

2018 Summary of Benefits

Health Net Seniority Plus Sapphire (HMO)

Los Angeles, Orange and San Diego Counties, CA

H0562 -111-001



Health Net®

MEDICARE PROGRAMS

Benefits effective January 1, 2018
H0562_18_3041SB_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 Sapphire (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 the Health Net Seniority Plus Sapphire (HMO) service area county). Our service area includes the following counties in California: Los Angeles, Orange and San Diego.
- 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.)

The Health Net Seniority Plus Sapphire (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 Seniority Plus Sapphire (HMO)
Monthly Plan Premium, including Part C and Part D premium	<p>\$35.50</p> <p>You must continue to pay your Medicare Part B premium.</p>
Deductible	<p>\$0 deductible for Part C services.</p> <p>\$240 deductible for Part D prescription drugs Deductible does not apply to Tiers 1 and 6.</p> <p>\$35 deductible for routine Dental services.</p> <p>This plan has a deductible amount of \$1,316 for days 1 through 60 per benefit period for inpatient hospital services. This amount may change for 2018.</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 monthly premium and prescription drugs)</i>	<p>\$6,700 annually</p> <p>This is the most you pay in copays, coinsurance and other costs for medical services for the year.</p> <p>You will still need to pay your monthly premiums and cost sharing for your Part D prescription drugs.</p> <p>Not all covered services count towards the maximum out-of-pocket amount. For more information, please see the plan's Evidence of Coverage (EOC).</p>
Inpatient Hospital Coverage	<p>In 2017 the amounts for each benefit period or:</p> <ul style="list-style-type: none"> • \$1,316 deductible per day, for days 1 through 60 • \$329 copay per day, for days 61 through 90 • \$658 copay per day, for 60 lifetime reserve days <p>The inpatient cost sharing amounts are for 2017 and may change for 2018. We will provide updated rates as soon as Medicare releases them.</p> <p><i>Prior authorization (approval in advance) may be required.</i> Referral may be required.</p>

Premiums and Benefits	Health Net Seniority Plus Sapphire (HMO)
Outpatient Hospital <i>(including services provided at hospital outpatient facilities and ambulatory surgical centers)</i>	<ul style="list-style-type: none"> • Hospital Visit (Including Epidural Injections): 20% coinsurance per visit • Ambulatory Surgical Center Visit (Including Epidural Injections): 20% coinsurance per visit <p><i>Prior authorization (approval in advance) may be required.</i> Referral may be required</p>
Doctor Visits	<ul style="list-style-type: none"> • Primary Care: \$0 copay per visit • Specialist: \$0 copay per visit <p><i>Specialist services may require Prior Authorization (approval in advance).</i> A referral may be required for specialist visits.</p>
Preventive Care	<p>\$0 copay for Medicare-covered zero cost-sharing preventive services</p> <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><i>Some services may require Prior Authorization (approval in advance).</i> Referral may be required.</p>
Emergency Care	<p>\$80 copay per visit</p> <p>If you are immediately admitted to the hospital, you do not have to pay your share of the cost for emergency care.</p>
Urgently Needed Services	<p>20% coinsurance (up to \$65) per visit</p> <p>If you are immediately admitted to the hospital, you do not have to pay your share of the cost for urgently needed services.</p>
Diagnostic Services/Labs/ Imaging	<ul style="list-style-type: none"> • Lab services: \$0 copay • Diagnostic tests and procedures: 20% coinsurance • EKG: 20% coinsurance • Outpatient x-ray: 20% coinsurance • Diagnostic radiology service (such as, MRI, MRA, CT, PET): 20% coinsurance • Therapeutic Radiological services (such as radiation treatment for cancer): 20% coinsurance <p><i>Some services may require Prior Authorization (approval in advance).</i> Referral may be required.</p>

Premiums and Benefits	Health Net Seniority Plus Sapphire (HMO)
Hearing Services	<ul style="list-style-type: none"> • Hearing exam (Medicare-covered): 20% coinsurance per visit Medicare-covered services include an exam to diagnose and treat hearing and balance issues. • Routine hearing exam (non Medicare-covered): \$0 copay per visit (1 every year) • Hearing aid: \$0 copay (one pair hearing aid) every 3 years. <p>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.</p> <p><i>Some services may require Prior Authorization (approval in advance). Referral may be required.</i></p>
Dental Services	<p>Dental services (Medicare-covered): 20% coinsurance per visit</p> <p>Medicare-covered services: Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).</p> <p>DPPO: There is a separate annual deductible of \$35 for in-network and out-of-network covered dental services. A combined \$1,000 annual benefit maximum is for covered services from in- and out-of-network providers.</p> <p>Preventive and diagnostic dental services:</p> <ul style="list-style-type: none"> • Routine cleanings, exams, & fluoride treatments: \$0 (up to 2 per calendar year) • Dental x-rays: \$0 (up to 2 per calendar year) Out-of-network: 20% of Maximum Allowable Charge (MAC) after deductible <p>Additional Comprehensive (non Medicare-covered) dental services:</p> <ul style="list-style-type: none"> • Restorative Services, extractions and periodontics: 20% coinsurance Out-of-network: 40% of Maximum Allowable Charge (MAC) after deductible <p><i>Some services may require Prior Authorization (approval in advance). Referral may be required.</i></p>

Premiums and Benefits	Health Net Seniority Plus Sapphire (HMO)
Vision Services	<ul style="list-style-type: none"> • Vision exam to diagnose and treat diseases and conditions of the eye (Medicare-covered): \$0 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): \$0 copay per visit • Routine (non Medicare-covered) eyewear: up to \$350 allowance for contact lenses and/or eyeglasses (frames and lenses) every 24 months <p><i>Some services may require Prior Authorization (approval in advance).</i></p>
Mental Health Services	<p>Outpatient: 20% coinsurance per visit</p> <p>Inpatient: \$90 copay per day for days 1 through 15 \$0 copay per day for days 16 through 90</p> <p>The cost sharing amounts are for 2017 and may change for 2018. <i>Some services may require Prior Authorization (approval in advance).</i></p>
Skilled Nursing Facility	<p>In 2017 the amounts for each benefit period were:</p> <ul style="list-style-type: none"> • \$0 copay per day, days 1 through 20 • \$164.50 copay per day, days 21 through 100 <p>The cost sharing amounts are for 2017 and may change for 2018.</p> <p><i>Some services may require Prior Authorization (approval in advance).</i> Referral may be required.</p>
Physical Therapy	<p>\$0 copay per visit</p> <p><i>Prior Authorization (approval in advance) may be required.</i> Referral may be required.</p>
Ambulance	<p>20% coinsurance</p> <p>Cost is per one-way trip for Medicare-covered Ambulance services. No charge for more than one trip in a single day.</p> <p><i>Prior Authorization (approval in advance) is required for non-emergency ambulance services.</i></p>
Transportation	<p>\$0 copay per trip</p> <p>Up to 20 one-way trips to plan approved locations every year.</p> <p><i>Some services may require Prior Authorization (approval in advance).</i></p>

Premiums and Benefits	Health Net Seniority Plus Sapphire (HMO)
Medicare Part B Drugs	<ul style="list-style-type: none"> • Chemotherapy drugs: 20% coinsurance • Other Part B drugs: 20% coinsurance <p><i>Prior Authorization (approval in advance) may be required.</i></p>
Over-the-Counter (OTC) Items	<p>\$0 copay The plan covers \$30 every 3 months for items available via mail order.</p> <p>Any unused plan benefit amounts do not carry forward into the next calendar quarter.</p> <p>Please visit the plan’s website to see the list of covered over-the-counter items.</p>
Wellness Programs	<ul style="list-style-type: none"> • 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 <p>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.</p> <p>For a detailed list of wellness program benefits offered, please refer to the Evidence of Coverage.</p>

Outpatient Prescription Drugs

Deductible Phase	\$240 Deductible. Deductible does not apply to Tiers 1 and 6.		
Initial Coverage Phase (After you pay your deductible, if applicable)	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.		
		Standard Retail Cost sharing Rx 30-day supply	Mail Order 90-day supply
	Tier 1: Preferred Generic	\$0 copay	\$0 copay
	Tier 2: Generic	\$20 copay	\$60 copay
	Tier 3: Preferred Brand	\$47 copay	\$141 copay
	Tier 4: Non-Preferred Drug	\$100 copay	\$300 copay
	Tier 5: Specialty	28% coinsurance	28% coinsurance
	Tier 6: Select Care Drugs	\$0 copay	\$0 copay
Important Info:	<p>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.</p> <p>This is not a complete list of drugs covered by our plan. For a complete listing, please call 1-800-431-9007 (TTY: 711) or visit https://ca.healthnetadvantage.com.</p> <p>You can also see our plan’s pharmacy directory on our website at, https://ca.healthnetadvantage.com.</p>		

For more information please contact

Health Net Seniority Plus Sapphire (HMO)
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 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.

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>.

Section 1557 Non-Discrimination Language
Multi-Language Interpreter Services

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 فتاه مقرر: 711).
PUNJABI	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

MON-KHMER,
CAMBODIAN

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូម
ទូរស័ព្ទទៅលេខ 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 हैं, आपको भाषा सहायता सेवाएं, निःशुल्क 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)
