Net Seniority Plus Amber I (HMO SNP)

Kern, Los Angeles, Orange, Riverside and San Bernardino counties, CA

Health Net®
MEDICARE PROGRAMS

Benefits effective January 1, 2016
H0562 Health Net of California, Inc.
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Summary of Benefits

January 1, 2016 – December 31, 2016

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

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 Seniority Plus Amber I (HMO SNP)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Health Net Seniority Plus Amber I (HMO SNP)** 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

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 1-800-431-9007 (TTY: 711).

Este documento puede estar disponible en un idioma distinto al inglés. Para obtener información adicional, llamenos al 1-800-431-9007 (TTY: 711).

Things to Know About Health Net Seniority Plus Amber I (HMO SNP)

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 Seniority Plus Amber I (HMO SNP) Phone Numbers and Website

- If you are a member of this plan, call toll-free1-800-431-9007 (TTY: 711).
- If you are not a member of this plan, call toll-free 1-800-977-6738 (TTY: 711).
- Our website: http://www.healthnet.com/medicare

Who can join?

To join **Health Net Seniority Plus Amber I (HMO SNP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and Medi-Cal and live in our service area.

Our service area includes the following counties in California: Kern, Los Angeles, Orange, Riverside, and San Bernardino.

Which doctors, hospitals, and pharmacies can I use?

Health Net Seniority Plus Amber I (HMO SNP) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

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 (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 after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

SUMMARY OF BENEFITS

January 1, 2016 – December 31, 2016	
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services	
How much is the monthly premium?	$31.00 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	$0 to $74 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 6 which are excluded from the deductible.
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. In this plan, you may pay nothing for some services, depending on your level of Medi-Cal eligibility. Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers. 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. 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	
Acupuncture	Not covered
Ambulance[1]	$0 or $50 copay
Chiropractic Care[1,2]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): You pay nothing
Dental Services[1,2]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): $0 copay Preventive dental services: •Cleaning (for up to 2 every year): $0 copay •Dental x-ray(s) (for up to 1 every year): $0 copay •Fluoride treatment (for up to 1 every year): $0 copay •Oral exam: $0 copay Additional comprehensive dental benefits are available
Diabetes Supplies and Services,[1,2]	Diabetes monitoring supplies: You pay nothing Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 0% or 15% of the cost
Diagnostic Tests, Lab and Radiology Services, and X-Rays *(Costs for these services may vary based on place of service)*[1,2]	Diagnostic radiology services (such as MRIs, CT scans): You pay nothing Diagnostic tests and procedures: You pay nothing Lab services: You pay nothing Outpatient x-rays: You pay nothing Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing
Doctor's Office Visits,[1,2]	Primary care physician visit: You pay nothing Specialist visit: You pay nothing
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	0% or 15% of the cost
Emergency Care	$0 or $30 copay If you are immediately admitted to the hospital, 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. $50,000 plan coverage limit for supplemental urgent/emergent services outside the U.S. and its territories every year.

Foot Care *(podiatry services)* [2]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: You pay nothing Routine foot care (for up to 12 visit(s) every year): You pay nothing
Hearing Services[1,2]	Exam to diagnose and treat hearing and balance issues: $0 copay Routine hearing exam (for up to 1 every year): $0 copay Hearing aid fitting/evaluation (for up to 1 every three years): $0 copay Hearing aid: $0 copay Our plan pays up to $1,000 every three years for hearing aids. Up to 2 supplemental hearing aids every three years
Home Health Care[1,2]	You pay nothing
Mental Health Care[1]	Inpatient visit: 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. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 90 days for an inpatient hospital stay. 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. • $0 or $900 copay per stay Outpatient group therapy visit: $0 or $10 copay Outpatient individual therapy visit: $0 or $10 copay
Outpatient Rehabilitation[1,2]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing Occupational therapy visit: You pay nothing Physical therapy and speech and language therapy visit: You pay nothing
Outpatient Substance Abuse[1]	Group therapy visit: $0 or $10 copay Individual therapy visit: $0 or $10 copay
Outpatient Surgery[1,2]	Ambulatory surgical center: You pay nothing Outpatient hospital: You pay nothing
Over-the-Counter Items	Not Covered
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: 0% or 15% of the cost Related medical supplies: You pay nothing
Renal Dialysis[1,2]	0% or 10% of the cost

Transportation[1]	You pay nothing Up to 24 one-way trips to plan approved location every year
Urgently Needed Services	You pay nothing If you are immediately admitted to the hospital, you do not have to pay your share of the cost for urgently needed services. See the "Inpatient Hospital Care" section of this booklet for other costs.
Vision Services[1,2]	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 copay Routine eye exam (for up to 1 every year): $0 copay Contact lenses (for up to 1 every two years): $0 copay Eyeglasses (frames and lenses) (for up to 1 every two years): $0 copay Eyeglass frames (for up to 1 every two years): $0 copay Eyeglass lenses (for up to 1 every two years): $0 copay Eyeglasses or contact lenses after cataract surgery: $0 copay Our plan pays up to $250 every two years for eyewear.
Preventive Care[1,2]	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit Any additional preventive services approved by Medicare during the contract year will be covered. Annual physical exam: You pay nothing

Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.			
Inpatient Care				
Inpatient Hospital Care[1,2]	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers an unlimited number of days for an inpatient hospital stay. You pay nothing			
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.			
Skilled Nursing Facility (SNF)[1,2]	Our plan covers up to 100 days in a SNF. • You pay nothing per day for days 1 through 20 • $0 or $50 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]: 0% or 20% of the cost Other Part B drugs[1]: 0% or 20% of the cost			
Initial Coverage	You pay the following: You may get your drugs at network retail pharmacies and mail order pharmacies.			
Standard Retail Cost-Sharing	**Tier**	**One-month supply**	**Two-month supply**	**Three-month supply**
	Tier 1 (Preferred Generic)	$0	$0	$0
	Tier 2 (Generic)	For generic drugs (including brand drugs treated as generic), either: • $0 copay; or • $1.20 copay; or • $2.95 copay For all other drugs, either: • $0 copay; or • $3.60 copay; or • $7.40 copay		

Standard Retail Cost-Sharing *(continued)*	Tier 3 (Preferred Brand)	For generic drugs (including brand drugs treated as generic), either: • $0 copay; or • $1.20 copay; or • $2.95 copay For all other drugs, either: • $0 copay; or • $3.60 copay; or • $7.40 copay		
	Tier 4 (Non-Preferred Brand)	For generic drugs (including brand drugs treated as generic), either: • $0 copay; or • $1.20 copay; or • $2.95 copay For all other drugs, either: • $0 copay; or • $3.60 copay; or • $7.40 copay		
	Tier 5 (Specialty Tier)	For generic drugs (including brand drugs treated as generic), either: • $0 copay; or • $1.20 copay; or • $2.95 copay For all other drugs, either: • $0 copay; or • $3.60 copay; or • $7.40 copay		
	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)	$0	$0	$0
	Tier 2 (Generic)	For generic drugs (including brand drugs treated as generic), either: • $0 copay; or • $1.20 copay; or • $2.95 copay For all other drugs, either: • $0 copay; or • $3.60 copay; or • $7.40 copay		
	Tier 3 (Preferred Brand)	For generic drugs (including brand drugs treated as generic), either: • $0 copay; or • $1.20 copay; or • $2.95 copay For all other drugs, either: • $0 copay; or • $3.60 copay; or • $7.40 copay		
	Tier 4 (Non-Preferred Brand)	For generic drugs (including brand drugs treated as generic), either: • $0 copay; or • $1.20 copay; or • $2.95 copay For all other drugs, either: • $0 copay; or • $3.60 copay; or • $7.40 copay		
	Tier 5 (Specialty Tier)	For generic drugs (including brand drugs treated as generic), either: • $0 copay; or • $1.20 copay; or • $2.95 copay For all other drugs, either: • $0 copay; or • $3.60 copay; or • $7.40 copay		
	Tier 6 (Select Care Drugs)	$0	$0	$0

Preferred Mail Order Cost-Sharing	Tier	One-month supply	Two-month supply	Three-month supply
	Tier 1 (Preferred Generic)	$0	$0	$0
	Tier 2 (Generic)	For generic drugs (including brand drugs treated as generic), either: • $0 copay; or • $1.20 copay; or • $2.95 copay For all other drugs, either: • $0 copay; or • $3.60 copay; or • $7.40 copay		
	Tier 3 (Preferred Brand)	For generic drugs (including brand drugs treated as generic), either: • $0 copay; or • $1.20 copay; or • $2.95 copay For all other drugs, either: • $0 copay; or • $3.60 copay; or • $7.40 copay		
	Tier 4 (Non-Preferred Brand)	For generic drugs (including brand drugs treated as generic), either: • $0 copay; or • $1.20 copay; or • $2.95 copay For all other drugs, either: • $0 copay; or • $3.60 copay; or • $7.40 copay		
	Tier 5 (Specialty Tier)	For generic drugs (including brand drugs treated as generic), either: • $0 copay; or • $1.20 copay; or • $2.95 copay For all other drugs, either: • $0 copay; or • $3.60 copay; or • $7.40 copay		
	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. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay nothing for all drugs.

STATE OF CALIFORNIA MEDICAID (MEDI-CAL) PROGRAM COVERED BENEFITS FOR DUAL ELIGIBLE (MEDICARE AND MEDICAID) BENEFICIARIES		
Benefit Category	***Medicaid (Medi-Cal)***	***Health Net Seniority Plus Amber I (HMO SNP)***
Inpatient hospital services	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered Inpatient hospital services. Plan covers unlimited number of days for an inpatient hospital stay. $0 or $900 copay per stay for Inpatient mental health care. 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 health services provided in a general hospital. Plan covers 90 days for an inpatient hospital stay. 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.
Outpatient hospital services	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Rural health clinic services	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Federally qualified health center services	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Laboratory services	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
X-rays	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services

Benefit Category	*Medicaid (Medi-Cal)*	*Health Net Seniority Plus Amber I (HMO SNP)*
Skilled nursing facility care for over 21 years of age – Subacute care	$0 copay for Medicaid-covered services	$0 copay days 1-20 $0 or $50 copay days 21-100 No prior hospital stay is required. Plan covers up to 100 days each benefit period.
Pediatric nursing facility care for under 21 years of age – Subacute services (Early & periodic screening, diagnosis and treatment supplemental services)	$0 copay for Medicaid-covered services	Not covered
Family planning services & supplies	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services. (Reasonable and necessary services associated with treatment for infertility are covered under Medicare.)
Physician services	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Medical & surgical dental services	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Ophthalmologist services	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, depending on the service. $0 copay for up to 1 supplemental routine eye exam every year.
Podiatry services*	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services $0 copay for up to 12 supplemental routine podiatry visit(s) every year.
Optometry services	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye (including glaucoma screening). $0 copay for up to 1 supplemental routine eye exam every year.

Benefit Category	*Medicaid (Medi-Cal)*	*Health Net Seniority Plus Amber I (HMO SNP)*
Chiropractic services*	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Psychology services	$0 copay for Medicaid-covered services	$0 or $10 copay for Medicare-covered services (as part of outpatient mental health care)
Nurse anesthetist services	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Optician and optical fabricating lab services*	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered eyeglasses or contact lenses after cataract surgery. $0 copay for eyeglasses (frames and lenses) or contact lenses up to 1 every two years. Plan pays up to $250 every two years for eyewear.
Medical supplies (does not include incontinence creams and washes)	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered medical supplies related to prosthetics, splints, and other devices.
Incontinence creams and washes*	$0 copay for Medicaid-covered services	Not covered
Durable medical equipment	$0 copay for Medicaid-covered services	0% or 15% of the cost for Medicare-covered services
Hearing aids	$0 copay for Medicaid-covered services Medicaid (Medi-Cal) has a maximum limit of $1,510 per person each year. *	$0 copay for up to 1 hearing aid fitting/evaluation every three years. $0 copay for up to 2 supplemental hearing aids (one pair) every three years. Plan pays up to $1,000 every three years for hearing aids.
Enteral formula	$0 copay for Medicaid-covered services	0% or 15% of the cost for Medicare-covered services
Acupuncture services*	$0 copay for Medicaid-covered services	Not covered
Licensed midwife services	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services

Benefit Category	*Medicaid (Medi-Cal)*	*Health Net Seniority Plus Amber I (HMO SNP)*
Home health services through a home health agency (including home health nursing and aide services, physical and occupational therapy, speech pathology and audiology services, intermittent nursing, home health aide care, medical supplies, equipment and appliances)	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Physical therapy and related services	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Rehabilitation facilities	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Private duty nursing (Waiver only)	$0 copay for Medicaid-covered services	Not covered
Clinic (Organized outpatient clinic, Indian Health Services, alternative birthing centers, ambulatory surgical centers)	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Dental services	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered dental benefits. $0 copay for preventive dental services. Plan offers additional comprehensive dental benefits. Refer to Chapter 4 of the Evidence of Coverage for more information.
Occupational therapy	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Speech pathology/Speech therapy*	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Audiology services*	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered diagnostic hearing exams. $0 copay for up to 1 supplemental routine hearing exam every year.

Benefit Category	*Medicaid (Medi-Cal)*	*Health Net Seniority Plus Amber I (HMO SNP)*
Pharmaceutical services and prescribed drugs	$0 copay for drugs excluded from Medicare Part D coverage	Drugs covered under Medicare Part B: 0% or 20% of the cost for chemotherapy drugs and other Part B drugs. Drugs covered under Medicare Part D: If you are eligible for extra help, see the Covered Medical and Hospital Prescription Drug benefits section of this Summary of Benefits for information about Medicare Part D prescription drug cost sharing. If you are not eligible for extra help, refer to the Evidence of Coverage, Chapter 6, for cost-sharing information.
Dentures	$0 copay for Medicaid-covered services	You pay the applicable copays for denture services. Limitations and exclusions apply. Refer to Chapter 4 of the Evidence of Coverage for more information.
Prosthetic appliances (Orthotic appliances) prosthetic eyes	$0 copay for Medicaid-covered services	0% or 15% of the cost for Medicare-covered services
Eyeglasses, other eye appliances*	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered eyeglasses or contact lenses after cataract surgery. $0 copay for eyeglasses (frames and lenses) or contact lenses up to 2 every two years. Plan pays up to $250 every two years for eyewear.
Comprehensive Perinatal Services Program (Preventive services)	$0 copay for Medicaid-covered services	Not covered
Community-Based Adult Services (CBAS) (waiver only)**	$0 copay for Medicaid-covered services	Not covered
Chronic dialysis services	$0 copay for Medicaid-covered services	0% or 10% of the cost for Medicare-covered services

Benefit Category	*Medicaid (Medi-Cal)*	*Health Net Seniority Plus Amber I (HMO SNP)*
Rehabilitation services (chronic dialysis, outpatient heroin detoxification, rehabilitative mental health, drug Medi-Cal, independent rehabilitation centers)	$0 copay for Medicaid-covered services	0% or 10% of the cost for Medicare-covered dialysis services. $0 or $10 copay for Medicare-covered outpatient mental health and substance abuse services. $0 copay for Medicare-covered partial hospitalization program services. $0 copay for Medicare-covered rehabilitation services.
Institutes for Mental Diseases (for under 21 years of age and over 65 years of age, including psychiatric care)	$0 copay for Medicaid-covered services	$0 or $900 copay per Medicare-covered inpatient mental health stay 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. Plan covers 90 days for an inpatient hospital stay. 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.
Intermediate Care Facility	$0 copay for Medicaid-covered services	Not covered.
Nurse midwife	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Hospice	$0 copay for Medicaid-covered services	$0 copay for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

Benefit Category	*Medicaid (Medi-Cal)*	*Health Net Seniority Plus Amber I (HMO SNP)*
TB-related services	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Respiratory care for ventilator-dependent patients	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Family nurse practitioner	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Home and community care for functionally disabled elderly (Waiver only)	$0 copay for Medicaid-covered services	Not covered
Community-supported living arrangements (Waiver only)	$0 copay for Medicaid-covered services	Not covered
Personal care services	$0 copay for Medicaid-covered services	Not covered
Rural primary care hospital	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Nonmedical health facilities	$0 copay for Medicaid-covered services	Not covered except for services of a religious nonmedical health care institution covered by Medicare.
Emergency hospital services	$0 copay for Medicaid-covered services	$0 or $30 copay for Medicare-covered emergency room visits. If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care. $50,000 plan coverage limit for supplemental urgent/emergent services outside the U.S. and its territories every year.
Transportation (State provides emergency and non-emergency medical transportation. Meets federal requirement for assurance of transportation to medically necessary services)	$0 copay for Medicaid-covered services	$0 or $50 copay for Medicare-covered ambulance services. $0 copay for non-emergency transportation; up to 24 one-way trips to plan approved locations every year.

Benefit Category	*Medicaid (Medi-Cal)*	*Health Net Seniority Plus Amber I (HMO SNP)*
Services for pregnant women that treat a condition that may impact the woman and/or the fetus (Not specifically stated as a benefit but is a mandated provision under federal regulations)	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Marriage and family counselor services (Early & periodic screening, diagnosis, and treatment services & waiver only)	$0 copay for Medicaid-covered services	$0 or $10 copay for Medicare-covered services (as a part of outpatient mental health care when provided in connection with covered treatment for a mental disorder or chemical dependency)
Licensed clinical social worker services (Early & periodic screening, diagnosis, and treatment services & waiver only)	$0 copay for Medicaid-covered services	$0 or $10 copay for Medicare-covered services (as a part of outpatient mental health care)
Case management (Early & periodic screening, diagnosis, and treatment services & waiver only)	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services (this is part of a treatment plan; not a separate benefit)
Private duty nursing agency services (Early & periodic screening, diagnosis, and treatment services & waiver only)	$0 copay for Medicaid-covered services	Not covered
Individual nurse provider services (Early & periodic screening, diagnosis, and treatment services waiver only)	$0 copay for Medicaid-covered services	Not covered
Nonmedical services (Waiver only)	$0 copay for Medicaid-covered services	Limited to non-religious aspects of care from a Medicare-certified religious non-medical health care institution.

***Optional Benefit Exclusion:**
The benefits noted above with * are only available to this beneficiary population: 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program;
2) beneficiaries residing in a skilled nursing facility (Nursing Facilities Level A and Level B, including subacute care facilities; 3) beneficiaries who are pregnant (pregnancy-related benefits and services; other benefits and services to treat conditions that, if left untreated, might cause difficulties for the pregnancy); 4) California Children's Services beneficiaries; and 5) beneficiaries enrolled in the Program of All-Inclusive Care for the Elderly.

****Community-Based Adult Services (CBAS)** has replaced Adult Day Health Care services. Adult Day Health Care services were eliminated on March 31, 2012. CBAS became effective April 1, 2012.

For more information please contact

Health Net Seniority Plus Amber I (HMO SNP)
Post Office Box 10420
Van Nuys, CA 91410-0420

Current members should call
1-800-431-9007 (TTY: 711)

Prospective members should call
1-800-977-6738 (TTY: 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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Health Net of California, Inc. has a contract with Medicare and the State of California to offer HMO SNP coordinated care plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.