2018 Summary *of* Benefits

Health Net Seniority Plus Amber II (HMO SNP)

Fresno, Los Angeles, Orange, San Diego, and San Francisco Counties, CA

H0562 -110-001

Health Net®
MEDICARE PROGRAMS

Benefits effective January 1, 2018
H0562_18_3032SB_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 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 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 the Health Net Seniority Plus Amber II (HMO SNP) service area counties).Our service area includes the following counties in California: Fresno, Los Angeles, Orange, San Diego, and San Francisco Counties, CA.

- You do not have end-stage renal disease (ESRD).

- 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 (Medicaid) 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 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 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, 2018 – December 31, 2018	
Premiums and Benefits	**Health Net Seniority Plus Amber II (HMO SNP)**
Monthly Plan Premium, including Part C and Part D premium	$0-$35.50, depending on the level of "Extra Help" you receive. You must continue to pay your Medicare Part B premium, if not otherwise paid for by Medicaid or another third party.
Deductible	$190 deductible for Part D prescription drugs (Applies to drugs in Tier 2, 3, 4 and 5.) $0 or $1,316 deductible for days 1 through 60 for Inpatient hospital coverage per benefit period, depending on the level of Medi-Cal (Medicaid) eligibility you receive. This amount may change for 2018.
Maximum Out-of-Pocket Responsibility ***(does not include monthly premium and prescription drugs)***	$4,950 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). You will still need to pay your monthly premiums and cost sharing for your Part D prescription drugs.
Inpatient Hospital Coverage	In 2017 the amounts for each benefit period were $0 or: • $1,316 deductible for days 1 through 60 • $329 copay per day for days 61 through 90 • $658 copay per day for 60 lifetime reserve days. You pay all costs for each day after you use all the lifetime reserve days. The inpatient cost sharing amounts are for 2017 and may change for 2018. *Prior Authorization (approval in advance) may be required.* Referral may be required.

Premiums and Benefits	Health Net Seniority Plus Amber II (HMO SNP)
Outpatient Hospital ***(including services provided at hospital outpatient facilities and ambulatory surgical centers)***	• Hospital Visit (Including Epidural Injections): 0% or 20% coinsurance per visit • Ambulatory Surgical Center Visit (Including Epidural Injections): 0% or 20% coinsurance per visit *Prior authorization (approval in advance) may be required.* Referral may be required
Doctor Visits	• Primary Care: $0 copay per visit • Specialist: $0 copay per visit *Specialist services may require Prior Authorization (approval in advance).* Referral may be required for specialist visits.
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	0% or 20% coinsurance (up to $80) per visit for Medicare-covered emergency room visits. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital. 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)
Diagnostic Services/Labs/ Imaging	• Lab services: $0 copay • Diagnostic tests and procedures: 0% or 20% coinsurance • EKG: 0% or 20% coinsurance • Outpatient x-ray: 0% or 20% coinsurance • Diagnostic radiology service (such as, MRI, MRA, CT, PET): 0% or 20% coinsurance • Therapeutic Radiological services (such as radiation treatment for cancer): 0% or 20% coinsurance *Some services may require Prior Authorization (approval in advance).* Referral may be required.
Hearing Services	• Hearing exam (Medicare-covered): 0% or 20% coinsurance 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 (up to 1 every year) • Hearing aid: $0 copay (one pair) every 3 years. This plan pays up to $2,000 for 2 hearing aids (for both ears combined) every 3 years. Members have no out-of-pocket cost sharing. *Some services may require Prior Authorization (approval in advance).* Referral may be required.
Dental Services	Dental services (Medicare-covered): 0% or 20% coinsurance Medicare-covered services: Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth). DHMO: Preventive dental services: • Oral exam: $0 copay (up to 2 every year) • Cleaning: $0 copay (up to 2 every year) Additional comprehensive dental benefits are available. Some services may require Prior Authorization (approval in advance). Referral may be required. Referral may be required.

Premiums and Benefits	Health Net Seniority Plus Amber II (HMO SNP)
Vision Services	• 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): $0 copay per visit (up to 1 every 12 months) • Routine (non Medicare-covered) eyewear: up to $250 allowance for contact lenses or eyeglasses (frames and lenses) every 2 years. *Some services may require Prior Authorization (approval in advance).* Referral may be required.
Mental Health Services	Outpatient: 0% or 20% coinsurance Inpatient visits: $90 copay per day, days 1 through 15, $0 copay per day, days16 through 90. *Some services may require Prior Authorization (approval in advance).*
Skilled Nursing Facility	In 2017 the amounts for each benefit period were $0 or: • $0 copay per day, days 1 through 20 • $164.50 copay per day, days 21 through 100 The cost sharing amounts are for 2017 and may change for 2018. *Some services may require Prior Authorization (approval in advance).* Referral may be required.
Physical Therapy	0% or 20% coinsurance per visit *Prior Authorization (approval in advance) may be required.* Referral may be required.
Ambulance	0% or 20% coinsurance 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 Seniority Plus Amber II (HMO SNP)
Transportation	$0 copay per trip Up to 20 one-way trips to plan approved locations every calendar year *Prior Authorization (approval in advance) may be required.*
Medicare Part B Drugs	• Chemotherapy drugs: 20% coinsurance • Other Part B drugs: 20% coinsurance *Prior Authorization (approval in advance) may be required.*
Wellness Programs	• Fitness program: $0 copay The plan covers a basic fitness membership at participating fitness facilities. Members can also request an in-home fitness program. • 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: $0 copay 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="4">Outpatient Prescription Drugs</th></tr>
<tr><td>Deductible Phase</td><td colspan="3">$190 Deductible.
Deductible does not apply to Tiers 1 and 6.</td></tr>
<tr><td rowspan="8">Initial Coverage Phase
(After you pay your deductible, if applicable)</td><td colspan="3">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>Standard Retail Rx 30-day supply</td><td>Mail Order 90-day supply</td></tr>
<tr><td>Tier 1:
Preferred Generic</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td>Tier 2:
Generic</td><td>$20 copay</td><td>$60 copay</td></tr>
<tr><td>Tier 3:
Preferred Brand</td><td>$47 copay</td><td>$141 copay</td></tr>
<tr><td>Tier 4:
Non-Preferred Brand</td><td>$100 copay</td><td>$300 copay</td></tr>
<tr><td>Tier 5:
Specialty</td><td>29% coinsurance</td><td>29% coinsurance</td></tr>
<tr><td>Tier 6:
Select Care Drugs</td><td>$0 copay</td><td>$0 copay</td></tr>
<tr><td>Important Info:</td><td colspan="3">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.
Premium, copays, coinsurance 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.
This is not a complete list of drugs covered by our plan. For a complete listing, please call 1-800-431-9007 (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>
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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.

Benefit Category	*Medicaid (Medi-Cal)*	*Health Net Seniority Plus Amber II (HMO SNP)*
Inpatient hospital services	$0 copay for Medicaid-covered services	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. In 2017 the amounts for each benefit period were $0 or: •$1,316 deductible for days 1 through 60 •$329 copay per day for days 61 through 90 •$658 copay per day for 60 lifetime reserve days These amounts may change for 2018.
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

Benefit Category	*Medicaid (Medi-Cal)*	*Health Net Seniority Plus Amber II (HMO SNP)*
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 2017 the amounts for each benefit period were $0 or: •$0 copay per day for days 1 through 20 •$164.50 copay per day for days 21 through 100 These amounts may change for 2018.
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 copay for Medicare-covered services
Medical & surgical dental services	$0 copay for Medicaid-covered services	0% or 20% coinsurance for Medicare-covered services

Benefit Category	*Medicaid (Medi-Cal)*	*Health Net Seniority Plus Amber II (HMO SNP)*
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 $250 every two years for routine (non-Medicare covered) eyewear.

Benefit Category	*Medicaid (Medi-Cal)*	*Health Net Seniority Plus Amber II (HMO SNP)*
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

Benefit Category	*Medicaid (Medi-Cal)*	*Health Net Seniority Plus Amber II (HMO SNP)*
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.

Benefit Category	*Medicaid (Medi-Cal)*	*Health Net Seniority Plus Amber II (HMO SNP)*
Pharmaceutical services and prescribed drugs	$0 copay for drugs excluded from Medicare Part D coverage	Drugs covered under Medicare Part B: 0% or 20% coinsurance for chemotherapy drugs and other Part B drugs. 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. Refer to the Evidence of Coverage, Chapter 6, for more information.
Dentures	$0 copay for Medicaid-covered services	You pay the applicable copays for denture services. Limitations and exclusions apply. Refer to Chapter 4 of the Evidence of Coverage for more information.
Prosthetic appliances (Orthotic appliances) prosthetic eyes	$0 copay for Medicaid-covered services	0% or 20% coinsurance for Medicare-covered services
Eyeglasses, other eye appliances*	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered eyeglasses or contact lenses after cataract surgery. $0 copay for eyeglasses (frames and lenses) or contact lenses every two years. Plan pays up to $250 every two years for routine (non-Medicare covered) eyewear.
Comprehensive Perinatal Services Program (Preventive services)	$0 copay for Medicaid-covered services	Not covered

Benefit Category	*Medicaid (Medi-Cal)*	*Health Net Seniority Plus Amber II (HMO SNP)*
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	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. $90 copay per day, days 1 through 15 $0 copay per day, days 16 through 90.

Benefit Category	*Medicaid (Medi-Cal)*	*Health Net Seniority Plus Amber II (HMO SNP)*
Intermediate Care Facility	$0 copay for Medicaid-covered services	Not covered.
Nurse midwife	$0 copay for Medicaid-covered services	$0 copay for Medicare-covered services
Hospice	$0 copay for Medicaid-covered services	$0 copay for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. $0 copay 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 copay for Medicare-covered services
Home and community care for functionally disabled elderly (Waiver only)	$0 copay for Medicaid-covered services	Not covered
Community-supported living arrangements (Waiver only)	$0 copay for Medicaid-covered services	Not covered
Personal care services	$0 copay for Medicaid-covered services	Not covered
Rural primary care hospital	$0 copay for Medicaid-covered services	0% or 20% coinsurance for Medicare-covered services
Non medical health facilities	$0 copay for Medicaid-covered services	Not covered except for services of a religious Non medical health care institution covered by Medicare.
Emergency hospital services	$0 copay for Medicaid-covered services	0% or 20% coinsurance (up to $80) for Medicare-covered services. $50,000 plan coverage limit for supplemental urgent/emergent services outside the U.S. and its territories every year.

Benefit Category	*Medicaid (Medi-Cal)*	*Health Net Seniority Plus Amber II (HMO SNP)*
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 20 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)

Benefit Category	*Medicaid (Medi-Cal)*	*Health Net Seniority Plus Amber II (HMO SNP)*
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
Non medical 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	***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).	

For more information please contact

Health Net Seniority Plus Amber II (HMO SNP)
Post Office Box 10420
Van Nuys, CA 91410-0420
https://ca.healthnetadvantage.com

Current members should call: 1-800-431-9007 (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 plan is available to anyone who has both Medical Assistance from the State and Medicare.

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

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.

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.

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) تماس بگیرید. 1-800-275-4737 (All Other HMO) (TTY: 711)
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)