Health Net®
MEDICARE PROGRAMS

This is your Summary of Benefits.

2020
Health Net Violet 2 (PPO) H5439: 014-003
Marion and Polk counties, OR

H5439_014_003_20_13124SB_M Accepted 09012019

Coverage for every stage of life™

This booklet provides you with a summary of what we cover and your cost-sharing responsibilities. 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 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: Marion and Polk.
- You do not have End-Stage Renal Disease (ESRD). (Exceptions may apply for individuals who develop ESRD while enrolled in Health Net commercial or group health plan, or a Medicaid plan.)

With Health Net Violet 2 (PPO) 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 or.healthnetadvantage.com.

This Health Net Violet 2 (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, 2020–DECEMBER 31, 2020

Benefits	Health Net Violet 2 (PPO) H5439: 014 003 Premiums / Copays / Coinsurance	
	In-Network	**Out-of-Network**
Monthly Plan Premium	$32 You must continue to pay your Medicare Part B premium.	
Deductible	• $195 deductible combined in-network and out-of-network covered for medical services • $150 deductible for Part D prescription drugs (applies to drugs on Tiers 3, 4 and 5)	
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	• $6,700 in-network annually • $8,700 combined in- and out-of-network annually This is the most you will pay in copays and coinsurance for medical services for the year.	
Inpatient Hospital Coverage*	For each admission, you pay: • $450 copay per day, for days 1 through 4 • $0 copay per day, for days 5 and beyond	For each admission, you pay: • $550 copay per day, for days 1 through 10 • $0 copay per day, for days 11 and beyond
Outpatient Hospital Coverage*	• Outpatient Hospital: $325 copay per visit • Observation Services: $325 copay per visit • Ambulatory Surgical Center: $275 copay per visit	• Outpatient Hospital: $500 copay per visit • Observation Services: $500 copay per visit • Ambulatory Surgical Center: $325 copay per visit
Doctor Visits	• Primary Care: $15 copay per visit • Specialist: $35 copay per visit	• Primary Care: $40 copay per visit • Specialist: $50 copay per visit
Preventive Care *(e.g., flu vaccine, diabetic screening)*	$0 copay	$0 copay
	Other preventive services are available. Cost-sharing may apply when other services are received in addition to the preventive service.	
Emergency Care	$90 copay per visit	$90 copay per visit
	You do not have to pay the copay if admitted to the hospital immediately.	
Urgently Needed Services	$35 copay per visit	$35 copay per visit
	Copay is not waived if admitted to hospital.	

In-Network services with an * (asterisk) may require prior authorization from your doctor.

Benefits	Health Net Violet 2 (PPO) H5439: 014-003 Premiums / Copays / Coinsurance	
	In-Network	**Out-of-Network**
Diagnostic Services/ Labs/Imaging*	• Lab services: $15 copay • Diagnostic tests and procedures: 0%-19% coinsurance • X-ray services: $18 copay • Diagnostic radiology services (such as, MRI, MRA, CT, PET): 19% coinsurance	• Lab services: $20 copay • Diagnostic tests and procedures: 0%-20% coinsurance • X-ray services: $20 copay • Diagnostic radiology services (such as, MRI, MRA, CT, PET): 20% coinsurance
Hearing Services	Hearing exam (Medicare-covered): $30 copay per visit	Hearing exam (Medicare-covered): $50 copay per visit
Dental Services	Dental services (Medicare-covered): $35 copay	Dental services (Medicare-covered): $50 copay
	Additional preventive and comprehensive dental benefits are available for an extra premium. See optional supplemental benefits section.	
Vision Services	• Vision exam (Medicare-covered): $10 copay per visit • Routine eye exam: $10 copay per visit (up to 1 every calendar year) • Routine eyewear: up to $250 allowance every 2 calendar years combined for both in- and out-of-network	• Vision exam (Medicare-covered): $50 copay per visit • Routine eye exam: $10 copay per visit (up to 1 every calendar year) • Routine eyewear: up to $250 allowance every 2 calendar years combined for both in- and out-of network
Mental Health Services	Individual and group therapy: $35 copay per visit	Individual and group therapy: $50 copay per visit
Skilled Nursing Facility*	For each benefit period, you pay: • $0 copay per day, for days 1 through 20 • $170 copay per day, for days 21 through 100	For each benefit period, you pay: • $0 copay per day, for days 1 through 20 • $220 copay per day, for days 21 through 100
Physical Therapy*	$35 copay per visit	$50 copay per visit
Ambulance*	$325 copay (per one-way trip) for ground or air ambulance services	$325 copay (per one-way trip) for ground or air ambulance services
Transportation	Not covered	
Medicare Part B Drugs*	• Chemotherapy drugs: 19% coinsurance • Other Part B drugs: 19% coinsurance	• Chemotherapy drugs: 20% coinsurance • Other Part B drugs: 20% coinsurance

In-Network services with an * (asterisk) may require prior authorization from your doctor.

Part D Prescription Drugs			
Deductible Stage	$150 deductible for Part D prescription drugs (applies to drugs on Tiers 3, 4 and 5). The Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, you must pay the full cost of your Part D drugs until you reach the plan's deductible amount. Once you have paid the plan's deductible amount for your Part D drugs, you leave the Deductible Stage and move on to the next payment stage (Initial Coverage Stage).		
Initial Coverage Stage *(after you pay your Part D deductible, if applicable)*	After you have met your deductible (if applicable), the plan pays its share of the cost of your drugs and you pay your share of the cost. You generally stay in this stage until the amount of your year-to-date "total drug costs" reaches $4,020. "Total drug costs" is the total of all payments made for your covered Part D drugs. It includes what the plan pays, what you pay. Once your "total drug costs" reach $4,020 you move to the next payment stage (Coverage Gap Stage).		
	Preferred Retail Rx 30-day supply	**Standard Retail Rx 30-day supply**	**Mail Order Rx 90-day supply**
Tier 1: Preferred Generic	$5 copay	$10 copay	$10 copay
Tier 2: Generic	$15 copay	$20 copay	$30 copay
Tier 3: Preferred Brand	$37 copay	$47 copay	$74 copay
Tier 4: Non-Preferred Drug	$90 copay	$100 copay	$225 copay
Tier 5: Specialty	30% coinsurance	30% coinsurance	Not available
Tier 6: Select Care Drugs	$0 copay	$0 copay	$0 copay
Coverage Gap Stage	During this payment stage, you receive a 70% manufacturer's discount on covered brand name drugs and the plan will cover another 5%, so you will pay 25% of the negotiated price and a portion of the dispensing fee on brand-name drugs. In addition the plan will pay 75% and you pay 25% for generic drugs. (The amount paid by the plan does not count towards your out-of-pocket costs.) You generally stay in this stage until the amount of your year-to-date "out-of-pocket costs" reaches $6,350. "Out of pocket costs" includes what you pay when you fill or refill a prescription for a covered Part D drug and payments made for your drugs by any of the following programs or organizations: "Extra Help" from Medicare; Medicare's Coverage Gap Discount Program; Indian Health Service; AIDS drug assistance programs; most charities; and most State Pharmaceutical Assistance Programs (SPAPs). Once your "out-of-pocket costs" reach $6,350, you move to the next payment stage (Catastrophic Coverage Stage).		

Part D Prescription Drugs	
Catastrophic Stage	During this payment stage, the plan pays most of the cost for your covered drugs. For each prescription, you pay whichever of these is greater: a payment equal to 5% coinsurance of the drug, or a copayment ($3.60 for a generic drug or a drug that is treated like a generic, $8.95 for all other drugs).
Important Info:	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 any of the four stages of the Part D benefit. For more information about the costs for Long-Term Supply, Home Infusion, or additional pharmacy-specific cost-sharing and the stages of the benefit, please call us or access our EOC online.

Additional Covered Benefits		
Benefits	**Health Net Violet 2 (PPO) H5439: 014-003 Premiums / Copays / Coinsurance**	
	In-Network	**Out-of-Network**
Opioid Treatment Program Services	• Individual setting: $35 copay per visit • Group setting: $35 copay per visit	• Individual setting: $50 copay per visit • Group setting: $50 copay per visit
Chiropractic Care	Chiropractic services (Medicare-covered): $20 copay per visit	Chiropractic services (Medicare-covered): $20 copay per visit
Medical Equipment/ Supplies*	• Durable Medical Equipment (e.g., wheelchairs, oxygen): 19% coinsurance • Prosthetics (e.g., braces, artificial limbs): 19% coinsurance • Diabetic supplies: $0 copay	• Durable Medical Equipment (e.g., wheelchairs, oxygen): 20% coinsurance • Prosthetics (e.g., braces, artificial limbs): 20% coinsurance Diabetic supplies: $0 copay
Foot Care (Podiatry Services)	Foot exams and treatment (Medicare-covered): $35 copay	Foot exams and treatment (Medicare-covered): $50 copay
Virtual Visit	Teladoc offers 24 hours a day/7days a week/365 days a year virtual visit access to board certified doctors to help address a wide variety of health concerns/questions.	
Wellness Programs	• Fitness program: $0 copay • 24-hour Nurse Connect: $0 copay • Supplemental smoking and tobacco use cessation (counseling to stop smoking or tobacco use): $0 copay For a detailed list of wellness program benefits offered, please refer to the EOC.	• Fitness program: $0 copay • 24-hour Nurse Connect: $0 copay • Supplemental smoking and tobacco use cessation (counseling to stop smoking or tobacco use): $0 copay For a detailed list of wellness program benefits offered, please refer to the EOC.
Worldwide Emergency Care	$50,000 plan coverage limit for supplemental urgent/emergent services outside the U.S. and its territories every calendar year.	$50,000 plan coverage limit for supplemental urgent/emergent services outside the U.S. and its territories every calendar year.
Routine Annual Exam	$0 Copay	$0 Copay

In-Network services with an * (asterisk) may require prior authorization from your doctor.

Optional Supplemental Benefits

(you must pay an extra premium each month for these benefits)

Health Net Complete Dental

Monthly Premium This additional monthly premium is in addition to your monthly plan premium and the monthly Medicare Part B premium.	$39 per month

Dental Care Benefits

Preventive/Comprehensive Dental Care

You can see any licensed dentist to receive covered preventive and/or comprehensive services with minor restorative and non-surgical periodontics; however, you may pay a little more to use providers who are out-of-network.

	In-network	Out-of-network
Annual benefit maximum	$1000 in-and out-of-network combined, applies to preventive and comprehensive services	
Preventive services		
Oral exams – 2 per year	You pay a $0 copay	You pay a $0 copay
Cleanings (prophylaxis) - 2 per year	You pay a $0 copay	You pay a $0 copay
Fluoride treatment – 1 per year	You pay a $0 copay	You pay a $0 copay
Dental x-rays – 1 set of preventive x-rays (up to 4 bitewing x-rays)	You pay a $0 copay	You pay a $0 copay
Comprehensive services		
Non-routine services	You pay 50%	You pay 50%
Diagnostic services	You pay a $0 copay	You pay a $0 copay
Restorative services	You pay 20%	You pay 20%
Endodontic services	You pay 50%	You pay 50%
Periodontics	You pay 50%	You pay 50%
Extractions	You pay 50%	You pay 50%
Prosthodontics (dentures, oral/maxillofacial surgery and other services)	You pay 50%	You pay 50%

Optional Supplemental Benefits *(you must pay an extra premium each month for these benefits)*		
Health Net Basic Dental		
Monthly Premium This additional monthly premium is in addition to your monthly plan premium and the monthly Medicare Part B premium.	$19 per month	
Dental Care Benefits		
Preventive Dental Care You can see any licensed dentist to receive covered preventive services; however, you may pay a little more to use providers who are out-of-network.		
	In-network	**Out-of-network**
Annual Deductible	$35 in- and out-of-network	
Annual benefit maximum	$500 in-and out-of-network combined, applies to preventive services	
Preventive services		
Oral exams – 2 per year	You pay a $0 copay	You pay 20%
Cleanings (prophylaxis) - 2 per year	You pay a $0 copay	You pay 20%
Fluoride treatment – 1 per year	You pay a $0 copay	You pay 20%
Dental x-rays – 1 set of preventive x-rays (up to 4 bitewing x-rays)	You pay a $0 copay	You pay 20%

For more information, please contact:

Health Net Violet 2 (PPO)
PO Box 10420
Van Nuys, CA 91410

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 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 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. Call 1-888-445-8913 (TTY: 711) for more information.

“Coinsurance” is the percentage you pay of the total cost of certain medical and/or prescription 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.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-445-8913 (TTY: 711).

Out-of-network/non-contracted providers are under no obligation to treat Health Net Violet 2 (PPO) members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Health Net is contracted with Medicare for PPO plans. Enrollment in Health Net depends on contract renewal.