Health Net®
MEDICARE PROGRAMS

Summary of Benefits

2021

Health Net Violet 4 (PPO) H5439: 017
Lane County, OR

H5439_017_21_19068SB_M Accepted 09012020

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 or.healthnetadvantage.com.

You are eligible to enroll in Health Net Violet 4 (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 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 Violet 4 (PPO) service area county). Our service area includes the following county in Oregon: Lane.

With Health Net Violet 4 (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 and pharmacy directory at our website at or.healthnetadvantage.com.

This Health Net Violet 4 (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, 2021 – DECEMBER 31, 2021

Benefits	Health Net Violet 4 (PPO) H5439: 017 Premiums / Copays / Coinsurance	
	In-network	**Out-of-network**
Monthly Plan Premium	$0 You must continue to pay your Medicare Part B premium.	
Deductibles	• $0 deductible combined in-network and out-of-network for covered medical services • $125 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)	• $3,450 in-network annually • $3,450 combined in and out-of-network 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: • $450 copay per day, for days 1 through 4 • $0 copay per day, for days 5 and beyond	For each admission, you pay: • $450 copay per day, for days 1 through 4 • $0 copay per day, for days 5 and beyond
Outpatient Hospital Coverage*	• Outpatient Hospital: 20% coinsurance (up to $325) per visit • Observation Services: $325 copay per visit	• Outpatient Hospital: $325 copay per visit • Observation Services: $325 copay per visit
Doctor Visits (Primary Care Providers and Specialists)	• Primary Care: $0 copay per visit • Specialist: $35 copay per visit	• Primary Care: $0 copay per visit • Specialist: $35 copay per visit
Preventive Care (e.g. flu vaccine, diabetic screening)	$0 copay	$0 copay
	Other preventive services are available.	
Emergency Care	$120 copay per visit	$120 copay per visit
	You do not have to pay the copay if admitted to the hospital immediately.	

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

Benefits	Health Net Violet 4 (PPO) H5439: 017 Premiums / Copays / Coinsurance	
	In-network	**Out-of-network**
Urgently Needed Services	$25 copay per visit	$25 copay per visit
	Copay is not waived if admitted to hospital.	
Diagnostic Services/ Labs/Imaging* (includes diagnostics tests and procedures, labs, diagnostic radiology, and X-rays)	COVID-19 testing and specified testing-related services at any location are $0. • Lab services: $0 copay • Diagnostic tests and procedures: 0% to 20% coinsurance • EKG: 0% coinsurance • X-ray services: $20 copay • Diagnostic radiology services (such as, MRI, MRA, CT, PET): 20% coinsurance	• Lab services: $0 copay • Diagnostic tests and procedures: 20% coinsurance • EKG: 0% coinsurance • X-ray services: $20 copay • Diagnostic radiology services (such as, MRI, MRA, CT, PET): 20% coinsurance
Hearing Services	• Hearing exam (Medicare-covered): $25 copay per visit • Routine hearing exam: $0 copay (1 every calendar year) • Hearing aid: $0 to $1,580 copay (2 hearing aids total, 1 per ear, per calendar year)	Hearing exam (Medicare-covered): $25 copay per visit
Dental Services	Dental services (Medicare-covered): $35 copay per visit	Dental services (Medicare-covered): $35 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): $0 to $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): $0 to $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
Mental Health Services	Individual and group therapy: $35 copay per visit	Individual and group therapy: $35 copay per visit

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Benefits	Health Net Violet 4 (PPO) H5439: 017 Premiums / Copays / Coinsurance	
	In-network	Out-of-network
Skilled Nursing Facility*	For each benefit period, you pay: • $0 copay per day, for days 1 through 20 • $184 copay per day, for days 21 through 100	For each benefit period, you pay: • $0 copay per day, for days 1 through 20 • $184 copay per day, for days 21 through 100
Physical Therapy*	$30 copay per visit	$30 copay per visit
Ambulance	$260 copay (per one-way trip) for ground or air ambulance services	$260 copay (per one-way trip) for ground or air ambulance services
Ambulatory Surgery Center*	Ambulatory Surgery Center: 20% coinsurance (up to $250) per visit	Ambulatory Surgery Center: $250 copay per visit
Transportation	Not covered	
Medicare Part B Drugs*	• Chemotherapy drugs: 20% coinsurance • Other Part B drugs: 20% coinsurance	• Chemotherapy drugs: 20% coinsurance • Other Part B drugs: 20% coinsurance

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Part D Prescription Drugs			
Deductible Stage	$125 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 $4,130. "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 $4,130 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 Drugs	$3 copay	$8 copay	$6 copay
Tier 2: Generic Drugs	$8 copay	$15 copay	$16 copay
Tier 3: Preferred Brand Drugs	$37 copay	$47 copay	$74 copay
Tier 4: Non-Preferred Drugs	$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 $6,550. "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).		

Part D Prescription Drugs	
Catastrophic Coverage 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 ($3.70 for a generic drug or a drug that is treated like a generic, $9.20 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 4 (PPO) H5439: 017 Premiums / Copays / Coinsurance**	
	In-network	**Out-of-network**
Additional Telehealth Services	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.	
Opioid Treatment Program Services	• Individual setting: $35 copay per visit • Group setting: $35 copay per visit	• Individual setting: $35 copay per visit • Group setting: $35 copay per visit
Chiropractic Care	Chiropractic services (Medicare-covered): $15 copay per visit	Chiropractic services (Medicare-covered): $15 copay per visit
Acupuncture	• Acupuncture services for chronic low back pain (Medicare-covered): $15 copay per visit in a chiropractic setting • Acupuncture services for chronic low back pain (Medicare-covered): $0 copay per visit in a Primary Care Provider's office • Acupuncture services for chronic low back pain (Medicare-covered): $35 copay per visit in a Specialist's office	• Acupuncture services for chronic low back pain (Medicare-covered): $15 copay per visit in a chiropractic setting • Acupuncture services for chronic low back pain (Medicare-covered): $0 copay per visit in a Primary Care Provider's office • Acupuncture services for chronic low back pain (Medicare-covered): $35 copay per visit in a Specialist's office
Medical Equipment/ Supplies*	• Durable Medical Equipment (e.g., wheelchairs, oxygen): 20% coinsurance • Prosthetics (e.g., braces, artificial limbs): 20% 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): $35 copay
Virtual Visit	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.	

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Additional Covered Benefits		
Benefits	**Health Net Violet 4 (PPO) H5439: 017 Premiums / Copays / Coinsurance**	
	In-network	**Out-of-network**
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 urgent/emergent services outside the U.S. and its territories every calendar year.	$50,000 plan coverage limit for urgent/emergent services outside the U.S. and its territories every calendar year.
Routine Annual Exam	$0 copay	$0 copay

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.	$6 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 and out-of-network
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	You pay a $0 copay

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.	$15 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	You pay a $0 copay	You pay a $0 copay
Comprehensive services		
Non-routine services	You pay a $0 copay	You pay a $0 copay
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%

For more information, please contact:

Health Net Violet 4 (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 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.

Out-of-network/non-contracted providers are under no obligation to treat
Health Net Violet 4 (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.

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