This is your Summary of Benefits.

2025

Health Net Seniority Plus Employer (HMO)

Alameda, Contra Costa, Fresno, Imperial, Kern, Los Angeles, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara*, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, and Yolo Counties, CA

Medical plan HG7
H0562_25_SB_M_09122024

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).

You are eligible to enroll in Health Net Seniority Plus Employer (HMO) if:

- You are entitled to Medicare Part A and enrolled in Medicare Part B. Members must continue to pay their Medicare Part B premium if not otherwise paid for under Medicaid or by another third party.
- You must be a United States citizen or are lawfully present in the United States and permanently reside in the service area of the plan (in other words, your permanent residence is within the Health Net Seniority Plus Employer (HMO) service area). You must also meet any additional eligibility requirements of your employer's or union's benefits administrator. Our service area includes the following counties in California: Alameda, Contra Costa, Fresno, Imperial, Kern, Los Angeles, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara*, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, and Yolo counties.

*Denotes partial county

For partial counties, you must live in one of the following zip codes to join this plan: 93013, 93014, 93067, 93101, 93102, 93103, 93105, 93106, 93107, 93108, 93109, 93110, 93111, 93116, 93117, 93118, 93120, 93121, 93130, 93140, 93150, 93160, 93190, 93199, 93252, 93427, 93436, 93437, 93438, 93440, 93441, 93460, 93463, or 93464.

The Health Net Seniority Plus Employer (HMO) plan gives you access to our network of highly skilled medical providers in your area. You can look forward to choosing a Primary Care Provider (PCP) to work with you and coordinate your care. You can ask for a current provider directory or, for an up-to-date list of network providers, visit healthnet.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 Seniority Plus Employer (HMO) will be responsible for the costs.)

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

The plan has a List of Covered Drugs (formulary). The list will tell you if your drug has any limits or restrictions. You can view the drug list on our website at healthnet.com/groupmedicareformulary. You can also call us to ask for a copy.

Summary of Benefits

JANUARY 1, 2025–DECEMBER 31, 2025

Benefits	Health Net Seniority Plus Employer (HMO) Premiums / Copays / Coinsurance
Monthly Plan Premium	Your coverage is provided through a contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
Deductibles	No deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	$3,400 annually This is the most you will pay in copays and coinsurance for covered medical services for the year.
Inpatient Hospital Coverage*	There is no limit to the number of days covered by the plan each hospital stay. You pay $0 copay per admission for Medicare-covered hospital stays. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. • Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
Outpatient Hospital Coverage*	There is no copayment for Medicare-covered outpatient hospital facility visits.
Doctor Visits***(Primary Care Providers and Specialists)**	• Primary Care: $5 copay per visit • Specialist: $5 copay per visit
Preventive Care (e.g. flu vaccine, diabetic screening)	$0 copay for most Medicare-covered preventive services Other preventive services are available. For a complete list of Preventive Services benefits, please refer to the EOC for this plan.

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

Benefits	Health Net Seniority Plus Employer (HMO) Premiums / Copays / Coinsurance
Emergency Care	$50 copay per visit You do not have to pay the copay if admitted to the hospital immediately.
Urgently Needed Services	$5 copay per visit You do not have to pay the copay if admitted to the hospital immediately.
Diagnostic Services/ Labs/Imaging* (includes diagnostic tests and procedures, labs, diagnostic radiology, and X-rays)	• COVID-19 testing and specified testing-related services at any location are $0. • Lab services: $0 copay • Diagnostic tests and procedures (such as EKG, EEG, nuclear cardiology, etc.): $0 copay • Outpatient X-ray services: $0 copay • Diagnostic Radiology Services (such as, MRI, MRA, CT, PET): $0 copay
Hearing Services*	• Hearing exam (Medicare-covered): $5 copay • Routine hearing exam: $0 copay (1 every calendar year) • Hearing aid: $0 copay (2 hearing aids every 12 months)
Dental Services*	• Dental services (Medicare-covered): $0 copay per visit (when medically necessary to properly monitor, control or treat a severe medical condition) • In general, routine preventive dental (Non-Medicare covered) benefits (such as cleanings) are not covered.
Vision Services*	• Vision exam (Medicare-covered): $5 copay per visit • Routine eye exam (refraction): $0 copay per visit (up to 1 every calendar year) Please refer to the Evidence of Coverage for a complete schedule of services and copayments.

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

Benefits	Health Net Seniority Plus Employer (HMO) Premiums / Copays / Coinsurance
Mental Health Services*	**Outpatient Mental Health Services:** • Individual and group therapy: $5 copay per visit **Inpatient Mental Health Services:** • You pay $0 copay per admission for Medicare-covered hospital stays. No limit to the number of days covered by the plan each hospital stay Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
Skilled Nursing Facility*	• Plan covers up to 100 days each benefit period. • You pay $0 copay per admission for Medicare-covered services in a Skilled Nursing Facility. • You pay all costs for each day after day 100 in the benefit period. • A “benefit period” begins the first day you go into a hospital or Skilled Nursing Facility. The benefit period ends when you haven’t received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.
Physical Therapy*	$0 copay per Medicare-covered Physical Therapy visit
Ambulance*	$0 copay (per one-way trip) for ground or air ambulance services
Ambulatory Surgery Center*	Ambulatory Surgery Center: $0 copay per visit
Transportation	Not covered
Medicare Part B Drugs*	• Chemotherapy drugs: $0 copay • Other Part B drugs: $0 copay

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Part D Prescription Drugs		
Deductible Stage	This plan does not have a Part D deductible. You begin in the Initial Coverage Stage when you fill your first prescription of the plan year.	
Initial Coverage Stage	After you have met your deductible (if applicable), the plan pays its share of the cost of your drugs and you pay your share of the cost. You generally stay in this stage until the amount of your year-to-date total out-of-pocket costs reaches -$2,000. Once your total out-of-pocket costs reach $2,000 you move to the next payment stage (Catastrophic Coverage Stage).	
	Standard Retail Rx 30-day supply	**Mail Order Rx 100-day supply**
	If you use one of our mail order pharmacies to fill up to a 100-day supply of your medications, you may be able to save money. Costs may vary depending on the type of pharmacy used and days' supply. Check your Evidence of Coverage for more information.	
Tier 1: Preferred Generic Drugs	$0 copay	$0 copay
Tier 2: Generic Drugs	$5 copay	$0 copay
Tier 3: Preferred Brand Drugs	$7.50 copay	$10 copay
Tier 4: Non-Preferred Drugs	$7.50 copay	$10 copay
Tier 5: Specialty Tier (includes high-cost generics and brands drugs)	$7.50 copay	N/A
Catastrophic Stage	Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the plan year. During this payment stage, the plan pays the full cost you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.	

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December).

To learn more about this payment option, please contact us at 1-833-750-9969. (TTY only, call 1-800-716-3231.) We are available for phone calls 24 hours a day, 7 days a week, 365 days a year or visit healthnet.com.

Additional Covered Benefits	
Benefits	**Health Net Seniority Plus Employer (HMO) Premiums / Copays / Coinsurance**
Acupuncture*	Acupuncture services (Medicare-covered): $0 copay per visit (up to 12 visits within 90 days), limited to treatment of chronic low back pain. • Routine acupuncture services: $0 copay per visit up to 20 visits when using our acupuncture network during the plan year Please refer to the Evidence of Coverage for the complete schedule of services and copayments.
Chiropractic Care*	• Chiropractic services (Medicare-covered): $0 copay per visit. • Routine chiropractic services: $5 copay per visit when using our chiropractic network, up to 12 visits during the plan year. Please refer to the Evidence of Coverage for the complete schedule of services and copayments.
Hospice Care*	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not the plan. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. • You pay $5 doctor office visit copay for a one-time consultation visit before you select hospice.
Home Health Agency Care*	• Home Health Agency Care: $0 copay for Medicare-covered home health visits
Medical Equipment/ Supplies*	• Durable Medical Equipment (e.g., wheelchairs, oxygen): $0 copay • Prosthetics (e.g., braces, artificial limbs): $0 copay • Diabetic supplies: $0 copay
Diabetes Self-management Training, Diabetic Services and Supplies*	• There is no copayment for Medicare-covered diabetes self-management training. • You pay $0 copay for Medicare-covered diabetes supplies. • You pay $0 copay for Medicare-covered diabetic therapeutic shoes or inserts.
Podiatry Services* (Foot Care)	• Foot exams and treatment (Medicare-covered): $0 copay • Routine foot care: $0 copay per visit (1 visit per calendar month) • Medicare-covered podiatry visits are for medically necessary foot care.

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Additional Covered Benefits	
Benefits	**Health Net Seniority Plus Employer (HMO) Premiums / Copays / Coinsurance**
Physical Exam/ Wellness Visit	• You pay $0 copay for each routine physical exam.
Wellness Programs	The plan covers the following supplemental wellness/education programs: • Health Education • Additional smoking and tobacco use cessation visits online and telephonic counseling • Nurse advice hotline • Health Club Membership/Fitness Classes – Silver&Fit® • There is no copayment for health and wellness education programs.
Worldwide Emergency Care	You pay $50 copay for worldwide emergency care services received outside of the United States[1]. • [1]United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.
Opioid Treatment Program Services*	• Individual setting: $5 copay per visit • Group setting: $5 copay per visit
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. • You pay $0 copay for (Non-Medicare covered) telehealth services provided through the Teladoc program. 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
Retail MinuteClinic through CVS Pharmacy	• You pay $0 copay for preventive services (including preventive physical examination, other immunization and preventive laboratory tests) performed at a retail clinic. • You pay $5 copay for non-preventive services performed at a retail clinic.

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

For more information, please contact:

Health Net Seniority Plus Employer (HMO)
Post Office Box 10420
Van Nuys, CA 91410-0420

healthnet.com/lausd

Current members should call: 1-844-542-0102 (TTY:711)

Prospective members should call: 1-800-275-4737 (TTY:711)

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

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

This information is not a complete description of benefits. Call 1-844-542-0102 (TTY: 711) for more information.

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

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

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-275-4737 (TTY: 711)

注意：如果您說中文，您可以獲得免費的語言協助服務。請致電 1-800-275-4737（聽障電話：711）

Health Net is contracted with Medicare for HMO plans. Enrollment in Health Net depends on contract renewal.

SBS065676EP00 (10/24)

ATTENTION: If you need help in your language, call 1-800-275-4737 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-275-4737 (TTY: 711). These services are free.

انتباه: إذا كنت بحاجة إلى مساعدة بلغتك، فاتصل على 1-800-275-4737 (TTY: 711).
تتوفر أيضًا مساعدات وخدمات للأشخاص ذوي الإعاقات مثل المستندات بطريقة برايل وبطباعة كبيرة. اتصل على 1-800-275-4737 (TTY: 711). هذه الخدمات مجانية.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե ցանկանում եք օգնություն ստանալ ձեր լեզվով, զանգահարեք 1-800-275-4737 (TTY՝ 711): Հասանելի են նաև հաշմանդամություն ունեցող անձանց համար նախատեսված օժանդակ միջոցներ և ծառայություններ, օրինակ՝ բրայլյան գրատեսակով և խոշոր տառաչափով փաստաթղթեր: Զանգահարեք 1-800-275-4737 (TTY՝ 711): Այս ծառայություններն անվճար են:

注意：如果您需要以您的语言提供的帮助，请致电 1-800-275-4737（TTY：711）。此外，还为残疾人提供辅助和相关服务，如盲文文件和大字体文件。请致电 1-800-275-4737（TTY：711）。这些服务均免费提供。

注意：如果您需要以您母語提供的協助，請致電 1-800-275-4737 (TTY：711)。我們也為殘疾人士提供輔助和服務，例如點字和大字體印刷的文件。請致電 1-800-275-4737 (TTY：711)。這些服務均為免費。

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ 1-800-275-4737 (TTY: 711) **'ਤੇ ਕਾਲ ਕਰੋ। ਬਰੇਲ ਲਿਪੀ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ਾਂ ਵਰਗੀਆਂ ਅਸਮਰੱਥਾ ਵਾਲੇ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਉਪਲਬਧ ਹਨ।** 1-800-275-4737 (TTY: 711) **'ਤੇ ਕਾਲ ਕਰੋ। ਇਹ ਮੁਫ਼ਤ ਸੇਵਾਵਾਂ ਹਨ।**

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है, तो 1-800-275-4737 (TTY: 711) पर कॉल करें. विकलांग लोगों के लिए ब्रेल और बड़े प्रिंट में दस्तावेज जैसी सहायताएं और सेवाएं भी उपलब्ध हैं. 1-800-275-4737 (TTY: 711) पर कॉल करें. ये सेवाएं निःशुल्क हैं.

H0562_WCM_165569M_C Internal Approved 08192024
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THOV MUAB SIAB RAU: Yog tias koj xav tau kev pab ua koj hom lus, ces hu rau 1-800-275-4737 (TTY: 711). Tsis tas i ntawd, peb tseem muaj cov neeg pab thiab cov kev pab cuam rau cov neeg uas muaj cov kev xiam oob qhab, xws li cov ntaub ntawv ua ntawv su rau neeg dig muag thiab ntawv luam loj. Hu rau 1-800-275-4737 (TTY: 711). Cov kev pab cuam no pab dawb xwb.

注意：言語のヘルプが必要な場合は 1-800-275-4737（TTY：711）**までお電話ください。障害をお持ちの方には、点字や大判プリントなどの補助機能やサービスもご利用になれます。** 1-800-275-4737（TTY：711）**にお電話ください。これらのサービスは無料です。**

주의: 귀하의 구사 언어로 도움을 받으셔야 한다면 1-800-275-4737(TTY: 711)번으로 연락해 주십시오. 점자 및 큰 활자 인쇄 형식으로 된 문서 등 장애인을 위한 도움 및 서비스도 제공됩니다. 1-800-275-4737(TTY: 711)번으로 연락해 주십시오. 이러한 서비스는 무료입니다.

ຂໍ້ຄວນເອົາໃຈໃສ່: ຫາກທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ, ໃຫ້ໂທຫາ 1-800-275-4737 (TTY: 711). **ນອກຈາກນີ້ ຍັງມີຄວາມຊ່ວຍເຫຼືອສຳລັບຜູ້ພິການ ເຊັ່ນ: ເອກະສານເປັນອັກສອນນູນ ແລະ ຕົວພິມໃຫຍ່ອີກດ້ວຍ.** ໃຫ້ໂທຫາ 1-800-275-4737 (TTY: 711). **ບໍລິການເຫຼົ່ານີ້ຟຣີ.**

LIOUH EIX: Oix se nongc zuqc meih nyei wac jouh mienh bong zouc, cingv mboqv 1-800-275-4737 (TTY: 711). Hac haih weic waic fangx mienh zoux sic taengx qaqv, hnangv mangh wenh souh nzangc caux domh nzangc yenx benx nyei souh nzangc. Mboqv 1-800-275-4737 (TTY: 711). Naiv deix bong taengx meih se mv siou zinh.

ចំណាំ៖ ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក សូមទូរសព្ទទៅលេខ 1-800-275-4737 (TTY: 711) **ជំនួយនិងសេវាកម្មសម្រាប់ជនពិការ ដូចជាឯកសារជាអក្សរស្មាបសម្រាប់ជនពិការភ្នែក និងពុម្ពអក្សរធំ ក៏មានផងដែរ។ សូមទូរសព្ទទៅលេខ** 1-800-275-4737 (TTY: 711)**។ សេវាទាំងនេះមិនគិតថ្លៃនោះទេ។**

توجه: اگر به زبان خودتان نیاز به کمک دارید با شماره 1-800-275-4737 (TTY: 711) تماس بگیرید. پشتیبانی و خدمات برای افراد دارای معلولیت، مانند اسناد با خط بریل و چاپ درشت، نیز موجود است. با شماره 1-800-275-4737 (TTY: 711) تماس بگیرید. این خدمات رایگان است.

ВНИМАНИЕ: если вам требуется помощь на родном языке, позвоните по номеру 1-800-275-4737 (TTY: 711). Также доступны сопутствующая помощь и услуги для людей с ограниченными возможностями, такие как материалы, напечатанные крупным шрифтом и шрифтом Брайля. Позвоните по номеру 1-800-275-4737 (TTY: 711). Эти услуги предоставляются бесплатно.

ATENCIÓN: Si necesita ayuda en su idioma llame al 1-800-275-4737 (TTY: 711). También están disponibles ayudas y servicios para personas con discapacidades, como documentos en Braille y letra grande. Llame al 1-800-275-4737 (TTY: 711). Estos servicios son gratuitos.

ATENSYON: Kung kailangan ninyo ng tulong sa inyong wika, tumawag sa 1-800-275-4737 (TTY: 711). Available din ang mga tulong at serbisyo para sa mga taong may kapansanan, gaya ng mga dokumento sa braille at malaking print. Tumawag sa 1-800-275-4737 (TTY: 711). Libre ang mga serbisyong ito.

โปรดทราบ: **หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ โปรดโทร** 1-800-275-4737 (TTY: 711) **นอกจากนี ยังมีความช่วยเหลือและบริการสำหรับผู้พิการ เช่น เอกสารทีเป็นอักษรเบรลล์และเอกสารทีใช้ตัวอักษรขนาดใหญ่ โปรดโทร** 1-800-275-4737 (TTY: 711) **บริการเหล่านีไม่มีค่าใช้จ่าย**

УВАГА! Якщо ви потребуєте підтримки своєю мовою, телефонуйте за номером 1-800-275-4737 (TTY: 711). Також доступні засоби та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля та великим шрифтом. Телефонуйте за номером 1-800-275-4737 (TTY: 711). Ці послуги безкоштовні.

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của quý vị, hãy gọi số 1-800-275-4737 (TTY: 711). Các hỗ trợ và dịch vụ dành cho người khuyết tật, chẳng hạn như tài liệu bằng chữ nổi và bản in cỡ chữ lớn cũng được cung cấp. Gọi số 1-800-275-4737 (TTY: 711). Các dịch vụ này miễn phí.