2016 Summary *of* Benefits

Health Net Ruby (HMO)

Clackamas, Multnomah, and Washington counties, OR

Health Net®
MEDICARE PROGRAMS

Benefits effective January 1, 2016
H6815 Health Net Health Plan of Oregon, Inc.
H6815_2016_0206 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 Ruby (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Health Net Ruby (HMO)** 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 1-888-445-8913 (TTY: 711).

Things to Know About Health Net Ruby (HMO)

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 Ruby (HMO) 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 Ruby (HMO)**, 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, Multnomah, and Washington.

Which doctors, hospitals, and pharmacies can I use?

Health Net Ruby (HMO) 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?	$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, and Part D prescription drugs. $125 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: • $3,400 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.

Outpatient Care and Services	
Acupuncture	Not covered
Ambulance[1]	$350 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): $15 copay
Dental Services[1]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): $30 copay after you pay your deductible
Diabetes Supplies and Services[1]	Diabetes monitoring supplies: You pay nothing Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 20% 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): 20% of the cost Diagnostic tests and procedures: 0-20% of the cost, depending on the service Lab services: You pay nothing Outpatient x-rays: $15 copay Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost
Doctor's Office Visits[1]	Primary care physician visit: $5 copay Specialist visit: $30 copay
Durable Medical Equipment (*wheelchairs, oxygen, etc.)*[1]	20% 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: $30 copay
Hearing Services[1]	Exam to diagnose and treat hearing and balance issues: $30 copay
Home Health Care[1]	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 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. • $375 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 Outpatient group therapy visit: $25 copay Outpatient individual therapy visit: $25 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): $25 copay Occupational therapy visit: $25 copay Physical therapy and speech and language therapy visit: $25 copay
Outpatient Substance Abuse[1]	Group therapy visit: $25 copay Individual therapy visit: $25 copay
Outpatient Surgery[1]	Ambulatory surgical center: $150 copay Outpatient hospital: $250 copay
Over-the-Counter Items	Not covered
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost
Renal Dialysis	20% of the cost
Transportation	Not covered
Urgently Needed Services	$25 copay 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[1]	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0-30 copay, depending on the service Routine eye exam (for up to 1 every year): $10 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 Eyeglasses frames (for up to 1 every two years): $0 copay Eyeglasses 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]	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. • $375 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 • You pay nothing per day for days 91 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. • You pay nothing per day for days 1 through 20 • $100 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]: 20% of the cost Other Part B drugs[1]: 20% 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)	$8 copay	$16 copay	$24 copay
	Tier 2 (Generic)	$15 copay	$30 copay	$45 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)	30% of the cost	30% of the cost	30% 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)	$3 copay	$6 copay	$9 copay
	Tier 2 (Generic)	$8 copay	$16 copay	$24 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)	30% of the cost	30% of the cost	30% 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)	$8 copay	$16 copay	$24 copay
	Tier 2 (Generic)	$15 copay	$30 copay	$45 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)	30% of the cost	30% of the cost	30% of the cost
	Tier 6 (Select Care Drugs)	$0	$0	$0

<table>
<tr><td rowspan="7">Preferred Mail Order Cost-Sharing</td><td>Tier</td><td>One-month supply</td><td>Two-month supply</td><td>Three-month supply</td></tr>
<tr><td>Tier 1
(Preferred Generic)</td><td>$3 copay</td><td>$6 copay</td><td>$6 copay</td></tr>
<tr><td>Tier 2
(Generic)</td><td>$8 copay</td><td>$16 copay</td><td>$16 copay</td></tr>
<tr><td>Tier 3
(Preferred Brand)</td><td>$37 copay</td><td>$74 copay</td><td>$74 copay</td></tr>
<tr><td>Tier 4
(Non-Preferred Brand)</td><td>$90 copay</td><td>$180 copay</td><td>$225 copay</td></tr>
<tr><td>Tier 5
(Specialty Tier)</td><td>30% of the cost</td><td>30% of the cost</td><td>30% of the cost</td></tr>
<tr><td>Tier 6
(Select Care Drugs)</td><td>$0</td><td>$0</td><td>$0</td></tr>
<tr><td colspan="5">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.</td></tr>
<tr><td>Coverage Gap</td><td colspan="4">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.</td></tr>
<tr><td>Catastrophic Coverage</td><td colspan="4">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.</td></tr>
</table>

Optional Benefits *(you must pay an extra premium each month for these benefits)*	
Package 1: **Comprehensive Dental PPO and Hearing Aids**	Benefits include: • Preventive Dental • Comprehensive Dental • Hearing Exams • Hearing Aids
How much is the monthly premium?	Additional $40.00 per month. You must keep paying your Medicare Part B premium and your $0 monthly plan premium.
How much is the deductible?	This package has deductibles for some services.
Is there a limit on how much the plan will pay?	Our plan pays up to $2,000 every year. Our plan has additional coverage limits for certain benefits.

Package 2: **P & D Plus Dental PPO and Hearing Aids**	Benefits include: • Hearing Exams • Hearing Aids • Preventive Dental
How much is the monthly premium?	Additional $16.00 per month. You must keep paying your Medicare Part B premium and your $0 monthly plan premium.
How much is the deductible?	This package has deductibles for some services.
Is there a limit on how much the plan will pay?	Our plan pays up to $1,500 every year. Our plan has additional coverage limits for certain benefits.

For more information please contact

Health Net Ruby (HMO)
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 Health Plan of Oregon, Inc. has a contract with Medicare to offer HMO plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.