

# Summary of Benefits

2021

Health Net Ruby Select (HMO) H0562: 113  
Alameda County, CA

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](http://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: Alameda.

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](http://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, 2021 – DECEMBER 31, 2021

Benefits	Health Net Ruby Select (HMO) H0562: 113 Premiums / Copays / Coinsurance
<b>Monthly Plan Premium</b>	\$0 You must continue to pay your Medicare Part B premium.
<b>Deductibles</b>	No deductible
<b>Maximum Out-of-Pocket Responsibility</b> (does not include prescription drugs)	\$6,700 annually This is the most you will pay in copays and coinsurance for covered medical services for the year.
<b>Inpatient Hospital Coverage* ■</b>	For each admission, you pay: <ul style="list-style-type: none"> <li>● \$275 copay per day, for days 1 through 7</li> <li>● \$0 copay per day, for days 8 and beyond</li> </ul>
<b>Outpatient Hospital Coverage* ■</b>	<ul style="list-style-type: none"> <li>● Outpatient Hospital: \$250 copay per visit</li> <li>● Observation Services: \$250 copay during an outpatient hospital facility visit</li> <li>● Observation Services: \$90 copay during an emergency room visit</li> </ul>
<b>Doctor Visits (Primary Care Providers and Specialists)* ■</b>	<ul style="list-style-type: none"> <li>● Primary Care: \$0 copay per visit</li> <li>● Specialist: \$15 copay per visit</li> </ul>
<b>Preventive Care* ■</b> (e.g. flu vaccine, diabetic screening)	\$0 copay for most Medicare-covered preventive services Other preventive services are available.
<b>Emergency Care</b>	\$90 copay per visit You do not have to pay the copay if admitted to the hospital immediately.
<b>Urgently Needed Services</b>	\$20 copay per visit Copay is not waived if admitted to hospital.
<b>Diagnostic Services/ Labs/Imaging* ■</b> (includes diagnostic tests and procedures, labs, diagnostic radiology, and X-rays)	COVID-19 testing and specified testing-related services at any location are \$0. <ul style="list-style-type: none"> <li>● Lab services: \$0 copay</li> <li>● Diagnostic tests and procedures: \$0 copay</li> <li>● Outpatient X-ray services: \$0 copay</li> <li>● Diagnostic Radiology Services (such as, MRI, MRA, CT, PET): \$60 copay</li> </ul>

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

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

<b>Benefits</b>	<b>Health Net Ruby Select (HMO) H0562: 113 Premiums / Copays / Coinsurance</b>
<b>Hearing Services* ■</b>	<ul style="list-style-type: none"> <li>● Hearing exam (Medicare-covered): \$0 copay</li> <li>● Routine hearing exam: \$0 copay (1 every calendar year)</li> <li>● Hearing aid: \$0 to \$1,350 copay (2 hearing aids total, 1 per ear, per calendar year)</li> </ul>
<b>Dental Services* ■</b>	<ul style="list-style-type: none"> <li>● Dental services (Medicare-covered): \$0 copay per visit</li> <li>● Preventive Dental Services: \$0 copay (including oral exams, cleanings, fluoride treatment, and X-rays)</li> </ul> <p>Comprehensive dental services: Additional comprehensive dental benefits are available.</p>
<b>Vision Services* ■</b>	<ul style="list-style-type: none"> <li>● Vision exam (Medicare-covered): \$0 to \$25 copay per visit</li> <li>● Routine eye exam: \$12 copay per visit (up to 1 every calendar year)</li> <li>● Routine eyewear: up to \$150 allowance every calendar year</li> </ul>
<b>Mental Health Services*</b>	Individual and group therapy: \$10 copay per visit
<b>Skilled Nursing Facility*</b>	<p>For each benefit period, you pay:</p> <ul style="list-style-type: none"> <li>● \$0 copay per day, days 1 through 20</li> <li>● \$140 copay per day, days 21 through 100</li> </ul>
<b>Physical Therapy* ■</b>	\$0 copay per visit
<b>Ambulance</b>	<ul style="list-style-type: none"> <li>● Ground ambulance services: \$250 copay (per one-way trip)</li> <li>● Air ambulance services: 5% coinsurance (per one-way trip)</li> </ul>
<b>Ambulatory Surgery Center* ■</b>	Ambulatory Surgery Center: \$200 copay per visit
<b>Transportation* ■</b>	<ul style="list-style-type: none"> <li>● \$0 copay (per one-way trip)</li> <li>● Up to 20 one-way trips to plan-approved health-related locations every calendar year. Mileage limits may apply.</li> </ul>
<b>Medicare Part B Drugs*</b>	<ul style="list-style-type: none"> <li>● Chemotherapy drugs: 20% coinsurance</li> <li>● Other Part B drugs: 20% coinsurance</li> </ul>

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

<b>Deductible Stage</b>	This plan does not have a Part D deductible.		
<b>Initial Coverage Stage</b> (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 \$4,130. “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 \$4,130 you move to the next payment stage (Coverage Gap Stage).		
	<b>Preferred Retail Rx 30-day supply</b>	<b>Standard Retail Rx 30-day supply</b>	<b>Mail Order Rx 90-day supply</b>
<b>Tier 1: Preferred Generic Drugs</b>	\$0 copay	\$8 copay	\$0 copay
<b>Tier 2: Generic Drugs</b>	\$5 copay	\$15 copay	\$10 copay
<b>Tier 3: Preferred Brand Drugs</b>	\$42 copay	\$47 copay	\$116 copay
<b>Tier 4: Non-Preferred Drugs</b>	\$95 copay	\$100 copay	\$275 copay
<b>Tier 5: Specialty</b>	33% coinsurance	33% coinsurance	Not available
<b>Tier 6: Select Care Drugs</b>	\$0 copay	\$0 copay	\$0 copay
<b>Coverage Gap Stage</b>	<p>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).</p> <p>You generally stay in this stage until the amount of your year-to-date “out-of-pocket costs” reaches \$6,550. “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 \$6,550, you move to the next payment stage (Catastrophic Coverage Stage).</p>		
<b>Catastrophic Coverage Stage</b>	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 (\$3.70 for a generic drug or a drug that is treated like a generic, \$9.20 for all other drugs).		

## Part D Prescription Drugs

**Important Info:**

Cost-sharing may change depending on the level of help you receive, the pharmacy you choose (such as Standard Retail, Preferred 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.

<b>Additional Covered Benefits</b>	
<b>Benefits</b>	<b>Health Net Ruby Select (HMO) H0562: 113 Premiums / Copays / Coinsurance</b>
<b>Additional Telehealth Services* ▣</b>	The cost share of Medicare-covered additional telehealth services with primary care physicians, specialists, individual/group sessions with mental health and psychiatric providers and other health care practitioners within these practices will be equal to the cost share of these individual services' office visits.
<b>Opioid Treatment Program Services*</b>	<ul style="list-style-type: none"> <li>• Individual setting: \$10 copay per visit</li> <li>• Group setting: \$10 copay per visit</li> </ul>
<b>Over-the-Counter (OTC) Items</b>	<p>\$0 copay (\$50 allowance per quarter) for items available via mail. There is a limit of 9 per item, per order, with the exception of certain products, which have additional limits. You are allowed to order once per quarter and any unused money does not carry over to the next quarter.</p> <p>Please visit the plan's website to see the list of covered over-the-counter items.</p>
<b>Chiropractic Care* ▣</b>	<ul style="list-style-type: none"> <li>• Chiropractic services (Medicare-covered): \$0 copay per visit</li> <li>• Routine chiropractic services: \$0 copay per visit (24 visits every calendar year combined with routine acupuncture services)</li> </ul>
<b>Acupuncture* ▣</b>	<ul style="list-style-type: none"> <li>• Acupuncture services for chronic low back pain (Medicare-covered): \$0 copay per visit in a chiropractic setting</li> <li>• Acupuncture services for chronic low back pain (Medicare-covered): \$0 copay per visit in a Primary Care Provider's office</li> <li>• Acupuncture services for chronic low back pain (Medicare-covered): \$15 copay per visit in a Specialist's office</li> <li>• Routine acupuncture services: \$0 copay per visit (24 visits every calendar year combined with routine chiropractic services)</li> </ul>
<b>Medical Equipment/Supplies*</b>	<ul style="list-style-type: none"> <li>• Durable Medical Equipment (e.g., wheelchairs, oxygen): 20% coinsurance</li> <li>• Prosthetics (e.g., braces, artificial limbs): 20% coinsurance</li> <li>• Diabetic supplies: 0% to 20% coinsurance. Minimum cost for preferred diabetic supplies and maximum cost for non-preferred diabetic supplies after prior authorization.</li> </ul>

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

<b>Additional Covered Benefits</b>	
<b>Benefits</b>	<b>Health Net Ruby Select (HMO) H0562: 113 Premiums / Copays / Coinsurance</b>
<b>Foot Care<sup>▪</sup> (Podiatry Services)</b>	<ul style="list-style-type: none"> <li>• Foot exams and treatment (Medicare-covered): \$25 copay</li> <li>• Routine foot care: \$25 copay per visit (12 visits every calendar year)</li> </ul>
<b>Virtual Visit</b>	Teladoc™ plan 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.
<b>Wellness Programs</b>	<ul style="list-style-type: none"> <li>• Fitness program: \$0 copay</li> <li>• 24-hour Nurse Connect: \$0 copay</li> <li>• Supplemental smoking and tobacco use cessation (counseling to stop smoking or tobacco use): \$0 copay</li> </ul> <p>For a detailed list of wellness program benefits offered, please refer to the EOC.</p>
<b>Worldwide Emergency Care</b>	\$50,000 plan coverage limit for urgent/emergent services outside the U.S. and its territories every calendar year.
<b>Routine Annual Exam</b>	\$0 Copay

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



## **PRIVACY PRACTICES:**

Once you become a Health Net member, Health Net uses and discloses a member's protected health information and nonpublic personal financial information\* for purposes of treatment, payment, health care operations, and where permitted or required by law. Health Net provides members with a Notice of Privacy Practices that describes how it uses and discloses protected health information; the individual's rights to access, to request amendments, restrictions, and an accounting of disclosures of protected health information; and the procedures for filing complaints. Health Net will provide you the opportunity to approve or refuse the release of your information for non-routine releases such as marketing. Health Net provides access to members to inspect or obtain a copy of the member's protected health information in designated record sets maintained by Health Net. Health Net protects oral, written and electronic information across the organization by using reasonable and appropriate security safeguards. These safeguards include limiting access to an individual's protected health information to only those who have a need to know in order to perform payment, treatment, health care operations or where permitted or required by law. Health Net's entire Notice of Privacy Practices can be found at [ca.healthnetadvantage.com](http://ca.healthnetadvantage.com) under "Privacy" or you may call the Customer Contact Center at the phone number on the back cover of this booklet to obtain a copy.

*\*Nonpublic personal financial information includes personally identifiable financial information that you provided to us to obtain health plan coverage or we obtained in providing benefits to you. Examples include Social Security numbers, account balances and payment history. We do not disclose any nonpublic personal information about you to anyone, except as permitted by law.*

## For more information, please contact:

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

[ca.healthnetadvantage.com](http://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](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.

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 drug 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 1-800-275-4737 (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.