

Summary of Benefits

2021

Health Net Amber II Premier (HMO D-SNP) H3561: 001
Fresno and Sacramento counties, CA

This booklet provides you with a summary of what we cover and the cost-sharing responsibilities. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call us at the number listed on the last page, and ask for the "Evidence of Coverage" (EOC), or you may access the EOC on our website at ca.healthnetadvantage.com.

You are eligible to enroll in Health Net Amber II Premier (HMO D-SNP) if:

- You are entitled to Medicare Part A and enrolled in Medicare Part B. Members must continue to pay their Medicare Part B premium if not otherwise paid for under Medicaid or by another third party.
- You must be a United States citizen, or are lawfully present in the United States and permanently reside in the service area of the plan (in other words, your permanent residence is within the Health Net Amber II Premier (HMO D-SNP) service area counties). Our service area includes the following counties in California: Fresno and Sacramento.
- For Health Net Amber II Premier (HMO D-SNP), you must also be enrolled in the California Medicaid plan. Premiums, copays, coinsurance, and deductibles may vary based on your Medicaid eligibility category and/or the level of Extra Help you receive. Your Part B premium is paid by the State of California for full-dual enrollees. Please contact the plan for further details.

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

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

Summary of Benefits

JANUARY 1, 2021 – DECEMBER 31, 2021

| Benefits | | Health Net Amber II Premier (HMO D-SNP) H3561: 001 Premiums / Copays / Coinsurance |
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| Premiums, copays, coinsurance, and deductibles may vary based on your Medicaid eligibility category and/or the level of Extra Help you receive | | |
| Monthly Plan Premium | You pay \$0 - \$20.20 based on your level of Medicaid eligibility (You must continue to pay your Medicare Part B premium, if not otherwise paid for by Medicaid or another third party.) | |
| Deductibles | <ul style="list-style-type: none"> • \$0 deductible for covered medical services • \$445 deductible for Part D prescription drugs (applies to drugs on Tiers 2, 3, 4 and 5) | |
| Maximum Out-of-Pocket Responsibility (does not include prescription drugs) | \$3,450 annually This is the most you will pay in copays and coinsurance for covered medical services for the year. | |
| Inpatient Hospital Coverage*■ | For each admission, you pay \$0 or, <ul style="list-style-type: none"> • \$670 copay per day, for days 1 through 3 • \$0 copay per day, for days 4 through 90 | |
| Outpatient Hospital Coverage*■ | <ul style="list-style-type: none"> • Outpatient Hospital: 0% or 20% coinsurance per visit • Observation Services: 0% or 20% coinsurance per visit | |
| Doctor Visits (Primary Care Providers and Specialists)*■ | <ul style="list-style-type: none"> • Primary Care: \$0 copay per visit • Specialist: \$0 copay per visit | |
| Preventive Care* ■ (e.g. flu vaccine, diabetic screening) | \$0 copay for most Medicare-covered preventive services Other preventive services are available. | |
| Emergency Care | 0% or 20% coinsurance (up to \$120) per visit You do not have to pay the copay if admitted to the hospital immediately. | |
| Urgently Needed Services | 0% or 20% coinsurance (up to \$65) per visit Copay is not waived if admitted to hospital. | |

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

| Benefits | Health Net Amber II Premier (HMO D-SNP) H3561: 001 Premiums / Copays / Coinsurance |
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| Diagnostic Services/ Labs/Imaging* ■ (including diagnostic tests and procedures, labs, diagnostic radiology, and X-rays) | COVID-19 testing and specified testing-related services at any location are \$0 <ul style="list-style-type: none"> • Lab services: \$0 copay • Diagnostic tests and procedures: 0% or 20% coinsurance • Outpatient X-ray services: 0% or 20% coinsurance • Diagnostic Radiology services (such as, MRI, MRA, CT, PET): 0% or 20% coinsurance |
| Hearing Services* ■ | <ul style="list-style-type: none"> • Hearing exam (Medicare-covered): 0% or 20% coinsurance • Routine hearing exam: \$0 copay (1 every calendar year) • Hearing aid: \$0 copay (2 hearing aids total, 1 per ear, 1 per calendar year) |
| Dental Services* ■ | <ul style="list-style-type: none"> • Dental services (Medicare-covered): \$0 copay • Comprehensive dental services: Additional comprehensive dental benefits are available. <p>There is a maximum allowance of \$1,000 every calendar year; it applies to all comprehensive dental benefits.</p> |
| Vision Services* ■ | <ul style="list-style-type: none"> • Vision exam (Medicare-covered): 0% or 20% coinsurance per visit • Routine eye exam: \$0 copay per visit (up to 1 every calendar year) • Routine eyewear: up to \$400 allowance every calendar year. |
| Mental Health Services* | Individual and group therapy: 0% or 20% coinsurance per visit |
| Skilled Nursing Facility* | In 2020, the amounts for each benefit period were: \$0 or, <ul style="list-style-type: none"> • \$0 copay per day, days 1 through 20 • \$176 copay per day, days 21 through 100 (may change for 2021) |
| Physical Therapy* ■ | 0% or 20% coinsurance per visit |
| Ambulance | 0% or 20% coinsurance (per one-way trip) for ground or air ambulance services |
| Ambulatory Surgery Center* ■ | Ambulatory Surgery Center: 0% or 20% coinsurance per visit |
| Transportation* ■ | <ul style="list-style-type: none"> • \$0 copay for each one-way trip • Up to 50 one-way trips to plan-approved health-related locations every calendar year. Mileage limits may apply. |
| Medicare Part B Drugs* | <ul style="list-style-type: none"> • Chemotherapy drugs: 0% or 20% coinsurance • Other Part B drugs: 0% or 20% coinsurance |

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Part D Prescription Drugs

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| Deductible Stage | <p>\$445 deductible for Part D prescription drugs (applies to drugs on Tier 2, 3, 4 and 5).</p> <p>The Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, you must pay the full cost of your Part D drugs until you reach the plan’s deductible amount.</p> <p>Once you have paid the plan’s deductible amount for your Part D drugs, you leave the Deductible Stage and move on to the next payment stage (Initial Coverage Stage). If you receive “Extra Help” to pay for your prescription drugs, your deductible amount will be either \$0 or \$92 depending on the level of “Extra Help” you receive.</p> | |
| Initial Coverage Stage (after you pay your Part D deductible, if applicable) | <p>After you have met your deductible (if applicable), the plan pays its share of the cost of your drugs and you pay your share of the cost. “Total drug costs” is the total of all payments made for your covered Part D drugs. It includes what the plan pays and what you pay. Once your “total drug costs” reach \$4,130 you move to the next payment stage (Coverage Gap Stage).</p> | |
| | Standard Retail Rx 30-day supply | Mail Order Rx 90-day supply |
| Tier 1: Preferred Generic Drugs | \$0 copay | \$0 copay |
| Tier 2: Generic Drugs | \$20 copay | \$60 copay |
| Tier 3: Preferred Brand Drugs | \$47 copay | \$141 copay |
| Tier 4: Non-Preferred Drugs | 49% coinsurance | 49% coinsurance |
| Tier 5: Specialty | 25% coinsurance | Not available |

Part D Prescription Drugs

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| Coverage Gap Stage | <p>During this payment stage, you receive a 70% manufacturer's discount on covered brand name drugs and the plan will cover another 5%, so you will pay 25% of the negotiated price and a portion of the dispensing fee on brand-name drugs. In addition the plan will pay 75% and you pay 25% for generic drugs. (The amount paid by the plan does not count towards your out-of-pocket costs).</p> <p>You generally stay in this stage until the amount of your year-to-date "out-of-pocket costs" reaches \$6,550. "Out of pocket costs" includes what you pay when you fill or refill a prescription for a covered Part D drug and payments made for your drugs by any of the following programs or organizations: "Extra Help" from Medicare; Medicare's Coverage Gap Discount Program; Indian Health Service; AIDS drug assistance programs; most charities; and most State Pharmaceutical Assistance Programs (SPAPs). Once your "out-of-pocket costs" reach \$6,550, you move to the next payment stage (Catastrophic Coverage Stage).</p> <p>If you qualify for "Extra Help" this stage doesn't apply-If you are not eligible for "Extra Help", call the plan or refer to the Evidence of Coverage (EOC), Chapter 6, for outpatient prescription drug cost-sharing information.</p> |
| Catastrophic Coverage Stage | <p>During this payment stage, the plan pays most of the cost for your covered drugs. For each prescription, you pay whichever of these is greater: a payment equal to 5% coinsurance of the drug, or a copayment (\$3.70 for a generic drug or a drug that is treated like a generic, \$9.20 for all other drugs).</p> |
| Important Info: | <p>Cost-sharing may change depending on the level of help you receive, the pharmacy you choose (such as Standard Retail, Mail Order, Long-Term Care, or Home Infusion) and when you enter any of the four stages of the Part D benefit.</p> <p>For more information about the costs for Long-Term Supply, Home Infusion, or additional pharmacy-specific cost-sharing and the stages of the benefit, please call us or access our EOC online.</p> <p>Low income subsidy (LIS) is extra help you receive from Medicare. To find out if you qualify, visit Medicare.gov or call Member Services at 1-800-431-9007 (TTY: 711).</p> |

| Additional Covered Benefits | |
|---|--|
| Benefits | Health Net Amber II Premier (HMO D-SNP) H3561: 001 Premiums / Copays / Coinsurance |
| Additional Telehealth Services * ■ | The cost share of Medicare-covered additional telehealth services with primary care physicians, specialists, individual/group sessions with mental health and psychiatric providers and other health care practitioners within these practices will be equal to the cost share of these individual services' office visits. |
| Opioid Treatment Program Services* | <ul style="list-style-type: none"> • Individual setting: 0% or 20% coinsurance per visit • Group setting: 0% or 20% coinsurance per visit |
| Over-the-Counter (OTC) Items | <p>\$0 copay (\$125 allowance per quarter) for items available via mail. There is a limit of 9 per item, per order, with the exception of certain products which have additional limits. You are allowed to order once per quarter and any unused money does not carry over to the next quarter.</p> <p>Please visit the plan's website to see the list of covered over-the-counter items.</p> |
| Chiropractic Care* ■ | <ul style="list-style-type: none"> • Chiropractic services (Medicare-covered): \$0 copay per visit • Routine chiropractic services: \$0 copay per visit (24 visits every calendar year combined with routine acupuncture services) |
| Acupuncture* ■ | <ul style="list-style-type: none"> • Acupuncture services for chronic low back pain (Medicare-covered): \$0 per visit in a chiropractic setting • Acupuncture services for chronic low back pain (Medicare-covered): \$0 copay per visit in a Primary Care Provider's office • Acupuncture services for chronic low back pain (Medicare-covered): \$0 copay per visit in a Specialist's office • Routine acupuncture services: \$0 copay per visit (24 visits every calendar year combined with routine chiropractic services) |

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| Additional Covered Benefits | |
|--|---|
| Benefits | Health Net Amber II Premier (HMO D-SNP) H3561: 001 Premiums / Copays / Coinsurance |
| Medical Equipment/Supplies* | <ul style="list-style-type: none"> • Durable Medical Equipment (e.g., wheelchairs, oxygen): 0% or 20% coinsurance • Prosthetics (e.g., braces, artificial limbs): 0% or 20% coinsurance • Diabetic supplies: 0% to 20% coinsurance. Minimum cost for preferred diabetic supplies and maximum cost for non-preferred diabetic supplies after prior authorization. |
| Foot Care[■] (Podiatry Services) | <ul style="list-style-type: none"> • Foot exams and treatment (Medicare-covered): 0% or 20% coinsurance per visit • Routine Foot care: \$0 copay per visit 12 visits every calendar year.) |
| Virtual Visit | Teladoc™ plan offers 24 hours a day/7days a week/365 days a year virtual visit access to board certified doctors to help address a wide variety of health concerns/questions. |
| Wellness Programs | <ul style="list-style-type: none"> • Fitness program: \$0 copay • 24-hour Nurse Connect: \$0 copay • Supplemental smoking and tobacco use cessation (counseling to stop smoking or tobacco use): \$0 copay <p>For a detailed list of wellness program benefits offered, please refer to the EOC.</p> |
| Worldwide Emergency Care | \$50,000 plan coverage limit for urgent/emergent services outside the U.S. and its territories every calendar year. |
| Routine Annual Exam | \$0 copay |

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

Comprehensive Written Statement for Prospective Enrollees

The benefits described in the Premium and Benefit section of the Summary of Benefits are covered by our Medicare Advantage plan. For each benefit listed, you can see what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility. Coverage of the benefits described in this Summary of Benefits depends upon your level of Medicaid eligibility. No matter what your level of Medicaid eligibility is, Health Net Amber II Premier (HMO D-SNP) will cover the benefits described in the Premium and Benefit section of the Summary of Benefits. If you have questions about your Medicaid eligibility and what benefits you are entitled to, call Medi-Cal toll-free at 1-800-430-4263 (TTY: 1-800-430-7077).

Our source of information for Medicaid benefits is <https://www.dhcs.ca.gov/services/medi-cal/pages/applyformedi-cal.aspx>. All Medicaid covered services are subject to change at any time. For the most current California Medicaid coverage information, please visit Department of Health Care Services (DHCS), or call Member Services for assistance. A detailed explanation of California Medicaid benefits can be found in the California Summary of Services online at <https://www.dhcs.ca.gov/services/medi-cal/pages/applyformedi-cal.aspx>.

| Service | State Plan Service Category | Definition | GMC | Two-Plan | COHS | Region | Imperia | San Benito |
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| Acupuncture Services | Other Practitioners' Services and Acupuncture Services | Acupuncture services shall be limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. | X ¹ | X ¹ | X ¹ | X ¹ | X ¹ | X ¹ |
| Acute Administrative Days | Intermediate Care Facility Services | Acute administrative days are covered, when authorized by a Medi-Cal consultant subject to the acute inpatient facility has made appropriate and timely discharge planning, all other coverage has been utilized and the acute inpatient facility meets the requirements contained in the Manual of Criteria for Medi-Cal Authorization. | X ⁵ | X ⁵ | X | X ⁵ | X ⁵ | X ⁵ |
| Blood and Blood Derivatives | Blood and Blood Derivatives | A facility that collects, stores, and distributes human blood and blood derivatives. Covers certification of blood ordered by a physician or facility where transfusion is given. | X | X | X | X | X | X |

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| California Children Services (CCS) | Service is not covered under the State Plan | California Children Services (CCS) means those services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member. | | | X ⁶ | | | |
| Certified Family nurse practitioner | Certified Family Nurse Practitioners' Services | A certified family nurse practitioners who provide services within the scope of their practice. | X | X | X | X | X | X |
| Certified Pediatric Nurse Practitioner Services | Certified Pediatric Nurse Practitioner Services | Covers the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks; can also include primary care services. | X | X | X | X | X | X |
| Child Health and Disability Prevention (CHDP) Program | | A preventive program that delivers periodic health assessments and provides care coordination to assist with medical appointment scheduling, transportation, and access to diagnostic and treatment services. | X | X | X ⁴ | X | X | X |
| Childhood Lead Poisoning Case Management (Provided by the Local County Health Departments) | | A case of childhood lead poisoning (for purposes of initiating case management) as a child from birth up to 21 years of age with one venous blood lead level (BLL) equal to or greater than 20 µg/dL, or two BLLs equal to or greater than 15 µg/dL that must be at least 30 and no more than 600 calendar days apart, the first specimen is not required to be venous, but the second must be venous. | | | | | | |

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| Chiropractic Services | Chiropractors' Services | Services provided by chiropractors, acting within the scope of their practice as authorized by California law, are covered, except that such services shall be limited to treatment of the spine by means of manual manipulation. | X ¹ | X ¹ | X ¹ | X ¹ | X ¹ | X ¹ |
| Chronic Hemodialysis | Chronic Hemodialysis | Procedure used to treat kidney failure - covered only as an outpatient service. Blood is removed from the body through a vein and circulated through a machine that filters the waste products and excess fluids from the blood. The "cleaned" blood is then returned to the body. Chronic means this procedure is performed on a regular basis. Prior authorization required when provided by renal dialysis centers or community hemodialysis units. | X | X | X | X | X | X |
| Community Based Adult Services (CBAS) | | <p>CBAS Bundled services: An outpatient, facility based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals and transportation to eligible Medi-Cal beneficiaries.</p> <p>CBAS Unbundled Services: Component parts of CBAS center services delivered outside of centers, under certain conditions, as specified in paragraph 94.</p> | X | X | X | X | X | X |
| Comprehensive Perinatal Services | Extended Services for Pregnant Women- Pregnancy Related and Postpartum Services | Comprehensive perinatal services means obstetrical, psychosocial, nutrition, and health education services, and related case coordination provided by or under the personal supervision of a physician during pregnancy and 60 days following delivery. | X | X | X | X | X | X |

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| Dental Services | | Professional services performed or provided by dentists including diagnosis and treatment of malposed human teeth, of disease or defects of the alveolar process, gums, jaws and associated structures; the use of drugs, anesthetics and physical evaluation; consultations; home, office and institutional calls. | | | | | | |
| Drug Medi-Cal Substance Abuse Services | Substance Abuse Treatment Services | Medically necessary substance abuse treatment to eligible beneficiaries. | | | | | | |
| Durable Medical Equipment | DME | Assistive medical devices and supplies. Covered with a prescription; prior authorization is required. | X | X | X | X | X | X |
| Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services | EPSDT | Preliminary evaluation to help identify potential health issues. | X | X | X | X | X | X |

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| Enhanced Case Management (ECM), as defined in paragraph 95 | | A service consisting of those “Complex Case Management” and “Person-Centered Planning” services including the coordination of beneficiaries’ individual needs for needed long-term care services and supports. | X | X | X | X | X | X |
| Erectile Dysfunction Drugs | | FDA-approved drugs that may be prescribed if a male patient experiences an inability or difficulty getting or keeping an erection as a result of a physical problem. | | | | | | |
| Expanded Alpha-Fetoprotein Testing (Administered by the Genetic Disease Branch of DHCS) | | A simple blood test recommended for all pregnant women to detect if they are carrying a fetus with certain genetic abnormalities such as open neural tube defects, Down Syndrome, chromosomal abnormalities, and defects in the abdominal wall of the fetus. | | | | | | |
| Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes and Other Eye Appliances | Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes, and Other Eye Appliances | Eye appliances are covered on the written prescription of a physician or optometrist. | X ^{1,3} | X ^{1,3} | X ^{1,3} | X ^{1,3} | X ^{1,3} | X ^{1,3} |
| Federally Qualified Health Centers (FQHC) (Medi-Cal covered services only) | FQHC | An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)). | X | X | X | X | X | X |

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| Hearing Aids | Hearing Aids | Hearing aids are covered only when supplied by a hearing aid dispenser on prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available in the community, plus an audio logical evaluation including a hearing aid evaluation which must be performed by or under the supervision of the above physician or by a licensed audiologist. | X | X | X | X | X | X |
| Home and Community-Based Waiver Services (Does not include EPSDT Services) | | Home and community-based waiver services shall be provided and reimbursed as Medi-Cal covered benefits only: (1) For the duration of the applicable federally approved waiver, (2) To the extent the services are set forth in the applicable waiver approved by the HHS; and (3) To the extent the Department can claim and be reimbursed federal funds for these services. | | | | | | |
| Home Health Agency Services | Home Health Services-Home Health Agency | Home health agency services are covered as specified below when prescribed by a physician and provided at the home of the beneficiary in accordance with a written treatment plan which the physician reviews every 60 days. | X | X | X | X | X | X |
| Home Health Aide Services | Home Health Services-Home Health Aide | Covers skilled nursing or other professional services in the residence including part-time and intermittent skilled nursing services, home health aide services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker. | X | X | X | X | X | X |

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| Hospice Care | Hospice Care | Covers services limited to individuals who have been certified as terminally ill in accordance with Title 42, CFR Part 418, Subpart B, and who directly or through their representative volunteer to receive such benefits in lieu of other care as specified. | X | X | X | X | X | X |
| Hospital Outpatient Department Services and Organized Outpatient Clinic Services | Clinic Services and Hospital Outpatient Department Services and Organized Outpatient Clinic Services | A scheduled administrative arrangement enabling outpatients to receive the attention of a healthcare provider. Provides the opportunity for consultation, investigation and minor treatment. | X | X | X | X | X | X |
| Human Immunodeficiency Virus and AIDS drugs | | Human Immunodeficiency Virus and AIDS drugs that are listed in the Medi-Cal Provider Manual | | | X ^L | | | |

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| Hysterectomy | Inpatient Hospital Services | <p>Except for previously sterile women, a nonemergency hysterectomy may be covered only if: (1) The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representatives, if any, orally and in writing, that the hysterectomy will render the individual permanently sterile, (2) The individual and the individual's representative, if any, has signed a written acknowledgment of the receipt of the information in and (3) The individual has been informed of the rights to consultation by a second physician. An emergency hysterectomy may be covered only if the physician certifies on the claim form or an attachment that the hysterectomy was performed because of a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible and includes a description of the nature of the emergency.</p> | | | X | | | |
| Indian Health Services (Medi-Cal covered services only) | | <p>Indian means any person who is eligible under federal law and regulations (25 U.S.C. Sections 1603c, 1679b, and 1680c) and covers health services provided directly by the United States Department of Health and Human Services, Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by contract.</p> | X | X | X | X | X | X |

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| In-Home Medical Care Waiver Services and Nursing Facility Waiver Services | | In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in-home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service. | X | X | X | X | X | X |
| Inpatient Hospital Services | Inpatient Hospital Services | Covers delivery services and hospitalization for newborns; emergency services without prior authorization; and any hospitalization deemed medically necessary with prior authorization. | X | X | X | X | X | X |
| Intermediate Care Facility Services for the Developmentally Disabled | Intermediate Care Facility Services for The Developmentally Disabled | Intermediate care facility services for the developmentally disabled are covered subject to prior authorization by the Department. Authorizations may be granted for up to six months. The authorization request shall be initiated by the facility. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care | X ⁵ | X ⁵ | X | X ⁵ | X ⁵ | X ⁵ |

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| Intermediate Care Facility Services for the Developmentally Disabled Habilitative | Intermediate Care Facility Services for the Developmentally Disabled Habilitative | Intermediate care facility services for the developmentally disabled habilitative (ICF-DDH) are covered subject to prior authorization by the Department of Health Services for the ICF-DDH level of care. Authorizations may be granted for up to six months. Requests for prior authorization of admission to an ICF-DDH or for continuation of services shall be initiated by the facility on forms designated by the Department. Certification documentation required by the Department of Developmental Services must be completed by regional center personnel and submitted with the Treatment Authorization Request form. The attending physician shall sign the Treatment Authorization Request form and shall certify to the Department that the beneficiary requires this level of care. | X ⁵ | X ⁵ | X | X ⁵ | X ⁵ | X ⁵ |
| Intermediate Care Facility Services for the Developmentally Disabled-Nursing. | | Intermediate care facility services for the developmentally disabled-nursing (ICF/DD-N) are covered subject to prior authorization by the Department for the ICF/DD-N level of care. Authorizations may be granted for up to six months. Requests for prior authorization of admission to an ICF/DD-N or for continuation of services shall be initiated by the facility on Certification for Special Treatment Program Services forms (HS 231). Certification documentation required by the Department of Developmental Services shall be completed by regional center personnel and submitted with the Treatment Authorization Request form. The attending physician shall sign the Treatment Authorization Request form and shall certify to the Department that the beneficiary requires this level of care. | X ⁵ | X ⁵ | X | X ⁵ | X ⁵ | X ⁵ |

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| Intermediate Care Services | Intermediate Care Facility Services | Intermediate care services are covered only after prior authorization has been obtained from the designated Medi-Cal consultant for the district where the facility is located. The authorization request shall be initiated by the facility. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care. | X ⁵ | X ⁵ | X | X ⁵ | X ⁵ | X ⁵ |
| Laboratory, Radiological and Radioisotope Services | Laboratory, X-Ray and Laboratory, Radiological and Radioisotope Services | Covers exams, tests, and therapeutic services ordered by a licensed practitioner | X | X | X | X | X | X |
| Licensed Midwife Services | Other Practitioners' Services and Licensed Midwife Services | The following services shall be covered as licensed midwife services under the Medi-Cal Program when provided by a licensed midwife supervised by a licensed physician and surgeon: (1) Attendance at cases of normal childbirth and (2) The provision of prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn. | X | X | X | X | X | X |

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|---|---|---|----------------|----------------|------|----------------|----------------|----------------|
| Local Educational Agency (LEA) Services | Local Education Agency Medi-Cal Billing Option Program Services | LEA health and mental health evaluation and health and mental health education services, which include any or all of the following: (A) Nutritional assessment and nutrition education, consisting of assessments and non-classroom nutrition education delivered to the LEA eligible beneficiary based on the outcome of the nutritional health assessment (diet, feeding, laboratory values, and growth), (B) Vision assessment, consisting of examination of visual acuity at the far point conducted by means of the Snellen Test, (C) Hearing assessment, consisting of testing for auditory impairment using at-risk criteria and appropriate screening techniques as defined in Title 17, California Code of Regulations, Sections 2951(c), (D) Developmental assessment, consisting of examination of the developmental level by review of developmental achievement in comparison with expected norms for age and background, (E) Assessment of psychosocial status, consisting of appraisal of cognitive, emotional, social, and behavioral functioning and self-concept through tests, interviews, and behavioral evaluations and (F) Health education and anticipatory guidance appropriate to age and health status, consisting of non-classroom health education and anticipatory guidance based on age and developmentally appropriate health education. | | | | | | |
| Long Term Care (LTC) | | Care in a facility for longer than the month of admission plus one month. | X ⁵ | X ⁵ | X | X ⁵ | X ⁵ | X ⁵ |
| Medical Supplies | Medical Supplies | Medically necessary supplies when prescribed by a licensed practitioner. Does not include incontinence creams and washes. | X | X | X | X | X | X |

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|---|--|--|-----|----------|------|--------|---------|------------|
| Medical Transportation Services | Transportation-Medical Transportation Services | Covers ambulance, litter van and wheelchair van medical transportation services are covered when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care. | X | X | X | X | X | X |
| Multipurpose Senior Services Program (MSSP) | | MSSP sites provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community. | | | | | | |
| Nurse Anesthetist Services | Other Practitioners' Services and Nurse Anesthetist Services | Covers anesthesiology services performed by a nurse anesthetist within the scope of his or her licensure. | X | X | X | X | X | X |
| Nurse Midwife Services | Nurse-Midwife Services | An advanced practice registered nurse who has specialized education and training in both Nursing and Midwifery, is trained in obstetrics, works under the supervision of an obstetrician, and provides care for mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks. | X | X | X | X | X | X |
| Optometry Services | Optometrists' Services | Covers eye examinations and prescriptions for corrective lenses. Further services are not covered. | X | X | X | X | X | X |

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|--------------------------------------|--|--|----------------|----------------|----------------|----------------|----------------|----------------|
| Outpatient Mental Health | Outpatient Mental Health | <p>Services provided by licensed health care professionals acting within the scope of their license for adults and children diagnosed with a mental condition as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Services include:</p> <ul style="list-style-type: none"> • Individual and group mental health evaluation and treatment (psychotherapy) • Psychological testing when clinically indicated to evaluate a mental health condition • Outpatient Services for the purpose of monitoring drug therapy • Outpatient laboratory, drugs, supplies and supplements • Screening and Brief Intervention (SBI) • Psychiatric consultation for medication management | X ² | X ² | X ² | X ² | X ² | X ² |
| Organized Outpatient Clinic Services | Clinic Services and Organized Outpatient Clinic Services | <p>In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in-home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.</p> | X | X | X | X | X | X |

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|--|--|--|----------------|----------------|------|----------------|----------------|----------------|
| Outpatient Heroin Detoxification Services | Outpatient Heroin Detoxification Services | Can cover of a number of medications and treatments, allowing for day to day functionality for a person choosing to not admit as an inpatient. Routine elective heroin detoxification services are covered, subject to prior authorization, only as an outpatient service. Outpatient services are limited to a maximum period of 21 days. Inpatient hospital services shall be limited to patients with serious medical complications of addiction or to patients with associated medical problems which require inpatient treatment. | | | | | | |
| Part D Drugs | | Drug benefits for full-benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act. | | | | | | |
| Pediatric Subacute Care Services | Nursing Facility Services and Pediatric Subacute Services (NF) | Pediatric Subacute care services are a type of skilled nursing facility service which is provided by a subacute care unit. | X ⁵ | X ⁵ | X | X ⁵ | X ⁵ | X ⁵ |
| Personal Care Services | Personal Care Services | Covers services which may be provided only to a categorically needy beneficiary who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services. | | | | | | |
| Pharmaceutical Services and Prescribed Drugs | Pharmaceutical Services and Prescribed Drugs | Covers medications including prescription and nonprescription and total parental nutrition supplied by licensed physician. | X | X | X | X | X | X |

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| Psychotherapeutic drugs | Services not covered under the State Plan | S. Psychotherapeutic drugs that are listed in the Medi-Cal Provider Manual | | | X ⁸ | | | |
| Rehabilitation Center Outpatient Services | Rehabilitative Services | A facility providing therapy and training for rehabilitation. The center may offer occupational therapy, physical therapy, vocational training, and special training | X | X | X | X | X | X |
| Rehabilitation Center Services | Rehabilitative Services | A facility which provides an integrated multidisciplinary program of restorative services designed to upgrade or maintain the physical functioning of patients. | X | X | X | X | X | X |
| Renal Homotransplantation | Organ Transplant Services | Renal homotransplantation is covered only when performed in a hospital which meets the standards established by the Department for renal homotransplantation centers. | X | X | X | X | X | X |
| Requirements Applicable to EPSDT Supplemental Services. | EPSDT | Early and Periodic Screening, Diagnosis and Treatment: for beneficiaries under 21 years of age; includes case management and supplemental nursing services; also covered by CCS for CCS services, and Mental Health services. | X | X | X | X | X | X |
| Respiratory Care Services | Respiratory Care Services | A provider trained and licensed for respiratory care to provide therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities affecting the pulmonary system and aspects of cardiopulmonary and other systems. | X | X | X | X | X | X |

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| Rural Health Clinic Services | Rural Health Clinic Services | Covers primary care services by a physician or a nonphysician medical practitioner, as well as any supplies incident to these services; home nursing services; and any other outpatient services, supplies, supplies, equipment and drugs. | X | X | X | X | X | X |
| Scope of Sign Language Interpreter Services | Sign Language Interpreter Services | Sign language interpreter services may be utilized for medically necessary health care services | X | X | X | X | X | X |
| Services provided in a State or Federal Hospital | | California state hospitals provide inpatient treatment services for Californians with serious mental illnesses. Federal hospitals provide services for certain populations, such as the military, for which the federal government is responsible. | | | | | | |
| Short-Doyle Mental Health Medi-Cal Program Services | Short-Doyle Program | Community mental health services provided by Short-Doyle Medi-Cal providers to Medi-Cal beneficiaries are covered by the Medi-Cal program. | | | | | | |
| Skilled Nursing Facility Services | Nursing Facility Services and Skilled Nursing Facility Services | A skilled nursing facility is any institution, place, building, or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital, (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. | X ⁵ | X ⁵ | X | X ⁵ | X ⁵ | X ⁵ |
| Special Duty Nursing | Private Duty Nursing Services | Private duty nursing is the planning of care and care of clients by nurses, whether a registered nurse or licensed practical nurse. | X | X | X | X | X | X |
| Specialty Mental health services | | Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services. | | | | | | |

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| Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities | Special Rehabilitative Services | Specialized rehabilitative services shall be covered. Such service shall include the medically necessary continuation of treatment services initiated in the hospital or short term intensive therapy expected to produce recovery of function leading to either (1) a sustained higher level of self-care and discharge to home or (2) a lower level of care. Specialized rehabilitation service shall be covered. | X ⁵ | X ⁵ | X | X ⁵ | X ⁵ | X ⁵ |
| State Supported Services | | State funded abortion services that are provided through a secondary contract. | X | X | X | X | X | X |
| Subacute Care Services | Nursing Facility Services and Skilled Subacute Care Services SNF | Subacute care services are a type of skilled nursing facility service which is provided by a subacute care unit. | X ⁵ | X ⁵ | X | X ⁵ | X ⁵ | X ⁵ |
| Swing Bed Services | Inpatient Hospital Services | Swing bed services is additional inpatient care services for those who qualify and need additional care before returning home. | X | X | X | X | X | X |
| Targeted Case Management Services Program | Targeted Case Management | Persons who are eligible to receive targeted case management services shall consist of the following Medi-Cal beneficiary groups: high risk, persons who have language or other comprehension barriers and persons who are 18 years of age and older. | | | | | | |

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| Targeted Case Management Services. | Targeted Case Management | Targeted case management services shall include at least one of the following service components: A documented assessment identifying the beneficiary's needs, development of a comprehensive, written, individual service plan, implementation of the service plan includes linkage and consultation with and referral to providers of service, assistance with accessing the services identified in the service plan, crisis assistance planning to coordinate and arrange immediate service or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific beneficiary, periodic review of the beneficiary's progress toward achieving the service outcomes identified in the service plan to determine whether current services should be continued, modified or discontinued. | | | | | | |
| Transitional Inpatient Care Services | Nursing Facility and Transitional Inpatient Care Services | Focus on transition of care from outpatient to inpatient. Inpatient care coordinators, along with providers from varying settings along the care continuum, should provide a safe and quality transition. | X | X | X | X | X | X |
| Tuberculosis (TB) Related Services | TB Related Services | Covers TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention. | | | | | | |

PRIVACY PRACTICES:

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

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

For more information, please contact:

Health Net Amber II Premier (HMO D-SNP)
PO Box 10420
Van Nuys, CA 91410

ca.healthnetadvantage.com

Current members should call: 1-800-431-9007 (TTY: 711)

Prospective members should call: 1-800-977-6738 (TTY: 711)

From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This plan is available to anyone who has both Medical Assistance from the State and Medicare.

This information is not a complete description of benefits. Call 1-800-431-9007 (TTY: 711) for more information.

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

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

This document is available in other formats such as Braille, large print or audio.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-431-9007 (TTY: 711)

Health Net is contracted with Medicare for an HMO D-SNP plan and with the state Medicaid program. Enrollment in Health Net depends on contract renewal.