Health Net®
MEDICARE PROGRAMS

# 2009 HEALTH NET

## SENIORITY PLUS RUBY

# *Summary of benefits*

## LOS ANGELES, ORANGE, RIVERSIDE AND SAN BERNARDINO COUNTIES

Benefits effective January 1, 2009
H0562 Medicare Advantage HMO

Material ID H0562-09-0042
CMS Approval 9/08

# INTRODUCTION TO SUMMARY OF BENEFITS

## FOR HEALTH NET SENIORITY PLUS RUBY

**January 1, 2009 – December 31, 2009**
**LOS ANGELES, ORANGE, RIVERSIDE AND SAN BERNARDINO COUNTIES**

Thank you for your interest in Health Net Seniority Plus Ruby. Our plan is offered by Health Net of California, a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Health Net Seniority Plus Ruby and ask for the "Evidence of Coverage."

### YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Health Net Seniority Plus Ruby. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call Health Net Seniority Plus Ruby at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

### HOW CAN I COMPARE MY OPTIONS?

You can compare Health Net Seniority Plus Ruby and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

### WHERE IS HEALTH NET SENIORITY PLUS RUBY AVAILABLE?

The service area for this plan includes: Los Angeles, Orange, Riverside and San Bernardino counties, CA. You must live in one of these areas to join the plan.

### WHO IS ELIGIBLE TO JOIN HEALTH NET SENIORITY PLUS RUBY?

You can join Health Net Seniority Plus Ruby if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in Health Net Seniority Plus Ruby unless they are members of our organization and have been since their dialysis began.

## CAN I CHOOSE MY DOCTORS?

Health Net Seniority Plus Ruby has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time. Our customer service number is listed at the end of this introduction. You can ask for current Provider Directory or for an up-to-date list visit us at www.healthnet.com.

## WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither Health Net Seniority Plus Ruby nor the Original Medicare Plan will pay for these services.

## DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

Health Net Seniority Plus Ruby does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

## WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

Health Net Seniority Plus Ruby has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at https://www.healthnet.com/formulary.htm. Our customer service number is listed at the end of this introduction.

Health Net Seniority Plus Ruby has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower co-pay or co-insurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

## WHAT IS A PRESCRIPTION DRUG FORMULARY?

Health Net Seniority Plus Ruby uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at https://www.healthnet.com/formulary.htm.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

## HOW CAN I GET EXTRA HELP WITH PRESCRIPTION DRUG PLAN COSTS?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join Health Net Seniority Plus Ruby, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

## WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Health Net Seniority Plus Ruby, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug.

## WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Health Net Seniority Plus Ruby for more details.

**Please call Health Net of California for more information about Health Net Seniority Plus Ruby. Visit us at www.healthnet.com or, call us:**

Customer Service Hours: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Pacific

Current members should call toll-free (800)-275-4737 for questions related to the Medicare Advantage Program and the Part D Prescription Drug Program. (TTY/TDD (800)-929-9955)

Prospective members should call toll-free (800)-935-6565 for questions related to the Medicare Advantage Program and the Part D Prescription Drug Program. (TTY/TDD (800)-929-9955)

Current members should call locally (800)-275-4737 for questions related to the Medicare Advantage Program. (TTY/TDD (800)-929-9955)

Prospective members should call locally (800)-935-6565 for questions related to the Medicare Advantage Program. (TTY/TDD (800)-929-9955)

Current members should call locally (800)-275-4737 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (800)-935-6565)

Prospective members should call locally (800)-935-6565 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (800)-929-9955)

For more information about Medicare, please call Medicare at (800)-MEDICARE (800)-633-4227). TTY users should call (877)-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the web.

*If you have special needs, this document may be available in other formats.*

# SUMMARY OF BENEFITS

| BENEFIT | ORIGINAL MEDICARE | HEALTH NET SENIORITY PLUS RUBY |
|---|---|---|
| **IMPORTANT INFORMATION** | | |
| **1. Premium and Other Important Information** | In 2009 the monthly Part B Premium is $96.40 and the yearly Part B deductible amount is $135.<br>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. | General<br>$0 monthly plan premium in addition to your monthly Medicare Part B premium. |
| **2. Doctor and Hospital Choice** (For more information, see Emergency - #15 and Urgently Needed Care - #16.) | You may go to any doctor, specialist, or hospital that accepts Medicare. | In-Network<br>You must go to network doctors, specialists, and hospitals.<br>Referral required for network hospitals and specialists (for certain benefits). |
| **SUMMARY OF BENEFITS** | | |
| **INPATIENT CARE** | | |
| **3. Inpatient Hospital Care** (Includes Substance Abuse and Rehabilitation Services) | In 2009 the amounts for each benefit period are:<br>Days 1–60: $1,068 deductible<br>Days 61–90: $267 per day<br>Days 91–150: $534 per lifetime reserve day.<br>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.<br>Lifetime reserve days can only be used once. | In-Network<br>For Medicare-covered hospital stays:<br>Days 1–4: $100 copay per day<br>Days 5–90: $0 copay per day<br>$0 copay for additional hospital days.<br>No limit to the number of days covered by the plan each benefit period.<br>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. |

| BENEFIT | ORIGINAL MEDICARE | HEALTH NET SENIORITY PLUS RUBY |
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| Inpatient Hospital Care (continued) | A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins.<br>You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. | |
| **4. Inpatient Mental Health Care** | Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above).<br>190 day limit in a Psychiatric Hospital. | In-Network<br>$900 copay for each Medicare-covered hospital stay.<br>You get up to 190 days in a Psychiatric Hospital in a lifetime.<br>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. |
| **5. Skilled Nursing Facility** (In a Medicare-certified skilled nursing facility) | In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay are:<br>Days 1–20: $0 per day<br>Days 21–100: $133.50 per day<br>100 days for each benefit period.<br>A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. | General<br>Authorization rules may apply.<br>In-Network<br>For SNF stays:<br>Days 1–20: $0 copay per day<br>Days 21–100: $75 copay per day<br>Plan covers up to 100 days each benefit period.<br>No prior hospital stay is required. |

| BENEFIT | ORIGINAL MEDICARE | HEALTH NET SENIORITY PLUS RUBY |
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| **6. Home Health Care** (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.) | $0 copay. | General<br>Authorization rules may apply.<br>In-Network<br>$0 copay for Medicare-covered home health visits. |
| **7. Hospice** | You pay part of the cost for outpatient drugs and inpatient respite care.<br>You must receive care from a Medicare-certified hospice. | General<br>You must get care from a Medicare-certified hospice. |
| **OUTPATIENT CARE** | | |
| **8. Doctor Office Visits** | 20% coinsurance. | General<br>See "Physical Exams," for more information.<br>Authorization rules may apply.<br>In-Network<br>$8 copay for each primary care doctor visit for Medicare-covered benefits.<br>$10 copay for each in-area, network urgent care Medicare-covered visit.<br>$11 copay for each specialist visit for Medicare-covered benefits |
| **9. Chiropractic Services** | Routine care not covered.<br>20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. | General<br>Authorization rules may apply.<br>In-Network<br>$10 copay for Medicare-covered visits.<br>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part. |

| BENEFIT | ORIGINAL MEDICARE | HEALTH NET SENIORITY PLUS RUBY |
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| **10. Podiatry Services** | Routine care not covered.<br>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs. | General<br>Authorization rules may apply.<br>In-Network<br>$10 copay for each Medicare-covered visit.<br>$10 copay for up to 1 routine visit(s).<br>Medicare-covered podiatry benefits are for medically-necessary foot care. |
| **11. Outpatient Mental Health Care** | 50% coinsurance for most outpatient mental health services. | General<br>Authorization rules may apply.<br>In-Network<br>$25 copay for each Medicare-covered individual or group therapy visit. |
| **12. Outpatient Substance Abuse Care** | 20% coinsurance. | General<br>Authorization rules may apply.<br>In-Network<br>$25 copay for Medicare-covered individual or group visits. |
| **13. Outpatient Services/ Surgery** | 20% coinsurance for the doctor.<br>20% of outpatient facility charges. | General<br>Authorization rules may apply.<br>In-Network<br>$100 copay for each Medicare-covered ambulatory surgical center visit.<br>$100 copay for each Medicare-covered outpatient hospital facility visit. |
| **14. Ambulance Services** (Medically necessary ambulance services) | 20% coinsurance. | General<br>Authorization rules may apply.<br>In-Network<br>$125 copay for Medicare-covered ambulance benefits. |

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| **15. Emergency Care** (You may go to any emergency room if you reasonably believe you need emergency care.) | 20% coinsurance for the doctor.<br>20% of facility charge, or a set copay per emergency room visit.<br>You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.<br>NOT covered outside the U.S. except under limited circumstances. | In-Network<br>$50 copay for Medicare-covered emergency room visits.<br>Out-of -Network<br>$50,000 limit for emergency services outside the U.S. every year.<br>In and Out-of -Network<br>If you are immediately admitted to the hospital, you pay $0 for the emergency room visit. |
| **16. Urgently Needed Care** (This is NOT emergency care, and in most cases, is out of the service area.) | 20% coinsurance, or a set copay.<br>NOT covered outside the U.S. except under limited circumstances. | General<br>$10 copay for Medicare-covered urgently needed care visits.<br>If you are immediately admitted to the hospital, you pay $0 for the urgent-care visit. |
| **17. Outpatient Rehabilitation Services** (Occupational Therapy, Physical Therapy, Speech and Language Therapy) | 20% coinsurance. | General<br>Authorization rules may apply.<br>In-Network<br>$0 copay for Medicare-covered Occupational Therapy visits.<br>$0 copay for Medicare-covered Physical and/or Speech/ Language Therapy visits. |
| **OUTPATIENT MEDICAL SERVICES AND SUPPLIES** | | |
| **18. Durable Medical Equipment** (Includes wheelchairs, oxygen, etc.) | 20% coinsurance. | General<br>Authorization rules may apply.<br>In-Network<br>20% of the cost for Medicare-covered items. |
| **19. Prosthetic Devices** (Includes braces, artificial limbs and eyes, etc.) | 20% coinsurance. | General<br>Authorization rules may apply.<br>In-Network<br>20% of the cost for Medicare-covered items. |

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| **20. Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies** (Includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training) | 20% coinsurance. | General<br>Authorization rules may apply.<br>In-Network<br>$0 copay for Diabetes self-monitoring training.<br>$0 copay for Nutrition Therapy for Diabetes.<br>$0 copay for Diabetes supplies. |
| **21. Diagnostic Tests, X-Rays, and Lab Services** | 20% coinsurance for diagnostic tests and X-rays.<br>$0 copay for Medicare-covered lab services.<br>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol. | General<br>Authorization rules may apply.<br>In-Network<br>$0 copay for Medicare-covered:<br>• lab services<br>• diagnostic procedures and tests<br>$0 copay forw Medicare-covered X-rays.<br>$0 to $250 copay for Medicare-covered diagnostic radiology services.<br>$0 to $250 copay for Medicare-covered therapeutic radiology services. |
| **PREVENTIVE SERVICES** | | |
| **22. Bone Mass Measurement** (For people with Medicare who are at risk) | 20% coinsurance.<br>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. | General<br>Authorization rules may apply.<br>In-Network<br>$0 copay for Medicare-covered bone mass measurement. |
| **23. Colorectal Screening Exams** (For people with Medicare age 50 and over) | 20% coinsurance.<br>Covered when you are high risk or when you are age 50 and older. | General<br>Authorization rules may apply.<br>In-Network<br>$0 copay for Medicare-covered colorectal screenings. |

| BENEFIT | ORIGINAL MEDICARE | HEALTH NET SENIORITY PLUS RUBY |
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| **24. Immunizations** (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine) | $0 copay for Flu and Pneumonia vaccines.<br>20% coinsurance for Hepatitis B vaccine.<br>You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. | General<br>Authorization rules may apply.<br>In-Network<br>$0 copay for Flu and Pneumonia vaccines.<br>$0 copay for Hepatitis B vaccine.<br>No referral needed for Flu and Pneumonia vaccines. |
| **25. Mammograms** (Annual Screening) (For women with Medicare age 40 and older) | 20% coinsurance.<br>No referral needed.<br>Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39. | In-Network<br>$0 copay for Medicare-covered screening mammograms. |
| **26. Pap Smears and Pelvic Exams** (For women with Medicare) | $0 copay for Pap smears.<br>Covered once every 2 years.<br>Covered once a year for women with Medicare at high risk.<br>20% coinsurance for Pelvic Exams. | In-Network<br>$0 copay for Medicare-covered pap smears and pelvic exams. |
| **27. Prostate Cancer Screening Exams** (For men with Medicare age 50 and older) | 20% coinsurance for the digital rectal exam.<br>$0 for the PSA test; 20% coinsurance for other related services.<br>Covered once a year for all men with Medicare over age 50. | General<br>Authorization rules may apply.<br>In-Network<br>$0 copay for Medicare-covered prostate cancer screening. |
| **28. End Stage Renal Disease** | 20% coinsurance for dialysis.<br>20% coinsurance for Nutrition Therapy for End-Stage Renal Disease.<br>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor.<br>These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease. | General<br>Authorization rules may apply.<br>In-Network<br>$25 copay for renal dialysis.<br>$0 copay for Nutrition Therapy for End-Stage Renal Disease. |

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| **29. Prescription Drugs** | Most drugs are not covered under Original Medicare.<br><br>You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage. | *Drugs covered under Medicare Part B*<br><br><u>General</u><br>20% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs).<br><br>20% of the cost for Part B-covered chemotherapy drugs.<br><br>*Drugs covered under Medicare Part D*<br><br><u>General</u><br>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at https://www.healthnet.com/formulary.htm on the Web.<br><br>Different out-of-pocket costs may apply for people who<br><br>• have limited incomes,<br><br>• live in long term care facilities, or<br><br>• have access to Indian/Tribal/Urban (Indian Health Service).<br><br>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). |

| BENEFIT | ORIGINAL MEDICARE | HEALTH NET SENIORITY PLUS RUBY |
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| Prescription Drugs (continued) | | Total yearly drug costs are the total drug costs paid by both you and the plan.<br><br>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.<br><br>Some drugs have quantity limits.<br><br>Your provider must get prior authorization from Health Net Seniority Plus Ruby for certain drugs.<br><br>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plans website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.<br><br>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.<br><br>You may have to pay more than your normal cost-sharing amount if you choose to use a higher cost drug when a lower cost drug is available. This may also occur if a new, lower cost generic version of a brand name drug is added to the plan's formulary after you enroll. |

| BENEFIT | ORIGINAL MEDICARE | HEALTH NET SENIORITY PLUS RUBY |
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| Prescription Drugs (continued) | | In-Network<br>$0 deductible.<br>Initial Coverage<br>You pay the following until total yearly drug costs reach $2,700:<br>Retail Pharmacy<br>Preferred Generic<br>• $5 copay for a one-month (30-day) supply of drugs in this tier<br>• $15 copay for a three-month (90-day) supply of drugs in this tier<br>• $10 copay for a 60-day supply of drugs in this tier<br>Preferred Brand<br>• $39 copay for a one-month (30-day) supply of drugs in this tier<br>• $117 copay for a three-month (90-day) supply of drugs in this tier<br>• $78 copay for a 60-day supply of drugs in this tier<br>Non-Preferred<br>• $78 copay for a one-month (30-day) supply of drugs in this tier<br>• $234 copay for a three-month (90-day) supply of drugs in this tier<br>• $156 copay for a 60-day supply of drugs in this tier<br>Injectable<br>• 33% coinsurance for a one-month (30-day) supply of drugs in this tier |

| BENEFIT | ORIGINAL MEDICARE | HEALTH NET SENIORITY PLUS RUBY |
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| Prescription Drugs (continued) | | Specialty<br>• 33% coinsurance for a one-month (30-day) supply of drugs in this tier<br><u>Long Term Care Pharmacy</u><br>Preferred Generic<br>• $5 copay for a one-month (34-day) supply of drugs in this tier<br>Preferred Brand<br>• $39 copay for a one-month (34-day) supply of drugs in this tier<br>Non-Preferred<br>• $78 copay for a one-month (34-day) supply of drugs in this tier<br>Injectable<br>• 33% coinsurance for a one-month (34-day) supply of drugs in this tier<br>Specialty<br>• 33% coinsurance for a one-month (34-day) supply of drugs in this tier<br><u>Mail Order</u><br>Preferred Generic<br>• $10 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy.<br>• $10 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy.<br>• $5 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. |

| BENEFIT | ORIGINAL MEDICARE | HEALTH NET SENIORITY PLUS RUBY |
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| Prescription Drugs (continued) | | • $15 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy.<br>• $10 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy.<br>Preferred Brand<br>• $78 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy.<br>• $78 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy.<br>• $39 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.<br>• $117 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy.<br>• $78 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy.<br>Non-Preferred<br>• $195 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy.<br>• $156 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. |

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| Prescription Drugs (continued) | | • $78 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.<br>• $234 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy.<br>• $156 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy.<br>Injectable<br>• 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy.<br>• 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.<br>Specialty<br>• 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy.<br>• 33% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.<br><u>Coverage Gap</u><br>The plan covers All Preferred Generics through the coverage gap. |

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| | | You pay the following:<br><br><u>Retail Pharmacy</u><br>Preferred Generic<br>• $5 copay for a one-month (30-day) supply of all drugs covered in this tier<br>• $15 copay for a three-month (90-day) supply of all drugs covered in this tier<br>• $10 copay for a 60-day supply of all drugs covered in this tier<br><br><u>Long Term Care Pharmacy</u><br>Preferred Generic<br>• $5 copay for a one-month (34-day) supply of all drugs<br><br><u>Mail Order</u><br>Preferred Generic<br>• $10 copay for a three-month (90-day) supply of all drugs covered in this tier from a preferred mail order pharmacy.<br>• $10 copay for a 60-day supply of all drugs covered in this tier from a preferred mail order pharmacy.<br>• $5 copay for a one-month (30-day) supply of all drugs covered in this tier from a non-preferred mail order pharmacy.<br>• $15 copay for a three-month (90-day) supply of all drugs covered in this tier from a non-preferred mail order pharmacy.<br>• $10 copay for a 60-day supply of all drugs covered in this tier from a non-preferred mail order pharmacy. |

| BENEFIT | ORIGINAL MEDICARE | HEALTH NET SENIORITY PLUS RUBY |
|---|---|---|
| Prescription Drugs (continued) | | For all other covered drugs, after your total yearly drug costs reach $2,700, you pay 100% until your yearly out-of-pocket drug costs reach $4,350.<br><br>Catastrophic Coverage<br>After your yearly out-of-pocket drug costs reach $4,350, you pay the greater of:<br>• A $2.40 copay for generic (including brand drugs treated as generic) and a $6 copay for all other drugs, or<br>• 5% coinsurance.<br><br>Out-of-Network<br>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Health Net Seniority Plus Ruby. |

| BENEFIT | ORIGINAL MEDICARE | HEALTH NET SENIORITY PLUS RUBY |
|---|---|---|
| Prescription Drugs (continued) | | <u>Out-of-Network Initial Coverage</u><br>You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,700.<br><u>Out-of-Network Pharmacy</u><br>Preferred Generic<br>• $5 copay for a one-month (30-day) supply of drugs in this tier<br>Preferred Brand<br>• $39 copay for a one-month (30-day) supply of drugs in this tier<br>Non-Preferred<br>• $78 copay for a one-month (30-day) supply of drugs in this tier<br>Injectable<br>• 33% coinsurance for a one-month (30-day) supply of drugs in this tier<br>Specialty<br>• 33% coinsurance for a one-month (30-day) supply of drugs in this tier<br><u>Out-of-Network Coverage Gap</u><br>The plan covers All Preferred Generics through the gap.<br>You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:<br>Preferred Generic<br>• $5 copay for a one-month (30-day) supply of all drugs covered in this tier |

| BENEFIT | ORIGINAL MEDICARE | HEALTH NET SENIORITY PLUS RUBY |
|---|---|---|
| Prescription Drugs (continued) | | Preferred Brand<br>• After your total yearly drug costs reach $2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,350. You will not be reimbursed by Health Net Seniority Plus Ruby for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Health Net Seniority Plus Ruby so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.<br>Non-Preferred<br>• After your total yearly drug costs reach $2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,350. You will not be reimbursed by Health Net Seniority Plus Ruby for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Health Net Seniority Plus Ruby so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. |

| BENEFIT | ORIGINAL MEDICARE | HEALTH NET SENIORITY PLUS RUBY |
|---|---|---|
| Prescription Drugs (continued) | | Injectable<br>• After your total yearly drug costs reach $2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,350.<br>You will not be reimbursed by Health Net Seniority Plus Ruby for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Health Net Seniority Plus Ruby so we can add the amounts you spent out-of- network to your total out-of-pocket costs for the year.<br>Specialty<br>• After your total yearly drug costs reach $2,700, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,350. You will not be reimbursed by Health Net Seniority Plus Ruby for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Health Net Seniority Plus Ruby so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. |

| BENEFIT | ORIGINAL MEDICARE | HEALTH NET SENIORITY PLUS RUBY |
|---|---|---|
| Prescription Drugs (continued) | | Out-of-Network Catastrophic Coverage<br>After your yearly out-of-pocket drug costs reach $4,350, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:<br>• A $2.40 copay for generic (including brand drugs treated as generic) and a $6 copay for all other drugs, or<br>• 5% coinsurance. |
| **30. Dental Services** | Preventive dental services (such as cleaning) not covered. | In-Network<br>In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits").<br>$0 copay for Medicare-covered dental benefits. |
| **31. Hearing Services** | Routine hearing exams and hearing aids not covered.<br>20% coinsurance for diagnostic hearing exams. | General<br>Authorization rules may apply.<br>In-Network<br>Hearing aids not covered.<br>$10 copay for Medicare-covered diagnostic hearing exams.<br>$10 copay for up to 1 routine hearing test(s) every year. |
| **32. Vision Services** | 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.<br>Routine eye exams and glasses not covered.<br>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.<br>Annual glaucoma screenings covered for people at risk. | General<br>Authorization rules may apply.<br>In-Network<br>$0 copay for<br>• one pair of eyeglasses or contact lenses after each cataract surgery.<br>$15 copay for exams to diagnose and treat diseases and conditions of the eye.<br>$15 copay for up to 1 routine eye exam(s) every year. |

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|---|---|---|
| **33. Physical Exams** | 20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage.<br>When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests. | General<br>Authorization rules may apply.<br>In-Network<br>$0 copay for routine exams.<br>Limited to 1 exam(s) every year. |
| **Health/Wellness Education** | Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies. | In-Network<br>This plan covers the following health/wellness education benefits.<br>• Written health education materials, including Newsletters<br>• Nutritional Training<br>• Additional Smoking Cessation<br>• Health Club Membership/ Fitness Classes<br>• Nursing Hotline |
| **Transportation** (Routine) | Not covered. | In-Network<br>This plan does not cover routine transportation. |
| **Acupuncture** | Not covered. | In-Network<br>This plan does not cover Acupuncture. |
| **OPTIONAL SUPPLEMENTAL PACKAGE #1** | | |
| **Premium and Other Important Information** | | General<br>Package: 1 - DHMO+Vision+Chiro/ Acupuncture:<br>$15 monthly premium, in addition to your $0 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:<br>• Chiropractic Services<br>• Dental Services<br>• Vision Services<br>• Acupuncture |

*If you have any questions about this plan's benefits or costs, please contact Health Net of California.*

| BENEFIT | ORIGINAL MEDICARE | HEALTH NET SENIORITY PLUS RUBY |
|---|---|---|
| **Chiropractic Services** | | In-Network<br>$10 copay for up to 30 routine visit(s) every year |
| **Dental Services** | | General<br>Plan offers additional comprehensive dental benefits.<br>In-Network<br>• $0 to $40 copay for up to 2 cleaning(s) every year<br>• $0 copay for fluoride treatments<br>• $0 to $15 for oral exams<br>• $0 copay for dental X-rays |
| **Vision Services** | | In-Network<br>$0 copay for<br>• up to 1 pair(s) of glasses every two years<br>• up to 1 pair(s) of contacts every two years<br>• up to 1 pair(s) of lenses every two years<br>• up to 1 frame(s) every two years |
| **OPTIONAL SUPPLEMENTAL PACKAGE #2** | | |
| **Premium and Other Important Information** | | General<br>Package: 2 - DPPO+Vision+Chiro/ Acupuncture:<br>$18 monthly premium, in addition to your $0 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits:<br>• Chiropractic Services<br>• Dental Services<br>• Vision Services<br>• Acupuncture |
| **Chiropractic Services** | | In-Network<br>$10 copay for up to 30 routine visit(s) every year |

*If you have any questions about this plan's benefits or costs, please contact Health Net of California.*

| BENEFIT | ORIGINAL MEDICARE | HEALTH NET SENIORITY PLUS RUBY |
|---|---|---|
| **Dental Services** | | General<br>Plan offers additional comprehensive dental benefits.<br>In-Network<br>$1,000 limit for preventive dental benefits.<br>$0 copay for the following preventive dental benefits:<br>• oral exams<br>• up to 2 cleaning(s) every year<br>• fluoride treatment<br>• dental X-rays |
| **Vision Services** | | In-Network<br>$0 copay for<br>• up to 1 pair(s) of glasses every two years.<br>• up to 1 pair(s) of contacts every two years.<br>• up to 1 pair(s) of lenses every two years.<br>• up to 1 frame(s) every two years. |

Health Net Seniority Plus
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Van Nuys, CA 91410-0198

**For more information, please contact us at:**

Current members should call
1-800-275-4737 (TTY/TDD 1-800-929-9955)
Monday, Tuesday, Wednesday, Thursday, Friday,
7:30 a.m. to 12:00 p.m. and 1:00 p.m. to 5:00 p.m. Pacific Time, except holidays.

Prospective members should call
1-800-977-6738 (TTY/TDD 1-800-929-9955)
Monday, Tuesday, Wednesday, Thursday, Friday,
8:00 a.m. to 6:30 p.m. Pacific Time, except holidays.

**www.healthnet.com**

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