2018 Summary of Benefits

Health Net Healthy Heart (HMO)

Alameda and Stanislaus Counties, CA

H0562 - 068

Health Net®
MEDICARE PROGRAMS

Benefits effective January 1, 2018

H0562_18_3073SB_Accepted 09092017

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, https://ca.healthnetadvantage.com.

You are eligible to enroll in Health Net Healthy Heart (HMO) 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 must be a United States citizen, or are lawfully present in the United States and permanently reside in the service area of the plan (in other words, your permanent residence is within one of the Health Net Healthy Heart (HMO) service area counties/county). Our service area includes the following counties in California: Alameda and Stanislaus Counties.
- You do not have end-stage renal disease (ESRD).

The Health Net Healthy Heart (HMO) 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 https://ca.healthnetadvantage.com. (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, https://ca.healthnetadvantage.com.

This Health Net (HMO) 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, 2018 – December 31, 2018	
Premiums and Benefits	**Health Net Healthy Heart (HMO)**
Monthly Plan Premium, including Part C and Part D premium	$157 You must continue to pay your Medicare Part B premium.
Deductible	No deductible
Maximum Out-of-Pocket Responsibility ***(does not include monthly premium and prescription drugs)***	$3,400 annually This is the most you pay in copays and coinsurance for medical services for the year. Not all covered services count towards the maximum out-of-pocket amount. For more information, please see the plan's Evidence of Coverage (EOC).
Inpatient Hospital Coverage	$275 copay per day for days 1 through 7 $0 copay per day for days 8 and beyond *Prior authorization (approval in advance) may be required.* Referral may be required.
Outpatient Hospital ***(including services provided at hospital outpatient facilities and ambulatory surgical centers)***	• Hospital Visit (Including Epidural Injections): $250 copay per visit • Ambulatory Surgical Center Visit (Including Epidural Injections): $125 copay per visit *Prior authorization (approval in advance) may be required.* Referral may be required
Doctor Visits	• Primary Care: $5 copay per visit • Specialist: $10 copay per visit *Specialist services may require Prior Authorization (approval in advance).* A referral may be required for specialist visits.

Premiums and Benefits	Health Net Healthy Heart (HMO)
Preventive Care	$0 copay for Medicare-covered zero cost-sharing preventive services For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. Cost-sharing may apply when other services are received in addition to the preventive service. *Some services may require Prior Authorization (approval in advance).* Referral may be required.
Emergency Care	$100 copay 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	$10 copay 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.
Diagnostic Services/Labs/ Imaging	• Lab services: $0 copay • Diagnostic tests and procedures: $0 copay • EKG: $0 copay • Outpatient x-ray: $0 copay • Diagnostic radiology service (such as MRI, MRA, CT, PET): $60 copay • Therapeutic radiological services (such as radiation treatment for cancer): $60 copay *Some services may require Prior Authorization (approval in advance).* Referral may be required.
Hearing Services	• Hearing exam (Medicare-covered): $0 copay per visit Medicare-covered services include an exam to diagnose and treat hearing and balance issues. • Routine hearing services (non Medicare-covered): $0 copay per visit (1 every year) • Hearing aid: $0 copay (one pair) every 3 years. This plan pays up to $2,000 for hearing aids (for both ears combined) every 3 years. Members are responsible for any remaining balance over the maximum coverage limit. Hearing aids are covered when determined to be medically necessary during the hearing exam. *Some services may require Prior Authorization (approval in advance).* Referral may be required.

Premiums and Benefits	Health Net Healthy Heart (HMO)
Dental Services	Dental services (Medicare-covered): $0 copay Medicare-covered services: Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth). Additional preventive and comprehensive dental benefits are available for an extra premium. See optional supplemental benefits section. *Some services may require Prior Authorization (approval in advance).* Referral may be required.
Vision Services	• Vision exam to diagnose and treat diseases and conditions of the eye (Medicare-covered): $10 copay 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): $10 copay per visit Routine eyewear (non Medicare-covered) available for an additional premium. See optional supplemental benefits section. *Some services may require Prior Authorization (approval in advance).* Referral may be required.
Mental Health Services	Outpatient: $25 copay per visit Inpatient: $900 copay per stay *Prior Authorization (approval in advance) may be required.*
Skilled Nursing Facility	For each benefit period, you pay: • $0 copay per day for days 1 through 20 • $75 copay per day for days 21 through 100 *Prior authorization (approval in advance) may be required.* Referral may be required.
Physical Therapy	$0 copay per visit *Prior Authorization (approval in advance) may be required.* Referral may be required.
Ambulance	$75 copay Cost is per one-way trip for Medicare-covered Ambulance services. No charge for more than one trip in a single day. *Prior Authorization (approval in advance) may be required for non-emergency ambulance services.*

Premiums and Benefits	Health Net Healthy Heart (HMO)
Transportation	Not covered
Medicare Part B Drugs	• Chemotherapy drugs: 20% coinsurance • Other Part B drugs: 20% coinsurance *Prior Authorization (approval in advance) may be required.*
Wellness Programs	• 24-hour nurse advice line: $0 copay You can call the nursing hotline 24 hours a day, 365 days a year with questions about your health. • Smoking and tobacco use cessation (Medicare-covered) (counseling to stop smoking or tobacco use): $0 copay Additional sessions of smoking and tobacco cessation counseling (unlimited additional sessions). On-line and telephonic smoking cessation counseling from trained clinicians. Includes guidance on steps of change, planning, counseling and education: In depth assessment and personalized quit plans, up to 4 proactive, one-on-one counseling calls, unlimited toll free access to a quit coach, unlimited access to an online community that offers e-learning tools, social support, and information about quitting, decision support for the type, dose, and use of medicine. For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage.

<table>
<tr><th colspan="5">Outpatient Prescription Drugs</th></tr>
<tr><td>Deductible Phase</td><td colspan="4">No deductible</td></tr>
<tr><td rowspan="8">Initial Coverage Phase
(After you pay your deductible, if applicable)</td><td colspan="4">Cost-Sharing may change depending on the pharmacy you choose (Such as Standard Retail, mail-order, Long Term Care or Home Infusion) and when you enter another of the four phases of the Part D benefit.</td></tr>
<tr><td></td><td>Preferred Retail Cost Sharing Rx 30-day supply</td><td>Standard Retail Cost Sharing Rx 30-day supply</td><td>Mail Order 90-day supply</td></tr>
<tr><td>Tier 1:
Preferred Generic</td><td>$5 copay</td><td>$10 copay</td><td>$10 copay</td></tr>
<tr><td>Tier 2:
Generic</td><td>$15 copay</td><td>$20 copay</td><td>$30 copay</td></tr>
<tr><td>Tier 3:
Preferred Brand</td><td>$37 copay</td><td>$47 copay</td><td>$101 copay</td></tr>
<tr><td>Tier 4:
Non-Preferred Brand</td><td>$90 copay</td><td>$100 copay</td><td>$260 copay</td></tr>
<tr><td>Tier 5:
Specialty</td><td>33% coinsurance</td><td>33% coinsurance</td><td>33% coinsurance</td></tr>
<tr><td>Tier 6:
Select Care Drugs</td><td>$0 copay</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td>Important Info:</td><td colspan="4">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.

This is not a complete list of drugs covered by our plan. For a complete listing, please call 1-800-275-4737 (TTY users should call 711) or visit https://ca.healthnetadvantage.com.
You can also see our plan’s pharmacy directory on our website at, https://ca.healthnetadvantage.com.</td></tr>
</table>

Optional Supplemental Benefits ***(you must pay an extra premium each month for these benefits)***	
Optional Supplemental Benefit Package # 1 Prior authorization (approval in advance) may be required.	
Monthly Premium This additional monthly premium is in addition to your monthly plan premium and the monthly Medicare Part B premium.	$19 per month
DHMO Dental services With the exception of emergency and urgent dental care services, all covered services must be provided by a contracting dentist. Most covered services will be available from, and provided by, your selected primary care general dentist. Comprehensive copayment amounts vary by service and procedure.	• Preventive Services (includes oral exam, cleaning, fluoride treatment and dental x- rays): $0 copay • Non-routine Dental Services: $0 copay • Diagnostic Services: $0 – $15 copay • Restorative Services (includes crowns, fillings): $0 – $300 copay • Endodontics: $5 – $275 • Periodontics: $0 – $375 copay • Extractions: $15 –$150 • Oral/Maxillofacial surgery/Other prosthodontics (includes partials, dentures): $0 – $2,250 copay
Routine Eyewear (non Medicare-covered) *Plan pays up to the allowance amount and the member is responsible for any remaining balance. Multi-year benefit may not be available in subsequent years.	Up to $250 allowance every 24 months*
Chiropractic and acupuncture services Combined annual visit limit: 30 visits	• Routine Chiropractic (non-Medicare covered): $10 copay per visit • Acupuncture: $10 copay per visit
Fitness Benefits	Choose a membership at a participating fitness facility or membership in the Home Fitness Program. There are no copays, coinsurance or deductibles for fitness benefit.

<table>
<tr><th colspan="3">Optional Supplemental Benefits
(you must pay an extra premium each month for these benefits)</th></tr>
<tr><th colspan="3">Optional Supplemental Benefit Package # 2
Prior authorization (approval in advance) may be required.</th></tr>
<tr><td>**Monthly Premium**
This additional monthly premium is in addition to your monthly plan premium and the monthly Medicare Part B premium.</td><td colspan="2">$30 per month</td></tr>
<tr><td>**DPPO Dental services**
You can see any licensed dentist to receive covered preventive and general comprehensive dental services; however, your cost-sharing will be less if you use plan providers.

*MAC: Maximum Allowable Charge is the maximum dollar amount allowed by the plan for a covered dental service. After the deductible, you will be responsible for the difference between the MAC and billed charges.</td><td>In-network

• One-time, annual in-network deductible of $35

• $1,000 plan maximum per year (combined with out-of-network for all services)

• Preventive Services: You pay $0 copay after deductible

• Limited General Comprehensive Services: You pay 20% coinsurance after deductible</td><td>Out-of-network

• One-time, annual out-of-network deductible of $35

• $1,000 plan maximum per year (combined with in-network for all services)

• Preventive Services: You pay 20% coinsurance of Maximum Allowable Charge (MAC)* after deductible

• Limited General Comprehensive Services: You pay 40% coinsurance of Maximum Allowable Charge (MAC)* after deductible</td></tr>
<tr><td>**Routine Eyewear (non Medicare-covered)**
Plan pays up to the allowance amount and the member is responsible for any remaining balance. Multi-year benefit may not be available in subsequent years</td><td colspan="2">Up to $250 allowance every 24 months

• Routine (non Medicare-covered) eyewear: up to $250 allowance for contact lenses and/or eyeglasses (frames and lenses) every 24 months</td></tr>
<tr><td>**Chiropractic and acupuncture services**
Combined annual visit limit: 30 visits</td><td colspan="2">• Routine (non-Medicare covered) Chiropractic : $10 copay per visit
• Acupuncture: $10 copay per visit</td></tr>
<tr><td>**Fitness Benefits**</td><td colspan="2">Choose a membership at a participating fitness facility or membership in the Home Fitness Program.
There are no copays, coinsurance or deductibles for fitness benefit.</td></tr>
</table>

For more information please contact

Health Net Healthy Heart (HMO)
Post Office Box 10420
Van Nuys, CA 91410-0420
https://ca.healthnetadvantage.com

Current members should call: 1-800-275-4737 (TTY: 711)

Prospective members should call: 1-800-977-6738 (TTY: 711)

From October 1 to February 14, you can call us 7 days a week from 8 a.m. to 8 p.m. From February 15 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

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. **"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 document is available in other formats such as Braille, large print or audio.

Health Net of California, Inc. has a contract with Medicare to offer HMO plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.

Health Net

Section 1557 Non-Discrimination Language
Notice of Non-Discrimination

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 and 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 and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at: 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711). From October 1 to February 14, you can call us 7 days a week from 8 a.m. to 8 p.m. From February 15 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

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 (TDD: 1-800-537-7697).

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

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Section 1557 Non-Discrimination Language
Multi-Language Interpreter Services

Language	Notice
SPANISH	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711).
CHINESE	注意：如果您說中文，您可以免費獲得語言援助服務。請致電 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711)。
VIETNAMESE	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711).
TAGALOG	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711).
KOREAN	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711) 번으로 전화해 주십시오.
ARMENIAN	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք: 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711).
PERSIAN	**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP) 1-800-275-4737 (All Other HMO) (TTY: 711) تماس بگیرید.
RUSSIAN	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (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。1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711) まで、お電話にてご連絡ください。
ARABIC	تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال بالرقم. 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (مكبلا و مصلا فتا ه مقر: 711).
PUNJABI	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711) 'ਤੇ ਕਾੱਲ ਕਰੋ।

MON-KHMER, CAMBODIAN	ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711)។
HMONG	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711).
HINDI	ध्यान दें: यदि आप हिंदी बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711). पर कॉल करें।
THAI	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711)