

2018 Summary of Benefits

Health Net Violet 2 (PPO)

Clackamas, Lane, Multnomah and Washington Counties, OR

H5439-014-001



Benefits effective January 1, 2018
Health Net Life Insurance Company

H5439_18_3170SB_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://or.healthnetadvantage.com>.

You are eligible to enroll in Health Net Violet 2 (PPO) if:

- You are entitled to Medicare Part A and enrolled in Medicare Part B. Members must continue to pay their Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party.
- You permanently reside in the service area of the plan (in other words, your permanent residence is within one of the Health Net Violet 2 (PPO) service area counties). Our service area includes the following counties in Oregon: Clackamas, Lane, Multnomah and Washington.
- 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.)
- With Health Net's PPO Medicare Advantage Violet 2 plan, you'll enjoy the freedom and flexibility to access your health care where you want it and when you want it. You may seek care from any Medicare provider in the country who agrees to see you as a Medicare member, but you'll generally pay less when you use contracting providers in our network. Either way, doctor visits, hospital stays and many other services have a simple copayment, which helps make health care costs more predictable.
- You can see our plan's provider directory at our website at <https://or.healthnetadvantage.com>.
- This Health Net PPO plan also includes prescription drug coverage and access to our large network of pharmacies. Our drug plan is designed specifically for Medicare beneficiaries and includes a comprehensive selection of affordable generic and brand-name drugs.

SUMMARY OF BENEFITS

January 1, 2018 – December 31, 2018

Premiums and Benefits	Health Net Violet 2 (PPO)
Monthly Plan Premium, including Part C and Part D premium.	\$19 You must continue to pay your Medicare Part B premium.
Deductible	\$215 combined in-network and out-of-network medical services \$150 deductible for Part D prescription services (applies to drugs on Tiers 3-5.) The medical deductible does not apply to all services.
Maximum Out-of-Pocket Responsibility (does not include monthly premium and prescription drugs)	\$5,550 in-network annually \$6,600 combined in- network and out-of-network annually This is the most you will 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	<u>In-network</u> \$375 copay per day, days 1 through 4, \$0 copay per day, days 5 and beyond <u>Out-of-network</u> \$500 copay per day, days 1 through 10, \$0 copay per day, days 11 and beyond Deductible applies in-and out-of-network. <i>Prior authorization (approval in advance) may be required.</i>

Premiums and Benefits	Health Net Violet 2 (PPO)
Outpatient Hospital (including services provided at hospital outpatient facilities and ambulatory surgical centers)	<u>In-network</u> - Hospital Visit (Including Epidural Injections): 18% coinsurance per visit - Ambulatory Surgical Center Visit (Including Epidural Injections): 18% coinsurance per visit Deductible applies for in-network. <u>Out-of-network</u> - Hospital Visit (Including Epidural Injections): 20% coinsurance per visit - Ambulatory Surgical Center Visit (Including Epidural Injections): 20% coinsurance per visit Deductible applies for out-of-network. <i>Prior authorization (approval in advance) may be required.</i>
Doctor Visits	<u>In-network</u> - Primary care: \$15 copay per visit - Specialist: \$30 copay per visit Deductible waived for in-network. <u>Out-of-network</u> - Primary care: \$30 copay per visit - Specialist: \$50 copay per visit Deductible applies for out-of-network.
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.

Premiums and Benefits	Health Net Violet 2 (PPO)
Emergency Care	<u>In-network</u> \$80 copay per visit <u>Out-of-network</u> \$80 copay per visit Deductible waived in- and out-of-network. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.
Urgently Needed Services	<u>In-network</u> \$35 copay per visit <u>Out-of-network</u> \$50 copay per visit Deductible waived in-and out-of-network. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.
Diagnostic Services/Labs/Imaging	<u>In-network</u> • Lab services: \$18 copay • Diagnostic tests and procedures: 18% coinsurance • Outpatient x-ray services: \$18 copay • Diagnostic radiological services (such as MRI, MRA, CT, PET): 18% coinsurance • Therapeutic radiological services (such as radiation treatment for cancer): 18% coinsurance <u>Out-of-network</u> • Lab services: \$20 copay • Diagnostic tests and procedures: 20% coinsurance • Outpatient x-ray services: \$20 copay • Diagnostic radiological services (such as MRI, MRA, CT, PET): 20% coinsurance • Therapeutic radiological services (such as radiation treatment for cancer): 20% coinsurance Deductible waived in-network for lab services and outpatient x-ray. Deductible applies in-network for diagnostic radiology services, diagnostic tests and/or procedures, and therapeutic radiological services.

Premiums and Benefits	Health Net Violet 2 (PPO)
Diagnostic Services/Labs/Imaging (continued)	Deductible applies out-of-network for all diagnostic, lab, imaging, and therapeutic radiological services. <i>Some services may require Prior Authorization (approval in advance).</i>
Hearing Services	<u>In-network</u> - Hearing exam (Medicare-covered): \$30 copay per visit Medicare-covered services include an exam to diagnose and treat hearing and balance issues. <u>Out-of-network</u> - Hearing exam (Medicare-covered): \$50 copay per visit Medicare-covered services include an exam to diagnose and treat hearing and balance issues. Deductible waived in-network. Deductible applies out-of-network.
Dental Services	<u>In-network</u> Dental services (Medicare-covered): \$30 copay per visit Medicare-covered dental includes limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth). <u>Out-of-network</u> Dental services (Medicare-covered): \$50 copay per visit Medicare-covered dental includes limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth). Deductible waived in-network. Deductible applies out-of-network. Preventive/comprehensive dental benefits are available for an additional premium. See optional supplemental benefits section.

Premiums and Benefits	Health Net Violet 2 (PPO)
Vision Services	<u>In-network</u> • Vision exams to diagnose and treat diseases and conditions of the eye (Medicare-covered): \$10 copay per visit • Yearly glaucoma screening (Medicare-covered): \$0 copay • Eyeglasses or contact lenses after cataract surgery (Medicare-covered): \$0 copay <u>Out-of-network</u> • Vision exams to diagnose and treat diseases and conditions of the eye (Medicare-covered): \$50 copay per visit • Yearly glaucoma screening (Medicare-covered): \$0 copay • Eyeglasses or contact lenses after cataract surgery (Medicare-covered): 20% coinsurance Deductible waived in-network for Medicare-covered eye exams, yearly glaucoma screening, and Medicare-covered eyewear. Deductible applies out-of-network for Medicare-covered eye exams, yearly glaucoma screening, and Medicare-covered eyewear. Routine vision benefits are available for an additional premium. See optional supplemental benefits section.
Mental Health Services	<u>In-network</u> Outpatient Mental Health Services: \$30 copay per visit Inpatient Psychiatric Services: \$375 copay per day, days 1 through 4, \$0 copay per day, days 5 through 90 <u>Out-of-network</u> Outpatient Mental Health Services: \$50 copay per visit Inpatient Psychiatric Services: \$500 copay per day, days 1 through 10, \$0 copay per day, days 11 through 190 Deductible waived in-network for outpatient visits. Deductible applies out-of-network for outpatient visits. Deductible applies in-and out-of-network for inpatient services. <i>Some services may require Prior Authorization (approval in advance).</i>

Premiums and Benefits	Health Net Violet 2 (PPO)
Skilled Nursing Facility	<u>In-network</u> \$0 copay per day, days 1 through 20, \$150 copay per day, days 21 through 100 <u>Out-of-network</u> \$0 copay per day, days 1 through 20, \$200 copay per day, days 21 through 100 Deductible waived in-network. Deductible applies out-of-network. <i>Prior authorization (approval in advance) may be required.</i>
Physical Therapy	<u>In-network</u> Physical Therapy: \$30 copay per visit <u>Out-of-network</u> Physical Therapy: \$50 copay per visit Deductible applies in- and out-of-network. <i>Prior Authorization (approval in advance) may be required.</i>
Ambulance	<u>In-network</u> \$380 copay <u>Out-of-network</u> \$380 copay Deductible applies in- and out-of-network. Cost is per one-way trip for Medicare-covered ambulance services. <i>Prior authorization (approval in advance) is required for non-emergency ambulance services</i>
Transportation	Not covered

Premiums and Benefits	Health Net Violet 2 (PPO)
Medicare Part B Drugs	<u>In-network</u> • Chemotherapy drugs: 18% coinsurance • Other Part B drugs: 18% coinsurance <u>Out-of-network</u> • Chemotherapy drugs: 20% coinsurance • Other Part B drugs: 20% coinsurance Deductible applies in- and out-of- network. <i>Prior Authorization (approval in advance) may be required.</i>
Wellness Programs (e.g. fitness)	• Fitness program: \$0 copay The plan covers a basic fitness membership at participating fitness facilities. Members can also request an in-home fitness program. Deductible waived in-network for the 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. Deductible waived in- and out-of-network for the 24-hour nurse advice line. • 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 for unlimited additional sessions. Deductible waived in- and out-of-network for Medicare-covered smoking and tobacco use cessation. Deductible waived in-network for additional sessions of smoking and tobacco cessation. 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.

Outpatient Prescription Drugs			
Deductible Phase	\$150 Deductible. Deductible does not apply to tiers 1, 2 and 6.		
Initial Coverage Phase (After you pay your Part D deductible, if applicable)	Cost-Sharing may change depending on the pharmacy you choose (such as Preferred Retail, Standard Retail, mail-order, Long Term Care or Home Infusion) and when you enter another of the four phases of the Part D benefit. You may get drugs from an out-of-network pharmacy at the same cost as standard pricing at an in-network pharmacy.		
		Preferred Retail Rx 30-day supply	Standard Retail Rx 30-day supply
	Tier 1: Preferred Generic	\$5 copay	\$10 copay
	Tier 2: Generic	\$15 copay	\$20 copay
	Tier 3: Preferred Brand	\$37 copay	\$47 copay
	Tier 4: Non-Preferred Brand	\$90 copay	\$100 copay
	Tier 5: Specialty Tier	30% coinsurance	30% coinsurance
	Tier 6: Select Care Drugs	\$0 copay	\$0 copay
Important Info:	For more information about the costs for Long Term Supply, Home Infusion or additional pharmacy-specific cost-sharing and the phases of the benefit, please call us or access our Evidence of Coverage online. This is not a complete list of drugs covered by our plan. For a complete listing, please call 1-888-445-8913 (TTY: 711) or visit https://or.healthnetadvantage.com .		

Optional Supplemental Benefits	
Routine Vision Optional Package	
Monthly Premium This additional monthly premium is in addition to your monthly plan premium and the monthly Medicare Part B premium.	\$6 per month
Annual routine eye exam	In-Network: \$10 copay Out-of-Network: Up to a \$45 allowance. Plan pays up to the allowance amount, and member is responsible for any remaining balance.
Routine eyewear	Up to \$250 allowance every 24 months combined for in-network and out-of-network. Plan pays up to the allowance amount, and member is responsible for any remaining balance. Multi-year benefit may not be available in subsequent years.

Optional Supplemental Benefits

Preventive Dental Optional Package

Monthly Premium

This additional monthly premium is in addition to your monthly plan premium and the monthly Medicare Part B premium.

\$15 per month

Annual deductible

\$35 in- and out-of-network combined

Annual benefit maximum

\$500 in- and out-of-network combined

Preventive services

Every year: 2 routine cleanings, 2 exams, bitewing X-rays;
Every 3 years* : panoramic X-ray

In-Network:

0% coinsurance of MAC**

Out-of-Network:

20% coinsurance of UCR***

*Multi-year benefits may not be available in subsequent years.

**MAC: Maximum Allowable Charge (MAC) is the maximum dollar amount allowed by the plan for a covered dental service. Balance billing occurs when a dentist bills you for the difference between the plan's Maximum Allowable Charge (MAC) and the dentist's total billed charge. Network dentists cannot balance bill you for covered services which exceed the Maximum Allowable Charge (MAC) they have contractually agreed to; however, it is possible that non-network dentists may balance bill you for treatment rendered.

***UCR: Usual, Customary, and Reasonable means the maximum allowable amount for a dental service based on fees usually charged by providers for that service in the same geographic area. Member is responsible for the difference between the UCR and billed charges.

Optional Supplemental Benefits

Comprehensive Dental Optional Package

Monthly Premium This additional monthly premium is in addition to your monthly plan premium and the monthly Medicare Part B premium.	\$39 per month
Annual deductible	\$50 in-network \$100 out-of-network
Annual benefit maximum	\$1,000 in- and out-of-network combined
Preventive services Every year: 2 routine cleanings, 2 exams, bitewing X-rays; Every 3 years*: panoramic X-ray	In-Network: 0% coinsurance Out-of-Network: 50% coinsurance of MAC**
Restorative services Amalgam and resin composite fillings	In-Network: 20% coinsurance Out-of-Network: 50% coinsurance of MAC**
Major services Crowns, removable and fixed bridges, complete and partial dentures, oral surgery, periodontics, endodontics	In-Network: 50% coinsurance Out-of-Network: 50% coinsurance of MAC**

*Multi-year benefit may not be available in subsequent years.

**MAC: Maximum Allowable Charge (MAC) is the maximum dollar amount allowed by the plan for a covered dental service. Balance billing occurs when a dentist bills you for the difference between the plan's Maximum Allowable Charge (MAC) and the dentist's total billed charge. Network dentists cannot balance bill you for covered services which exceed the Maximum Allowable Charge (MAC) they have contractually agreed to; however, it is possible that non-network dentists may balance bill you for treatment rendered.

For more information please contact

Health Net Violet 2 (PPO)
Post Office Box 10420
Van Nuys, CA 91410-0420
<https://or.healthnetadvantage.com>

Current members should call: 1-888-445-8913 (TTY: 711)

Prospective members should call: 1-800-949-6192 (TTY: 711)

From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, our office hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. On weekends and certain holidays, your call will be handled by our automated phone system.

If you want to know more about the coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. View it online at <http://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.

Medicare beneficiaries may also enroll in Health Net through the CMS Medicare Online Enrollment Center located at <http://www.medicare.gov>.

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. Out-of-network/non-contracted providers are under no obligation to treat members, except in emergency situations. For a decision about whether we will cover an out-of-network service, you or your provider may ask us for a pre-service organization determination before you receive the service. Please call our member services number or see Evidence of Coverage (EOC) for more information, including the cost-sharing that applies to out-of-network services.

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.

This information is available for free in other languages. Please call our member services number at 1-888-445-8913 (TTY: 711). From October 1 through February 14, our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week, excluding certain holidays. However, after February 14, our office hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. On weekends and certain holidays, your call will be handled by our automated phone system.

Health Net Life Insurance Company has a contract with Medicare to offer PPO plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.

BKT013547EK00 (6/17)

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: 1-888-445-8913 (HMO and PPO) (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 1-888-445-8913 (HMO and PPO) (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 1-888-445-8913 (HMO and PPO) (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 1-888-445-8913 (HMO and PPO) (TTY: 711)。
RUSSIAN	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-445-8913 (HMO and PPO) (TTY: 711).
KOREAN	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-445-8913 (HMO and PPO) (TTY: 711) 번으로 전화해 주십시오.
UKRAINIAN	УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-445-8913 (HMO and PPO) (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。1-888-445-8913 (HMO and PPO) (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. 1-888-445-8913 (HMO and PPO) (مكبراً مصلاً ففاه مقر: 711).
ROMANIAN	ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-445-8913 (HMO and PPO) (TTY: 711).
MON-KHMER CAMBODIAN	ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-888-445-8913 (HMO and PPO) (TTY: 711) ។
CUSHITE	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-445-8913 (HMO and PPO) (TTY: 711).
GERMAN	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-445-8913 (HMO and PPO) (TTY: 711).
PERSIAN	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-445-8913 (HMO and PPO) (TTY: 711) تماس بگیرید.
FRENCH	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-445-8913 (HMO and PPO) (TTY: 711).
THAI	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-445-8913 (HMO and PPO) (TTY: 711).