Health Net®
MEDICARE PROGRAMS

This is your Summary of Benefits.

2020
Health Net Ruby Select (HMO) H0562: 097
San Francisco County, CA

H0562_097_20_13080SB_M_Accepted 09012019

Coverage for every stage of life™

This booklet provides you with a summary of what we cover and the 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 ca.healthnetadvantage.com.

You are eligible to enroll in Health Net Ruby Select (HMO) if:

- You are entitled to Medicare Part A and enrolled in Medicare Part B. Members must continue to pay their Medicare Part B premium if not otherwise paid for under Medicaid or by another third party.
- You must be a United States citizen, or are lawfully present in the United States and permanently reside in the service area of the plan (in other words, your permanent residence is within the Health Net Ruby Select (HMO) service area county). Our service area includes the following county in California: San Francisco.
- You do not have End-Stage Renal Disease (ESRD). (Exceptions may apply for individuals who develop ESRD while enrolled in a Health Net commercial or group health plan, or a Medicaid plan.)

The Health Net Ruby Select (HMO) plan gives you access to our network of highly skilled medical providers in your area. You can look forward to choosing a Primary Care Provider (PCP) to work with you and coordinate your care. You can ask for a current provider and pharmacy directory or, for an up-to-date list of network providers, visit ca.healthnetadvantage.com. (Please note that, except for emergency care, urgently needed care when you are out of the network, out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers, if you obtain medical care from out-of-plan providers, neither Medicare nor Health Net Ruby Select (HMO) will be responsible for the costs.)

This Health Net Ruby Select (HMO) plan also includes Part D coverage, which provides you with the ease of having both your medical and prescription drug needs coordinated through a single convenient source.

Summary of Benefits

JANUARY 1, 2020–DECEMBER 31, 2020

Benefits	Health Net Ruby Select (HMO) H0562: 097 Premiums / Copays / Coinsurance
Monthly Plan Premium	$0 You must continue to pay your Medicare Part B premium.
Deductible	No deductible
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	$4,400 annually This is the most you will pay in copays and coinsurance for covered medical services for the year.
Inpatient Hospital Coverage* ▪	For each admission, you pay: • $345 copay per day, for days 1 through 5 • $0 copay per day, for days 6 and beyond
Outpatient Hospital Coverage* ▪	• Outpatient Hospital: $345 copay per visit • Observation Services: $345 copay during an outpatient hospital facility visit • Observation Services: $90 copay during an emergency room visit • Ambulatory Surgical Center: $200 copay per visit
Doctor Visits* ▪	• Primary Care: $5 copay per visit • Specialist: $20 copay per visit
Preventive Care* ▪ (e.g. flu vaccine, diabetic screening)	$0 copay for most Medicare-covered preventive services Other preventive services are available.
Emergency Care	$90 copay per visit You do not have to pay the copay if admitted to the hospital immediately.
Urgently Needed Services	$20 copay per visit
Diagnostic Services/ Labs/Imaging*	• Lab services: $0 copay • Diagnostic tests and procedures: $0 copay • Outpatient X-ray services: $0 copay • Diagnostic Radiology Services (such as, MRI, MRA, CT, PET): $60 copay
Hearing Services* ▪	• Hearing exam (Medicare-covered): $0 copay • Routine hearing exam: $0 copay (1 every calendar year) • Hearing aid: $0 - $1,580 copay (2 hearing aids total, 1 per ear, per calendar year)

Services with an * (asterisk) may require prior authorization from your doctor.

Services with a ▪ (square) may require referral from your doctor.

Benefits	Health Net Ruby Select (HMO) H0562: 097 Premiums / Copays / Coinsurance
Dental Services* ▪	• Dental services (Medicare-covered): $0 copay per visit Additional preventive and comprehensive dental benefits are available for an extra premium. See optional supplemental benefits section.
Vision Services* ▪	• Vision exam (Medicare-covered): $25 copay per visit • Routine eye exam: $12 copay per visit (up to 1 every calendar year) • $150 max allowance for eyeglass frames (or contact lenses in lieu of frames) every 2 years. • $120 max allowance for progressive eyeglass lenses or lens upgrades every 2 years (upgrades limited to progressive lenses only).
Mental Health Services*	Individual and group therapy: $15 copay per visit
Skilled Nursing Facility*	For each benefit period you pay: • $0 copay per day, days 1 through 20 • $75 copay per day, days 21 through 100
Physical Therapy* ▪	$0 copay per visit
Ambulance*	• Ground ambulance services: $295 copay (per one-way trip) • Air ambulance services: 5% coinsurance (per one-way trip)
Transportation	Not covered
Medicare Part B Drugs*	• Chemotherapy drugs: 20% coinsurance • Other Part B drugs: 20% coinsurance

Services with an * (asterisk) may require prior authorization from your doctor.

Services with a ▪ (square) may require referral from your doctor.

Part D Prescription Drugs			
Deductible Stage	This plan does not have a Part D deductible.		
Initial Coverage Stage *(after you pay your 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 and 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	$8 copay	$10 copay
Tier 2: Generic	$12 copay	$15 copay	$24 copay
Tier 3: Preferred Brand	$37 copay	$47 copay	$101 copay
Tier 4: Non-Preferred Drug	$90 copay	$100 copay	$260 copay
Tier 5: Specialty	33% coinsurance	33% coinsurance	Not available
Tier 6: Select Care Drugs	$0 copay	$0 copay	$0 copay

Part D Prescription Drugs	
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).
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 level of help you receive, 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 Ruby Select (HMO) H0562: 097 Premiums / Copays / Coinsurance
Opioid Treatment Program Services*	• Individual setting: $15 copay per visit • Group setting: $15 copay per visit
Over-the-Counter (OTC) Items	$0 copay ($30 allowance per quarter) for items available via mail There is a limit of 15 per item, per order, with the exception of blood pressure monitors, which are limited to one per year. Please visit the plan's website to see the list of covered over-the-counter items.
Chiropractic Care* ▪	• Chiropractic services (Medicare-covered): $10 copay per visit • Additional Chiropractic services are available for an extra premium. See optional supplemental benefits section.
Medical Equipment/ Supplies*	• 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): $25 copay • Routine foot care: $25 copay per visit (12 visits every calendar year)
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.
Worldwide Emergency Care	$50,000 plan coverage limit for supplemental urgent/emergent services outside the U.S. and its territories every calendar year.

Services with an * (asterisk) may require prior authorization from your doctor.
Services with a ▪ (square) may require referral from your doctor.

Optional Supplemental Benefits

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

Health Net Total	
Monthly Premium This additional monthly premium is in addition to your monthly plan premium and the monthly Medicare Part B premium.	$11 per month

Dental Care Benefits

Preventive/Comprehensive Dental Care

You must select a dentist from our list of network providers to use the benefits of the Dental HMO plan. Additional service limits apply.

	What you pay at an in-network provider
Preventive services	
Oral exams – 2 per year	You pay a $0 copay
Cleanings (prophylaxis) - 2 per year	You pay a $0 copay
Fluoride treatment – 1 per year	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
Comprehensive services	
Non-routine services	You pay a $0 copay
Diagnostic services	You pay a $0 - $15 copay
Restorative services	You pay a $0 - $300 copay
Endodontic services	You pay a $5 - $275 copay
Periodontics – limited to 1 per calendar year	You pay a $0 - $375 copay
Extractions	You pay a $15 - $150 copay
Prosthodontics (dentures, oral/maxillofacial surgery and other services)	You pay a $0 - $2,250 copay

Chiropractic and Acupuncture Services

	In-network	Out-of-network
Chiropractic	$10 copay per visit	You pay 50%
Acupuncture	$10 copay per visit	You pay 50%

Limited to 30 visits per year (acupuncture and chiropractic visits combined)

Optional Supplemental Benefits

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

Health Net Total FLEX	
Monthly Premium This additional monthly premium is in addition to your monthly plan premium and the monthly Medicare Part B premium.	$28 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%

Chiropractic and Acupuncture Services

	In-network	Out-of-network
Chiropractic	$10 copay per visit	You pay 50%
Acupuncture	$10 copay per visit	You pay 50%
Limited to 30 visits per year (acupuncture and chiropractic visits combined)		

For more information, please contact:

Health Net Ruby Select (HMO)
PO Box 10420
Van Nuys, CA 91410

ca.healthnetadvantage.com

Current members should call: 1-800-275-4737 (TTY: 711)
Prospective members should call: 1-800-977-6738 (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 1-800-275-4737 (TTY: 711) for more information.

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

The 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 1-800-275-4737 (TTY: 711)

注意：如果您說中文，您可以獲得免費的語言協助服務。請致電 1-800-275-4737（聽障電話：711)

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

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