Health Net®
MEDICARE PROGRAMS

2010
HEALTH NET RUBY OPTION 1 (HMO), HEALTH NET RUBY OPTION 2 (HMO), HEALTH NET RUBY OPTION 3 (HMO), HEALTH NET GREEN (HMO), HEALTH NET NAVY 1 (HMO-POS), HEALTH NET NAVY 2 (HMO-POS)

SUMMARY OF BENEFITS

Connecticut

Benefits effective January 1, 2010
H0755 Health Net of Connecticut, Inc.

Material ID# H0755_2010_0048
CMS Approval (10/09)

SECTION I

INTRODUCTION TO SUMMARY OF BENEFITS

for Health Net Ruby Option 1 (HMO), Health Net Ruby Option 2 (HMO), Health Net Ruby Option 3 (HMO), Health Net Green (HMO), Health Net Navy 1 (HMO-POS), Health Net Navy 2 (HMO-POS)

Thank you for your interest in Health Net. Our plans are offered by HEALTH NET OF CONNECTICUT, a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you some features of our plans. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Health Net and ask for the "Evidence of Coverage."

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like these offered by Health Net. You may have other options, too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call Health Net at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare these Health Net plans and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plans cover and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE IS HEALTH NET AVAILABLE?

There is more than one plan listed in this Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of

the year. Please call Customer Service for more information.

The service area for the Health Net Ruby Option 1 (HMO), Health Net Ruby Option 2 (HMO), Health Net Ruby Option 3 (HMO), Health Net Green (HMO), Health Net Navy 1 (HMO-POS), Health Net Navy 2 (HMO-POS) plans includes: Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, Windham Counties, CT. You must live in one of these areas to join one of these plans.

WHO IS ELIGIBLE TO JOIN A HEALTH NET MEDICARE ADVANTAGE PLAN?

You can join a Health Net Medicare Advantage plan if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in a Health Net Medicare Advantage plan unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

Health Net has formed a network of doctors, specialists, and hospitals. As a member of Health Net Ruby Option 1 (HMO), Health Net Ruby Option 2 (HMO), Health Net Ruby Option 3 (HMO), or Health Net Green (HMO), you can only use doctors who are part of our network. As a member of Health Net Navy 1 (HMO-POS) or Health Net Navy 2 (HMO-POS), you can use any doctor who is part of our network. In some cases, you may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current Provider Directory or for an up-to-date list visit us at www.healthnet.com.

Our Customer Service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

For members of all plans except Health Net Navy 1 (HMO-POS) or Health Net Navy 2 (HMO-POS), which include out-of-network benefits, if you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither Health Net nor the Original Medicare Plan will pay for these services.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

Health Net Ruby Option 1 (HMO), Health Net Ruby Option 2 (HMO), Health Net Ruby Option 3 (HMO), Health Net Green (HMO), Health Net Navy 1 (HMO-POS), Health Net Navy 2 (HMO-POS), does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs. Health Net Green (HMO) covers Medicare Part B prescription drugs, but does NOT cover Medicare Part D prescription drugs.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

For members of all plans except Health Net Green (HMO):

Health Net has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at https://www.healthnet.com/formulary.htm. Our Customer Service number is listed at the end of this introduction.

Health Net has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower co-pay or coinsurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

For members of all plans except Health Net Green (HMO):

Health Net uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our web site at https://www.healthnet.com/formulary.htm.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS?

For members of all plans except Health Net Green (HMO):

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1- 800-325-0778 or
- Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Health Net you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Qualidigm, (800) 553-7590.

For members of all plans except Health Net Green (HMO):

As a member of Health Net, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you

believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Qualidigm, (800) 553-7590.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

For members of all plans except Health Net Green (HMO):

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Health Net for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Health Net for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs provided through DME.

PLAN RATINGS

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly at 1-800-547-8734 to obtain a copy of the plan ratings for this plan. TTY users call TTY/TDD 1-888-747-2424.

Please call Health Net of Connecticut for more information about our plans. Visit us at www.healthnet.com or, call us:

Customer Service Hours:
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Eastern.

Current members should call toll-free (800)-547-8734 for questions related to the Medicare Advantage or Medicare Part D Prescription Drug programs. (TTY/TDD (888)-747- 2424)

Prospective members should call toll-free (800)-709-4192 for questions related to the Medicare Advantage or Medicare Part D Prescription Drug programs. (TTY/TDD (888)-747- 2424)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit www.medicare.gov on the web.

If you have special needs, this document may be available in other formats.

SECTION II

SUMMARY OF BENEFITS

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
IMPORTANT INFORMATION			
1. Premium and Other Important Information	In 2009 the monthly Part B Premium was $96.40 and will change for 2010 and the yearly Part B deductible amount was $135 and will change for 2010. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2009, this amount was $85,000 for singles, $170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	General $122 monthly plan premium in addition to your monthly Medicare Part B premium.	General $12 monthly plan premium in addition to your monthly Medicare Part B premium.

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
IMPORTANT INFORMATION			
General $71 monthly plan premium in addition to your monthly Medicare Part B premium.	General $5 monthly plan premium in addition to your monthly Medicare Part B premium.	General $162 monthly plan premium in addition to your monthly Medicare Part B premium.	General $89 monthly plan premium in addition to your monthly Medicare Part B premium. Out-of-Network $1,200 yearly deductible. Contact the plan for services that apply.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
2. Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist, or hospital that accepts Medicare.	In-Network You must go to network doctors, specialists, and hospitals. No referral required for network doctors, specialists, and hospitals.	In-Network You must go to network doctors, specialists, and hospitals. No referral required for network doctors, specialists, and hospitals.
SUMMARY OF BENEFITS			
INPATIENT CARE			
3. Inpatient Hospital Care (Includes Substance Abuse and Rehabilitation Services)	In 2009 the amounts for each benefit period were: Days 1 - 60: $1,068 deductible Days 61 - 90: $267 per day Days 91 - 150: $534 per lifetime reserve day These amounts will change for 2010.	In-Network For Medicare-covered hospital stays: Days 1 - 3: $50 copay per day Days 4 - 10: $100 copay per day Days 11 - 90: $0 copay per day $0 copay for additional hospital days $1,000 out-of-pocket limit every year. No limit to the number of days covered by the plan each benefit period.	In-Network For Medicare-covered hospital stays: Days 1 - 7: $250 copay per day Days 8 - 90: $0 copay per day $0 copay for each additional hospital days. $3,500 out-of-pocket limit every year. No limit to the number of days covered by the plan each benefit period.

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
In-Network You must go to network doctors, specialists, and hospitals. No referral required for network doctors, specialists, and hospitals.	In-Network You must go to network doctors, specialists, and hospitals. No referral required for network doctors, specialists, and hospitals.	In-Network No referral required for network doctors, specialists, and hospitals.	In-Network No referral required for network doctors, specialists, and hospitals.
SUMMARY OF BENEFITS			
INPATIENT CARE			
In-Network For Medicare-covered hospital stays: Days 1 - 10: $100 copay per day Days 11 - 90: $0 copay per day $0 copay for additional hospital days $1,500 out of pocket limit every year. No limit to the number of days covered by the plan each benefit period.	In-Network For Medicare-covered hospital stays: Days 1 - 8: $200 copay per day Days 9 - 90: $0 copay per day $0 copay for additional hospital days $3,000 out of pocket limit every year. No limit to the number of days covered by the plan each benefit period.	In-Network For Medicare-covered hospital stays: Days 1 - 3: $100 copay per day Days 4 - 5: $150 copay per day Days 6 - 90: $0 copay per day $0 copay for additional hospital days $1,200 out of pocket limit every year.	In-Network For Medicare-covered hospital stays: Days 1 - 10: $100 copay per day Days 11 - 90: $0 copay per day $0 copay for additional hospital days $1,500 out of pocket limit every year. No limit to the number of days covered by the plan each benefit period.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
3. Inpatient Hospital Care (continued)	Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
4. Inpatient Mental Health Care	Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above). 190 day lifetime limit in a Psychiatric Hospital.	In-Network For Medicare-covered hospital stays: Days 1 - 3: $50 copay per day Days 4 - 10: $100 copay per day Days 11 - 90: $0 copay per day The maximum out of pocket limit is covered under "Inpatient Hospital Care." You get up to 190 days in a Psychiatric Hospital in a lifetime.	In-Network For Medicare-covered hospital stays: Days 1 - 7: $250 copay per day Days 8 - 90: $0 copay per day The maximum out of pocket limit is covered under "Inpatient Hospital Care." You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	No limit to the number of days covered by the plan each benefit period. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
In-Network For Medicare-covered hospital stays: Days 1 - 10: $100 copay per day Days 11 - 90: $0 copay per day The maximum out of pocket limit is covered under "Inpatient Hospital Care." You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your	In-Network For Medicare-covered hospital stays: Days 1 - 8: $200 copay per day Days 9 - 90: $0 copay per day The maximum out of pocket limit is covered under "Inpatient Hospital Care." You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your	In-Network For Medicare-covered hospital stays: Days 1 - 3: $100 copay per day Days 4 - 5: $150 copay per day Days 6 - 90: $0 copay per day The maximum out of pocket limit is covered under "Inpatient Hospital Care." You get up to 190 days in a Psychiatric Hospital in a lifetime.	In-Network For Medicare-covered hospital stays: Days 1 - 10: $100 copay per day Days 11 - 90: $0 copay per day The maximum out of pocket limit is covered under "Inpatient Hospital Care." You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
4. Inpatient Mental Health Care (continued)		Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	doctor must tell the plan that you are going to be admitted to the hospital.
5. Skilled Nursing Facility (SNF) (In a Medicare-certified skilled nursing facility)	In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1 - 20: $0 per day Days 21 - 100: $133.50 per day These amounts will change for 2010. 100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	General Authorization rules may apply. In-Network For SNF stays: Days 1 - 20: $0 copay per day Days 21 - 100: $100 copay per day Plan covers up to 100 days each benefit period. No prior hospital stay is required.	General Authorization rules may apply. In-Network For SNF stays: Days 1 - 20: $0 copay per day Days 21 - 100: $100 copay per day Plan covers up to 100 days each benefit period. No prior hospital stay is required.

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
doctor must tell the plan that you are going to be admitted to the hospital.	doctor must tell the plan that you are going to be admitted to the hospital.	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	doctor must tell the plan that you are going to be admitted to the hospital.
General Authorization rules may apply. In-Network For SNF stays: Days 1 - 20: $0 copay per day Days 21 - 100: $100 copay per day Plan covers up to 100 days each benefit period. No prior hospital stay is required.	General Authorization rules may apply. In-Network For SNF stays: Days 1 - 20: $0 copay per day Days 21 - 100: $100 copay per day Plan covers up to 100 days each benefit period No prior hospital stay is required.	General Authorization rules may apply. In-Network For SNF stays: Days 1 - 20: $0 copay per day Days 21 - 100: $100 copay per day Plan covers up to 100 days each benefit period No prior hospital stay is required.	General Authorization rules may apply. In-Network For SNF stays: Days 1 - 20: $0 copay per day Days 21 - 100: $100 copay per day Plan covers up to 100 days each benefit period No prior hospital stay is required.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
6. Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	$0 copay.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered home health visits.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered home health visits.
7. Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.
OUTPATIENT CARE			
8. Doctor Office Visits	20% coinsurance.	General See "Physical Exams," for more information. In-Network $10 copay for each primary care doctor visit for Medicare-covered benefits. $10 copay for each in-area, network urgent care Medicare-covered visit. $20 copay for each specialist visit for Medicare-covered benefits.	General See "Physical Exams," for more information. In-Network $20 copay for each primary care doctor visit for Medicare-covered benefits. $20 copay for each in-area, network urgent care Medicare-covered visit. $30 copay for each specialist visit for Medicare-covered benefits.

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
General Authorization rules may apply. In-Network $0 copay for Medicare-covered home health visits.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered home health visits.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered home health visits.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered home health visits.
General You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.
OUTPATIENT CARE			
General See "Physical Exams," for more information. In-Network $15 copay for each primary care doctor visit for Medicare-covered benefits. $15 copay for each in-area, network urgent care Medicare-covered visit. $25 copay for each specialist visit for Medicare-covered benefits.	General See "Physical Exams," for more information. In-Network $20 copay for each primary care doctor visit for Medicare-covered benefits. $20 copay for each in-area, network urgent care Medicare-covered visit. $30 copay for each specialist visit for Medicare-covered benefits.	General See "Physical Exams," for more information. In-Network $20 copay for each primary care doctor visit for Medicare-covered benefits. $35 copay for each in-area, network urgent care Medicare-covered visit. $35 copay for each specialist visit for Medicare-covered benefits.	General See "Physical Exams," for more information. In-Network $15 copay for each primary care doctor visit for Medicare-covered benefits. $25 copay for each in-area, network urgent care Medicare-covered visit. $25 copay for each specialist visit for Medicare-covered benefits.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
9. Chiropractic Services	Routine care not covered. 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	General Authorization rules may apply. In-Network $20 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	General Authorization rules may apply. In-Network $30 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.
10. Podiatry Services	Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	In-Network $20 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.	In-Network $30 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.
11. Outpatient Mental Health Care	45% coinsurance for most outpatient mental health services.	General Authorization rules may apply. In-Network $20 copay for each Medicare-covered individual or group therapy visit.	General Authorization rules may apply. In-Network $30 copay for each Medicare-covered individual or group therapy visit.

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
General Authorization rules may apply. In-Network $25 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	General Authorization rules may apply. In-Network $30 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	General Authorization rules may apply. In-Network $35 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	General Authorization rules may apply. In-Network $25 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.
In-Network $25 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.	In-Network $30 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.	In-Network $35 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.	In-Network $25 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.
General Authorization rules may apply. In-Network $25 copay for each Medicare-covered individual or group therapy visit.	General Authorization rules may apply. In-Network $30 copay for each Medicare-covered individual or group therapy visit.	General Authorization rules may apply. In-Network $35 copay for each Medicare-covered individual or group therapy visit.	General Authorization rules may apply. In-Network $25 copay for each Medicare-covered individual or group therapy visit.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
12. Outpatient Substance Abuse Care	20% coinsurance.	General Authorization rules may apply. In-Network $20 copay for Medicare-covered individual or group visits.	General Authorization rules may apply. In-Network $30 copay for Medicare-covered individual or group visits.
13. Outpatient Services/ Surgery	20% coinsurance for the doctor. 20% of outpatient facility charges.	General Authorization rules may apply. In-Network $0 to $75 copay for each Medicare-covered ambulatory surgical center visit. $0 to $75 copay for each Medicare-covered outpatient hospital facility visit.	General Authorization rules may apply. In-Network $125 copay for each Medicare-covered ambulatory surgical center visit. $125 copay for each Medicare-covered outpatient hospital facility visit.
14. Ambulance Services (Medically necessary ambulance services)	20% coinsurance.	General Authorization rules may apply. In-Network $125 copay for Medicare-covered ambulance benefits.	General Authorization rules may apply. In-Network $125 copay for Medicare-covered ambulance benefits.
15. Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor. 20% of facility charge, or a set copay per emergency room visit. You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances.	General $50 copay for Medicare-covered emergency room visits. $50,000 limit for emergency services outside the U.S. every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.	General $50 copay for Medicare-covered emergency room visits. $50,000 limit for emergency services outside the U.S. every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
General Authorization rules may apply. In-Network $25 copay for Medicare-covered individual or group visits.	General Authorization rules may apply. In-Network $30 copay for Medicare-covered individual or group visits.	General Authorization rules may apply. In-Network $35 copay for Medicare-covered individual or group visits.	General Authorization rules may apply. In-Network $25 copay for Medicare-covered individual or group visits.
General Authorization rules may apply. In-Network $50 to $100 copay for each Medicare-covered ambulatory surgical center visit. $50 to $100 copay for each Medicare-covered outpatient hospital facility visit.	General Authorization rules may apply. In-Network $125 copay for each Medicare-covered ambulatory surgical center visit. $125 copay for each Medicare-covered outpatient hospital facility visit.	General Authorization rules may apply. In-Network $50 to $100 copay for each Medicare-covered ambulatory surgical center visit. $50 to $100 copay for each Medicare-covered outpatient hospital facility visit.	General Authorization rules may apply. In-Network $50 to $100 copay for each Medicare-covered ambulatory surgical center visit. $50 to $100 copay for each Medicare-covered outpatient hospital facility visit.
General Authorization rules may apply. In-Network $125 copay for Medicare-covered ambulance benefits.	General Authorization rules may apply. In-Network $125 copay for Medicare-covered ambulance benefits.	General Authorization rules may apply. In-Network $125 copay for Medicare-covered ambulance benefits.	General Authorization rules may apply. In-Network $150 copay for Medicare-covered ambulance benefits.
General $50 copay for Medicare-covered emergency room visits. $50,000 limit for emergency services outside the U.S. every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.	General $50 copay for Medicare-covered emergency room visits. $50,000 limit for emergency services outside the U.S. every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.	General $50 copay for Medicare-covered emergency room visits. $50,000 limit for emergency services outside the U.S. every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.	General $50 copay for Medicare-covered emergency room visits. $50,000 limit for emergency services outside the U.S. every year. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
16. Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay. NOT covered outside the U.S. except under limited circumstances.	General $20 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, $0 for the urgent-care visit.	General $30 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, $0 for the urgent-care visit.
17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance.	General Authorization rules may apply. In-Network $10 copay for Medicare-covered Occupational Therapy visits. $10 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.	General Authorization rules may apply. In-Network $30 copay for Medicare-covered Occupational Therapy visits. $30 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
18. Durable Medical Equipment (Includes wheelchairs, oxygen, etc.)	20% coinsurance.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.
19. Prosthetic Devices (Includes braces, artificial limbs and eyes, etc.)	20% coinsurance.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
General $25 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, $0 for the urgent-care visit.	General $30 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, $0 for the urgent-care visit.	General $35 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, $0 for the urgent-care visit.	General $25 copay for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, $0 for the urgent-care visit.
General Authorization rules may apply. In-Network $25 copay for Medicare-covered Occupational Therapy visits. $25 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.	General Authorization rules may apply. In-Network $30 copay for Medicare-covered Occupational Therapy visits. $30 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.	General Authorization rules may apply. In-Network $35 copay for Medicare-covered Occupational Therapy visits. $35 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.	General Authorization rules may apply. In-Network $25 copay for Medicare-covered Occupational Therapy visits. $25 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.
General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
20. Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (Includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	20% coinsurance. Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	General Authorization rules may apply. In-Network $0 copay for Diabetes self-monitoring training. $0 copay for Nutrition Therapy for Diabetes. $0 copay for Diabetes supplies.	General Authorization rules may apply. In-Network $0 copay for Diabetes self-monitoring training. $0 copay for Nutrition Therapy for Diabetes. 20% of the cost for Diabetes supplies.
21. Diagnostic Tests, X-Rays, Lab Services and Radiology Services	20% coinsurance for diagnostic tests and X-rays. $0 copay for Medicare-covered lab services. Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests $20 copay for Medicare-covered X-rays. $50 copay for Medicare-covered diagnostic radiology services. $20 copay for Medicare-covered therapeutic radiology services.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests $20 copay for Medicare-covered X-rays. $150 copay for Medicare-covered diagnostic radiology services. $20 copay for Medicare-covered therapeutic radiology services.

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
General Authorization rules may apply. In-Network $0 copay for Diabetes self-monitoring training. $0 copay for Nutrition Therapy for Diabetes. $0 copay for Diabetes supplies.	General Authorization rules may apply. In-Network 20% of the cost for Diabetes self-monitoring training. $0 copay for Nutrition Therapy for Diabetes. 20% of the cost for Diabetes supplies.	General Authorization rules may apply. In-Network $0 copay for Diabetes self-monitoring training. $0 copay for Nutrition Therapy for Diabetes. $0 copay for Diabetes supplies.	General Authorization rules may apply. In-Network $0 copay for Diabetes self-monitoring training. $0 copay for Nutrition Therapy for Diabetes. $0 copay for Diabetes supplies.
General Authorization rules may apply. In-Network $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests $20 copay for Medicare-covered X-rays. $100 copay for Medicare-covered diagnostic radiology services. $20 copay for Medicare-covered therapeutic radiology services.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests $20 copay for Medicare-covered X-rays. $175 to $200 copay for Medicare-covered diagnostic radiology services. $20 copay for Medicare-covered therapeutic radiology services. Separate Office Visit cost sharing of $20 copay may apply.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests $20 copay for Medicare-covered X-rays. $100 copay for Medicare-covered diagnostic radiology services. $20 copay for Medicare-covered therapeutic radiology services.	General Authorization rules may apply. In-Network $0 copay for Medicare-covered: • lab services • diagnostic procedures and tests $25 copay for Medicare-covered X-rays. $100 copay for Medicare-covered diagnostic radiology services. $25 copay for Medicare-covered therapeutic radiology services.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
PREVENTIVE SERVICES			
22. Bone Mass Measurement (For people with Medicare who are at risk)	20% coinsurance. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	In-Network $0 copay for Medicare-covered bone mass measurement.	In-Network $0 copay for Medicare-covered bone mass measurement.
23. Colorectal Screening Exams (For people with Medicare age 50 and over)	20% coinsurance. Covered when you are high risk or when you are age 50 and older.	In-Network $0 copay for Medicare-covered colorectal screenings.	In-Network $0 copay for Medicare-covered colorectal screenings.
24. Immunizations (Flu vaccine, Hepatitis B vaccine – for people with Medicare who are at risk, Pneumonia vaccine)	$0 copay for Flu and Pneumonia vaccines. 20% coinsurance for Hepatitis B vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	General Authorization rules may apply. In-Network $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and Pneumonia vaccines. Separate Office Visit cost sharing of $10 copay may apply. No referral needed for other immunizations.	In-Network $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and Pneumonia vaccines. Separate Office Visit cost sharing of $20 copay may apply. No referral needed for other immunizations.
25. Mammograms (Annual Screening) (For women with Medicare age 40 and older)	20% coinsurance. No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	In-Network $0 copay for Medicare-covered screening mammograms.	In-Network $0 copay for Medicare-covered screening mammograms.

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
PREVENTIVE SERVICES			
In-Network $0 copay for Medicare-covered bone mass measurement.	In-Network $0 copay for Medicare-covered bone mass measurement.	In-Network $0 copay for Medicare-covered bone mass measurement.	In-Network $0 copay for Medicare-covered bone mass measurement.
In-Network $0 copay for Medicare-covered colorectal screenings.	In-Network $0 copay for Medicare-covered colorectal screenings.	In-Network $0 copay for Medicare-covered colorectal screenings.	In-Network $0 copay for Medicare-covered colorectal screenings.
In-Network $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and Pneumonia vaccines. Separate Office Visit cost sharing of $15 copay may apply. No referral needed for other immunizations.	General Authorization rules may apply. In-Network $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines. Separate Office Visit cost sharing of $20 copay may apply. No referral needed for other immunizations.	General Authorization rules may apply. In-Network $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines. Separate Office Visit cost sharing of $20 copay may apply. No referral needed for other immunizations.	General Authorization rules may apply. In-Network $0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines. Separate Office Visit cost sharing of $15 copay may apply. No referral needed for other immunizations.
In-Network $0 copay for Medicare-covered screening mammograms.	In-Network $0 copay for Medicare-covered screening mammograms.	In-Network $0 copay for Medicare-covered screening mammograms.	In-Network $0 copay for Medicare-covered screening mammograms.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
26. Pap Smears and Pelvic Exams (For women with Medicare)	$0 copay for Pap smears. Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for Pelvic Exams.	In-Network $0 copay for Medicare-covered pap smears and pelvic exams – up to 1 additional pap smear(s) and pelvic exam(s) every year.	In-Network $0 copay for Medicare-covered pap smears and pelvic exams – up to 1 additional pap smear(s) and pelvic exam(s) every year.
27. Prostate Cancer Screening Exams (For men with Medicare age 50 and older)	20% coinsurance for the digital rectal exam. $0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.	In-Network $0 copay for Medicare-covered prostate cancer screening.	In-Network $0 copay for Medicare-covered prostate cancer screening.
28. End Stage Renal Disease	20% coinsurance for renal dialysis. 20% coinsurance for Nutrition Therapy for End-Stage Renal Disease. Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	General Authorization rules may apply. In-Network 20% of the cost for renal dialysis. $0 copay for Nutrition Therapy for End-Stage Renal Disease.	General Authorization rules may apply. In-Network 20% of the cost for renal dialysis. $0 copay for Nutrition Therapy for End-Stage Renal Disease.

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
In-Network $0 copay for Medicare-covered pap smears and pelvic exams – up to 1 additional pap smear(s) and pelvic exam(s) every year.	In-Network $0 copay for Medicare-covered pap smears and pelvic exams – up to 1 additional pap smear(s) and pelvic exam(s) every year.	In-Network $0 copay for Medicare-covered pap smears and pelvic exams – up to 1 additional pap smear(s) and pelvic exam(s) every year.	In-Network $0 copay for Medicare-covered pap smears and pelvic exams – up to 1 additional pap smear(s) and pelvic exam(s) every year.
In-Network $0 copay for Medicare-covered prostate cancer screening.	In-Network $0 copay for Medicare-covered prostate cancer screening.	In-Network $0 copay for Medicare-covered prostate cancer screening.	In-Network $0 copay for Medicare-covered prostate cancer screening.
General Authorization rules may apply. In-Network 20% of the cost for renal dialysis. $0 copay for Nutrition Therapy for End-Stage Renal Disease.	General Authorization rules may apply. In-Network 20% of the cost for renal dialysis. $0 copay for Nutrition Therapy for End-Stage Renal Disease.	General Authorization rules may apply. In-Network 20% of the cost for renal dialysis. $0 copay for Nutrition Therapy for End-Stage Renal Disease.	General Authorization rules may apply. In-Network 20% of the cost for renal dialysis. $0 copay for Nutrition Therapy for End-Stage Renal Disease.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
29. Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	*Drugs covered under Medicare Part B* General $0 copay for Part B-covered drugs *Drugs covered under Medicare Part D* General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at https://www.healthnet.com/formulary.htm on the web. Different out-of-pocket costs may apply for people who: • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service). The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).	*Drugs covered under Medicare Part B* General $0 copay for Part B-covered drugs *Drugs covered under Medicare Part D* General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at https://www.healthnet.com/formulary.htm on the web. Different out-of-pocket costs may apply for people who: • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service). The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
Drugs covered under Medicare Part B General $0 copay for Part B-covered drugs *Drugs covered under Medicare Part D* General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at https://www.healthnet.com/formulary.htm on the web. Different out-of-pocket costs may apply for people who: • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service). The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).	*Drugs covered under Medicare Part B* General Most drugs not covered. $0 copay for Part B-covered drugs. *Drugs covered under Medicare Part D* General This plan does not offer prescription drug coverage.	*Drugs covered under Medicare Part B* General $0 copay for Part B-covered drugs *Drugs covered under Medicare Part D* General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at https://www.healthnet.com/formulary.htm on the web. Different out-of-pocket costs may apply for people who: • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service). The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).	*Drugs covered under Medicare Part B* General $0 copay for Part B-covered drugs *Drugs covered under Medicare Part D* General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at https://www.healthnet.com/formulary.htm on the web. Different out-of-pocket costs may apply for people who: • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service). The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
Prescription Drugs (continued)		Total yearly drug costs are the total drug costs paid by both you and the plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Health Net Ruby Option 1 (HMO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher	Total yearly drug costs are the total drug costs paid by both you and the plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Health Net Ruby Option 2 (HMO) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
Total yearly drug costs are the total drug costs paid by both you and the plan.		Total yearly drug costs are the total drug costs paid by both you and the plan.	Total yearly drug costs are the total drug costs paid by both you and the plan.
The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.		The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.	The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
Some drugs have quantity limits.		Some drugs have quantity limits.	Some drugs have quantity limits.
Your provider must get prior authorization from Health Net Ruby Option 3 (HMO) for certain drugs.		Your provider must get prior authorization from Health Net Navy 1 (HMO-POS) for certain drugs.	Your provider must get prior authorization from Health Net Navy 2 (HMO-POS) for certain drugs.
You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.		You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.	You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.
If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher		If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher	If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
Prescription Drugs (continued)		cost-sharing amount. If you request a formulary exception for a drug and Health Net Ruby Option 1 (HMO) approves the exception, you will pay Tier 3 Non-Preferred cost-sharing for that drug. In-Network $0 deductible. Initial Coverage You pay the following until total yearly drug costs reach $2,830: Retail Pharmacy **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of drugs in this tier • $24 copay for a three-month (90-day) supply of drugs in this tier • $16 copay for a 60-day supply of drugs in this tier **Tier 2 Preferred Brand** • $38 copay for a one-month (30-day) supply of drugs in this tier • $114 copay for a three-month (90-day) supply of drugs in this tier	cost-sharing amount. If you request a formulary exception for a drug and Health Net Ruby Option 2 (HMO) approves the exception, you will pay Tier 3 Non-Preferred cost-sharing for that drug. In-Network $0 deductible. Initial Coverage You pay the following until total yearly drug costs reach $2,830: Retail Pharmacy **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of drugs in this tier • $24 copay for a three-month (90-day) supply of drugs in this tier • $16 copay for a 60-day supply of drugs in this tier **Tier 2 Preferred Brand** • $38 copay for a one-month (30-day) supply of drugs in this tier • $114 copay for a three-month (90-day) supply of drugs in this tier

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
cost-sharing amount. If you request a formulary exception for a drug and Health Net Ruby Option 3 (HMO) approves the exception, you will pay Tier 3 Non-Preferred cost-sharing for that drug. In-Network $0 deductible. Initial Coverage You pay the following until total yearly drug costs reach $2,830: Retail Pharmacy **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of drugs in this tier • $24 copay for a three-month (90-day) supply of drugs in this tier • $16 copay for a 60-day supply of drugs in this tier **Tier 2 Preferred Brand** • $38 copay for a one-month (30-day) supply of drugs in this tier • $114 copay for a three-month (90-day) supply of drugs in this tier		cost-sharing amount. If you request a formulary exception for a drug and Health Net Navy 1 (HMO-POS) approves the exception, you will pay Tier 3 Non-Preferred cost-sharing for that drug. In-Network $0 deductible. Initial Coverage You pay the following until total yearly drug costs reach $2,830: Retail Pharmacy **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of drugs in this tier • $24 copay for a three-month (90-day) supply of drugs in this tier • $16 copay for a 60-day supply of drugs in this tier **Tier 2 Preferred Brand** • $38 copay for a one-month (30-day) supply of drugs in this tier • $114 copay for a three-month (90-day) supply of drugs in this tier	cost-sharing amount. If you request a formulary exception for a drug and Health Net Navy 2 (HMO-POS) approves the exception, you will pay Tier 3 Non-Preferred cost-sharing for that drug. In-Network $0 deductible. Initial Coverage You pay the following until total yearly drug costs reach $2,830: Retail Pharmacy **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of drugs in this tier • $24 copay for a three-month (90-day) supply of drugs in this tier • $16 copay for a 60-day supply of drugs in this tier **Tier 2 Preferred Brand** • $38 copay for a one-month (30-day) supply of drugs in this tier • $114 copay for a three-month (90-day) supply of drugs in this tier

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
Prescription Drugs (continued)		• $76 copay for a 60-day supply of drugs in this tier **Tier 3 Non-Preferred** • $76 copay for a one-month (30-day) supply of drugs in this tier • $228 copay for a three-month (90-day) supply of drugs in this tier • $152 copay for a 60-day supply of drugs in this tier **Tier 4 Injectable** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier **Tier 5 Specialty** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier Long Term Care Pharmacy **Tier 1 Preferred Generic** • $8 copay for a one-month (34-day) supply of drugs in this tier **Tier 2 Preferred Brand** • $38 copay for a one-month (34-day) supply of drugs in this tier	• $76 copay for a 60-day supply of drugs in this tier **Tier 3 Non-Preferred** • $76 copay for a one-month (30-day) supply of drugs in this tier • $228 copay for a three-month (90-day) supply of drugs in this tier • $152 copay for a 60-day supply of drugs in this tier **Tier 4 Injectable** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier **Tier 5 Specialty** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier Long Term Care Pharmacy **Tier 1 Preferred Generic** • $8 copay for a one-month (34-day) supply of drugs in this tier **Tier 2 Preferred Brand** • $38 copay for a one-month (34-day) supply of drugs in this tier

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
• $76 copay for a 60-day supply of drugs in this tier		• $76 copay for a 60-day supply of drugs in this tier	• $76 copay for a 60-day supply of drugs in this tier
Tier 3 Non-Preferred		**Tier 3 Non-Preferred**	**Tier 3 Non-Preferred**
• $76 copay for a one-month (30-day) supply of drugs in this tier		• $76 copay for a one-month (30-day) supply of drugs in this tier	• $76 copay for a one-month (30-day) supply of drugs in this tier
• $228 copay for a three-month (90-day) supply of drugs in this tier		• $228 copay for a three-month (90-day) supply of drugs in this tier	• $228 copay for a three-month (90-day) supply of drugs in this tier
• $152 copay for a 60-day supply of drugs in this tier		• $152 copay for a 60-day supply of drugs in this tier	• $152 copay for a 60-day supply of drugs in this tier
Tier 4 Injectable		**Tier 4 Injectable**	**Tier 4 Injectable**
• 33% coinsurance for a one-month (30-day) supply of drugs in this tier		• 33% coinsurance for a one-month (30-day) supply of drugs in this tier	• 33% coinsurance for a one-month (30-day) supply of drugs in this tier
Tier 5 Specialty		**Tier 5 Specialty**	**Tier 5 Specialty**
• 33% coinsurance for a one-month (30-day) supply of drugs in this tier		• 33% coinsurance for a one-month (30-day) supply of drugs in this tier	• 33% coinsurance for a one-month (30-day) supply of drugs in this tier
Long Term Care Pharmacy		Long Term Care Pharmacy	Long Term Care Pharmacy
Tier 1 Preferred Generic		**Tier 1 Preferred Generic**	**Tier 1 Preferred Generic**
• $8 copay for a one-month (34-day) supply of drugs in this tier		• $8 copay for a one-month (34-day) supply of drugs in this tier	• $8 copay for a one-month (34-day) supply of drugs in this tier
Tier 2 Preferred Brand		**Tier 2 Preferred Brand**	**Tier 2 Preferred Brand**
• $38 copay for a one-month (34-day) supply of drugs in this tier		• $38 copay for a one-month (34-day) supply of drugs in this tier	• $38 copay for a one-month (34-day) supply of drugs in this tier

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
Prescription Drugs (continued)		**Tier 3 Non-Preferred** • $76 copay for a one-month (34-day) supply of drugs in this tier **Tier 4 Injectable** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier **Tier 5 Specialty** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier Mail Order **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. • $16 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $16 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. • $8 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.	**Tier 3 Non-Preferred** • $76 copay for a one-month (34-day) supply of drugs in this tier **Tier 4 Injectable** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier **Tier 5 Specialty** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier Mail Order **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. • $16 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $16 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. • $8 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
Tier 3 Non-Preferred • $76 copay for a one-month (34-day) supply of drugs in this tier **Tier 4 Injectable** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier **Tier 5 Specialty** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier Mail Order **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. • $16 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $16 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. • $8 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.		**Tier 3 Non-Preferred** • $76 copay for a one-month (34-day) supply of drugs in this tier **Tier 4 Injectable** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier **Tier 5 Specialty** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier Mail Order **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. • $16 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $16 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. • $8 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.	**Tier 3 Non-Preferred** • $76 copay for a one-month (34-day) supply of drugs in this tier **Tier 4 Injectable** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier **Tier 5 Specialty** • 33% coinsurance for a one-month (34-day) supply of drugs in this tier Mail Order **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. • $16 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $16 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. • $8 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
Prescription Drugs (continued)		• $24 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • $16 copay for a (60-day) supply of drugs in this tier from a non-preferred mail order pharmacy. **Tier 2 Preferred Brand** • $38 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. • $76 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $76 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. • $38 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • $114 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy.	• $24 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • $16 copay for a (60-day) supply of drugs in this tier from a non-preferred mail order pharmacy. **Tier 2 Preferred Brand** • $38 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. • $76 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $76 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. • $38 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • $114 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy.

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
• $24 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • $16 copay for a (60-day) supply of drugs in this tier from a non-preferred mail order pharmacy.		• $24 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • $16 copay for a (60-day) supply of drugs in this tier from a non-preferred mail order pharmacy.	• $24 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • $16 copay for a (60-day) supply of drugs in this tier from a non-preferred mail order pharmacy.
Tier 2 Preferred Brand • $38 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. • $76 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $76 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. • $38 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • $114 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy.		**Tier 2 Preferred Brand** • $38 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. • $76 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $76 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. • $38 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • $114 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy.	**Tier 2 Preferred Brand** • $38 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. • $76 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $76 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. • $38 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • $114 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
Prescription Drugs (continued)		• $76 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy. **Tier 3 Non-Preferred** • $76 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. • $190 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $152 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. • $76 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • $228 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • $152 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy.	• $76 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy. **Tier 3 Non-Preferred** • $76 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy. • $190 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy. • $152 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy. • $76 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • $228 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy. • $152 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy.

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
• $76 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy.		• $76 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy.	• $76 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy.
Tier 3 Non-Preferred		**Tier 3 Non-Preferred**	**Tier 3 Non-Preferred**
• $76 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy.		• $76 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy.	• $76 copay for a one-month (30-day) supply of drugs in this tier from a preferred mail order pharmacy.
• $190 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy.		• $190 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy.	• $190 copay for a three-month (90-day) supply of drugs in this tier from a preferred mail order pharmacy.
• $152 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy.		• $152 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy.	• $152 copay for a 60-day supply of drugs in this tier from a preferred mail order pharmacy.
• $76 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.		• $76 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.	• $76 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred mail order pharmacy.
• $228 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy.		• $228 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy.	• $228 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred mail order pharmacy.
• $152 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy.		• $152 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy.	• $152 copay for a 60-day supply of drugs in this tier from a non-preferred mail order pharmacy.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
Prescription Drugs (continued)		Coverage Gap The plan covers many generics (65%-99% of formulary generic drugs) AND few brands (less than 10% of formulary brand drugs) through the coverage gap. *You pay the following:* Retail Pharmacy **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of all drugs covered in this tier • $24 copay for a three-month (90-day) supply of all drugs covered in this tier • $16 copay for a 60-day supply of all drugs covered in this tier Long Term Care Pharmacy **Tier 1 Preferred Generic** • $8 copay for a one-month (34-day) supply of all drugs covered in this tier Mail Order **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of all drugs covered in this tier from a preferred mail order pharmacy	Coverage Gap After your total yearly drug costs reach $2,830, you pay 100% until your yearly out-of-pocket drug costs reach $4,550. Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance. Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Health Net Ruby Option 2 (HMO).

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
Coverage Gap After your total yearly drug costs reach $2,830, you pay 100% until your yearly out-of-pocket drug costs reach $4,550. Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance. Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Health Net Ruby Option 3 (HMO).		Coverage Gap The plan covers many generics (65%-99% of formulary generic drugs) AND few brands (less than 10% of formulary brand drugs) through the coverage gap. *You pay the following:* Retail Pharmacy **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of all drugs covered in this tier • $24 copay for a three-month (90-day) supply of all drugs covered in this tier • $16 copay for a 60-day supply of all drugs covered in this tier Long Term Care Pharmacy **Tier 1 Preferred Generic** • $8 copay for a one-month (34-day) supply of all drugs covered in this tier Mail Order **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of all drugs covered in this tier from a preferred mail order pharmacy	Coverage Gap After your total yearly drug costs reach $2,830, you pay 100% until your yearly out-of-pocket drug costs reach $4,550. Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance. Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Health Net Navy 2 (HMO-POS).

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
Prescription Drugs (continued)		• $16 copay for a three-month (90-day) supply of all drugs covered in this tier from a preferred mail order pharmacy • $16 copay for a 60-day supply of all drugs covered in this tier from a preferred mail order pharmacy • $8 copay for a one-month (30-day) supply of all drugs covered in this tier from a non-preferred mail order pharmacy • $24 copay for a three-month (90-day) supply of all drugs covered in this tier from a non-preferred mail order pharmacy • $16 copay for a 60-day supply of all drugs covered in this tier from a non-preferred mail order pharmacy For all other covered drugs, after your total yearly drug costs reach $2,830, you pay 100% until your yearly out-of-pocket drug costs reach $4,550.	Out-of-Network Initial Coverage You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,830: **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of drugs in this tier **Tier 2 Preferred Brand** • $38 copay for a one-month (30-day) supply of drugs in this tier **Tier 3 Non-Preferred** • $76 copay for a one-month (30-day) supply of drugs in this tier **Tier 4 Injectable** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier **Tier 5 Specialty** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
Out-of-Network Initial Coverage You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,830: **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of drugs in this tier **Tier 2 Preferred Brand** • $38 copay for a one-month (30-day) supply of drugs in this tier **Tier 3 Non-Preferred** • $76 copay for a one-month (30-day) supply of drugs in this tier **Tier 4 Injectable** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier **Tier 5 Specialty** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier		• $16 copay for a three-month (90-day) supply of all drugs covered in this tier from a preferred mail order pharmacy • $16 copay for a 60-day supply of all drugs covered in this tier from a preferred mail order pharmacy • $8 copay for a one-month (30-day) supply of all drugs covered in this tier from a non-preferred mail order pharmacy • $24 copay for a three-month (90-day) supply of all drugs covered in this tier from a non-preferred mail order pharmacy • $16 copay for a 60-day supply of all drugs covered in this tier from a non-preferred mail order pharmacy For all other covered drugs, after your total yearly drug costs reach $2,830, you pay 100% until your yearly out-of-pocket drug costs reach $4,550.	Out-of-Network Initial Coverage You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,830: **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of drugs in this tier **Tier 2 Preferred Brand** • $38 copay for a one-month (30-day) supply of drugs in this tier **Tier 3 Non-Preferred** • $76 copay for a one-month (30-day) supply of drugs in this tier **Tier 4 Injectable** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier **Tier 5 Specialty** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
Prescription Drugs (continued)		Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance. Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Health Net Ruby Option 1 (HMO). Out-of-Network Initial Coverage You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total	Out-of-Network Coverage Gap After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by Health Net Ruby Option 2 (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Health Net Ruby Option 2 (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance.

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
Out-of-Network Coverage Gap After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by Health Net Ruby Option 3 (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Health Net Ruby Option 3 (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance.		Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance. Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Health Net Navy 1 (HMO-POS). Out-of-Network Initial Coverage You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total	Out-of-Network Coverage Gap After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by Health Net Navy 2 (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Health Net Navy 2 (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
Prescription Drugs (continued)		yearly drug costs reach $2,830: **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of drugs in this tier **Tier 2 Preferred Brand** • $38 copay for a one-month (30-day) supply of drugs in this tier **Tier 3 Non-Preferred** • $76 copay for a one-month (30-day) supply of drugs in this tier **Tier 4 Injectable** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier **Tier 5 Specialty** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier Out-of-Network Coverage Gap You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following: **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of all drugs covered in this tier	

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
		yearly drug costs reach $2,830: **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of drugs in this tier **Tier 2 Preferred Brand** • $38 copay for a one-month (30-day) supply of drugs in this tier **Tier 3 Non-Preferred** • $76 copay for a one-month (30-day) supply of drugs in this tier **Tier 4 Injectable** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier **Tier 5 Specialty** • 33% coinsurance for a one-month (30-day) supply of drugs in this tier Out-of-Network Coverage Gap You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following: **Tier 1 Preferred Generic** • $8 copay for a one-month (30-day) supply of all drugs covered in this tier	

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
Prescription Drugs (continued)		**Tier 2 Preferred Brand** • After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by Health Net Ruby Option 1 (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Health Net Ruby Option 1 (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. **Tier 3 Non-Preferred** • After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by Health Net Ruby Option 1 (HMO) for	

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
		Tier 2 Preferred Brand • After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by Health Net Navy 1 (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Health Net Navy 1 (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. **Tier 3 Non-Preferred** • After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by Health Net Navy 1 (HMO-POS) for	

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
Prescription Drugs (continued)		out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Health Net Ruby Option 1 (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. **Tier 4 Injectable** • After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by Health Net Ruby Option 1 (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Health Net Ruby Option 1 (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.	

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
		out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Health Net Navy 1 (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. **Tier 4 Injectable** • After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by Health Net Navy 1 (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Health Net Navy 1 (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.	

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
Prescription Drugs (continued)		**Tier 5 Specialty** • After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by Health Net Ruby Option 1 (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Health Net Ruby Option 1 (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance.	

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
		Tier 5 Specialty • After your total yearly drug costs reach $2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed by Health Net Navy 1 (HMO-POS) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Health Net Navy 1 (HMO-POS) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year. Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: • A $2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or • 5% coinsurance.	

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
30. Dental Services	Preventive dental services (such as cleaning) not covered.	In-Network In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits"). $20 copay for Medicare-covered dental benefits.	In-Network In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits"). $30 copay for Medicare-covered dental benefits.
31. Hearing Services	Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	In-Network Hearing aids not covered. • $20 copay for Medicare-covered diagnostic hearing exams. • $20 copay for up to 1 routine hearing test(s) every year.	In-Network Hearing aids not covered. • $30 copay for Medicare-covered diagnostic hearing exams. • $30 copay for up to 1 routine hearing test(s) every year.
32. Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	In-Network $0 copay for: • one pair of eyeglasses or contact lenses after cataract surgery. • $20 copay for exams to diagnose and treat diseases and conditions of the eye. • $20 copay for up to 1 routine eye exam(s) every year.	In-Network $0 copay for: • one pair of eyeglasses or contact lenses after cataract surgery. • $30 copay for exams to diagnose and treat diseases and conditions of the eye. • $30 copay for up to 1 routine eye exam(s) every year.

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
In-Network In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits"). $25 copay for Medicare-covered dental benefits.	In-Network In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits"). $30 copay for Medicare-covered dental benefits.	In-Network In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits"). $35 copay for Medicare-covered dental benefits.	In-Network In general, preventive dental benefits (such as cleaning) not covered. However, this plan covers preventive dental benefits for an extra cost (see "Optional Benefits"). $25 copay for Medicare-covered dental benefits.
In-Network Hearing aids not covered. • $25 copay for Medicare-covered diagnostic hearing exams. • $25 copay for up to 1 routine hearing test(s) every year.	In-Network Hearing aids not covered. • $30 copay for Medicare-covered diagnostic hearing exams. • $30 copay for up to 1 routine hearing test(s) every year.	In-Network Hearing aids not covered. • $35 copay for Medicare-covered diagnostic hearing exams. • $35 copay for up to 1 routine hearing test(s) every year.	In-Network Hearing aids not covered. • $25 copay for Medicare-covered diagnostic hearing exams. • $25 copay for up to 1 routine hearing test(s) every year.
In-Network $0 copay for: • one pair of eyeglasses or contact lenses after cataract surgery. • $25 copay for exams to diagnose and treat diseases and conditions of the eye. • $25 copay for up to 1 routine eye exam(s) every year.	In-Network $0 copay for: • one pair of eyeglasses or contact lenses after cataract surgery. • $30 copay for exams to diagnose and treat diseases and conditions of the eye. • $30 copay for up to 1 routine eye exam(s) every year.	In-Network $0 copay for: • one pair of eyeglasses or contact lenses after cataract surgery. • $35 copay for exams to diagnose and treat diseases and conditions of the eye. • $35 copay for up to 1 routine eye exam(s) every year.	In-Network $0 copay for: • one pair of eyeglasses or contact lenses after cataract surgery. • $25 copay for exams to diagnose and treat diseases and conditions of the eye. • $25 copay for up to 1 routine eye exam(s) every year.

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
33. Physical Exams	20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage. When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.	In-Network $0 copay for routine exams. Limited to 1 exam(s) every year.	In-Network $0 copay for routine exams. Limited to 1 exam(s) every year.
Health/Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.	In-Network The plan covers the following health/ wellness education benefits: • Nursing Hotline $0 copay for each Medicare-covered smoking cessation counseling session.	In-Network The plan covers the following health/ wellness education benefits: • Nursing Hotline $0 copay for each Medicare-covered smoking cessation counseling session.
Transportation (Routine)	Not covered.	In-Network This plan does not cover routine transportation.	In-Network This plan does not cover routine transportation.
Acupuncture	Not covered.	In-Network This plan does not cover Acupuncture.	In-Network This plan does not cover Acupuncture.
Point of Service	You may go to any doctor, specialist or hospital that accepts Medicare.		

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
In-Network $0 copay for routine exams. Limited to 1 exam(s) every year.	In-Network $0 copay for routine exams. Limited to 1 exam(s) every year.	In-Network $0 copay for routine exams. Limited to 1 exam(s) every year.	In-Network $0 copay for routine exams. Limited to 1 exam(s) every year.
In-Network The plan covers the following health/ wellness education benefits: • Nursing Hotline $0 copay for each Medicare-covered smoking cessation counseling session.	In-Network The plan covers the following health/ wellness education benefits: • Nursing Hotline $0 copay for each Medicare-covered smoking cessation counseling session.	In-Network The plan covers the following health/ wellness education benefits: • Nursing Hotline $0 copay for each Medicare-covered smoking cessation counseling session.	In-Network The plan covers the following health/ wellness education benefits: • Nursing Hotline $0 copay for each Medicare-covered smoking cessation counseling session.
In-Network This plan does not cover routine transportation.	In-Network This plan does not cover routine transportation.	In-Network This plan does not cover routine transportation.	In-Network This plan does not cover routine transportation.
In-Network This plan does not cover Acupuncture.	In-Network This plan does not cover Acupuncture.	In-Network This plan does not cover Acupuncture.	In-Network This plan does not cover Acupuncture.
		Out-of-Network Point of Service coverage is available for the following benefits: • Inpatient Hospital Care • Doctor Office Visits • Chiropractic Services • Podiatry Services	Out-of-Network Point of Service coverage is available for the following benefits: • Inpatient Hospital Care • Doctor Office Visits • Chiropractic Services • Podiatry Services

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
Point of Service (continued)			

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
		• Outpatient Services/Surgery • Ambulance Services • Outpatient Rehabilitation Services • Durable Medical Equipment • Prosthetic Devices • Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies • Diagnostic Tests, X-Rays, Lab Services, and Radiology Services • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • Dental Services • Hearing Services • Vision Services • Physical Exams • Comprehensive Outpatient Rehabilitation Facility (CORF) • Other Health Care Professional Services	• Outpatient Services/Surgery • Ambulance Services • Outpatient Rehabilitation Services • Durable Medical Equipment • Prosthetic Devices • Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies • Diagnostic Tests, X-Rays, Lab Services, and Radiology Services • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • Dental Services • Hearing Services • Vision Services • Physical Exams • Comprehensive Outpatient Rehabilitation Facility (CORF) • Other Health Care Professional Services

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
Point of Service (continued)			

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
		• Diagnostic Radiological Services • Therapeutic Radiological Services • Outpatient X-Rays • Cardiac Rehabilitation Services • Outpatient Blood • Nutrition Therapy for Diabetes and Renal Disease $0 copay for inpatient hospital benefits. 20% of the cost for • Durable Medical Equipment • Prosthetic Devices • Diabetes Supplies • Outpatient Blood $45 copay for • Doctor Office Visits • Chiropractic Services • Podiatry Services • Outpatient Rehabilitation Services • Diagnostic Tests, X-Rays, Lab Services, and Radiology Services • Dental Services • Hearing Services • Vision Services	• Diagnostic Radiological Services • Therapeutic Radiological Services • Outpatient X-Rays • Cardiac Rehabilitation Services • Outpatient Blood • Nutrition Therapy for Diabetes and Renal Disease For hospital stays: Days 1 - 10: $100 copay per day Days 11 and beyond: $0 copay per day 20% of the cost for • Chiropractic Services • Podiatry Services • Outpatient Services/ Surgery • Outpatient Rehabilitation Services • Durable Medical Equipment • Prosthetic Devices • Diabetes Supplies • Diagnostic Tests, X-Rays, Lab Services, and Radiology Services • CORF

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
		• Physical Exams • CORF • Other Health Care Professional Services • Therapeutic Radiological Services • Outpatient X-Rays • Cardiac Rehabilitation Services $125 copay for • Ambulance Services $100 to $200 copay for • Outpatient Services/ Surgery $200 copay for • Diagnostic Radiological Services $0 copay for • Diabetes Self-Monitoring Training and Nutrition Therapy	• Diagnostic Radiological Services • Therapeutic Radiological Services • Outpatient X-Rays • Cardiac Rehabilitation Services • Outpatient Blood $50 copay for • Doctor Office Visits • Dental Services • Hearing Services • Vision Services • Physical Exams • Other Health Care Professional Services $150 copay for • Ambulance Services $0 copay for • Diabetes Self-Monitoring Training and Nutrition Therapy • Bone Mass Measurement • Colorectal Screening Exam • Immunizations • Mammograms (Annual Screenings) • Pap Smears and Pelvic Exams • Prostate Cancer Screening Exams • Vision Services • Nutrition Therapy for Diabetes and Renal Disease

BENEFIT	ORIGINAL MEDICARE	HEALTH NET RUBY OPTION 1 (HMO)	HEALTH NET RUBY OPTION 2 (HMO)
OPTIONAL SUPPLEMENTAL PACKAGE #1			
Premium and Other Important Information		General Package: 1 - Dental PPO: $27 monthly premium, in addition to your $122 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Dental Services $1,000 limit every year for these benefits	General Package: 1 - Dental PPO: $27 monthly premium, in addition to your $12 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Dental Services $1,000 limit every year for these benefits
Dental Services		General Plan offers additional comprehensive dental benefits. In-Network $0 copay for the following preventive dental benefits: • up to 2 oral exam(s) every year • up to 2 cleaning(s) every year • up to 1 dental x-ray(s) every year $1,000 limit for dental benefits every year	General Plan offers additional comprehensive dental benefits. In-Network $0 copay for the following preventive dental benefits: • up to 2 oral exam(s) every year • up to 2 cleaning(s) every year • up to 1 dental x-ray(s) every year $1,000 limit for dental benefits every year

HEALTH NET RUBY OPTION 3 (HMO)	HEALTH NET GREEN (HMO)	HEALTH NET NAVY 1 (HMO-POS)	HEALTH NET NAVY 2 (HMO-POS)
OPTIONAL SUPPLEMENTAL PACKAGE #2			
General Package: 1 - Dental PPO: $27 monthly premium, in addition to your $71 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Dental Services $1,000 limit every year for these benefits	General Package: 1 - Dental PPO: $27 monthly premium, in addition to your $5 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Dental Services $1,000 limit every year for these benefits	General Package: 1 - Dental PPO: $27 monthly premium, in addition to your $162 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Dental Services $1,000 limit every year for these benefits	General Package: 1 - Dental PPO: $27 monthly premium, in addition to your $89 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Dental Services $1,000 limit every year for these benefits
General Plan offers additional comprehensive dental benefits. In-Network $0 copay for the following preventive dental benefits: • up to 2 oral exam(s) every year • up to 2 cleaning(s) every year • up to 1 dental x-ray(s) every year $1,000 limit for dental benefits every year	General Plan offers additional comprehensive dental benefits. In-Network $0 copay for the following preventive dental benefits: • up to 2 oral exam(s) every year • up to 2 cleaning(s) every year • up to 1 dental x-ray(s) every year $1,000 limit for dental benefits every year	General Plan offers additional comprehensive dental benefits. In-Network $0 copay for the following preventive dental benefits: • up to 2 oral exam(s) every year • up to 2 cleaning(s) every year • up to 1 dental x-ray(s) every year $1,000 limit for dental benefits every year	General Plan offers additional comprehensive dental benefits. In-Network $0 copay for the following preventive dental benefits: • up to 2 oral exam(s) every year • up to 2 cleaning(s) every year • up to 1 dental x-ray(s) every year $1,000 limit for dental benefits every year

Health Net of Connecticut, Inc.
One Far Mill Crossing
P.O. Box 904
Shelton, CT 06484

For more information, please contact us at:

Current members should call
1-800-547-8734 (TTY/TDD 1-888-747-2424)
8:00 a.m. to 8:00 p.m., 7 days a week.

Prospective members should call
1-800-709-4192 (TTY/TDD 1-888-747-2424)
8:00 a.m. to 8:00 p.m., 7 days a weeks.

www.healthnet.com

CT60540 (7/09)
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