Health Net Seniority Plus Amber II Premier (HMO D-SNP) offered by Health Net Community Solutions, Inc.

Annual Notice of Changes for 2020

You are currently enrolled as a member of Health Net Seniority Plus Amber II Premier (HMO SNP). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 2.5 and 2.6 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost-sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2020 Drug List and look in Section 2.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

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☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 2.3 for information about our Provider & Pharmacy Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area.

- Use the personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 4.2 to learn more about your choices.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you want to **keep** Health Net Seniority Plus Amber II Premier (HMO SNP), you don't need to do anything. You will stay in Health Net Seniority Plus Amber II Premier (HMO SNP).
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in section 4.2, page 15 to learn more about your choices.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2019**

- If you don't join another plan **by December 7, 2019**, you will stay in Health Net Seniority Plus Amber II Premier (HMO SNP).
- If you join another plan between **October 15** and **December 7, 2019**, your new coverage will start on **January 1, 2020**.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-800-431-9007 for additional information. (TTY users should call 711). Hours are 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.
- We must provide information in a way that works for you (in languages other than English, in audio, in large print, or other alternate formats, etc.).
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Health Net Seniority Plus Amber II Premier (HMO D-SNP)

- Health Net is contracted with Medicare for HMO and HMO SNP plans, and with the state Medicaid program. Enrollment in Health Net depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Health Net Community Solutions, Inc. When it says "plan" or "our plan," it means Health Net Seniority Plus Amber II Premier (HMO D-SNP).

Summary of Important Costs for 2020

The table below compares the 2019 costs and 2020 costs for Health Net Seniority Plus Amber II Premier (HMO D-SNP) in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at ca.healthnetadvantage.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage.* If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2019 (this year)	2020 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 2.1 for details.	$0 – $34.80	$0 – $32
Doctor office visits	Primary care visits: You pay a 0 copay per visit. Specialist visits: You pay a $0 copay per visit.	Primary care visits: You pay a $0 copay per visit. Specialist visits: You pay a $0 copay per visit.
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day**.**	If you are eligible for partial Medicare cost-sharing assistance under Medicaid, you pay the Medicare defined cost-sharing amounts. In 2019, the Medicare-defined cost-sharing amounts for each benefit period are: $1,364 deductible for each benefit period. Days 1-60: $0 copay per day Days 61-90: $341 copay per day Lifetime reserve days 1-60: $682 copay per day Beyond lifetime reserve days: You are responsible for all costs.	If you are eligible for partial Medicare cost-sharing assistance under Medicaid, you pay the Medicare defined cost-sharing amounts. In 2019, the Medicare-defined cost-sharing amounts for each benefit period are: $1,364 deductible for each benefit period. Days 1-60: $0 copay per day Days 61-90: $341 copay per day Lifetime reserve days 1-60: $682 copay per day Beyond lifetime reserve days: You are responsible for all costs.

Cost	2019 (this year)	2020 (next year)
		These are 2019 cost sharing amounts and may change for 2020. Please contact Member Services for more information (See Section 8.1).
Part D prescription drug coverage (See Section 2.6 for details.)	Deductible: $290 (applies to drugs in Tiers 2, 3, 4, and 5) Copayment/Coinsurance as applicable during the Initial Coverage Stage: • **Drug Tier 1 – Preferred Generic Drugs:** Standard cost-sharing: You pay a $0 copay for a one-month (30-day) supply. • **Drug Tier 2 – Generic Drugs:** Standard cost-sharing: You pay a $20 copay for a one-month (30-day) supply. • **Drug Tier 3 – Preferred Brand Drugs:** Standard cost-sharing: You pay a $47 copay for a one-month (30-day) supply.	Deductible: $395 (applies to drugs in Tiers 2, 3, 4, and 5) Copayment/Coinsurance as applicable during the Initial Coverage Stage: • **Drug Tier 1 – Preferred Generic Drugs:** Standard cost-sharing: You pay a $0 copay for a one-month (30-day) supply. • **Drug Tier 2 - Generic Drugs:** Standard cost-sharing: You pay a $20 copay for a one-month (30-day) supply. • **Drug Tier 3 – Preferred Brand Drugs:** Standard cost-sharing: You pay a $47 copay for a one-month (30-day) supply.

Cost	2019 (this year)	2020 (next year)
	• **Drug Tier 4 – Non-Preferred Drugs:** Standard cost-sharing: You pay a $100 copay for a one-month (30-day) supply. • **Drug Tier 5 – Specialty Tier:** Standard cost-sharing: You pay 27% of the total cost for a one-month (30-day) supply. • **Drug Tier 6 – Select Care Drugs:** Standard cost-sharing: You pay a $0 copay for a one-month (30-day) supply.	• **Drug Tier 4 – Non-Preferred Drugs** Standard cost-sharing: You pay a $100 copay for a one-month (30-day) supply. • **Drug Tier 5 – Specialty Tier:** Standard cost-sharing: You pay 25% of the total cost for a one-month (30-day) supply. • **Drug Tier 6 – Select Care Drugs:** Standard cost-sharing: You pay a $0 copay for a one-month (30-day) supply.
Maximum out-of-pocket amount This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	$5,000 If you are eligible for partial Medicare cost-sharing assistance under Medicaid, you may be responsible for paying out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	$3,500 If you are eligible for partial Medicare cost-sharing assistance under Medicaid, you may be responsible for paying out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

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SECTION 1 We Are Changing the Plan's Name

On January 1, 2020, our plan name will change from Health Net Seniority Plus Amber II Premier (HMO SNP) to Health Net Seniority Plus Amber II Premier (HMO D-SNP).

You will receive a new ID card in the mail with this new plan name. Also, any new information provided to you regarding your plan will reference the new plan name.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2019 (this year)	2020 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0 – $34.80 Your premium is based on your Low Income Subsidy status.	$0 – $32 Your premium is based on your Low Income Subsidy status.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2019 (this year)	2020 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** If you are eligible for partial Medicare cost-sharing assistance under Medicaid, you may be responsible for paying out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$5,000	$3,500 Once you have paid $3,500 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 2.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider & Pharmacy Directory is located on our website at ca.healthnetadvantage.com. You may also call Member Services for updated provider information or to ask us to mail you a Provider & Pharmacy Directory. **Please review the 2020 Provider & Pharmacy Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.

- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Section 2.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. An updated Provider & Pharmacy Directory is located on our website at ca.healthnetadvantage.com. You may also call Member Services for updated pharmacy information or to ask us to mail you a Provider & Pharmacy Directory. **Please review the 2020 Provider & Pharmacy Directory to see which pharmacies are in our network**.

Section 2.5 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Benefits Chart (what is covered and what you pay)*, in your *2020 Evidence of Coverage.* A copy of the *Evidence of Coverage* is located on our website at ca.healthnetadvantage.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage.*

Cost	2019 (this year)	2020 (next year)
Prior Authorization	The following required prior authorization: • Inpatient hospital care • Inpatient mental health care • Skilled Nursing Facility (SNF) care • Cardiac and pulmonary rehabilitation services • Partial hospitalization services • Home health services	The following will require prior authorization: • Inpatient hospital care • Inpatient mental health care • Skilled Nursing Facility (SNF) care • Cardiac and pulmonary rehabilitation services • Partial hospitalization services • Home health services

Cost	2019 (this year)	2020 (next year)

	• Chiropractic services
	• Physician specialist services
	• Outpatient mental health specialty services
	• Outpatient mental health care (psychiatric)
	• Outpatient rehabilitation services:
	  o Occupational therapy
	  o Physical therapy
	  o Speech therapy
	• Outpatient diagnostic tests and lab services
	• Outpatient diagnostic/ therapeutic radiological services
	• Outpatient hospital services
	• Outpatient observation services
	• Ambulatory Surgical Center (ASC) services
	• Outpatient substance abuse
	• Outpatient blood services
	• Ambulance services for fixed wing aircraft and non-emergency services
	• Transportation services
	• Durable medical equipment
	• Prosthetic devices and related supplies
	• Diabetic services and supplies
	• Services to treat kidney disease and conditions:
	  o Renal dialysis
	  o Kidney disease education
	• Medicare-covered preventive services
		• Chiropractic services
		• Physician specialist services
		• Outpatient mental health specialty services
		• Outpatient mental health care (psychiatric)
		• Outpatient rehab rehabilitation services:
		  o Occupational therapy
		  o Physical therapy
		  o Speech therapy
		• Opioid treatment services
		• Outpatient diagnostic tests and lab services
		• Outpatient diagnostic/ therapeutic radiological services
		• Outpatient hospital services
		• Outpatient observation services
		• Ambulatory Surgical Center (ASC) services
		• Outpatient substance abuse
		• Outpatient blood services
		• Ambulance services for fixed wing aircraft and non-emergency services
		• Transportation services
		• Durable medical equipment
		• Prosthetic devices and related supplies
		• Diabetic services and supplies
		• Medicare-covered preventive services
		• Medicare Part B prescription drugs
		• Comprehensive dental services

Cost	2019 (this year)	2020 (next year)

	• Other Medicare-covered preventive services:
	  o Glaucoma screening
	  o Diabetes self-management training
	  o Barium enema
	  o Digital rectal exam
	  o EKG following welcome visit
	  o Other Medicare-covered preventive services
	• Medicare Part B prescription drugs
	• Comprehensive dental services
	• Vision care exams
	• Vision care eyewear
	• Hearing exams
		• Vision care eyewear
		• Hearing aids
		
		The following will no longer require prior authorization:
		• Services to treat kidney disease and conditions:
		  o Renal dialysis
		  o Kidney disease education
		• Other Medicare-covered preventive services:
		  o Glaucoma screening
		  o Diabetes self-management training
		  o Barium enema
		  o Digital rectal exam
		  o EKG following welcome visit
		  o Other Medicare-covered preventive services
		• Vision care exams
		• Hearing exams

Opioid treatment services	Not covered as a separate benefit. Some services for Opioid Use Treatment were covered under your Substance Abuse benefits.	You pay 20% of the total cost for each Medicare-covered opioid treatment in a group or individual setting, if you are eligible for partial Medicare cost-sharing assistance under Medicaid. If you are eligible for full Medicare cost-sharing assistance under Medicaid, you pay $0.

Cost	2019 (this year)	2020 (next year)
Routine Vision (Eyewear)	You pay a $65 copay for standard progressive lenses. You pay a $65 copay plus 80% of the retail charge, minus $120 plan allowance for premium progressive lenses every 2 calendar years. Please refer to your Evidence of Coverage for more details.	You pay a $65 copay for standard and premium progressive lenses. There is a $120 benefit limit on progressive lenses every 2 calendar years. You are responsible for amounts over the benefit limit. Please refer to your Evidence of Coverage for more details.
Additional smoking cessation	Additional smoking cessation is not offered.	You pay a $0 copay for up to 4 additional outbound coaching calls through our telephonic and online tobacco cessation program per calendar year. Includes online support and unlimited inbound calls to a quit coach. Please refer to your Evidence of Coverage for more details.

Section 2.6 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.

  - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.

- **Work with your doctor (or prescriber) to find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage.)

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. Because you receive "Extra Help" and haven't received this insert by September 30, 2019, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in 8.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2019 (this year)	2020 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 2 (Generic Drugs), Tier 3 (Preferred Brand Drugs), Tier 4 (Non-Preferred Drugs), and Tier 5 (Specialty Tier) drugs until you have reached the yearly deductible.	The deductible is $290. During this stage, you pay $0 cost-sharing for drugs on Tier 1 (Preferred Generic Drugs) and Tier 6 (Select Care Drugs) and the full cost of drugs on Tier 2 (Generic Drugs), Tier 3 (Preferred Brand Drugs), Tier 4 (Non-Preferred Drugs), and Tier 5 (Specialty Tier) until you have reached the yearly deductible. Your deductible amount is either $0 or $85, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)	The deductible is $395. During this stage, you pay $0 cost-sharing for drugs on Tier 1 (Preferred Generic Drugs) and Tier 6 (Select Care Drugs) and the full cost of drugs on Tier 2 (Generic Drugs), Tier 3 (Preferred Brand Drugs), Tier 4 (Non-Preferred Drugs), and Tier 5 (Specialty Tier) until you have reached the yearly deductible. Your deductible amount is either $0 or $89, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2019 (this year)	2020 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the**	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Drug Tier 1 – Preferred Generic Drugs:** You pay a $0 copay per prescription.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Drug Tier 1 – Preferred Generic Drugs:** You pay a $0 copay per prescription.

Stage	2019 (this year)	2020 (next year)
cost. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply, at a network pharmacy that offers preferred cost-sharing; or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	**Drug Tier 2 – Generic Drugs:** You pay a $20 copay per prescription. **Drug Tier 3 – Preferred Brand Drugs:** You pay a $47 copay per prescription. **Drug Tier 4 – Non-Preferred Drugs:** You pay a $100 copay per prescription. **Drug Tier 5 – Specialty Tier:** You pay 27% of the total cost. **Drug Tier 6 – Select Care Drugs:** You pay a $0 copay per prescription. _____ Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).	**Drug Tier 2 – Generic Drugs:** You pay a $20 copay per prescription. **Drug Tier 3 – Preferred Brand Drugs:** You pay a $47 copay per prescription. **Drug Tier 4 – Non-Preferred Drugs:** You pay a $100 copay per prescription. **Drug Tier 5 – Specialty Tier:** You pay 25% of the total cost. **Drug Tier 6 – Select Care Drugs:** You pay a $0 copay per prescription. _____ Once your total drug costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage**.

For information about your costs in these stages, look at your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 3 Administrative Changes

Process	2019 (this year)	2020 (next year)
Maximum Out-of-Pocket (MOOP)	The following benefits and services apply to your maximum out-of-pocket : All in-network Medicare-covered benefits Worldwide emergency care, urgent care , and emergency transportation services Non-Medicare covered routine foot care First 3 pints of blood Routine eye exams	The following benefits and services apply to your maximum out-of-pocket : All in-network Medicare-covered benefits Non-Medicare covered routine foot care First 3 pints of blood Transportation services to plan-approved location Non-Medicare covered annual physical exam Fitness benefit Nurse advice line Additional sessions of smoking and tobacco Preventive dental services Routine eye exams Routine eyewear Routine hearing exams Fitting for hearing aids
Transportation	You called member services to access your Transportation Benefit.	To access your Transportation Benefit call Circulation to schedule your ride at 1-877-718-4201 from 8 a.m. – 6 p.m. (Local Time), Monday – Friday. TTY users call 1-866-288-3133.

Process	2019 (this year)	2020 (next year)
Referral changes	Your plan requires Referrals from your PCP for select services.	Referral requirements may have changed for 2020. See the Medical Benefits Chart in Chapter 4 of your 2020 Evidence of Coverage for benefits that require referral.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Health Net Seniority Plus Amber II Premier (HMO D-SNP)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare, you will automatically stay enrolled as a member of our plan for 2020.

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2020 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2020*, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Health Net Seniority Plus Amber II Premier (HMO D-SNP).
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Health Net Seniority Plus Amber II Premier (HMO D-SNP).
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 8.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

  If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 5 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from now until December 7. The change will take effect on January 1, 2020.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area may be allowed to make a change at other times of the year.

If you enrolled in a Medicare Advantage plan for January 1, 2020, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2020. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

SECTION 6 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In California, the SHIP is called Health Insurance Counseling & Advocacy Program (HICAP).

HICAP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. HICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call HICAP at 1-800-434-0222. TTY users should call 711 (National Relay Service). You can learn more about HICAP by visiting their website (www.hicapservices.net).

For information about your Medi-Cal benefits, contact Medi-Cal - administered by Department of Health Care Services at 1-800-541-5555, Monday – Friday, 8 a.m. – 5 p.m., except holidays. TTY users call 1-866-784-2595. Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal coverage.

SECTION 7 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in 'Extra Help,' also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about Extra Help, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the California Office of AIDS - ADAP. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-844-421-7050 from Monday through Friday, between 8 a.m. and 5 p.m., excluding holidays. TTY users call 711.

SECTION 8 Questions?

Section 8.1 – Getting Help from Health Net Seniority Plus Amber II Premier (HMO D-SNP)

Questions? We're here to help. Please call Member Services at 1-800-431-9007. (TTY only, call 711.) We are available for phone calls 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. Calls to these numbers are free.

Read your 2020 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2020. For details, look in the 2020 *Evidence of Coverage* for Health Net Seniority Plus Amber II Premier (HMO D-SNP). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at ca.healthnetadvantage.com. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at ca.healthnetadvantage.com. As a reminder, our website has the most up-to-date information about our provider network (Provider & Pharmacy Directory) and our list of covered drugs (Formulary/Drug List).

Section 8.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2020*

You can read *Medicare & You 2020* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or 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.

Section 8.3 – Getting Help from Medicaid

To get information from Medicaid you can call Department of Health Care Services (DHCS)/Medi-Cal at 1-800-541-5555 from Monday to Friday between 8 a.m. to 5 p.m., except holidays. TTY users call 1-866-784-2595.