Health Net Seniority Plus Green (HMO) offered by
Health Net of California, Inc.

Annual Notice of Changes for 2019

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

- You have from October 15 until December 7 to make changes to your Medicare coverage for next year.

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 Section 1.4 for information about benefit and cost changes for our plan.

2. **COMPARE: Learn about other plan choices**
   - Check to see if your doctors and other providers will be in our network next year.
     - Are your doctors in our network?
     - What about the hospitals or other providers you use?
     - Look in Section 1.3 for information about our Provider 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.
Check coverage and costs of plans in your area.

- Review the list in the back of your Medicare & You handbook.
- Look in Section 3.2 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 Green (HMO), you don’t need to do anything. You will stay in Health Net Seniority Plus Green (HMO).
- To change to a different plan that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between October 15 and December 7, 2018

- If you don’t join another plan by December 7, 2018, you will stay in Health Net Seniority Plus Green (HMO).
- If you join another plan by December 7, 2018, your new coverage will start on January 1, 2019.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Member Services number at 1-800-275-4737 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 Green (HMO)

- Health Net is contracted with Medicare for HMO, HMO SNP and PPO plans, and with some state Medicaid programs. Enrollment in Health Net depends on contract renewal.
- When this booklet says “we,” “us,” or “our,” it means Health Net of California, Inc. When it says “plan” or “our plan,” it means Health Net Seniority Plus Green (HMO).
**Summary of Important Costs for 2019**

The table below compares the 2018 costs and 2019 costs for Health Net Seniority Plus Green (HMO) in several important areas. Please note this is only a summary of changes. It is important to read the rest of this Annual Notice of Changes and review the Evidence of Coverage to see if other benefit or cost changes affect you.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2018 (this year)</th>
<th>2019 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly plan premium</strong></td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(See Section 1.1 for details.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maximum out-of-pocket amount</strong></td>
<td>$3,400</td>
<td>$3,400</td>
</tr>
<tr>
<td>This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctor office visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You pay a $7 copay per visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist visits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You pay a $10 copay per visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient hospital stays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days 1 - 5:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You pay a $200 copay per day, per benefit period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days 6 – and beyond:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You pay a $0 copay per day, per benefit period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days 1 - 5:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You pay a $200 copay per day, per admission.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days 6 – and beyond:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You pay a $0 copay per day, per admission.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Annual Notice of Changes for 2019
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## SECTION 1 Changes to Benefits and Costs for Next Year

### Section 1.1 – Changes to the Monthly Premium

<table>
<thead>
<tr>
<th>Cost</th>
<th>2018 (this year)</th>
<th>2019 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly premium</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

(You must also continue to pay your Medicare Part B premium.)
## Section 1.2 – 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.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2018 (this year)</th>
<th>2019 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum out-of-pocket amount</strong></td>
<td>$3,400</td>
<td>$3,400</td>
</tr>
<tr>
<td>Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Once you have paid $3,400 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 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider 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 Directory. **Please review the 2019 Provider 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, Medicare requires that we 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 1.4 – Changes to Benefits and Costs for Medical Services

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, *Medical Benefits Chart (what is covered and what you pay)*, in your 2019 *Evidence of Coverage*.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2018 (this year)</th>
<th>2019 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient hospital care</strong></td>
<td><strong>Days 1 - 5:</strong> You pay a $200 copay per day, per benefit period.</td>
<td><strong>Days 1 - 5:</strong> You pay a $200 copay per day, per admission.</td>
</tr>
<tr>
<td></td>
<td><strong>Days 6 – and beyond:</strong> You pay a $0 copay per day, per benefit period.</td>
<td><strong>Days 6 – and beyond:</strong> You pay a $0 copay per day, per admission.</td>
</tr>
<tr>
<td><strong>Inpatient mental health care</strong></td>
<td>You pay a $900 copay per admission, per benefit period, for Medicare-covered inpatient mental health care.</td>
<td>You pay a $900 copay per admission, for Medicare-covered inpatient mental health care.</td>
</tr>
<tr>
<td><strong>Emergency care</strong></td>
<td>You pay a $100 copay for each Medicare-covered emergency room visit.</td>
<td>You pay a $120 copay for each Medicare-covered emergency room visit.</td>
</tr>
<tr>
<td></td>
<td>You do not pay this amount if you are immediately admitted to the hospital.</td>
<td>You do not pay this amount if you are immediately admitted to the hospital.</td>
</tr>
<tr>
<td><strong>Urgently needed services</strong></td>
<td>You pay a $10 copay for each Medicare-covered urgently needed services visit.</td>
<td>You pay a $10 copay for each Medicare-covered urgently needed services visit.</td>
</tr>
<tr>
<td></td>
<td>You do not pay this amount if you are immediately admitted to the hospital.</td>
<td>Copay is not waived if admitted to hospital.</td>
</tr>
<tr>
<td><strong>Outpatient surgery, including services provided at hospital outpatient facilities</strong></td>
<td>You pay a $200 copay for each Medicare-covered visit to an outpatient hospital facility.</td>
<td>You pay a $200 copay for each Medicare-covered visit to an outpatient hospital facility.</td>
</tr>
<tr>
<td>Cost</td>
<td>2018 (this year)</td>
<td>2019 (next year)</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Cost</td>
<td>You pay a $120 - $200 copay for each Medicare-covered Observation Services.</td>
<td></td>
</tr>
<tr>
<td>Ambulance services</td>
<td>You pay a $125 copay for Medicare-covered ambulance services. No charge for more than one trip in a single day.</td>
<td>You pay 5% of the total cost for Medicare-covered air ambulance services per one-way trip.</td>
</tr>
<tr>
<td>Ambulance services</td>
<td></td>
<td>You pay a $125 copay for Medicare-covered ground ambulance services per one-way trip.</td>
</tr>
<tr>
<td>Health and wellness education programs</td>
<td><strong>Health Education</strong>&lt;br&gt;Health education is offered as part of your plan.</td>
<td><strong>Health Education</strong>&lt;br&gt;Health Education is <strong>not</strong> covered.</td>
</tr>
<tr>
<td>Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</td>
<td>Additional smoking cessation counseling sessions are covered.</td>
<td>Additional smoking cessation counseling sessions are <strong>not</strong> covered.</td>
</tr>
<tr>
<td>Vision care (Non Medicare covered)</td>
<td>You have a $100 allowance for eyeglasses (frames and lenses) or contact lenses every 24 months.</td>
<td>You have a $100 allowance for eyeglasses (frames and lenses) or contact lenses every 2 calendar years.</td>
</tr>
<tr>
<td>Medicare Part B Drugs</td>
<td>For 2018 the plan does not ask you to try other, similarly therapeutic medications first (step-therapy) for Medicare Part B Medications.</td>
<td>For 2019, the plan may ask you to try other, similarly therapeutic medications first (step-therapy) for Medicare Part B Medications.</td>
</tr>
</tbody>
</table>
SECTION 2 Administrative Changes

<table>
<thead>
<tr>
<th>Process</th>
<th>2018 (this year)</th>
<th>2019 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine (Non-Medicare covered) eyewear</td>
<td>Routine eyewear is provided by EyeMed Vision Care.</td>
<td>Routine eyewear is provided by Envolve Vision.</td>
</tr>
</tbody>
</table>

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Health Net Seniority Plus Green (HMO)

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 by December 7, you will automatically stay enrolled as a member of our plan for 2019.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2019 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.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (SHIP) (see Section 5), or call Medicare (see Section 7.2).

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 Green (HMO).
- 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 Green (HMO).
• To **change to Original Medicare without a prescription drug plan**, you must either:
  
  o 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 7.1 of this booklet).
  
  o – 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.

**SECTION 4 Deadline for Changing Plans**

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2019.

**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. For more information, see Chapter 8, Section 2.3 of the **Evidence of Coverage**.

If you enrolled in a Medicare Advantage plan for January 1, 2019, 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, 2019. For more information, see Chapter 8, Section 2.2 of the **Evidence of Coverage**.

**SECTION 5 Programs That Offer Free Counseling about Medicare**

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 (https://aging.ca.gov/HICAP/).
SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **“Extra Help” from Medicare.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don’t even know it. To see if you qualify, 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).

- **What if you have coverage from an AIDS Drug Assistance Program (ADAP)?** The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance California Office of AIDS – ADAP program. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/underinsured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. California Office of AIDS – ADAP program can be contacted at 1-844-421-7050. TTY users should call 711 (National Relay Service).

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call California Office of AIDS – ADAP program at 1-844-421-7050. TTY users should call 711 (National Relay Service).

SECTION 7 Questions?

Section 7.1 – Getting Help from Health Net Seniority Plus Green (HMO)

Questions? We’re here to help. Please call Member Services at 1-800-275-4737. (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 8:00 a.m. to 8:00 p.m. From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. A messaging system is used after hours, weekends, and on federal holidays. Calls to these numbers are free.

**Read your 2019 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 2019. For details, look in the 2019 Evidence of Coverage for Health Net Seniority Plus Green (HMO). 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.

**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 Directory).

**Section 7.2 – 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 2019**

You can read Medicare & You 2019 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.