2016 Summary *of* Benefits

Health Net Violet Option 1 (PPO)

Benton, Clackamas, Lane, Linn, Marion, Multnomah, Polk, Washington, and Yamhill counties, OR; Clark County, WA

Health Net®
MEDICARE PROGRAMS

Benefits effective January 1, 2016
H5520 Health Net Life Insurance Company
H5520_2016_0196 CMS Accepted 09132015

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 Violet Option 1 (PPO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Health Net Violet Option 1 (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 1 (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: 711).

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

Things to Know About Health Net Violet Option 1 (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 1 (PPO) Phone Numbers and Website

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

Who can join?

To join **Health Net Violet Option 1 (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: Benton, Clackamas, Lane, Linn, Marion, Multnomah, Polk, Washington, and Yamhill; Washington: Clark.

Which doctors, hospitals, and pharmacies can I use?

Health Net Violet Option 1 (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 (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?	$116 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, and Part D Prescription drugs. $225 per year for some in-network and out-of-network services. $95 per year for Part D prescription drugs except for drugs listed on Tier 1, Tier 2, 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. Your yearly limit(s) in this plan: • $2,900 for services you receive from in-network providers. • $4,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. 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 benefits from any provider. Contact us for the services that apply.

Covered Medical and Hospital Benefits

Note:
• Services with a 1 may require prior authorization.

Outpatient Care and Services	
Acupuncture[1]	There is a limit to how much our plan will pay: • In-network: $15 copay • Out-of-network: $0-15 copay, depending on the service Combined $500 annual allowance for in and out-of-network routine chiropractic, acupuncture, and naturopathic services.
Ambulance[1]	• In-network: $295 copay • Out-of-network: $295 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): • In-network: $15 copay • Out-of-network: $15 copay Routine chiropractic visit (there is a limit to how much our plan will pay): • In-network: $15 copay • Out-of-network: $0-15 copay, depending on the service Combined $500 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): • In-network: $25 copay • Out-of-network: $20-40 copay, depending on the service You will always pay a $40 copay for out-of-network dental services.
Diabetes Supplies and Services[1]	Diabetes monitoring supplies: • In-network: You pay nothing • Out-of-network: 19% of the cost Diabetes self-management training: • In-network: You pay nothing • Out-of-network: You pay nothing Therapeutic shoes or inserts: • In-network: 17% of the cost • Out-of-network: 19% of the cost
Diagnostic Tests, Lab and Radiology Services, and X-Rays *(Costs for these services may vary based on place of service)*[1]	Diagnostic radiology services (such as MRIs, CT scans): • In-network: 17% of the cost • Out-of-network: 19% of the cost Diagnostic tests and procedures: • In-network: 0-17% of the cost, depending on the service • Out-of-network: 0-19% of the cost, depending on the service Lab services: • In-network: $12 copay • Out-of-network: $20-40 copay, depending on the service

Diagnostic Tests, Lab and Radiology Services, and X-Rays *(Costs for these services may vary based on place of service)*[1] (continued)	Outpatient x-rays: • In-network: $12 copay • Out-of-network: $20-40 copay, depending on the service Therapeutic radiology services (such as radiation treatment for cancer): • In-network: 17% of the cost • Out-of-network: 19% of the cost You will always pay a $20 copay for out-of-network lab services. You will always pay a $20 copay for out-of-network X-ray services.
Doctor's Office Visits	Primary care physician visit: • In-network: $12 copay • Out-of-network: $20-40 copay, depending on the service Specialist visit: • In-network: $25 copay • Out-of-network: $20-40 copay, depending on the service You will always pay a $20 copay for out-of-network Primary care physician visits. You will always pay a $40 copay for out-of-network Specialist visits.
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	• In-network: 17% of the cost • Out-of-network: 19% of the cost
Emergency Care	$75 copay 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. $50,000 plan coverage limit for supplemental urgent/emergent 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: • In-network: $25 copay • Out-of-network: $20-40 copay, depending on the service You will always pay a $40 copay for out-of-network podiatry services.
Hearing Services	Exam to diagnose and treat hearing and balance issues: • In-network: $25 copay • Out-of-network: $20-40 copay, depending on the service You will always pay a $40 copay for out-of-network hearing services.
Home Health Care[1]	• In-network: You pay nothing • Out-of-network: $15 copay

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 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. • In-network: • $225 copay per day for days 1 through 7 • You pay nothing per day for days 8 through 90 • Out-of-network: • $250 copay per day for days 1 through 7 • You pay nothing per day for days 8 through 190 Outpatient group therapy visit: • In-network: $25 copay • Out-of-network: $50 copay Outpatient individual therapy visit: • In-network: $25 copay • 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): • In-network: $25 copay • Out-of-network: $35 copay Occupational therapy visit: • In-network: $25 copay • Out-of-network: $35 copay Physical therapy and speech and language therapy visit: • In-network: $25 copay • Out-of-network: $35 copay
Outpatient Substance Abuse[1]	Group therapy visit: • In-network: $25 copay • Out-of-network: $50 copay Individual therapy visit: • In-network: $25 copay • Out-of-network: $50 copay

Outpatient Surgery[1]	Ambulatory surgical center: • In-network: $200 copay • Out-of-network: $225 copay Outpatient hospital: • In-network: $225 copay • Out-of-network: $250 copay
Over-the-Counter Items	Not Covered
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: • In-network: 17% of the cost • Out-of-network: 19% of the cost Related medical supplies: • In-network: 17% of the cost • Out-of-network: 19% of the cost
Renal Dialysis	• In-network: 20% of the cost • Out-of-network: 20% of the cost
Transportation	Not covered
Urgently Needed Services	$35-50 copay, depending on the service If you are admitted to the hospital within 24 hours, 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	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-25 copay, depending on the service • Out-of-network: $0-40 copay, depending on the service Routine eye exam (for up to 1 every year): • In-network: $10 copay • Out-of-network: $0-40 copay, depending on the service Contact lenses (for up to 1 every two years): • In-network: $0 copay • Out-of-network: $0 copay Eyeglasses (frames and lenses) (for up to 1 every two years): • In-network: $0 copay • Out-of-network: $0 copay Eyeglasses frames (for up to 1 every two years): • In-network: $0 copay • Out-of-network: $0 copay Eyeglasses lenses (for up to 1 every two years): • In-network: $0 copay • Out-of-network: $0 copay Eyeglasses or contact lenses after cataract surgery: • In-network: $0 copay • Out-of-network: $0 copay Our plan pays up to $250 every two years for eyewear from any provider.

Preventive Care	• In-network: You pay nothing • Out-of-network: 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.
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. Hospice is covered outside of our plan. Please contact us for more details.
Inpatient Care	

Inpatient Hospital Care[1]	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.
	• In-network:
	  • $225 copay per day for days 1 through 7
	  • You pay nothing per day for days 8 through 90
	  • You pay nothing per day for days 91 and beyond
	• Out-of-network:
	  • $250 copay per day for days 1 through 7
	  • You pay nothing per day for days 8 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. • In-network: • You pay nothing per day for days 1 through 20 • $100 copay per day for days 21 through 100 • Out-of-network: • You pay nothing per day for days 1 through 20 • $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]: • In-network: 17% of the cost • Out-of-network: 19% of the cost Other Part B drugs[1]: • In-network: 17% of the cost • Out-of-network: 19% of the cost			
Initial Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. 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)	$10 copay	$20 copay	$30 copay
	Tier 2 (Generic)	$20 copay	$40 copay	$60 copay
	Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay
	Tier 4 (Non-Preferred Brand)	$100 copay	$200 copay	$300 copay
	Tier 5 (Specialty Tier)	31% of the cost	31% of the cost	31% of the cost
	Tier 6 (Select Care Drugs)	$0	$0	$0

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 (Generic)	$10 copay	$20 copay	$30 copay
	Tier 3 (Preferred Brand)	$37 copay	$74 copay	$111 copay
	Tier 4 (Non-Preferred Brand)	$90 copay	$180 copay	$270 copay
	Tier 5 (Specialty Tier)	31% of the cost	31% of the cost	31% 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 (Generic)	$20 copay	$40 copay	$60 copay
	Tier 3 (Preferred Brand)	$47 copay	$94 copay	$141 copay
	Tier 4 (Non-Preferred Brand)	$100 copay	$200 copay	$300 copay
	Tier 5 (Specialty Tier)	31% of the cost	31% of the cost	31% of the cost
	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)	$5 copay	$10 copay	$10 copay
	Tier 2 (Generic)	$10 copay	$20 copay	$20 copay
	Tier 3 (Preferred Brand)	$37 copay	$74 copay	$74 copay
	Tier 4 (Non-Preferred Brand)	$90 copay	$180 copay	$225 copay
	Tier 5 (Specialty Tier)	31% of the cost	31% of the cost	31% 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. 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 $3,310. After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total $4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.			
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 the greater of: • 5% of the cost, or • $2.95 copay for generic (including brand drugs treated as generic) and a $7.40 copayment for all other drugs.			

Optional Benefits *(you must pay an extra premium each month for these benefits)*	
Package 1: **Preventive and Comprehensive Dental PPO**	Benefits include: • Preventive Dental • Comprehensive Dental
How much is the monthly premium?	Additional $39.00 per month. You must keep paying your Medicare Part B premium and your $116 monthly plan premium.
How much is the deductible?	$100 per year.
Is there a limit on how much the plan will pay?	Our plan pays up to $1,000 every year. Our plan has additional coverage limits for certain benefits.

Package 2: **Preventive & Diagnostic Plus Dental PPO**	Benefits include: • Preventive Dental
How much is the monthly premium?	Additional $15.00 per month. You must keep paying your Medicare Part B premium and your $116 monthly plan premium.
How much is the deductible?	$35 per year.
Is there a limit on how much the plan will pay?	Our plan pays up to $500 every year. Our plan has additional coverage limits for certain benefits.

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: 711)

Prospective members should call
1-800-949-6192 (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 has a contract with Medicare to offer PPO plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.