

2017 Summary of Benefits

Health Net Seniority Plus Amber II (HMO SNP)

Kern and Tulare Counties, CA

H0562-110-002



Health Net®

MEDICARE PROGRAMS

Benefits effective January 1, 2017
Health Net of California, Inc.
H0562_2017_0291 CMS Accepted 09112016

This booklet provides you with a summary of what we cover and your cost-sharing. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call us at the number listed on the last page, and ask for the "Evidence of Coverage" (EOC), or you may access the EOC on our website at <http://www.healthnet.com/medicare>.

You are eligible to enroll in Health Net Seniority Plus Amber II (HMO SNP) if:

- You are entitled to Medicare Part A and enrolled in Medicare Part B. Members must continue to pay their Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.
- You permanently reside in the service area of the plan (in other words, your permanent residence is within one of the Health Net Seniority Plus Amber II service area counties). Our service area includes the following counties in California: Kern and Tulare Counties.
- You do not have end-stage renal disease (ESRD). (Exceptions may apply for individuals who develop ESRD while enrolled in a Health Net commercial or group health plan, or a Medicaid plan).
- For Health Net Seniority Plus Amber II (HMO SNP), you must also be enrolled in California Medicaid (Medi-Cal). Premiums, copays, coinsurance, and deductibles may vary based on your Medicaid (Medi-Cal) eligibility category and/or the level of "Extra Help" you receive. Your Part B premium is paid by the State of California for full-dual enrollees. Please contact the plan for further details.

The Health Net Seniority Plus Amber II (HMO SNP) plan gives you access to our network of highly skilled medical providers in your area. You can look forward to choosing a primary care provider (PCP) to work with you and coordinate your care. You can ask for a current Provider Directory or, for an up-to-date list of network providers, visit www.healthnet.com/medicareplans. (Please note that, except for emergency care, urgently needed care when you are out of the network, out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers, if you obtain medical care from out-of-plan providers, neither Medicare nor Health Net will be responsible for the costs.)

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

This Health Net (HMO SNP) plan also includes Part D coverage, which provides you with the ease of having both your medical and prescription drug needs coordinated through a single convenient source.

SUMMARY OF BENEFITS

January 1, 2017 – December 31, 2017

| Premiums and Benefits | Health Net Seniority Plus Amber II (HMO SNP) | What you should know |
|---|---|--|
| Monthly Plan Premium, including Part C and Part D premium | \$0-\$36.20, depending on the level of “Extra Help” you receive. | You must continue to pay your Medicare Part B premium. |
| Deductible | <p>\$0 or \$1,288 deductible for days 1 through 60 for In-patient hospital coverage (which includes Inpatient Mental Health Stays) per benefit period, depending on the level of Medi-Cal (Medicaid) eligibility you receive.</p> <p>This amount may change for 2017.</p> | <p>Deductible does not apply to all services.</p> <p>Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your copayment or coinsurance amount) for the rest of the benefit period.</p> |
| Maximum Out-of-Pocket Responsibility <i>(does not include prescription drugs)</i> | \$4,950 annually | This is the most you pay in copays, coinsurance and other costs for medical services for the year. |
| Inpatient Hospital Coverage | <p>In 2016 the amounts for each benefit period were \$0 or:</p> <ul style="list-style-type: none"> •\$1,288 deductible for days 1 through 60 •\$322 copay per day for days 61 through 90 •\$644 copay per day for 60 lifetime reserve days <p>These amounts may change for 2017.</p> | <p>Deductible Applies</p> <p>Our plan covers 90 days per benefit period for an inpatient hospital stay.</p> <p>Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.</p> |

| Premiums and Benefits | Health Net Seniority Plus Amber II (HMO SNP) | What you should know |
|---------------------------------|--|--|
| Doctor Visits | <ul style="list-style-type: none"> • Primary Care: 0% or 20% coinsurance per visit • Specialist: 0% or 20% coinsurance per visit | Some specialist services may require Prior Authorization (approval in advance) to be covered, except in an emergency. |
| Preventive Care | \$0 copay | <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.</p> <p>Cost-sharing may apply when other services are received in addition to the preventive service.</p> <p>Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.</p> |
| Emergency Care | 0% or 20% coinsurance (up to \$75) per visit | If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care. |
| Urgently Needed Services | 0% or 20% coinsurance (up to \$65) per visit | If you are immediately admitted to the hospital, you do not have to pay your share of the cost for urgently needed services. |

| Premiums and Benefits | Health Net Seniority Plus Amber II (HMO SNP) | What you should know |
|---|--|---|
| Diagnostic Services/Labs/Imaging | <ul style="list-style-type: none"> • Diagnostic radiology service (e.g., MRI, MRA, CT, PET): 0% or 20% coinsurance • Lab service: \$0 copay • Diagnostic tests and/or procedure: 0% or 20% coinsurance • EKG: 0% or 20% coinsurance • Outpatient x-ray: 0% or 20% coinsurance • Therapeutic Radiological services (Radiation therapy): 0% or 20% coinsurance | Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency. |
| Hearing Services | <ul style="list-style-type: none"> • Hearing exam (Medicare-covered): 0% or 20% coinsurance per visit • Routine hearing services (non Medicare-covered): \$0 copay per visit (1 every year) • Hearing aid: \$0 copay | <p>\$ 2,000 benefit maximum for 2 hearing aids (for both ears combined) every 3 years.</p> <p>Members have no out-of-pocket cost sharing.</p> <p>Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.</p> |
| Dental Services | <p>Dental services (Medicare-covered): 0% or 20% coinsurance</p> <p>Preventive dental services:</p> <ul style="list-style-type: none"> • Oral exam: \$0 copay (unlimited) • Cleaning: \$0 copay (up to 2 every year) • Dental x-ray and Fluoride treatment : \$0 copay (up to 1 every year) <p>Additional comprehensive dental benefits are available.</p> | <p>Medicare-covered services:</p> <p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).</p> |

| Premiums and Benefits | Health Net Seniority Plus Amber II (HMO SNP) | What you should know |
|--|--|---|
| Dental Services <i>(continued)</i> | | Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency. |
| Vision Services | <ul style="list-style-type: none"> • Vision exam to diagnose and treat diseases and conditions of the eye (Medicare-covered): 0% or 20% coinsurance per visit • Yearly Glaucoma screening (Medicare-covered): \$0 copay • Eyeglasses or contact lenses after cataract surgery (Medicare-covered): \$0 copay • Routine eye exam (non Medicare-covered) (once every 12 months): \$0 copay per visit • Routine (non Medicare-covered) eyewear: up to \$150 allowance | <p>Our plan pays up to \$150 every two years for routine (non-Medicare covered) eyewear.</p> <p>Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.</p> |
| Mental Health Services | <p>Outpatient: 0% or 20% coinsurance</p> <p>Inpatient visits:</p> <p>In 2016 the amounts for each benefit period were \$0 or:</p> <ul style="list-style-type: none"> •\$1,288 deductible for days 1 through 60 •\$322 copay per day for days 61 through 90 •\$644 copay per day for 60 lifetime reserve days <p>These amounts may change for 2017</p> | <p>Deductible Applies to Inpatient Visits.</p> <p>Our plan covers 90 days per benefit period for an inpatient mental health stay.</p> <p>Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.</p> |
| Skilled Nursing Facility | <p>In 2016 the amounts for each benefit period are \$0 or:</p> <ul style="list-style-type: none"> •\$0 copay per day, days 1 through 20 •\$161 copay per day, days 21 through 100 <p>These amounts may change for 2017.</p> | <p>Our plan covers up to 100 days in a SNF each benefit period. You pay all costs for each day after day 100 in the benefit period.</p> |

| Premiums and Benefits | Health Net Seniority Plus Amber II (HMO SNP) | What you should know |
|--|---|---|
| Skilled Nursing Facility <i>(continued)</i> | | Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency. |
| Rehabilitation Services | Outpatient rehabilitation services: 0% or 20% coinsurance per visit | <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.</p> |
| Ambulance | 0% or 20% coinsurance | <p>Cost is per one-way trip for Medicare-covered Ambulance services.</p> <p>No charge for more than one trip in a single day.</p> <p>Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.</p> |
| Transportation | \$0 copay per trip | <p>Up to 30 one-way trips to plan approved locations every year.</p> <p>Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency.</p> |

| Premiums and Benefits | Health Net Seniority Plus Amber II (HMO SNP) | What you should know |
|--------------------------------------|---|--|
| Foot Care (podiatry services) | <ul style="list-style-type: none"> • Foot exams and treatment (Medicare-covered): 0% or 20% coinsurance per visit • Routine foot care (non-Medicare covered): \$0 copay per visit | Up to 12 visits every year for routine (non Medicare-covered) foot care. |
| Medical Equipment/Supplies | <ul style="list-style-type: none"> • Durable Medical Equipment (e.g., wheelchairs, oxygen): 0% or 20% coinsurance • Prosthetics (e.g., braces, artificial limbs): 0% or 20% coinsurance • Diabetic supplies: 0% or 20% coinsurance | Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency. |
| Wellness Programs | \$0 copay | For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage. |
| Medicare Part B Drugs | <ul style="list-style-type: none"> • 0% or 20% coinsurance for chemotherapy drugs • 0% or 20% coinsurance for other Part B drugs | Prior Authorization (approval in advance) may be required to be covered, except in an emergency. |

Outpatient Prescription Drugs

| | | | |
|---|--|---|-------------------------------------|
| Deductible Phase | <p>You begin in this payment phase when you fill your first prescription of the calendar year. During this phase, you pay the full cost of your drugs on Tiers 2, 3, 4 and 5. You generally stay in this phase until you (or others on your behalf) have paid your deductible. Once you have paid your deductible, you move to the next payment phase (Initial Coverage). If you receive “Extra Help” to pay for your prescription drugs, your deductible amount will be either \$0 or \$82 depending on the level of “Extra Help” you receive. Tier 1 and Tier 6 are excluded from the deductible. If you are not eligible for “Extra Help”, refer to the Evidence of Coverage, Chapter 6, for outpatient prescription drug cost-sharing information.</p> | | |
| <p>Initial Coverage Phase (After you pay your deductible, if applicable)</p> <p>Cost-Sharing may change when you enter another phase of the Part D benefit. For more information about the costs for Long Term Supply, Home infusion or additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online.</p> | <p>After you have met your deductible (if applicable), the plan pays its share of the cost of your drugs and you pay your share of the cost.</p> | | |
| | | Standard Retail Rx 30-day supply | Mail Order 90-day supply |
| | Tier 1: Preferred Generic | \$0 copay | \$0 copay |
| | Tier 2: Generic | <p>Includes generic drugs:</p> <ul style="list-style-type: none"> • \$0 copay; or • \$1.20 copay; or • \$3.30 copay <p>For all other drugs, either:</p> <ul style="list-style-type: none"> • \$0 copay; or • \$3.70 copay; or • \$8.25 copay | |
| | Tier 3: Preferred Brand | <p>Includes preferred brand drugs and may include some generic drugs:</p> <ul style="list-style-type: none"> • \$0 copay; or • \$1.20 copay; or • \$3.30 copay <p>For all other drugs, either:</p> <ul style="list-style-type: none"> • \$0 copay; or • \$3.70 copay; or • \$8.25 copay | |
| Tier 4: Non-Preferred Brand | <p>Includes non-preferred brand drugs and may include some generic drugs:</p> <ul style="list-style-type: none"> • \$0 copay; or • \$1.20 copay; or • \$3.30 copay <p>For all other drugs, either:</p> <ul style="list-style-type: none"> • \$0 copay; or • \$3.70 copay; or • \$8.25 copay | | |

Outpatient Prescription Drugs

| | | | |
|--|--|--|-----------|
| Initial Coverage Phase <i>(continued)</i> | Tier 5: Specialty Tier | Includes high cost drugs: \$0 copay; or <ul style="list-style-type: none"> • \$1.20 copay; or • \$3.30 copay For all other drugs, either: <ul style="list-style-type: none"> • \$0 copay; or • \$3.70 copay; or • \$8.25 copay | |
| | Tier 6: Select Care Drugs | \$0 copay | \$0 copay |
| Coverage Gap Phase | If you qualify for extra help this phase doesn't apply-If you are not eligible for "Extra Help", call the plan or refer to the Evidence of Coverage, Chapter 6, for outpatient prescription drug cost-sharing information. | | |
| Catastrophic Phase | When you reach the out-of-pocket limit of \$4,950 for your prescription drugs, the Catastrophic Coverage Phase begins. You will stay in the Catastrophic Coverage Phase until the end of the calendar year. During this phase, the plan will pay most of the cost for your covered Medicare drugs. | | |
| Important Info: | <p>Premium, co-pays, co-insurance and deductibles may vary based on the level of "Extra Help" you receive. Please contact the plan for further details. If you qualify for "Extra Help" with your prescription drug costs, the "Extra Help" program will pay all or part of your monthly plan premium and your prescription drug deductibles and copays/coinsurance. If you are not eligible for "Extra Help", refer to the Evidence of Coverage, Chapter 6, for outpatient prescription drug cost-sharing information.</p> <p>We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.</p> <p>You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at http://www.healthnet.com/medicare.</p> <p>You can see our plan's pharmacy directory at our website at http://www.healthnet.com/medicare.</p> | | |

| Additional Covered Benefits | | |
|--|---|--|
| Premiums and Benefits | Health Net Seniority Plus Amber II (HMO SNP) | What you should know |
| Outpatient services/surgery (ambulatory care) | 0% or 20% coinsurance per visit | Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency. |
| Outpatient services/surgery (hospital care) | 0% or 20% coinsurance per visit | Some services may require Prior Authorization (approval in advance) to be covered, except in an emergency. Refer to the Medical Benefits chart in the Evidence of Coverage for the specific service. |
| Worldwide Emergency/Urgent Coverage | \$0 copay | \$50,000 plan coverage limit for supplemental Worldwide Emergency/Urgent Coverage outside the U.S. and its territories every year. |
| Fitness Benefit | \$0 copay | Includes a basic gym membership at a participating facility. |

State of California Medicaid (Medi-Cal) Program Covered Benefits for Dual Eligible (Medicare and Medicaid) Beneficiaries

The benefits described below are covered by Medicaid (Medi-Cal). The benefits described in the Covered Medical and Hospital Benefits section of the Summary of Benefits are covered by Medicare. For each benefit listed below, you can see what Medicaid (Medi-Cal) covers and what our plan covers. What you pay for covered services may depend on your level of Medicaid (Medi-Cal) eligibility.

| <i>Benefit Category</i> | <i>Medicaid (Medi-Cal)</i> | <i>Health Net Seniority Plus Amber II (HMO SNP)</i> |
|--|---|---|
| Inpatient hospital services | \$0 copay for Medicaid-covered services | <p>Plan covers 90 days per benefit period for an inpatient hospital stay.</p> <p>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.</p> <p>In 2016 the amounts for each benefit period were \$0 or:</p> <ul style="list-style-type: none"> •\$1,288 deductible for days 1 through 60 •\$322 copay per day for days 61 through 90 •\$644 copay per day for 60 lifetime reserve days <p>These amounts may change for 2017.</p> |
| Outpatient hospital services | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered services |
| Rural health clinic services | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered services |
| Federally qualified health center services | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered services |
| Laboratory services | \$0 copay for Medicaid-covered services | \$0 copay for Medicare-covered services |

| <i>Benefit Category</i> | <i>Medicaid (Medi-Cal)</i> | <i>Health Net Seniority Plus Amber II (HMO SNP)</i> |
|---|---|---|
| X-rays | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered services |
| Skilled nursing facility care for over 21 years of age – Subacute care | \$0 copay for Medicaid-covered services | Plan covers up to 100 days each benefit period. You pay all costs for each day after day 100 in the benefit period. No prior hospital stay is required. In 2016 the amounts for each benefit period were \$0 or: <ul style="list-style-type: none"> •\$0 copay per day for days 1 through 20 •\$161 copay per day for days 21 through 100 These amounts may change for 2017. |
| 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% or 20% coinsurance 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% or 20% coinsurance for Medicare-covered services |
| Medical & surgical dental services | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered services |

| <i>Benefit Category</i> | <i>Medicaid (Medi-Cal)</i> | <i>Health Net Seniority Plus Amber II (HMO SNP)</i> |
|--|---|--|
| Ophthalmologist services | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. \$0 copay for up to 1 routine (non-Medicare covered) eye exam every year. |
| Podiatry services* | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered services \$0 copay for each routine (Non-Medicare covered) foot care, up to 12 visits every year |
| Optometry services | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered exams to diagnose and treat diseases and conditions of the eye. \$0 copay for up to 1 routine (non-Medicare covered) eye exam every year. |
| Chiropractic services* | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered services |
| Psychology services | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered services |
| Nurse anesthetist services | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance 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 every two years. Plan pays up to \$150 every two years for routine (non-Medicare covered) eyewear. |

| <i>Benefit Category</i> | <i>Medicaid (Medi-Cal)</i> | <i>Health Net Seniority Plus Amber II (HMO SNP)</i> |
|--|--|---|
| Medical supplies (does not include incontinence creams and washes) | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered services |
| Incontinence creams and washes* | \$0 copay for Medicaid-covered services | Not covered |
| Durable medical equipment | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered services |
| Hearing aids | \$0 copay for Medicaid-covered services Medicaid (Medi-Cal) has a maximum limit of \$1,510 per person for each year.* | \$0 copay for up to 1 hearing aid fitting/evaluation every three years. \$0 copay for up to 2 hearing aids (one pair) every three years. Plan pays up to \$2,000 every three years for hearing aids. |
| Enteral formula | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered services |
| Acupuncture services | \$0 copay for Medicaid-covered services | Not covered |
| Licensed midwife services | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered services |
| 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% or 20% coinsurance for Medicare-covered services |
| Rehabilitation facilities | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered services |
| Private duty nursing (Waiver only) | \$0 copay for Medicaid-covered services | Not covered |

| <i>Benefit Category</i> | <i>Medicaid (Medi-Cal)</i> | <i>Health Net Seniority Plus Amber II (HMO SNP)</i> |
|---|---|--|
| Clinic (Organized outpatient clinic, Indian Health Services, alternative birthing centers, ambulatory surgical centers) | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered services |
| Dental services | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance 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% or 20% coinsurance for Medicare-covered services |
| Speech pathology/Speech therapy* | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered services |
| Audiology services* | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered diagnostic hearing exams. \$0 copay for up to 1 routine (non-Medicare covered) hearing exam every year. |

| <i>Benefit Category</i> | <i>Medicaid (Medi-Cal)</i> | <i>Health Net Seniority Plus Amber II (HMO SNP)</i> |
|--|--|--|
| Pharmaceutical services and prescribed drugs | \$0 copay for drugs excluded from Medicare Part D coverage | <p>Drugs covered under Medicare Part B: 0% or 20% coinsurance for chemotherapy drugs and other Part B drugs.</p> <p>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.</p> |
| Dentures | \$0 copay for Medicaid-covered services | <p>You pay the applicable copays for denture services.</p> <p>Limitations and exclusions apply. Refer to Chapter 4 of the Evidence of Coverage for more information.</p> |
| Prosthetic appliances (Orthotic appliances) prosthetic eyes | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered services |
| Eyeglasses, other eye appliances* | \$0 copay for Medicaid-covered services | <p>\$0 copay for Medicare-covered eyeglasses or contact lenses after cataract surgery.</p> <p>\$0 copay for eyeglasses (frames and lenses) or contact lenses every two years. Plan pays up to \$150 every two years for routine (non-Medicare covered) eyewear.</p> |
| Comprehensive Perinatal Services Program (Preventive services) | \$0 copay for Medicaid-covered services | Not covered |

| <i>Benefit Category</i> | <i>Medicaid (Medi-Cal)</i> | <i>Health Net Seniority Plus Amber II (HMO SNP)</i> |
|---|---|---|
| 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 20% coinsurance for Medicare-covered services |
| Rehabilitation services (chronic dialysis, outpatient heroin detoxification, rehabilitative mental health, drug Medi-Cal, independent rehabilitation centers) | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered 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 | <p>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 per benefit period 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.</p> <p>In 2016 the amounts for each benefit period were \$0 or:</p> <p>\$1,288 deductible for days 1 through 60 \$322 copay per day for days 61 through 90 \$644 copay per day for 60 lifetime reserve days</p> <p>These amounts may change for 2017.</p> |

| <i>Benefit Category</i> | <i>Medicaid (Medi-Cal)</i> | <i>Health Net Seniority Plus Amber II (HMO SNP)</i> |
|---|---|---|
| Intermediate Care Facility | \$0 copay for Medicaid-covered services | Not covered. |
| Nurse midwife | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance 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. 0% or 20% coinsurance for the one-time only hospice consultation. |
| TB-related services | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered services |
| Respiratory care for ventilator-dependent patients | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance for Medicare-covered services |
| Family nurse practitioner | \$0 copay for Medicaid-covered services | 0% or 20% coinsurance 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% or 20% coinsurance 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 20% coinsurance (up to \$75) for Medicare-covered services. \$50,000 plan coverage limit for supplemental urgent/emergent services outside the U.S. and its territories every year. |

| <i>Benefit Category</i> | <i>Medicaid (Medi-Cal)</i> | <i>Health Net Seniority Plus Amber II (HMO SNP)</i> |
|--|---|--|
| 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 20% coinsurance for Medicare-covered ambulance services. \$0 copay for non-emergency transportation; up to 30 one-way trips to plan approved locations every year. |
| 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% or 20% coinsurance 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 20% coinsurance 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 20% coinsurance 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% or 20% coinsurance 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 |

| <i>Benefit Category</i> | <i>Medicaid (Medi-Cal)</i> | <i>Health Net Seniority Plus Amber II (HMO SNP)</i> |
|-----------------------------------|---|---|
| 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. |
| Important information | <p>*Optional Benefits Coverage: The benefits noted above with an asterisk* are only available to the following beneficiaries: 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program; 2) beneficiaries residing in a Skilled Nursing Facility (SNF) (Nursing Facilities Level A and Level B, including subacute care facilities; 3) beneficiaries who are pregnant; 4) California Children’s Services (CCS) beneficiaries; and 5) beneficiaries enrolled in the Program of All-Inclusive Care for the Elderly (PACE).</p> | |

Health Net complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters & Written information in other formats (large print, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters & Information written in other languages

If you need these services, contact Health Net's Customer Contact Center at 1-800-431-9007 (TTY: 711), 8:00 a.m. to 8:00 p.m., Pacific Time, seven days a week.

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

For more information please contact

Health Net Seniority Plus Amber II (HMO SNP)
Post Office Box 10420
Van Nuys, CA 91410-0420
<http://www.healthnet.com/medicare>

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, our office hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. On weekends and certain holidays, your call will be handled by our automated phone system.

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 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.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. Premium, co-pays, co-insurance, and deductibles may vary based on the level of “Extra Help” you receive. Please contact the plan for further details. “**Coinsurance**” is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

This information is available for free in other languages. Please call our member services number at 1-800-431-9007 (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, our office hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. On weekends and certain holidays, your call will be handled by our automated phone system.

Esta información está disponible en forma gratuita en otros idiomas. Llame a nuestro Departamento de Servicios al Afiliado al 1-800-431-9007 (TTY: 711). Desde el 1.º de octubre hasta el 14 de febrero, nuestro horario de atención es de 8:00 a. m. a 8:00 p. m., los 7 días a la semana, excepto ciertos días feriados. Sin embargo, luego del 14 de febrero, nuestro horario de atención es de 8:00 a. m. a 8:00 p.m., de lunes a viernes. Durante los fines de semana y ciertos días feriados, su llamada será atendida por nuestro sistema automático de teléfono.

Health Net of California, Inc. has a contract with Medicare and the California Medicaid (Medi-Cal) program to offer HMO SNP coordinated care plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.

BKT008802EK00 (9/16)

Multi-Language Insert

Multi-language Interpreter Services

English:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Spanish:

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Chinese:

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)。

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

French:

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (ATS :711).

Vietnamese:

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Korean:

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711) 번으로 전화해 주십시오.

Russian:

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (телетайп: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (رقم هاتف الصم والبكم: 711).

Hindi:

ध्यान दें: यदि आप हदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711) पर कॉल करें।

Italian:

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Portuguese:

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

French Creole:

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Polish:

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Japanese:

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)まで、お電話にてご連絡ください。

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
با (TTY: 711) 1-888-445-8913 (Oregon), 1-800-275-4737 (California), 1-800-977-7522 (Arizona) تماس بگیرید.

Armenian:

ՈՒՇԱՂՐՈՒԹՅՈՒՆՆԵՐ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Ջանգահարեք 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY (հեռատիպ)՝ 711):

Cambodian:

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតលុយ គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ
1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711)។

Punjabi:

ਪਿਆਰ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Thai:

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Laotian:

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY: 711).

Serbo-Croatian:

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Ukranian:

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-977-7522 (Arizona), 1-800-275-4737 (California), 1-888-445-8913 (Oregon) (телетайп: 711).

