Health Net®
MEDICARE PROGRAMS

January 1 – December 31, 2014

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Health Net Aqua (PPO)

This booklet gives you the details about your Medicare health care coverage from January 1 – December 31, 2014. It explains how to get coverage for the health care services you need.
This is an important legal document. Please keep it in a safe place.

This plan, Health Net Aqua (PPO), is offered by Health Net Life Insurance Company. (When this *Evidence of Coverage* says "we," "us," or "our," it means Health Net Life Insurance Company. When it says "plan" or "our plan," it means Health Net Aqua (PPO).)

Health Net Life Insurance Company is a Medicare Advantage organization with a Medicare contract to offer this PPO plan. Enrollment in a Medicare Advantage plan depends on contract renewal.

Member Services has free language interpreter services available for non-English speakers (phone numbers are printed on the back cover of this booklet).

This information is also available in a different format, including large print and audio. Please call Member Services at the phone number listed on the back cover of this booklet if you need plan information in another format.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2015.

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H5520-001

2014 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

414770
6028784
H5520-001

Chapter 1. Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Health Net Aqua (PPO), which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, Health Net Aqua (PPO).

There are different types of Medicare health plans. Our plan is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). This plan does not include Part D prescription drug coverage. Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

This plan, Health Net Aqua (PPO), is offered by Health Net Life Insurance Company. (When this *Evidence of Coverage* says "we," "us," or "our," it means Health Net Life Insurance Company. When it says "plan" or "our plan," it means Health Net Aqua (PPO).)

The words "coverage" and "covered services" refer to the medical care and services available to you as a member of our plan.

Section 1.3 What does this Chapter tell you?

Look through Chapter 1 of this *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What is your plan's service area?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- How do you keep the information in your membership record up to date?

Section 1.4 What if you are new to our plan?

If you are a new member, then it's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan's Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.5 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how our plan covers your care. Other parts of this contract include your enrollment form and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in Health Net Aqua (PPO) between January 1, 2014 and December 31, 2014.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Health Net Aqua (PPO) after December 31, 2014. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2014.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You live in our geographic service area (Section 2.3 below describes our service area)
- -- *and* -- you have both Medicare Part A and Medicare Part B
- -- *and* -- you do *not* have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services furnished by institutional providers such as hospitals (for inpatient services), skilled nursing facilities, or home health agencies.

- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment and supplies).

Section 2.3 Here is the plan service area for our plan

Although Medicare is a Federal program, our plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must keep living in this service area. The service area is described below

Our service area includes these counties in Oregon: Benton, Clackamas, Columbia, Lane, Linn, Marion, Multnomah, Polk, Washington, Yamhill

Our service area also includes this county in Washington: Clark.

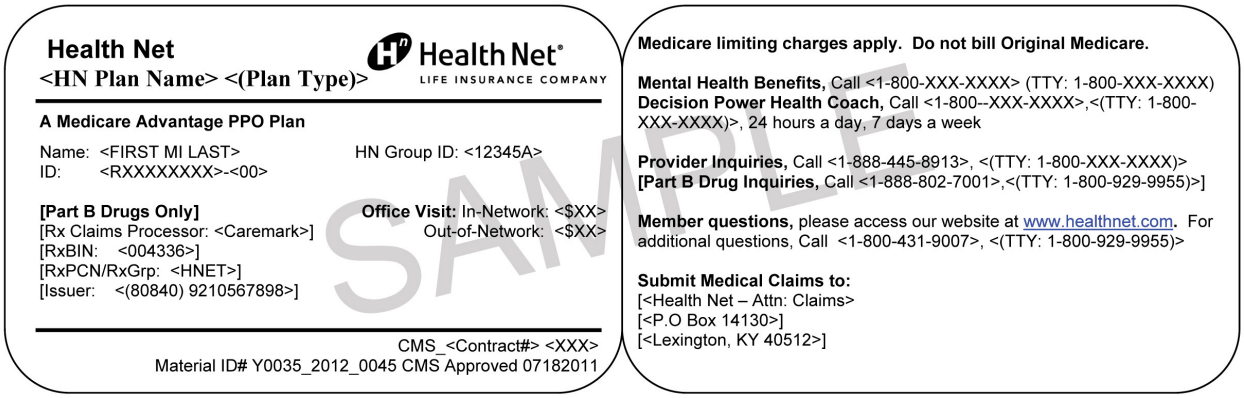
If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan. Here's a sample membership card to show you what yours will look like:



As long as you are a member of our plan, **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your Health Net Aqua (PPO) membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Section 3.2 The *Provider Directory*: Your guide to all providers in the plan's network

The *Provider Directory* lists our network providers.

What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan.

Why do you need to know which providers are part of our network?

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information.

If you don't have your copy of the *Provider Directory*, you can request a copy from Member Services (phone numbers are printed on the back cover of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. You can also see the *Provider Directory* at www.healthnet.com, or download it from this Web site. Both Member Services and the Web site can give you the most up-to-date information about changes in our network providers.

SECTION 4 Your monthly premium for Health Net Aqua (PPO)

Section 4.1 How much is your plan premium?

As a member of our plan, you pay a monthly plan premium. For 2014, the monthly premium for our plan is $45. 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).

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed above in Section 4.1. If you signed up for extra benefits, also called "optional supplemental benefits", then you pay an additional premium each month for these extra benefits. If you have any questions about your plan premiums, please call Member Services (phone numbers are printed on the back cover of this booklet).

- If you enroll in the Preventive Dental Plus Package, you pay an additional monthly premium of $31.

Please see Chapter 4, Section 2.2 for more information on the optional supplemental benefits you can buy.

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. And most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

Your copy of *Medicare & You 2014* gives information about these premiums in the section called "2014 Medicare Costs." This explains how the Medicare Part B premium differs for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2014* from the Medicare Web site (http://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2 There are several ways you can pay your plan premium

There are four ways you can pay your plan premium. You can choose your payment option when you enroll and make changes at any time by calling Member Services at the phone number on the back cover of this booklet.

If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.

Option 1: You can pay by check or money order

You may decide to pay your monthly plan premium payments directly to our plan by check or money order. Please include your Health Net Member ID number with your payment.

The monthly plan premium payment is due to us by the 1st day of each month. You can make the payment by sending your check or money order to:

Health Net
P.O. Box 894702
Los Angeles, CA 90189-4702

Checks and money orders should be made payable to Health Net, Inc., and not to the Centers for Medicare & Medicaid Services (CMS) nor the United States Department of Health and Human Services (HHS). Premium payments may not be dropped off at the Health Net office. A $15 fee will be charged for all returned checks due to nonsufficient funds (NSF).

Option 2: You can have your premium automatically withdrawn from your bank account

Instead of paying by check or money order, you can have your monthly plan premium payment automatically withdrawn from your bank account. If you are interested in this option, call Member Services at the phone number listed on the back cover of this booklet to ask for the appropriate form. Once Automatic Bank Draft is set up by your bank, we will send you a confirmation letter telling you when the first payment will be deducted from your bank account. Until you receive the confirmation from us, please continue to pay as you are billed.

On or about the 6th of each month (or the next business day if the 6th falls on a holiday or weekend), we will communicate directly with your bank to deduct the premium due for that month. Your monthly bank statement will reflect the amount debited for your Health Net premium. You will not receive a bill for your monthly premium from us while this service is in effect. If you receive a bill for your premium payments while this service is in effect, please disregard it.

Option 3: You can have the plan premium taken out of your monthly Social Security check

You can have the plan premium taken out of your monthly Social Security check. Contact Member Services for more information on how to pay your plan premium this way. We will be happy to help you set this up. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Option 4: You can have the plan premium taken out of your monthly Retirement Board (RRB) check

You can have the plan premium taken out of your monthly Railroad Retirement Board (RRB) check. Contact Member Services for more information on how to pay your monthly plan premium this way. We will be happy to help you set this up. (Phone numbers for Member Services are printed on the back cover of this booklet.)

What to do if you are having trouble paying your plan premium

Your plan premium is due in our office by the 1st of each month. If we have not received your premium payment by the 7th business day of the month, we will send you a reminder notice telling you that we have not received your monthly plan premium payment. If you have elected an optional supplemental benefit package, and we do not receive your premium by the 7th business day of the month, we will notify you in writing that your optional supplemental benefits may end.

If you are having trouble paying your premium on time, please contact Member Services to see if we can direct you to programs that will help with your plan premium. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Section 4.3 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in September and the change will take effect on January 1.

SECTION 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage.

The doctors, hospitals, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)

- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the back cover of this booklet).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are printed on the back cover of this booklet).

Here are other ways you can tell us about any other medical or drug insurance coverage that you have:

- You can call Member Services to tell us about this other coverage (phone numbers are printed on the back cover of this booklet).
- You can indicate this coverage on your enrollment form when you enroll in our plan. Health Net will then send a letter to you to get more detailed information about this other coverage.

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the size of the employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family member is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
    - If you're over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are printed on the back cover of this booklet.) You may need to give your plan

member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2. Important phone numbers and resources

SECTION 1 Our plan contacts (how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

For assistance with claims, billing or member card questions, please call or write to Health Net Aqua (PPO) Member Services. We will be happy to help you.

Member Services	
CALL	1-888-445-8913 Calls to this number are free.8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. From October 1 through February 14, our plan operates a toll-free call center for both current and prospective members that is staffed seven days a week from 8:00 a.m. to 8:00 p.m. Pacific time. During this time period, current and prospective members are able to speak with a Member Service representative. If you call outside these hours, you will receive a voice mail. When leaving a message, you should include your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message. However, after February 14, 2014, your call will be handled by our automated phone system, Saturdays, Sundays, and holidays. When leaving a message, please include your name, phone number and the time that you called, and a representative will return your call no later than one business day after you leave a message. Member Services also has free language interpreter services available for non-English speakers.
TTY/TDD	1-800-929-9955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	1-866-214-1992

WRITE	Health Net Medicare Advantage P.O. Box 10420 Van Nuys, CA 91410-0420
WEB SITE	www.healthnet.com

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

You may call us if you have questions about our coverage decision process.

Coverage Decisions for Medical Care	
CALL	1-888-445-8913 Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
TTY/TDD	1-800-929-9955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	1-866-295-8562
WRITE	Health Net Medicare Advantage Health Services Department 13221 SW 68th Parkway, Suite 200 Tigard, OR 97223
WEB SITE	www.healthnet.com

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Appeals for Medical Care	
CALL	1-888-445-8913 Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
TTY/TDD	1-800-929-9955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	1-877-713-6189
WRITE	Health Net Medicare Advantage Appeals and Grievances Department P.O. Box 10343 Van Nuys, CA 91410-0343
WEB SITE	www.healthnet.com

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Complaints about Medical Care	
CALL	1-888-445-8913 Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
TTY/TDD	1-800-929-9955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	1-877-713-6189
WRITE	Health Net Medicare Advantage Appeals and Grievances Department P.O. Box 10343 Van Nuys, CA 91410-0343
MEDICARE WEB SITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our share of the cost for medical care you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Payment Requests	
CALL	1-888-445-8913 Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
TTY/TDD	1-800-929-9955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
WRITE	Health Net of Oregon P.O. Box 14130 Lexington, KY 40512
WEB SITE	www.healthnet.com

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations including us.

Medicare	
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.

TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEB SITE	http://www.medicare.gov This is the official government Web site for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare Web site also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the Web site to tell Medicare about any complaints you have about our plan: • **Tell Medicare about your complaint:** You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this Web site using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the Web site, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Here is a list of the State Health Insurance Assistance Programs in each state we serve:

- In Oregon, the SHIP is called Senior Health Insurance Benefits Assistance (SHIBA).
- In Washington, the SHIP is called Statewide Health Insurance Benefits Advisors (SHIBA).

The State Health Insurance Assistance Program is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

The State Health Insurance Assistance Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. The State Health Insurance Assistance Program counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Senior Health Insurance Benefits Assistance (SHIBA) (Oregon SHIP)	
CALL	1-800-722-4134 or 1-503-947-7979
TTY	1-800-735-2900 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	1-503-947-7092
WRITE	Oregon Division of Insurance Senior Health Insurance Benefits Assistance 350 Winter Street NE, Suite 330 P.O. Box 14480 Salem, OR 97309-0405
WEB SITE	http://oregonshiba.org

Statewide Health Insurance Benefits Advisors (SHIBA) (Washington SHIP)	
CALL	1-800-562-6900
TDD	1-360-586-0241 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	WA State Office of Insurance Commissioner Statewide Health Insurance Benefits Advisors P.O. Box 40256 Olympia, WA 98504-0256
WEB SITE	www.insurance.wa.gov

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a Quality Improvement Organization for each state. For Oregon and Washington, the Quality Improvement Organization is called Livanta.

Livanta Organization has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. Livanta is an independent organization. It is not connected with our plan.

You should contact Livanta in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Livanta (Oregon and Washington Quality Improvement Organization)	
CALL	1-877-588-1123

TTY	1-855-887-6668 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	Appeals: 1-855-694-2929 All other reviews: 1-844-420-6672
WRITE	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701
WEB SITE	www.BFCCQIOAREA5.com

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Social Security	
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.

TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
WEB SITE	http://www.ssa.gov

SECTION 6 Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact: your state Medicaid agency.

Division of Medical Assistance Programs (Oregon's Medicaid program)	
CALL	In state only: 1-800-527-5772 Local: 1-503-945-5772
TTY	1-800-375-2863

	This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Division of Medical Assistance Programs Administrative Office 500 Summer Street NE Salem, OR 97301-1079
WEB SITE	www.oregon.gov

Washington State Health Care Authority (Washington's Medicaid Program)	
CALL	1-800-562-3022
TTY	711 (National Relay Service)
WRITE	Washington State Health Care Authority P.O. Box 45502 Olympia, WA 98504 DSHS Customer Service Center P.O. Box 11699 Tacoma, WA 98411-9905
WEB SITE	www.dshs.wa.gov

SECTION 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Railroad Retirement Board	
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEB SITE	http://www.rrb.gov

SECTION 8 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group, call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Chapter 3. Using the plan's coverage for your medical services

SECTION 1 Things to know about getting your medical care covered as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care coverage. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the medical benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart (what is covered and what you pay)*).

Section 1.1 What are "network providers" and "covered services"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network generally bill us directly for care they give you. When you see a network provider, you usually pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the medical benefits chart in Chapter 4.

Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, our plan must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Our plan will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a

network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).

- The providers in our network are listed in the *Provider Directory*.
- If you use an out-of-network provider, your share of the costs for your covered services may be higher.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

SECTION 2 Using network and out-of-network providers to get your medical care

Section 2.1 You may choose a Physician of Choice (POC) to provide and oversee your medical care

What is a "POC" and what does the POC do for you?

When you become a member of our plan, you may choose a plan provider to be your Physician of Choice (POC). (Some people may call a POC a "Primary Care Physician" or "PCP"). Choosing a POC is optional and not a requirement of this plan. Your POC is a health care professional who meets state requirements and is trained to give you basic medical care. Providers that can act as your POC are those that provide a basic level of care. These include doctors providing general and/or family medical care, internists who provide internal medical care, and gynecologists who provide care for women. A nurse practitioner (NP), a State licensed registered nurse with special training providing a basic level of health care, can also act as your POC.

You may choose to get your routine or basic care from your POC. Your POC can also help arrange or coordinate the rest of the covered services you get as a member of our plan. Since your POC can provide and coordinate your medical care, you may want to have all of your past medical records sent to your POC's office.

You may choose to see your POC first for most of your routine health care needs. However, you can still obtain services on your own without contacting your POC first. Some types of services may require approval in advance from our plan (this is called getting prior authorization). If the service you need requires prior authorization, your POC (if you have chosen one) or other network provider will request the authorization from our plan. Please see Chapter 4 for the specific benefits that require prior authorization.

How do you choose your POC?

When you enroll in our plan, you may choose a contracting provider to serve as your POC from our network. To select a POC, you will indicate your choice of POC on your enrollment form and submit it to our plan. You can find a list of contracting providers in the *Provider Directory* or you may visit our Web site at www.healthnet.com. To confirm the availability of a provider, or to ask about a specific provider, please contact Member Services at the phone number on the back cover of this booklet.

Changing your POC

You may change your POC for any reason, at any time. Also, it's possible that your POC might leave our plan's network of providers and you would have to find a new POC in our plan.

If this happens, you may choose another network provider to serve as your Physician of Choice. If you continue seeing the provider after the provider leaves our network, you will be subject to the out-of-network level of cost sharing for services provided by your POC.

To change your POC, call Member Services at the phone number on the back cover of this booklet. This change will take effect immediately. Choosing a POC is optional and not a requirement of this plan.

Section 2.2 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

You do not need a referral to see a specialist. Some in-network services may require prior authorization (approval in advance) from our plan. Prior authorization is an approval process that happens before you get certain services. If the service you need requires prior authorization, your POC (if you have chosen one) or other network provider will request it from our plan. Our plan will review the request and will send a decision (organization determination) to you and your provider. See the Medical Benefits Chart in Chapter 4, Section 2.1 of this booklet for the specific services that require prior authorization.

Prior authorization for out-of-network services is not required, although it is recommended. We recommend that your out-of-network provider requests prior authorization from our plan for out-of-network services to confirm that the out-of-network service is medically necessary. If our plan determines that the out-of-network service was not medically necessary after you receive the service, you will have to pay for the service yourself.

What if a specialist or another network provider leaves our plan?

Sometimes a specialist, clinic, hospital, or other network provider you are using might leave the plan. If this happens, and it is a provider you see on a regular basis (2 or more visits within the last 12 months from the provider's termination effective date), Health Net will make a good faith effort to send you notification at least 30 days prior to the provider's termination effective date. If you continue seeing a provider that leaves our plan after the termination effective date, you will be subject to the out-of-network level of cost sharing. To get help with choosing another contracted provider, specialist, or if you have an urgent situation, Member Services can help you. Phone numbers are located on the back cover of this booklet.

For more information about Out-of-network providers, please see Section 2.3 below and see the definition of Out-of-network providers in Chapter 10.

Section 2.3 How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher.** Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers, you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
    - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do if you receive a bill or if you need to ask for reimbursement.

- If you are using an out-of-network provider for emergency care, urgently needed care, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

SECTION 3 How to get covered services when you have an emergency or urgent need for care

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

A **"medical emergency"** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The phone number for Member Services is printed on the back cover of this booklet. It is also located on your membership card.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

You may get covered emergency medical care outside the United States. This benefit is limited to $50,000 per year. For more information, see "Worldwide coverage" in the Medical Benefits Chart in Chapter 4 of this booklet or call Member Services at the phone number listed on the back cover of this booklet.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If you get your follow-up care from out-of-network providers, you will pay the higher out-of-network cost sharing.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

Section 3.2 Getting care when you have an urgent need for care

What is "urgently needed care"?

"Urgently needed care" is a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

In most situations, if you are in the plan's service area and you use an out-of-network provider, you will pay a higher share of the costs for your care. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we will allow you to get covered services from an out-of-network provider at the lower in-network cost-sharing amount.

What to do when you need medical care immediately

In serious emergency situations: Call "911" or go to the nearest hospital.

If your situation is not so severe: Call your Physician of Choice (POC). If you don't have a POC or can't call your POC, or if you need medical care right away, go to the nearest medical center, urgent care center, or hospital.

If you are unsure of whether an emergency medical condition exists, you may call your POC for help.

Your POC, on-call physician or answering service is available 24 hours a day, seven days a week, to respond to your phone calls regarding medical care that you believe is needed immediately. They will evaluate your situation and give you direction about where to go for the care you need.

If you are not sure whether you have an emergency or require urgent care, please contact a clinician by calling Decision Power® toll free at 1-800-893-5597 (TTY/TDD: 1-800-276-3821) 24 hours a day, 7 days a week. This phone number is also located on your member ID card. As a Health Net Member, you have access to triage or screening services, 24 hours a day, 7 days a week.

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed care that you get from any provider at the lower in-network cost-sharing amount.

Urgently needed care received outside of the United States may be considered an emergency under the worldwide coverage benefit. For more information, see "Worldwide coverage" in the Medical Benefits Chart in Chapter 4 of this booklet.

SECTION 4 What if you are billed directly for the full cost of your covered services?

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

Our plan covers all medical services that are medically necessary, are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or plan rules were not followed.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services to get more information about how to do this (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. The amount you pay for the costs once a benefit limit has been reached will not count toward the out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your provider. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.** Here is why you need to tell us:

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet).

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost sharing in Original Medicare and your cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

> *Here's an example of how the cost sharing works:* Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 5 for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following**:

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare Web site (http://www.medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care covered in a "religious non-medical health care institution"

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2 What care from a religious non-medical health care institution is covered by our plan?

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in your home, our plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:

- You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
- – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Coverage limits for Inpatient Hospital Care apply. For more information on Inpatient Hospital Care coverage limits, see the Medical Benefits Chart in Chapter 4 of this booklet.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment includes items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a provider for use in the home. Certain items, such as prosthetics, are always owned by the member. In this section, we discuss other types of durable medical equipment that must be rented.

In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying copayments for the item for 13 months.

As a member of our plan, there are also certain types of durable medical equipment you will own after paying copayments for the item for a specified number of months. We follow Medicare guidelines for ownership of durable medical equipment. Your previous payments towards a durable medical equipment item when you had Original Medicare do not count towards payments you make while a member of our plan. If you acquire ownership of a durable medical equipment item while you are a member of our plan, the provider may bill you a maintenance fee every six months. There are also certain types of durable medical equipment you will not acquire ownership no matter how many copayments you make for the item while a member of our plan. Call Member Services (phone numbers are printed on the back cover of this booklet) to find out about the rental or ownership requirements of durable medical equipment and the documentation you need to provide.

What happens to payments you have made for durable medical equipment if you switch to Original Medicare?

If you switch to Original Medicare after being a member of our plan: If you did not acquire ownership of the durable medical equipment item while in our plan, you will have to make 13 new consecutive payments for the item while in Original Medicare in order to acquire ownership of the item. Your previous payments while in our plan do not count toward these 13 consecutive payments.

If you made payments for the durable medical equipment item under Original Medicare *before* you joined our plan, these previous Original Medicare payments also do not count toward the 13 consecutive payments. You will have to make 13 consecutive payments for the item under Original Medicare in order to acquire ownership. There are no exceptions to this case when you return to Original Medicare.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of our plan. Later in this chapter, you can find information about medical services that are not covered. It also tells about limitations on certain services. Further exclusions can also be found in this chapter for members who have additional benefits or who have purchased Optional Supplemental Benefits.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- The **"deductible"** is the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about your yearly plan deductible.)
- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Some people qualify for State Medicaid programs to help them pay their out-of-pocket costs for Medicare. (These "Medicare Savings Programs" include the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled & Working Individuals (QDWI) programs.) If you are enrolled in one of these programs, you may still have to pay a copayment for the service, depending on the rules in your state.

Section 1.2 What is your yearly plan deductible?

Your yearly deductible is $125. This is the amount you have to pay out-of-pocket before we will pay our share for your covered medical services.

Until you have paid the deductible amount, you must pay the full cost for most of your covered services. (The deductible does not apply to the services that are listed below.) Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your copayment or coinsurance amount) for the rest of the calendar year.

The deductible does not apply to some services, including certain in-network preventive services. This means that we will pay our share of the costs for these services even if you haven't paid your yearly deductible yet.

The deductible does not apply to the following services received in-network:

- Acupuncture and naturopathy from the "Complementary/Alternative health care" benefit category
- Additional smoking and tobacco use cessation from the "Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)" benefit category
- Annual physical exam (routine Non-Medicare covered)
- Chiropractic services (Medicare-covered)
- Chiropractic services (routine Non-Medicare covered) from the "Complementary/Alternative health care" benefit category
- Dental services (Medicare-covered)
- Diabetic supplies from the "Diabetes self-management training, diabetic services and supplies" benefit category
- Emergency care
- Eye exam (Medicare-covered) from the "Vision care" benefit category
- Eye exam (routine Non-Medicare covered) from the "Vision care" benefit category
- Eyewear (Medicare-covered) from the "Vision care" benefit category
- Eyewear (routine Non-Medicare covered) from the "Vision care" benefit category
- Fitness facility membership/fitness classes (The Silver&Fit Program)
- Health education from the "Health and wellness education programs" benefit category
- Hearing tests (Medicare-covered) from the "Hearing services" benefit category
- Home health agency care
- Hospice care (Medicare covered services) and the one-time hospice consultation
- Kidney disease education services from the "Services to treat kidney disease and conditions" benefit category
- Lab services from the "Outpatient diagnostic tests and therapeutic services and supplies" benefit category
- Nursing hotline from the "Health and wellness education programs" benefit category
- Outpatient mental health care
- Outpatient substance abuse services
- Podiatry services (Medicare-covered)
- Preventive services (those indicated in the Medical Benefits Chart with an apple, unless otherwise noted)

- Primary care doctor office visits from the "Physician/Practitioner services, including doctor's office visits" benefit category
- Specialist office visits from the "Physician/Practitioner services, including doctor's office visits" benefit category
- Therapeutic shoes and inserts from the "Diabetes self-management training, diabetic services and supplies" benefit category
- Urgently needed care
- Worldwide coverage
- X-rays from the "Outpatient diagnostic tests and therapeutic services and supplies" benefit category

The deductible does not apply to the following services received out-of network:

- Acupuncture and naturopathy from the "Complementary/Alternative health care" benefit category
- Additional smoking and tobacco use cessation from the "Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)" benefit category
- Annual physical exam (routine Non-Medicare covered)
- Chiropractic services (routine Non-Medicare covered) from the "Complementary/Alternative health care" benefit category
- Emergency care
- Eye exam (routine Non-Medicare covered) from the "Vision care" benefit category
- Eyewear (routine Non-Medicare covered) from the "Vision care" benefit category
- Fitness facility membership/fitness classes (The Silver&Fit Program)
- Health education from the "Health and wellness education programs" benefit category
- Nursing hotline from the "Health and wellness education programs" benefit category
- Preventive services (those indicated in the Medical Benefits Chart with an apple, unless otherwise noted)
- Urgently needed care
- Worldwide coverage

Section 1.3 What is the most you will pay for Medicare Part A and Part B covered medical services?

Under our plan, there are two different limits on what you have to pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount** is $2,500. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from in-network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services from in-network providers count toward this in-network

maximum out-of-pocket amount. (The amounts you pay for plan premiums and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk (*) in the Medical Benefits Chart.) If you have paid $2,500 for covered Part A and Part B services from in-network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

- Your **combined maximum out-of-pocket amount** is $5,100. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums do not count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are marked with a diamond (◈) in the Medical Benefits Chart.) If you have paid $5,100 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.4 Our plan does not allow providers to “balance bill” you

As a member of our plan, an important protection for you is that after you meet any deductibles, you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called “balance billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider. You will generally have higher copays when you obtain care from out-of-network providers.

- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:

- If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
- If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
- If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services our plan covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from our plan.
  - Covered services that need approval in advance to be covered as in-network services are marked in italics in the Medical Benefits Chart.
  - You never need approval in advance for out-of-network services from out-of-network providers.
  - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as

determined in the contract between the provider and the plan)

- If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers,
- If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2014* handbook. View it online at http://www.medicare.gov or ask for 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.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2014, either Medicare or our plan will cover those services.

 You will see this apple next to the preventive services in the medical benefits chart.

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" preventive visit. **Note:** For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no copayment for each Medicare-covered screening.	
Ambulance services *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required for out-of-network services.* • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health) or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied. You pay $100 for Medicare-covered ambulance services. One copayment per day when there is more than one trip in a single day.	

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
Annual Routine Physical Exam Our plan covers an annual routine physical exam in addition to the Medicare-covered Annual Wellness Visit. The annual routine physical exam allows you to get a separate visit with your physician to discuss general health questions or issues without presentation of a specific chief complaint and includes a comprehensive review of systems and physical examination. This physical exam could include all or some of the following components as applicable: history, vital signs, general appearance, heart exam, lung exam, head and neck exam, abdominal exam, neurological exam, dermatological exam, and extremities exam.	There is no copayment for the annual routine physical exam.	
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months. **Note:** For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical	There is no coinsurance, copayment, or deductible for the annual wellness visit.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	Out-of-Network
condition.		
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months, or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. **Note:** For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no copayment for each Medicare-covered exam.	
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months **Note:** For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you	There is no copayment for Medicare-covered breast cancer screenings.	

Services that are covered for you	What you must pay when you get these services	
	In-Network	Out-of-Network
receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.		
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied.	
	You pay $25 each Medicare-covered cardiac rehabilitation services visit.	You pay $35 each Medicare-covered cardiac rehabilitation services visit.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover 1 visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well. **Note:** For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no copayment for each Medicare-covered visit.	

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). **Note:** For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no copayment for Medicare-covered screening tests.	
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months **Note:** For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no copayment for Medicare-covered Pap tests and Medicare-covered pelvic exams.	

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
Chiropractic services *In-network services may require prior authorization (approval in advance) to be covered except in an emergency. Prior authorization is recommended, although not required for out-of-network services.* Covered services include: • We cover only manual manipulation of the spine to correct subluxation	You pay $15 for each Medicare-covered visit for the manual manipulation of the spine to correct subluxation.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied. You pay $15 for each Medicare-covered visit for the manual manipulation of the spine to correct subluxation.
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy **Note:** For all preventive services that are covered at no	There is no copayment for Medicare-covered screenings.	

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a Copayment or coinsurance will apply for the care received for the existing medical condition.		
Complementary/Alternative health care*◈ *Except for emergency care, verification of medical necessity may be required for In-Network services to be covered. Out-of-Network services require medical necessity verification. To ensure that services are covered, prior authorization is recommended, although not required.* • Routine (Non-Medicare covered) chiropractic services • Acupuncture • Naturopathy *The amounts you pay for these services do not count towards your in-network maximum out-of-pocket amount of $2,500. ◈The amounts you pay for these services do not count toward your combined maximum out-of-pocket amount of $5,100. Refer to "Additional Benefit Information" later in this chart for more information on Complementary/Alternative Care services.	You pay $15 for in-network and out-of-network for each routine chiropractic, acupuncture, or naturopathy visit.*◈ There is a combined in-network and out-of-network $500 annual coverage limit for Complementary/Alternative Care services.	
Dental services In general, preventive dental services (such as cleaning,	You pay $12 for each Medicare-covered dental	You pay the amounts shown below after the one-time -

<table>
<tr><th rowspan="2">Services that are covered for you</th><th colspan="2">What you must pay when you get these services</th></tr>
<tr><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td rowspan="2">routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover:

Medicare-covered dental services include the following:

• Otherwise non-covered procedures or services, such as tooth removal, when performed by a dentist incident to and as an integral part of an otherwise Medicare-covered procedure.
• Extractions of teeth to prepare jaw for radiation treatment of neoplastic disease.
• Dental exams prior to kidney transplantation.</td><td>service.</td><td>combined in network and out-of-network yearly plan deductible of $125 has been satisfied.

You pay $20 for each Medicare-covered dental service.</td></tr>
<tr><td colspan="2">Routine (Non-Medicare covered) preventive and comprehensive dental services are not covered. However, this plan covers routine preventive and comprehensive dental services for an extra cost. Refer to Section 2.2, “Extra ‘optional supplemental’ benefits you can buy”, for more information on optional supplemental dental services, including limitations.</td></tr>
<tr><td>Depression screening

We cover 1 screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.

Note: For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</td><td colspan="2">There is no copayment for Medicare-covered depression screening.</td></tr>
</table>

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. **Note:** For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no copayment for Medicare-covered diabetes screening. There is no copayment for Medicare-covered fasting plasma glucose tests for persons at risk of diabetes.	
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors ○ Supplies to monitor your blood glucose obtained through a pharmacy may be limited to supplies from select manufacturers. Please contact Member Services for additional information. Phone numbers are listed on the back cover of this booklet.	There is no copayment for Medicare-covered diabetes supplies. You pay 15% based on Health Net's contracted rate for Medicare-covered therapeutic shoes for people with diabetes who have severe	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied, excluding diabetes self-management training preventive services. There is no copayment for Medicare-covered

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training preventive serves are covered under certain conditions. **Note:** For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	diabetic foot disease. There is no copayment for Medicare-covered diabetes self-management training.	diabetes supplies. You pay 20% coinsurance based on the Medicare Allowable Cost for Medicare-covered therapeutic shoes for people with diabetes who have severe diabetic foot disease. There is no copayment for Medicare-covered diabetes self-management training.
Durable medical equipment and related supplies *In-network prior authorization (approval in advance) may be required for Bone growth stimulator, Neuro and spinal cord stimulator, Power wheelchairs, scooters, hospital beds, custom-made items, continuous positive airway pressure (CPAP) devices and supplies. Prior authorization is recommended, although not required for out-of-network.* (For a definition of "Durable Medical Equipment," see Chapter 10 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied.	
	You pay 15% coinsurance based on Health Net's contracted rate for Medicare-covered durable medical equipment and related supplies.	You pay 20% coinsurance based on the Medicare Allowable Cost for Medicare-covered durable medical equipment and related supplies.

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.		
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. • Coverage in 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.	You pay $65 for each Medicare-covered emergency room visit. You do not pay this amount if you are admitted to the hospital within 24 hours. If you receive emergency care at an out-of-network hospital and get inpatient care after your emergency condition is stabilized, your cost is the cost sharing you would pay at an in-network hospital.	
Fitness Facility Membership/Fitness Classes (The Silver&Fit® Program)	There is no copayment for fitness facility membership/fitness classes. There is a combined in-network and out-of-network $360 annual coverage limit for Fitness Facility Membership/Fitness Classes. Refer to "Additional Benefit	

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
	Information" later in this chart for more information on Silver&Fit benefits.	
Health and wellness education programs **Health Education** Trained clinicians promote healthy behaviors and help build skills to enhance self-care capabilities. Provides support/education on treatment choices to assist in making health care decisions. Clinicians also send educational materials and advise of educational modules on Health Net's Web site. **Nursing Hotline** Toll-free telephonic coaching from trained clinicians is available 24 hours a day, 7 days a week and offers: one-on-one consultations, answers to health questions, techniques for talking with the doctor and evaluating treatment options, guidance/support for living with an ongoing illness, specialized support for end-stage diseases and severe trauma.	There is no copayment for health and wellness education programs. Refer to "Decision Power®: Health in Balance" under "Additional Benefit Information" later in this chart for more information on these benefits.	
Hearing services Covered services include: Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	You pay $12 for each Medicare-covered hearing test.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied. You pay $20 for

Services that are covered for you	What you must pay when you get these services	
	In-Network	Out-of-Network
		each Medicare-covered hearing test.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy **Note:** For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no copayment for Medicare-covered HIV screening.	
Home health agency care *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required for out-of-network services.* Prior to receiving home health services, a doctor must certify that you need home health services and will order	There is no copayment for Medicare-covered home health visits.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied.

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies		There is no copayment for Medicare-covered home health visits.
Hospice care You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal condition: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal condition: If you need non-	You pay $12 for the one-time only hospice consultation.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied. You pay $20 for the one-time only hospice consultation.

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal condition, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the plan cost sharing for out-of-network services For services that are covered by our plan but are not covered by Medicare Part A or B: Our plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal condition. You pay your plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.		
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet	There is no copayment for the Medicare-covered Pneumonia vaccine. There is no copayment for the Medicare-covered Flu vaccine. There is no copayment for the Medicare-covered Hepatitis B vaccine.	

<table>
<tr><th rowspan="2">Services that are covered for you</th><th colspan="2">What you must pay when you get these services</th></tr>
<tr><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td>Medicare Part B coverage rules.

Note: For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</td><td colspan="2">For other Medicare-covered vaccines, (if you are at risk and they meet Medicare Part B coverage rules), please refer to the Medicare Part B prescription drugs section of this chart for applicable cost-sharing.</td></tr>
<tr><td rowspan="2">Inpatient hospital care

In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required for out-of-network services.

You are covered unlimited days per benefit period for Medicare-covered stays.

Covered services include but are not limited to:

• Semi-private room (or a private room if medically necessary)
• Meals including special diets
• Regular nursing services
• Costs of special care units (such as intensive care or coronary care units)
• Drugs and medications
• Lab tests
• X-rays and other radiology services
• Necessary surgical and medical supplies
• Use of appliances, such as wheelchairs</td><td colspan="2">You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied.</td></tr>
<tr><td>You pay $175 each day from days 1 through 8 per benefit period, for Medicare-covered inpatient hospital care.

There is no copayment from days 9 and beyond per benefit period, for Medicare-covered inpatient hospital care.</td><td>You pay $200 each day from days 1 through 8 per benefit period, for Medicare-covered inpatient hospital care.

There is no copayment from days 9 and beyond per benefit period, for Medicare-covered inpatient hospital care.</td></tr>
</table>

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
• Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Original Medicare rate, then you can choose to obtain your transplant services locally or at a distant location offered by the plan. If our plan provides transplant services at a distant location (outside the service area) and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient?	If you get 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. 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.	

<table>
<tr><th rowspan="2">Services that are covered for you</th><th colspan="2">What you must pay when you get these services</th></tr>
<tr><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td>If You Have Medicare – Ask!” This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</td><td colspan="2"></td></tr>
<tr><td rowspan="3">Inpatient mental health care

In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required for out-of-network services.

Covered services include mental health care services that require a hospital stay.

• There is a 190-day lifetime limit for inpatient mental health services provided in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.
• If the member has used part of the 190-day Medicare lifetime benefit prior to enrolling in our plan, then the member is only entitled to receive the difference between the number of lifetime days already used and the plan benefit.

Refer to “Additional Benefit Information” later in this chart for more information on mental health services.</td><td colspan="2">You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied.</td></tr>
<tr><td>You pay $175 each day from days 1 through 8 per benefit period, for Medicare-covered inpatient mental health care.

There is no copayment from days 9 and beyond for Medicare-covered inpatient mental health care.</td><td>You pay $200 each day from days 1 through 8 per benefit period, for Medicare-covered inpatient mental health care.

There is no copayment from days 9 and beyond for Medicare-covered inpatient mental health care.</td></tr>
<tr><td colspan="2">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)</td></tr>
</table>

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
	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.	
Inpatient services covered during a non-covered inpatient stay *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Refer to the benefits chart for the specific services. Prior authorization is recommended, although not required for out-of-network services.* As described in this Medical Benefit Chart under "Skilled Nursing Facility (SNF) care" the plan covers up to100 days per benefit period for skilled nursing facility (SNF) care. Once you have reached these coverage limits, the plan will no longer cover your stay in the SNF. However, we will cover certain types of services that you receive while you are still in the SNF. If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings	The listed services will continue to be covered at the cost-sharing amounts shown in the benefits chart for the specific service. For Medicare-covered medical supplies, including cast and splints, you pay the applicable cost-sharing amount where the specific service is provided. For example, if these medical supplies were used during a visit to an emergency room, then they would be included as part of the emergency room visit copayment.	

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
• Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy		
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. **Note:** For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored	There is no copayment for each Medicare-covered medical nutrition therapy visit.	

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.		
Medicare Part B prescription drugs *Prior authorization (approval in advance) may be required for self-injectables and certain prescription drugs that may be covered under Part B or Part D to determine the correct benefit.* *Prior authorization may be required when obtaining Part B prescription drugs through home infusion or from a retail pharmacy.* These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied. You pay 15% coinsurance based on Health Net's contracted rate for Medicare-covered Part B drugs. You pay 15% coinsurance based on Health Net's contracted rate for Medicare-covered Part B chemotherapy drugs.	You pay 20% coinsurance based on the Medicare Allowable Cost for Medicare-covered Part B drugs. You pay 20% coinsurance based on the Medicare Allowable Cost for Medicare-covered Part B chemotherapy drugs.

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
• Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases		
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more. **Note:** For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no copayment for Medicare-covered screening and therapy.	
Outpatient diagnostic tests and therapeutic services and supplies *In-network prior authorization (approval in advance) may be required for virtual colonoscopy, sleep studies, radiation therapy, CT, MRA, MRI, PET, and Nuclear cardiac imaging. Prior authorization is recommended, although not required for out-of-network.*	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
Covered services include, but are not limited to: • X-rays • Therapeutic radiological services (radiation therapy, radium and isotope) including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory services (includes blood tests, urinalysis, and some screening tests) • Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other diagnostic tests • Diagnostic radiological services (includes complex tests such as CT, MRI, MRA, SPECT) • EKG tests	deductible of $125 has been satisfied, excluding the following services: x-rays and laboratory services. You pay $12 per visit for Medicare-covered x-rays. There is no copayment for Medicare-covered laboratory services. You pay 15% coinsurance based on Health Net's contracted rate for Medicare-covered radiation therapy and Medicare-covered diagnostic procedures and tests (complex diagnostic radiology services).	has been satisfied. You pay $20 per visit for Medicare-covered x-rays. There is no copayment for Medicare-covered laboratory services. You pay 20% coinsurance based on the Medicare Allowable Cost for Medicare-covered radiation therapy and Medicare-covered diagnostic procedures and tests (complex diagnostic radiology services). You pay 20% coinsurance based on the Medicare Allowable Cost for Medicare-covered complex diagnostic imaging services. There is no copayment for Medicare-covered EKG tests. There is no

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
	You pay 15% coinsurance based on Health Net's contracted rate for Medicare-covered complex diagnostic imaging services. There is no copayment for Medicare-covered EKG tests. There is no copayment for Medicare-covered blood and blood services.	copayment for Medicare-covered blood and blood services.
Outpatient hospital services *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Refer to the benefits chart for the specific services. Prior authorization is recommended, although not required for out-of-network services.* We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient	You pay the applicable cost-sharing amounts shown in this Medical Benefits Chart for the specific service. For Medicare-covered medical supplies including cast and splints, you pay the applicable cost-sharing amount where the specific service is provided. For example, if these medical supplies were used during a visit to an emergency room, then they would be included as part of the emergency room visit copayment.	

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Certain screenings and preventive services • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.		
Outpatient mental health care *In-network services may require prior authorization (approval in advance) to be covered, with the exception of individual or group therapy visit. Prior authorization is*	You pay $25 for each Medicare-covered individual or group therapy	You pay the amounts shown below after the one-time combined in-network and out-of-

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
recommended, although not required for out-of-network services. Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	visit.	network yearly plan deductible of $125 has been satisfied. You pay $50 for each Medicare-covered individual or group therapy visit.
	Refer to "Additional Benefit Information" later in this chart for more information on outpatient mental health services, including the outpatient registration process.	
Outpatient rehabilitation services *In-network services may require prior authorization (approval in advance) to be covered, with the exception of initial evaluations. Prior authorization is recommended, although not required for out-of-network services.* Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied.	
	You pay $25 for each Medicare-covered outpatient rehabilitation therapy visit.	You pay $35 for each Medicare-covered outpatient rehabilitation therapy visit.
Outpatient substance abuse services	You pay $25 for each Medicare-covered	You pay the amounts shown below after the one-

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
Covered services include: Substance Use Disorder services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional or program as allowed under applicable state laws.	individual or group therapy visit.	time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied. You pay $50 for each Medicare-covered individual or group therapy visit.
	Refer to "Additional Benefit Information" later in this chart for more information on outpatient substance abuse services, including the outpatient registration process.	
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers *The following in-network services may require prior authorization (approval in advance) to be covered. Prior authorization is recommended, although not required for these services when received out-of-network:* • *Back surgery (including laminotomy, diskectomy, vertebroplasty, and nucleoplasty);* • *Blepharoplasty;* • *Rhinoplasty;* • *Bariatric procedures;* • *Chondrocyte implants;* • *Septoplasty;*	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied.	
	You pay $175 for each Medicare-covered visit to an outpatient hospital facility. You pay $150 for each Medicare-	You pay $200 for each Medicare-covered visit to an outpatient hospital facility. You pay $175 for each Medicare-covered visit to an

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
• *Treatment of varicose veins;* • *Orthognathic (jaw) surgery and procedures (includes TMJ treatment);* • *Uvulopalatopharyngoplasty (UPPP) and laser-assisted UPPP (LAUP);* • *Transplant evaluation and/or procedures (only when done in an outpatient hospital facility);* • *Mastectomy for gynecomastia; and* • *Breast reduction and augmentation.* **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	covered visit to an ambulatory surgical center.	ambulatory surgical center.
Partial hospitalization services *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required for out-of-network services.* "Partial hospitalization" is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied. There is no copayment for the Medicare-covered partial hospitalization program. Refer to "Additional Benefit Information" later in this chart for more information on mental health services.	
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery	You pay $12 for each Medicare-covered primary care doctor office visit or medically-	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your POC or specialist, if your doctor orders it to see if you need medical treatment • Second opinion prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	necessary surgery services furnished in a physician's office. You pay $12 for each Medicare-covered specialist visit or medically-necessary surgery services furnished in a specialist's office.	deductible of $125 has been satisfied. You pay $20 for each Medicare-covered primary care doctor office visit or medically-necessary surgery services furnished in a physician's office. You pay $20 for each Medicare-covered specialist visit or medically-necessary surgery services furnished in a specialist's office.
	For medically-necessary surgery services furnished in a certified ambulatory surgical center, hospital outpatient department, or any other location, you pay the applicable cost-sharing amount for where the specific service is provided.	
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe	You pay $12 for each Medicare-covered visit (medically necessary foot	You pay the amounts shown below after the one-time combined in-network and out-of-

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	care).	network yearly plan deductible of $125 has been satisfied. You pay $20 for each Medicare-covered visit (medically necessary foot care).
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test **Note:** For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no copayment for Medicare-covered prostate cancer screening exams.	
Prosthetic devices and related supplies *In-network services may require prior authorization (approval in advance) to be covered for neuro or spinal cord stimulator, custom orthotics and items exceeding $2,500 in billed charges, except in an emergency. Prior authorization is recommended, although not required for out-of-network services.* • Devices (other than dental) that replace all or part	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied.	
	You pay 15% coinsurance based on Health	You pay 20% coinsurance based

Services that are covered for you	What you must pay when you get these services	
	In-Network	Out-of-Network
of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail. • Medicare-covered parenteral and enteral nutrition (PEN): Covers related supplies and nutrients. Does not cover baby food and other regular grocery products that can be blenderized and used with the enteral system or any additional nutritional supplementation (such as those for daily protein or caloric intake).	Net's contracted rate for Medicare-covered prosthetic devices and related supplies. You pay 15% coinsurance based on Health Net's contracted rate for Medicare-covered parenteral and enteral related supplies and nutrients.	on the Medicare Allowable Cost for Medicare-covered prosthetic devices and related supplies. You pay 20% coinsurance based on the Medicare Allowable Cost for Medicare-covered parenteral and enteral related supplies and nutrients.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied.	
	You pay $25 for each Medicare-covered pulmonary rehabilitation services visit.	You pay $35 for each Medicare-covered pulmonary rehabilitation services visit.

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting. **Note:** For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a Copayment or coinsurance will apply for the care received for the existing medical condition.	There is no copayment for Medicare-covered screenings and counseling.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a	There is no copayment for Medicare-covered screenings and counseling.	

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office. **Note:** For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.		
Services to treat kidney disease and conditions Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied, excluding kidney disease education services. You pay 20% coinsurance based on Health Net's contracted rate for Medicare-covered renal dialysis (kidney) services. There is no	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied. You pay 20% coinsurance based on the Medicare Allowable Cost for Medicare-covered renal dialysis (kidney) services. There is no copayment for Medicare-covered kidney disease education services, up to 6 sessions per lifetime.

Services that are covered for you	What you must pay when you get these services	
	In-Network	Out-of-Network
coverage for Part B Drugs, please go to the section above, "Medicare Part B prescription drugs."	copayment for Medicare-covered kidney disease education services, up to 6 sessions per lifetime.	
Skilled nursing facility (SNF) care *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required for out-of-network services.*	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied.	
(For a definition of "skilled nursing facility (SNF) care," see Chapter 10 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") You are covered for 100 days each benefit period. No hospital stay required prior to admission. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration.	There is no copayment each day from days 1 through 20 per benefit period, for Medicare-covered skilled nursing facility care. You pay $100 each day from days 21 through 100 per benefit period, for Medicare-covered skilled nursing facility care. You pay all costs	There is no copayment each day from days 1 through 20 per benefit period, for Medicare-covered skilled nursing facility care. You pay $150 each day from days 21 through 100 per benefit period, for Medicare-covered skilled nursing facility care. You pay all costs for each day after day 100 in the benefit period.

<table>
<tr><th rowspan="2">Services that are covered for you</th><th colspan="2">What you must pay when you get these services</th></tr>
<tr><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td>Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used.
• Medical and surgical supplies ordinarily provided by SNFs
• Laboratory tests ordinarily provided by SNFs
• X-rays and other radiology services ordinarily provided by SNFs
• Use of appliances such as wheelchairs ordinarily provided by SNFs
• Physician/Practitioner services

Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn’t a network provider, if the facility accepts our plan’s amounts for payment.

• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).
• A SNF where your spouse is living at the time you leave the hospital.</td><td>for each day after day 100 in the benefit period.</td><td></td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)

<u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease</u>: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</td><td colspan="2">If you haven't been diagnosed with an illness caused or complicated by tobacco use:

There is no copayment for Medicare-covered smoking cessation counseling sessions.</td></tr>
</table>

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable inpatient or outpatient cost sharing. Each counseling attempt includes up to four face-to-face visits. Our plan also covers additional on-line and telephonic smoking cessation counseling. Refer to "Decision Power®: Health in Balance" under "Additional Benefit Information" later in this chart for more information on these benefits.	There is no copayment for additional Non-Medicare covered smoking cessation counseling sessions. If you have been diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco: You pay the applicable cost sharing for Medicare-covered smoking cessation counseling sessions where services are received. For example, if your counseling session is received as part of an outpatient mental health visit, you pay the applicable outpatient mental health cost sharing.	
Urgently needed care Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. • Coverage in the United States [1] • Urgently needed care received outside of the United States may be considered an emergency under the Worldwide coverage benefit. Please refer to Worldwide Coverage listed later in this chart. [1] United States means 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.	You pay $25 for each Medicare-covered urgently needed care visit. You do not pay this amount if you are admitted to the hospital within 24 hours.	You pay $50 for each Medicare-covered urgently needed care visit.

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	Out-of-Network
Vision care Medicare-covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are age 65 or older: glaucoma screening once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. Additional covered services include: • Routine eye exam (refraction), limited to one exam per year*◈ • Routine eyewear: Choice of 1 routine eyewear purchase every two years*◈[1] o Limited to 1 set of frames and 1 pair of eyeglass lenses or contact lenses (non-medically necessary conventional or disposable) during a two-year period[1] o Contact lens fit and two follow-up	You pay $12 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). There is no copayment for Medicare-covered glaucoma screening. There is no copayment for Medicare-covered eyewear after cataract surgery. You pay $10 for each routine (Non-Medicare covered) eye exam.*◈ There is no copayment for routine (Non-Medicare covered) eyewear.*◈ There is no copayment for	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $125 has been satisfied, excluding routine vision care. You pay $20 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). There is no copayment for Medicare-covered glaucoma screening. There is no copayment for Medicare-covered eyewear after cataract surgery. Health Net pays the first $45 for routine (Non-Medicare covered) eye exams. You pay any remaining

<table>
<tr><th rowspan="2">Services that are covered for you</th><th colspan="2">What you must pay when you get these services</th></tr>
<tr><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td>visits available once a comprehensive eye exam has been completed.[2]

[1]Multi-year benefits may not be available in subsequent years.

[2]If disposable Contact Lenses are used, you need to purchase enough pairs of disposable contact lenses to reach the maximum benefit limit at one visit. If you do not use the full maximum benefit amount during the initial purchase, the remaining balance will not carry over.

*The amounts you pay for these services do not count towards your in-network maximum out-of-pocket amount of $2,500.

◈The amounts you pay for these services do not count toward your combined maximum out-of-pocket amount of $5,100.

Additional routine eyewear benefits available. Refer to “Additional Benefit Information” later in this chart for more information on routine vision benefits.

Note: For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</td><td>contact lens fit and follow-up visits.</td><td>balance up to the billed charge. ◈

There is no copayment for routine (Non-Medicare covered) eyewear.◈

There is no copayment for contact lens fit and follow-up visits.</td></tr>
<tr><td colspan="2">There is a combined maximum benefit limit of $250 every two years for routine (Non-Medicare covered) eyewear purchased from in-network or out-of-network providers. (Multi-year benefits may not be available in subsequent years.)</td></tr>
<tr><td>“Welcome to Medicare” Preventive Visit
The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive</td><td colspan="2">There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.</td></tr>
</table>

Services that are covered for you	What you must pay when you get these services	
	In-Network	Out-of-Network
services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit. **Note:** For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.		
Worldwide Coverage Worldwide coverage: Urgent, emergent, and post-stabilization care received outside of the United States.[1] • Limited only to services that would be classified as emergency, urgently needed, or post-stabilization care had they been provided in the United States.[1] • Ambulance services are covered in situations where getting to the emergency room in any other way could endanger your health. • Foreign taxes and fees (including but not limited to currency conversion or transaction fees) are not covered. [1]United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.	You pay $65 for worldwide emergency care services received outside of the United States.[1] You do not pay this amount if you are admitted to the hospital within 24 hours. There is an annual limit of $50,000 for Worldwide Coverage.	
Additional Benefit Information		

Mental Health Care and Substance Abuse Benefits

The Mental Health and Substance Abuse benefits are administered by MHN Services (MHN), which contracts with Health Net to underwrite and administer these benefits. Health Net Medicare Advantage members have the freedom to choose any Medicare-eligible provider in the country who provides mental health and substance abuse services to them as a Medicare patient.

Your plan gives you two levels of benefits and many choices of providers. You receive a specific level of benefits based on how you choose to get covered services. Think of your PPO as two plans in one:

- In-network benefits apply when you receive covered services from eligible mental health professionals in MHN's PPO network.
- Out-of-network benefits apply when you receive covered services from eligible mental health professionals who do not participate in MHN's PPO network.

Getting Services from MHN In-Network providers

You may save money when using in-network providers (providers who are in MHN's PPO network), or you may pay a little more to use providers who are out-of-network (providers who are not in the MHN PPO network).

Inpatient and Alternate Levels of Care (Partial Hospitalization, Intensive Outpatient)

MHN must authorize these services and supplies to be covered. To get authorization for in-network services, you must call MHN at 1-800-977-8216 (or TTY/TDD 1-800-735-2929 for the hearing and speech impaired) 24 hours a day, seven days a week. MHN will refer you to a nearby MHN-Contracted Mental Health Professional in your area. That professional will evaluate you to determine if additional treatment is necessary. If you need treatment, the MHN-contracted mental health professional will develop a treatment plan and submit that plan to MHN for review. When authorized by MHN, the proposed services will be covered by this plan.

If MHN does not approve the treatment plan, no further services or supplies will be covered for that condition. However, MHN may direct you to community resources where alternative forms of assistance are available.

For up-to-date provider information or to get in-network services, please contact MHN at 1-800-977-8216 (or TTY/TDD 1-800-735-2929 for the hearing and speech impaired) 24 hours a day, seven days a week. Or visit MHN's web site at www.mhn.com for a list of MHN participating providers in your area. You may also contact the Health Net Medicare Advantage Member Services Department at the telephone number located on the back cover of this booklet, or visit our Web site at www.healthnet.com.

Outpatient Registration Process

For outpatient, office-based mental health services, you or your provider should contact MHN to register your care. You or your provider will receive a reference number, can verify eligibility, and discuss your benefits and any applicable copayments. Registering your outpatient care can help ensure smooth claims payment as your case will be in our system, but services still will be reimbursed if registration does not take place as registration is voluntary.

Medical necessity review may take place in the form of discussion with your provider about your treatment plan sometime during your course of treatment. MHN is available to answer any questions regarding your care. To contact MHN, call 1-800-977-8216 (or TTY/TDD: 1-800-735-2929 for the hearing and speech impaired), 24 hours a day, seven days a week.

Getting Services from Out-of-Network Providers

Out-of-network benefits apply when covered services are received from a provider not participating in MHN's network. MHN will review claims received from out-of-network mental health professionals and payment will be issued if the services received are determined to have been medically necessary covered services.

What Mental Health and Substance Abuse Services are covered?

All Health Net Medicare Advantage members have Mental Health Care and Substance Abuse benefits. Please see the "Inpatient mental health care", "Outpatient mental health care" and "Outpatient substance abuse services" portions of the Medical Benefits Chart for cost-sharing information.

The following Mental Health and Substance Abuse services are covered under your plan. Please refer to the Medical Benefits Chart for copayment, coinsurance and annual maximums information.

Outpatient Services
Outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy and any rehabilitative care that is related to substance abuse are covered with unlimited visits, subject to medical necessity review as determined by MHN. Medication management care is also covered when appropriate. Refer to "Outpatient mental health care" and "Outpatient substance abuse services" in the Medical Benefits Chart for your cost-sharing information.

Second Opinion
For in-network benefit coverage you may request a second opinion when:

- Your MHN-contracted mental health professional renders a diagnosis or recommends a treatment plan that you are not satisfied with;
- You are diagnosed with, or a treatment plan is recommended for, a condition that threatens loss of life, limb or bodily function or a substantial impairment, including but not limited to a serious chronic condition; or

- Your contracted mental health professional is unable to diagnose your condition or test results are conflicting.

To request an authorization for a second opinion at the in-network benefit level please contact MHN at 1-800-977-8216 (or TTY/TDD: 1-800-735-2929 for the hearing and speech impaired), 24 hours a day, seven days a week. MHN-contracted mental health professionals will review your request in accordance with MHN's second opinion policy. When you request a second opinion, you will be responsible for any applicable co-payments.

Second opinions for in-network benefit coverage will only be authorized for MHN-contracted mental health professionals, unless it is demonstrated that an appropriately qualified MHN-contracted mental health professional is not available. MHN will ensure that the provider selected for the second opinion is appropriately licensed and has expertise in the specific clinical area in question.

Out-of network benefits for a second opinion apply when covered services are received from a provider not participating in MHN's network and have been reviewed and determined as medically necessary.

If you face an imminent and serious threat to health, including, but not limited to, the potential loss of life, limb or other major bodily function, or lack of timeliness would be detrimental to the ability to regain maximum function, the second opinion will be rendered in a timely fashion appropriate to the nature of the condition not to exceed 72 hours of MHN's receipt of the request, whenever possible. For a complete copy of this policy, contact MHN at 1-800-977-8216 (TTY/TDD 1-800-735-2929), available 24 hours, seven days a week.

Emergency Services

Screening, examination and evaluation by a physician or other personnel, to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition, within the capability of the facility.

MHN has a licensed clinician available 24 hours a day, seven days a week to address all requests for immediate admission to a facility if the patient poses a danger to self or others or is gravely disabled. MHN can be contacted at 1-800-977-8216 (or TTY/TDD 1-800-735-2929 for the hearing and speech impaired) 24 hours a day, seven days a week.

In cases of emergency services, MHN uses the following "Prudent Layperson Standard" definition. **The "Prudent Layperson Standard" is as follows:** Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; 2) serious impairment to bodily function; and/or 3) serious dysfunction of any organ or part.

Emergency services will be covered at the in-network benefit level for hospitalization at all contracted facilities and non-contracted facilities due to an immediate medical emergency. Once the condition is stabilized, services are required to be provided at an MHN in-network facility to receive the in-network benefit level of coverage. MHN will arrange a transfer to an MHN in-network facility, if necessary, and will be financially responsible for the cost of the transportation. Post-stabilization services received at an out-of-network facility at the member's request will be covered at the out-of-network benefit level.

Inpatient Services

Inpatient treatment of a mental disorder or substance abuse is covered, limited to a combined lifetime maximum of 190 days per member for inpatient mental health services provided in a psychiatric hospital. The 190-day limit does not apply to mental health or substance abuse services provided in a psychiatric unit of a general hospital. Refer to the "Inpatient mental health care" portion of the Medical Benefits Chart for your cost-sharing information.

Covered inpatient services and supplies include:

- Accommodations in a room of two or more beds, including special treatment units, such as intensive care units and psychiatric care units, unless a private room is determined to be medically necessary.
- Supplies and ancillary services normally provided by the facility, including professional services, laboratory services, drugs and medications dispensed for use during the confinement, psychological testing and individual, family or group therapy or counseling.

Detoxification

Inpatient services for acute detoxification and treatment of acute medical conditions relating to substance abuse are covered, except as stated under "Mental Disorders and Substance Abuse Exclusion and Limitations."

Mental Disorders and Substance Abuse Exclusions and Limitations

Mental health care as a condition of parole, probation or court-ordered testing for mental disorders is limited to medically necessary services and subject to this plan's visit limits described earlier in this section.

Services and supplies for treating mental disorders and Substance Abuse are covered only as specified in the Medical Benefits Chart under "Inpatient mental health care," "Outpatient mental health care" and "Outpatient substance abuse services."

The following items and services are limited or excluded under the Mental Disorders and Substance Abuse Services:

- Court-ordered testing and treatment, except when medically necessary and within the allowable visits under the plan contract.

- Private hospital rooms and/or private duty nursing, unless determined to be a medically necessary service by MHN.
- Treatment in a Residential Treatment Center.
- Ancillary services such as:
    - Vocational rehabilitation and other rehabilitation services.
    - Behavioral training.
    - Speech or occupational therapy.
    - Sleep therapy and employment counseling.
    - Training or educational therapy or services.
    - Other education services.
    - Nutrition services.
- Treatment by providers other than those within licensing categories recognized by Medicare or MHN as providing medically necessary services in accordance with applicable medical community standards.
- In-network inpatient services in excess of those with respect to which Authorization by MHN is obtained when authorization is required. Out-of-network services do not require authorization.
- Out-of-network services that are not "medically necessary" as determined by MHN.
- Psychological testing, except as conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification and specifically excluding all educational, academic and achievement tests, psychological testing related to medical conditions or to determine surgical readiness and automated, computer-based reports.
- All prescription or non-prescription drugs and laboratory fees, except for drugs and laboratory fees prescribed by a practitioner in connection with inpatient treatment.
- In-network services, treatment, or supplies rendered without authorization when authorization is required, except in the event of emergency services.
- Damage to a hospital or facility caused by the member.
- Healthcare services, treatment or supplies determined to be experimental by MHN in accordance with accepted mental health standards, except as otherwise required by law.
- Treatment for biofeedback, acupuncture or hypnotherapy.
- Healthcare services, treatment, or supplies rendered to the member, which are not medically necessary services. This includes, but is not limited to, services, treatment, or supplies primarily for rest or convalescence, custodial care or domiciliary care as determined by MHN.
- Services received before the member's effective date during an Inpatient stay that began before the member's effective date or services received after the member's coverage ended, except as specifically stated herein.
- Professional services received from a person who lives in the member's home or who is related to the member by blood or marriage.

- Services performed in any emergency room which are not directly related to the treatment of a mental disorder.
- Services received out of the member's primary state of residence, except in the event of emergency services and as otherwise authorized by MHN.
- Electro-Convulsive Therapy (ECT), except as authorized by MHN according to MHN policies and procedures.
- All other services, confinements, treatments or supplies not provided primarily for the treatment of specific covered benefits and/or specifically included as covered services elsewhere in this plan.

How do I file a claim for Mental Health and Substance Abuse Services?

In most cases, your mental health provider will submit your claims directly to MHN. If you should receive a bill for the services, submit your claim to MHN. Claims forms can be found online at www.mhn.com or call MHN's Claims Line for assistance at the toll-free number at 1-800-444-4281 (National Relay Service: 711, available for the hearing and speech impaired), Monday through Friday from 8:00 a.m. to 7:00 p.m., Central time.

Attach your itemized bill to the claim form. Mail the itemized bill and completed claim form to:

MHN Claims Department
Post Office Box 14621
Lexington, KY 40512-4621

You can also contact MHN at 1-800-977-8216 (TTY/TDD: 1-800-735-2929), 24 hours a day, seven days a week, to check the status of your claim. They will be able to provide a status within 72 hours of receipt of your claim. If a reimbursement is due to you, a check will be mailed no later than 60 days of receipt of your claim.

QUESTIONS?

For up-to-date provider information or to obtain authorization to receive services, please call MHN Services at 1-800-977-8216 (or TTY/TDD 1-800-735-2929 for hearing and speech assistance), 24 hours a day, seven days a week. Calls to these numbers are free. Or visit MHN Services' web site at www.mhn.com.

If you have any further questions about these benefits or services, please contact the Health Net Member Services department at the telephone number located on the back cover of this booklet.

The benefits included in this section are subject to the same appeals process as any other benefits. See Chapter 7 for information about making complaints.

Routine Vision Care

Routine eye exams and routine eyewear are administered by Health Net Vision, which is serviced by EyeMed Vision Care, LLC. Vision services are covered as shown in the Medical Benefits Chart earlier in this chapter. You can see any licensed vision provider to receive covered vision care. However, your cost-sharing may be higher when you receive covered services from out-of-network providers than from in-network providers.

Getting services from Health Net Vision In-Network providers

You may save money when using in-network providers (providers who are in Health Net Vision's PPO network). Health Net Vision in-network providers are listed in your *Provider Directory*. For up-to-date provider information, please contact Health Net Vision at 1-866-392-6058 (or TTY/TDD 1-866-308-5375 Monday through Friday from 5:00 a.m. to 5:00 p.m., Pacific time for the hearing and speech impaired) Monday through Saturday, 5:00 a.m. to 8:00 p.m., and Sunday, 8:00 a.m. to 5:00 p.m., except major holidays. You may also contact the Health Net Medicare Advantage Member Services department at the telephone number located on the back cover of this *Evidence of Coverage*, or visit our Web site at www.healthnet.com.

Getting services from Out-of-Network Vision providers

Out-of-network benefits apply when covered services are received from a provider not participating in Health Net Vision's network. Health Net Vision will review claims received from out-of-network vision professionals, and payment will be issued if the services received are determined to have been covered services.

What is covered by Health Net Vision?

All members have Medicare-covered vision and routine vision benefits. Please see the "Vision care" portion of the Medical Benefits Chart earlier in this chapter for cost-sharing information.

How much do I pay for routine eyewear covered by this plan?

You have the option to choose from in-network and out-of-network providers when purchasing routine eyewear. You may save money when using in-network providers (providers who are in Health Net Vision's network) or you may pay a little more to use providers who are out-of-network (providers who are not in the Health Net Vision's PPO network).

Health Net will cover one eyewear purchase every two years (multi-year benefits may not be available in subsequent years.)

There is no co-payment for routine eyewear; however, there is a $250 benefit maximum amount Health Net Vision will pay for frame purchases, contact lenses (non-medically necessary conventional or disposable[1]), and lenses (standard plastic) every two years.

[1]You need to purchase enough pairs of disposable contact lenses to reach your maximum benefit amount. If you do not use the full maximum benefit allowance during the initial purchase, the remaining balance will not carry over.

If you purchase eyewear out-of-network, you will be responsible for 100% of the remaining balance once you've reached the benefit maximum amount. If you purchase eyewear in-network, you may have additional coverage once you've reached the maximum benefit amount:

	In-network: **Once the benefit maximum is reached you pay:**	**Out-of-network:** **Once the benefit maximum is reached you pay:**
Frames, Lens and Options Package	80% of the remaining balance	100% of the remaining balance
Contact lenses (conventional)	85% of the remaining balance	100% of the remaining balance
Contact lenses (disposable)	100% of the remaining balance	100% of the remaining balance

You receive a 20% discount on items not covered by the plan at network Providers. This discount cannot be combined with any other discounts or promotional offers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location.

What Vision services are not covered by our Plan?

The following items and services are limited or excluded as part of the Routine Vision Care services provided by Health Net Vision:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.
- Medical and/or surgical treatment of the eye, eyes, or supporting structures (see the Medical Benefits Chart earlier in this chapter under "Vision Care" for a description of your Medicare-covered vision coverage).
- Corrective eyewear required by an employer as a condition of employment and safety eyewear, unless specifically covered under plan.
- Services provided as a result of any Worker's Compensation law.
- Plano - non-prescription lenses and non-prescription sunglasses (except for 20% discount).
- Two pairs of glasses in lieu of bifocals.
- Benefit is not available on certain frame brands in which the manufacturer imposes a "no discount" policy.

- Aniseikonic lenses.
- Discounts or promotional offers do not apply for benefits provided by other benefit plans. If a discount or promotional offer is accepted, plan benefits do not apply for the benefit period. Allowances are one-time use benefits (either in-network, out-of-network, or both); no remaining balance.

How do I file a Health Net Vision claim?

When you receive services from an out-of-network vision provider, you may have to file a claim with Health Net Vision. Health Net Vision will pay you for any covered services up to the benefit maximum. You are responsible for paying the provider the difference. Please call or write to the Health Net Vision customer service department for a claim form and claim filing instructions at the toll-free number 1-866-392-6058 (or TTY/TDD 1-866-308-5375 Monday through Friday from 5:00 a.m. to 5:00 p.m., Pacific time), Monday through Saturday, 5:00 a.m. to 8:00 p.m., and Sunday, 8:00 a.m. to 5:00 p.m., except major holidays. Out-of-network providers may require payment in full at the time of service.

Attach your itemized bill to the claim form, and mail to:

Health Net Vision
Post Office Box 8504
Mason, OH 45040-7111

The benefits included in this section are subject to the same appeals process as any other benefits. See Chapter 7 for information about making complaints.

Complementary/Alternative Health Care

Complementary/Alternative Health Care services are administered by American Specialty Health Group, Inc. (ASH Group). Complementary/Alternative Health Care services consist of Subluxation-Only (Medicare-covered) Chiropractic and Routine (Non-Medicare covered) Chiropractic, Naturopathy, and Acupuncture. These services are covered as shown in the Medical Benefits Chart earlier in this chapter under “Chiropractic care” and “Complementary/Alternative health care.” All covered Routine (Non-Medicare covered) Chiropractic, Acupuncture, and Naturopathy services must be Medically Necessary and may require verification of Medical Necessity. ASH Group-contracted practitioners understand this process and are responsible for obtaining any required verification of Medical Necessity. If you seek out-of-network services you may be responsible for obtaining medical necessity verification.

Getting services from In-Network Complementary/Alternative Health Care practitioners

You may save money when using in-network practitioners. In-network practitioners are those who are duly licensed to practice in the state in which services are furnished and who have

entered into an agreement with ASH Group to provide covered services to you. ASH Group in-network practitioners are listed in the Wellnet Directory. For up-to-date practitioner information, please contact ASH Group at 1-800-678-9133 (or TTY/TDD 1-877-710-2746 for the hearing and speech impaired) Monday through Friday, 5:00 a.m. to 6:00 p.m., except major holidays. You may also contact the Health Net Medicare Advantage Member Services department at the telephone number located on the back cover of this booklet, or visit our Web site at www.healthnet.com.

Getting services from Out-of-Network Complementary/Alternative Health Care practitioners

Out-of-network benefits apply when covered services are received from a practitioner who does not have an agreement with ASH Group. ASH Group will review claims received from out-of-network complementary/alternative care professionals, and payment will be issued if the services received are determined to have been Medically Necessary covered services.

Note: Out-of-network Complementary/Alternative Health Care Services may be subject to verification of Medical Necessity. To ensure that services are covered, prior authorization is recommended, although not required.

Chiropractic Services

What Chiropractic Services are covered?

All Health Net Medicare Advantage members have direct access to ASH Group chiropractors, or out-of-network practitioners qualified to provide the benefit in question and who accept Health Net's terms and conditions of payment for all visits. A copayment is required for each visit to the office. All Chiropractic Services, except for the initial evaluation, may require verification of Medical Necessity.

- A new patient exam, or an established patient exam, for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of chiropractic services. A new patient is one who has not received any professional services from the practitioner, or another practitioner of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the practitioner, or another practitioner of the same specialty who belongs to the same group practice, within the past three years.
- Established patient exams assess the need to initiate, continue, extend, or change a course of treatment. The established patient exam is only covered when used to determine the appropriateness of chiropractic services. The established patient exam must be Medically Necessary.
- Follow-up office visits include manipulation of the spine, joints and/or musculoskeletal soft tissue, a re-evaluation, and/or other services, in various combinations.
- Adjunctive modalities and procedures such as rehabilitative exercise, traction, ultrasound, electrical muscle stimulation, and other therapies are covered only when Medically

Necessary and provided during the same Course of Treatment and in support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.
- X-rays and clinical laboratory tests are payable in full when provided by or referred by a Contracted Chiropractor and approved by ASH Group. Radiological consultations are a covered benefit when approved by ASH Group as Medically Necessary Services and when provided by a licensed chiropractic radiologist, medical radiologist, radiology group, or hospital that has contracted with ASH Group to provide those services.
- Chiropractic Supports and Appliances are covered up to a maximum of $50 per year when approved by ASH Group as Medically Necessary for treatment of either Musculoskeletal and Related Disorders or Pain Syndromes or both.
- Urgent Services.
- Emergency Services.

Second Opinion

You have direct access to any other ASH Group-Contracted Chiropractor or non-plan practitioner. Your visit to another ASH Group-Contracted Chiropractor or non-plan practitioner for purposes of obtaining a second opinion generally will count as one visit, and you must pay any Copayment that applies for that visit on the same terms and conditions as a visit to any other ASH Group-Contracted Chiropractor or non-plan practitioner as applicable.

X-ray and Laboratory Tests

X-ray services are covered when Medically Necessary and performed in the ASH Group-Contracted Chiropractor's or non-plan practitioner's office. An X-ray service may be performed during an initial examination or a subsequent office visit, or separately. If performed separately, a copayment will be required.

X-ray services with radiological consultations are a covered benefit when approved by ASH Group as Medically Necessary Chiropractic Services and provided by a licensed chiropractic radiologist, medical radiologist, radiology group, or hospital which has contracted with ASH Group to provide those services. ASH Group approval of X-rays, laboratory tests, and radiological consultations is not required to the extent any such services constitute Emergency Chiropractic Services. Laboratory tests are payable in full when prescribed by an ASH Contracted Chiropractor or non-plan practitioner and authorized by ASH Group.

Chiropractic procedure codes covered under the Subluxation Only (Medicare) benefit include:

CODE	PROCEDURE NAME
98940	Chiropractic Manipulative Treatment

98941	Chiropractic Manipulative Treatment
98942	Chiropractic Manipulative Treatment

NOTE: Any other procedures billed with these codes will not be covered under this benefit.

Chiropractic procedure codes covered under the Routine benefit for Oregon include:

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	
99201	New Patient Evaluation & Management Service	covered
99202	New Patient Evaluation & Management Service	covered
99203	New Patient Evaluation & Management Service	covered
99204	New Patient Evaluation & Management Service	covered
99211	Established Patient Evaluation & Management Service	covered
99212	Established Patient Evaluation & Management Service	covered
99213	Established Patient Evaluation & Management Service	covered
99214	Established Patient Evaluation & Management Service	covered

CPT Codes 99201-99214 billed with modifier -25 will be covered at the same rate as the base code listed above.

CHIROPRACTIC MANIPULATIVE TREATMENT

CODE	DESCRIPTION	
98940	Chiropractic Manipulative Treatment	covered
98941	Chiropractic Manipulative Treatment	covered
98942	Chiropractic Manipulative Treatment	covered
98943	Chiropractic Manipulative Treatment - Extraspinal	covered

ADJUNCTIVE THERAPIES/MODALITIES (SUPERVISED)

CODE	DESCRIPTION	
97010	Hot/Cold Packs	(1)
97012	Traction, mechanical	(1)
97014	Electrical Stimulation (unattended)	(1)
G0283	Electrical Stimulation (unattended)	(1)

(1) Covered under all-inclusive per-diem reimbursement for the Chiropractic Manipulative Treatment (CPT Codes 98940-98943).

97016	Vasopneumatic devices	(1)
97018	Paraffin bath	(1)
97022	Whirlpool	(1)
97024	Diathermy (e.g., microwave)	(1)
97026	Infrared	(1)
97028	Ultraviolet	(1)

Other CPT Codes and/or services for treatment, examination and/or therapy are not covered or eligible for reimbursement by ASH Group.

ADJUNCTIVE THERAPIES/MODALITIES (CONSTANT ATTENDANCE)

CODE	DESCRIPTION	
97032	Electrical stimulation (manual)	(1)
97033	Iontophoresis	(1)
97034	Contrast baths	(1)
97035	Ultrasound	(1)
97036	Hubbard tank	(1)
97039	Unlisted modality	(1)

ADJUNCTIVE THERAPIES/THERAPEUTIC PROCEDURES

CODE	DESCRIPTION	
97110	Therapeutic procedure, one or more areas; therapeutic exercises to develop strength & endurance, range of motion & flexibility	(1)
97112	Neuromuscular reeducation	(1)
97113	Aquatic therapy with therapeutic exercises	(1)
97139	Unlisted therapeutic procedure	(1)
97140	Manual Therapy Techniques (i.e. manual traction, myofascial release)	(1)
97140-59	Manual Therapy Techniques; if performed with CMT; every 15 min	(1)
97150	Therapeutic procedure(s), group	(1)
97150-59	Therapeutic procedure(s), group	(1)
97530	Therapeutic activities, direct patient contact	(1)
97532	Development of cognitive skills to improve attention, memory, problem solving, direct patient contact	(1)
97535	Self-care/home management training	(1)
97537	Community/work reintegration training	(1)
97542	Wheelchair management, each 15 min	(1)

(1) Covered under all-inclusive per-diem reimbursement for the Chiropractic Manipulative Treatment (CPT Codes 98940-98943).

CODE	DESCRIPTION	
97545	Work hardening/conditioning; initial 2 hours	(1)
97546	Each additional hour	(1)
29260	Strapping - Any Age - elbow/wrist	(1)
29280	Strapping - Any Age - hand/finger	(1)
29520	Strapping - Any Age - hip	(1)
29530	Strapping - Any Age - knee	(1)
29540	Strapping - Any Age - ankle/foot	(1)
29550	Strapping - Any Age - toes	(1)

TESTS AND MEASUREMENTS

CODE	DESCRIPTION	
97760	Orthotic(s) management and training, each 15 min.	(1)

NOTE: ALL COVERED CODES ARE SUBJECT TO CHANGE.

Chiropractic procedure codes covered under the Routine benefit for Washington include:

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	
99201	New Patient Evaluation & Management Service	covered
99202	New Patient Evaluation & Management Service	covered
99203	New Patient Evaluation & Management Service	covered
99204	New Patient Evaluation & Management Service	covered
99205	New Patient Evaluation & Management Service	covered
99211	Established Patient Evaluation & Management Service	covered
99212	Established Patient Evaluation & Management Service	covered
99213	Established Patient Evaluation & Management Service	covered
99214	Established Patient Evaluation & Management Service	covered
99215	Established Patient Evaluation & Management Service	covered

CPT Codes 99201-99215 billed with modifier -25 will be covered at the same rate as the base code listed above.

(1) Covered under all-inclusive per-diem reimbursement for the Chiropractic Manipulative Treatment (CPT Codes 98940-98943).

PROLONGED SERVICES

CODE	DESCRIPTION	
98940	Chiropractic Manipulative Treatment	covered
98941	Chiropractic Manipulative Treatment	covered
98942	Chiropractic Manipulative Treatment	covered
98943	Chiropractic Manipulative Treatment - Extraspinal	covered

CHIROPRACTIC MANIPULATIVE TREATMENT

CODE	DESCRIPTION	
98940	Chiropractic Manipulative Treatment	covered
98941	Chiropractic Manipulative Treatment	covered
98942	Chiropractic Manipulative Treatment	covered
98943	Chiropractic Manipulative Treatment - Extraspinal	covered

ADJUNCTIVE THERAPIES/MODALITIES (SUPERVISED)

CODE	DESCRIPTION	
97010	Hot/Cold Packs	covered
97012	Traction, mechanical	covered
97016	Vasopneumatic devices	covered
97018	Paraffin bath	covered
97022	Whirlpool	covered

Other CPT Codes and/or services for treatment, examination and/or therapy are not covered or eligible for reimbursement by ASH Group.

ADJUNCTIVE THERAPIES/MODALITIES (CONSTANT ATTENDANCE)

CODE	DESCRIPTION	
97034	Contrast baths	covered
97036	Hubbard tank	covered
97039	Unlisted modality	(18)

(18) 70% of billed charges

ADJUNCTIVE THERAPIES/THERAPEUTIC PROCEDURES

CODE	DESCRIPTION	
97110	Therapeutic procedure, one or more areas; therapeutic exercises to develop strength & endurance, range of motion & flexibility	covered
97112	Neuromuscular reeducation	covered
97113	Aquatic therapy with therapeutic exercises	covered
97116	Gait training (includes stair climbing)	covered
97139	Unlisted therapeutic procedure	(18)
97140	Manual Therapy Techniques (i.e., manual traction, myofascial release)	covered
97140-59	Manual Therapy Techniques; if performed with CMT; every 15 min	covered
97150	Therapeutic procedure(s), group	covered
97150-59	Therapeutic procedure(s), group	covered
97530	Therapeutic activities, direct patient contact	covered
97532	Development of cognitive skills to improve attention, memory, problem solving, direct patient contact	covered
97535	Self-care/home management training	covered
97537	Community/work reintegration training	covered
97542	Wheelchair management, each 15 min	covered
97545	Work hardening/conditioning; initial 2 hours	(18)
97546	Each additional hour	(18)
29260	Strapping - Any Age - elbow/wrist	covered
29280	Strapping - Any Age - hand/finger	covered
29520	Strapping - Any Age - hip	covered
29530	Strapping - Any Age - knee	covered
29540	Strapping - Any Age - ankle	covered
29550	Strapping - Any Age - toes	covered

TESTS AND MEASUREMENTS

CODE	DESCRIPTION	
97750	Physical performance test or measurement	covered
97760	Orthotic(s) management and training, each 15 min.	covered
97761	Prosthetic training, each 15 min.	covered
97762	Checkout for orthotic/prosthetic use, est. patient, each 15 min	covered

NOTE: ALL COVERED CODES ARE SUBJECT TO CHANGE.

What Chiropractic Services are not covered by our Plan?

(18) 70% of billed charges

The following items and services are limited or excluded as part of the Chiropractic Services provided by ASH Group:

- Services or treatments that are not approved by ASH Group as Medically Necessary, in accordance with ASH Group's Clinical Services Program. This requirement does not apply to the following services or treatments: (a) a new patient exam; (b) Urgent Services; and (c) Emergency Services.
- Services, examinations (other than an initial examination to determine the appropriateness of chiropractic services) and/or treatments for conditions other than Musculoskeletal or Related Disorders or Pain Syndromes.
- Hypnotherapy, behavior training, sleep therapy and weight programs.
- Thermography; magnets used for diagnostic or therapeutic use; nerve conduction studies (e.g., EEG, EMG, SEMG, SSEP, and NCV); or electrocardiogram (EKG) studies.
- Services, clinical laboratory studies, X-rays, Support and Appliances, and other treatments or products that are classified as Experimental or Investigational.
- Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, therapeutic radiology, and any diagnostic radiology other than covered plain film studies.
- Transportation costs, including local ambulance charges.
- Education programs, non-medical lifestyle or self-help, or any self-help physical exercise training or related diagnostic testing.
- Services or treatments for pre-employment physicals or vocational rehabilitation.
- Services or treatments for conditions caused by or arising out of the course of employment or covered under Workers' Compensation or similar laws.
- Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all support appliances or durable medical equipment, except as defined in this agreement.
- Prescription drugs or medicines, including a non-legend or proprietary medicine or medication not requiring a prescription order.
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services or other related services.
- Auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.
- Adjunctive physiotherapy modalities and procedures, unless provided during the same Course of Treatment and in support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.
- Dietary and nutritional supplements, including vitamins, minerals, herbs, herbals and herbal products, injectable supplements and injection services, or other similar products.

Naturopathy Services

What Naturopathy Services are covered?

All Health Net Medicare Advantage members have direct access to an ASH Group-contracted naturopath, or out-of-network practitioners qualified to provide the benefit in question and who accept Health Net's terms and conditions of payment for all visits. A copayment is required for each visit to the office. All Naturopathic Services, except for the initial evaluation, may require verification of Medical Necessity.

- A new patient exam, or an established patient exam, for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of Naturopathic Services. A new patient is one who has not received any professional services from the practitioner, or another practitioner of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the practitioner, or another practitioner of the same specialty who belongs to the same group practice, within the past three years.
- Established patient exams assess the need to initiate, continue, extend, or change a course of treatment. The established patient examination is only covered when used to determine the appropriateness of naturopathic services. Unless the established patient exam is an initial evaluation of a new condition, the exam may be subject to verification of Medical Necessity.
- Subsequent office visits or consultations (including physical examination) are reimbursed as Medically Necessary, and approved according to your benefit plan. These services may be subject to verification of Medically Necessity.
- Office visits, consultations, therapeutic procedures and other services, in various combinations.
- X-rays and clinical laboratory tests are payable in full when Medically Necessary, provided by a licensed naturopath, and approved by ASH Group. Radiological consultations are a covered benefit when approved by ASH Group as Medically Necessary services and when provided by a licensed naturopathic radiologist, medical radiologist, radiology group, or hospital that has contracted with ASH Group to provide those services.
- Covered conditions and services are limited to those the practitioner is qualified to treat or perform pursuant to state licensure and scope of practice, excluding obstetrics, surgery, invasive procedures, treatment of psychiatric conditions and services listed as limitations and exclusions.
- Urgent Services.
- Emergency Services.

Second Opinion

You have direct access to any other ASH Group-contracted naturopaths or non-plan practitioner. Your visit to another ASH Group-contracted naturopaths or non-plan practitioner for purposes of

obtaining a second opinion generally will count as one visit, and you must pay any Copayment that applies for that visit on the same terms and conditions as a visit to any other ASH Group-contracted naturopaths or non-plan practitioner as applicable.

What Naturopathy Services are not covered by our Plan?

The following items and services are limited or excluded as part of the Naturopathy Services provided by ASH Group:

- Services, clinical laboratory studies, X-rays and other treatments or products as determined in accordance with professionally-recognized standards of practice that are not approved by ASH Group as Medically Necessary, in accordance with ASH Group's Clinical Services Program. This requirement does not apply to the following services or treatments: (a) a new patient exam; (b) Urgent Services; or (c) Emergency Services.
- Services, examinations (other than in initial examination to determine the appropriateness of Naturopathic Services) and/or treatments for conditions that are not listed as a covered condition or that are not appropriate Naturopathic Service treatments for a covered condition.
- Immunizations, vaccinations, injectables and intravenous infusions. This item shall not apply to venipuncture for the purpose of obtaining blood samples for laboratory studies.
- Disease preventive studies, such as routine clinical laboratory studies, PAP smears, PSA studies, mammograms, contraceptive devices and fitting, including those studies referred by your physician.
- Hypnotherapy, behavior training, sleep therapy and weight programs.
- Thermography; magnets used for diagnostic or therapeutic use; nerve conduction studies (e.g., EEG, EMG, SEMG, SSEP, and NCV); or electrocardiogram (EKG) studies.
- Services, clinical laboratory studies, x-rays and other treatments or products as determined in accordance with professionally-recognized standards of practice that are classified as Experimental or Investigational.
- Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, therapeutic radiology, and diagnostic radiology other than covered plain film studies.
- Transportation costs, including local ambulance charges.
- Education programs, non-medical lifestyle or self-help, or any self-help physical exercise training or related diagnostic testing.
- Services or treatments for pre-employment physicals or vocational rehabilitation.
- Services or treatments caused by or arising out of the course of employment or covered under Workers' Compensation or similar laws.
- Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices or appliances or durable medical equipment.
- Prescription drugs or medicines, including non-legend or proprietary medicine or medication not requiring a prescription order.
- Hospitalization surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services and other related services.
- Auxiliary aids and services, including, but not limited to, interpreters, transcription

services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.
- Adjunctive therapy that is considered by ASH Group to be invasive.

Acupuncture Services

What Acupuncture Services are covered?

All Health Net Medicare Advantage members have direct access to ASH Group-contracted acupuncturists, or out-of-network practitioners qualified to provide the benefit in question, and who accept Health Net's terms and conditions of payment for all visits. A copayment is required for each visit to the office. All Acupuncture Services, except for the initial evaluation, may require verification of Medical Necessity.

- A new patient exam, or an established patient exam, for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of acupuncture services. A new patient is one who has not received any professional services from the practitioner, or another practitioner of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the practitioner, or another practitioner of the same specialty who belongs to the same group practice, within the past three years.
- Established patient exams assess the need to initiate, continue, extend, or change a Course of Treatment. The established patient examination is only covered when used to determine the appropriateness of Acupuncture Services. The established patient exam must be Medically Necessary.
- Follow-up office visits include the provision of acupuncture services and/or a reevaluation.
- Adjunctive Therapies or Modalities such as acupressure, cupping, moxibustion and/or breathing techniques are covered only when provided during the same Course of Treatment and in support of Acupuncture Services. However, the following exception applies for the application of acupressure: if (a) a Contracted Practitioner of Acupuncture Services would recommend Acupuncture Services for a Member as a Covered Service but cannot do so in accordance with professionally-recognized, valid, evidence-based standards of practice because the insertion of needles is contraindicated (e.g., for a patient with an infectious disease that may be transmitted through blood or other bodily fluids), and (b) professionally-recognized, valid, evidence-based standards of practice indicate that acupressure would be efficacious in the treatment of the Member, then Acupuncture Services shall be deemed to include acupressure in that circumstance, even if Acupuncture Services are not provided to the Member at the same time and the Member shall be entitled to receive other Adjunctive Therapies or Modalities in conjunction with the provision of acupressure, in that circumstance, to the same extent as would be the case if the Member were receiving Acupuncture Services.
- Urgent Services.
- Emergency Services.

Second Opinion

You have direct access to any other ASH Group-contracted acupuncturists or non-plan practitioner. Your visit to other ASH Group-contracted acupuncturists or non-plan practitioners for purposes of obtaining a second opinion generally will count as one visit for purposes of any Maximum Benefit. And you must pay any Copayment that applies for that visit on the same terms and conditions as a visit to any other ASH Group-contracted acupuncturist or non-plan practitioner as applicable.

What Acupuncture Services are not covered by our Plan?

The following items and services are limited or excluded as part of the Acupuncture Services provided by ASH Group:

- Services or treatments that are not approved by ASH Group as Medically Necessary, in accordance with ASH Group's Clinical Services Program. This requirement does not apply to the following services or treatments: (a) a new patient exam; (b) Urgent Services; and (c) Emergency Services.
- Hypnotherapy, behavior training, sleep therapy and weight programs.
- Thermography, magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacement products, acupuncture point or trigger-point injections (including injectable substances), laser/laser biostim, colorpuncture, NAET diagnosis and/or treatment, and direct moxibustion.
- Services and other treatments that are classified as Experimental or Investigational.
- Radiological X-rays (plain film studies), magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, diagnostic radiology, and laboratory services.
- Transportation costs, including local ambulance charges.
- Education programs, non-medical lifestyle or self-help, or self-help physical exercise training or any related diagnostic testing.
- Services or treatments for pre-employment physicals or vocational rehabilitation.
- Services or treatments caused by or arising out of the course of employment or covered under Workers' Compensation or similar laws.
- Air conditioners/purifiers, therapeutic mattresses, supplies, or any other similar devices or durable medical equipment.
- Prescription drugs or medicines, including a non-legend or proprietary medicine or medication not requiring a prescription order.
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services and other related services.
- Auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

- Adjunctive therapy not associated with acupuncture.
- Dietary and nutritional supplements, including vitamins, minerals, herbs, herbals and herbal products, injectable supplements and injection services, or other similar products.

How do I file a Complementary/Alternative Health Care claim with ASH Group?

In most cases, your complementary/alternative health care practitioner will submit your claims directly to ASH Group. If you should receive a bill for the services, you can send us a letter or complete an ASH Group claim form. Please call or write to the ASH Group customer service department for a claim form and claim filing instructions at the toll-free number, 1-800-678-9133 (or TTY/TDD 1-877-710-2746), Monday through Friday, 5:00 a.m. to 6:00 p.m., except major holidays, or go online to www.ashcompanies.com.

Attach your itemized bill to the claim form or letter, and mail to:

American Specialty Health Group
P.O. Box 509001
San Diego, CA 92150-9001

If a reimbursement is due to you, a check will be mailed within 30 days of receipt of your claim.

The benefits included in this section are subject to the same appeals process as any other benefits. See Chapter 7 for information about making complaints.

Silver&Fit®

The Silver&Fit program is available to you as a Plan member and is included in your plan's core benefits. The Silver&Fit program is an exercise and healthy aging program which provides an annual allowance of up to $360 for membership dues at a local participating Silver&Fit fitness facility/exercise center or at any out-of-network fitness facility/exercise center. Members who are unable to participate in a fitness facility or prefer to work out at home can instead choose to participate in the Silver&Fit Home Fitness Program. The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). There are no copayments, coinsurance, or deductibles for Silver&Fit programs.

Note that the Silver&Fit benefit is available only to Health Net Aqua (PPO) members. I**f you are already enrolled in the Silver&Fit benefit and choose to remain enrolled, you do not need to take any action (there is no need to re-enroll).**

Prior to proceeding in any exercise or weight management program, it is important for you to seek the advice of a physician or other qualified health professional. Participation in the Silver&Fit program is at your own risk.

How do I enroll in Silver&Fit?

As a Plan member, you will have the opportunity to choose a fitness facility. Take your health plan ID card to a participating Silver&Fit facility. You may be required to sign a membership agreement with the fitness facility for a "standard fitness facility membership," which includes the covered services available through the program, described below. For more information on fitness facilities, or to enroll in the Home Fitness Program, you can go online or call Silver&Fit customer service directly. The phone number and Web site will be listed in the Silver&Fit pre-enrollment packet.

Note: You cannot enroll in the Silver&Fit program prior to your Health Net Aqua (PPO) effective date.

If you choose additional services from your fitness facility that are outside your Silver&Fit standard membership, your agreement with the fitness facility may require additional payments for those services.

Follow these steps to submit reimbursement when using a non-participating facility:

1. Go to www.SilverandFit.com and print the out-of-network reimbursement form or call Silver&Fit customer service directly to have one mailed to you
2. Complete the form.
3. Mail the completed form, along with a copy of your fitness membership agreement, and proof of payment (receipt or copy of bank statement) to the address on the form. (Reimbursement is only provided for previous months; reimbursement submitted for future months will be denied as ineligible.)

You should receive your reimbursement of membership dues, up to your annual allowance, within 30 days of receipt of your claim. For questions regarding your reimbursement, you can call Silver&Fit member services directly, at the number listed in your pre-enrollment packet.

What services are covered in a Silver&Fit standard fitness facility membership?

Participating Silver&Fit Fitness Facilities

The standard in-network fitness facility membership for Silver&Fit members includes all of the services and amenities included in the standard membership for the participating fitness facility that you select, such as:

- Cardiovascular equipment
- Free weights or resistance training equipment
- Exercise classes
- Where available, amenities such as saunas, steamrooms, pools, and whirlpools

Membership does not include any non-standard fitness facility services that typically require an additional fee.

The standard in-network Silver&Fit exercise center membership includes at least thirty minutes of strength, cardiovascular, and/or flexibility training, depending on what classes or programs are available at the exercise center. Exercise centers include Jazzercise® centers, Pilates, yoga studios, and others.

What services are covered in the Silver&Fit Home Fitness Program?

If during enrollment you chose to participate in the Silver&Fit Home Fitness Program, you will receive two of the following kits:

- Walking Kit
- Strength Exercise Kit
- Pilates Kit
- Yoga Kit
- Aqua Aerobics Kit
- Dance Kit
- Tai Chi Kit
- Stress Management Kit

The Silver&Fit Home Fitness Program kits may include:

- A DVD
- and booklet with general information about the topic
- A "Quick Start" guide that explains how to start using the equipment items— this may be part of the booklet, or it may be separate

Note: Kit offerings are subject to availability and may change without notice.

Your first kit will be sent within 10 days of enrolling in the Silver&Fit program. If you select a second kit, it will be sent 90 days of the shipment date of the first kit.

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What services are offered through the Silver&Fit Web site?

As a Silver&Fit enrolled member, you will have access to the Silver&Fit Web site, which is a valuable resource to you. You may:

- Utilize the fitness facility locator and enrollment change features in the event you wish to change fitness facilities
- Access fitness literature to help you make better health decisions
- Choose from dozens of health trackers to track your progress
- Access the Silver&Fit member newsletter, The Silver Slate®

Anytime after your plan effective date, you can go online to set up your account and access your Silver&Fit benefits.

What services are not covered through Silver&Fit?

The following services are not covered in the Silver&Fit benefit:

- Services or supplies provided by any person, company or facility other than the fitness facility that you have signed an agreement with are not covered. Out-of-network fitness facility and exercise center memberships where access to the facility is only valid for months that precede your claim submission date are also not covered.
- All education materials other than those produced for the Silver&Fit program by American Specialty Health Incorporated
- Telecommunications devices, telephone handset amplifiers, television recorders, and telephones compatible with hearing aids
- Education program services for individuals other than the member
- Prescription drugs, over-the-counter products, dietary supplements, herbal supplements, vitamins, minerals, weight control products, meal-replacement beverages or powders, prepackaged meals, or any other types of food or food product, whether or not it is recommended, prescribed, or supplied by a health care provider, fitness facility, or program
- All listening devices, including, but not limited to, audiotape and CD players
- Services for members with serious medical conditions for which the Silver&Fit program are not appropriate.

What services are offered through the "Customer Service Hotline"?

You may call Silver&Fit customer service at 1-877 427-4788 or TTY/TDD 1-877-710-2746, Monday through Friday, 5 a.m. – 6 p.m. (Pacific time), for information on any of the following:

- Enrollment
- Program design
- Eligibility
- Fitness facility search
- Changing facilities
- Fitness facility nominations

The benefits included in this section are subject to the same appeals process as any other benefits. See Chapter 7 for information about making complaints.

Silver&Fit and The Silver Slate are federally registered trademarks of American Specialty Health Incorporated and used with permission herein.

Decision Power®: Health in Balance

Information, resources and support for every person, every stage of health

With Health Net, you get more than health care coverage. You get Decision Power.

Decision Power brings together under one roof the information, resources and personal support that fit you, your health and your life. Whether you're focused on staying fit, dealing with back pain or facing a serious diagnosis, we're here to help you work with your doctor and make informed decisions. Here's how it works:

→ Staying healthy is just as important as getting well.
Making the most of your health is what Decision Power is all about. We're focused on your whole health, not just one concern or disease. So we work with you to identify potential health risks, and help prevent minor concerns from becoming big problems. And we're here should you face serious medical concerns.

→ Your health, your time, your choice.
Whether you …

- have a question
- want help with a specific health goal
- need treatment but need decision support to understand all your options
- are living with illness

…**you choose how and when** to use the information, resources and support available. You can use Decision Power online or by calling a clinician on our nurse 24 line. Try multiple resources at once, or one at a time. 24 hours a day, seven days a week, Decision Power is here for you.

Log on to www.healthnet.com:

- **Take the health risk questionnaire (HRQ) -** with its instant results and interactive features, the HRQ is your gateway to recommendations and resources based on your unique health profile. In just minutes, you'll get an instant health picture and more ways to take control of your health.
- **Try a step-by-step plan** that combines online coaching and self-help tools with phone support so making lasting, healthy changes is easier.
  - Tobacco use
  - Weight Management
  - Nutrition
  - Stress Reduction
  - High Cholesterol
  - High Blood Pressure (Hypertension)
- **Track your health progress** and build a complete medical snapshot to have whenever you need it. You can set up your Personal Health Record to capture claims data, and the self-reported data from your HRQ. You can also enter immunization and test records/results. Plus, you'll automatically receive next steps and alerts about things to discuss with your doctor.
- **Find support for mental health concerns** — tools and programs to assess depression, alcohol use and other emotional health concerns.
- **Keep track of prescriptions** in our **medication center** where you'll also find the most up-to-date information about potentially harmful drug interactions, prescription drugs and over-the-counter medications and supplements.
- **Know the numbers** with our handy tools including health trackers (cholesterol, diet, and fitness), hospital comparison report and treatment cost estimator.
- **Be informed** — Decision Power delivers trusted, easy to understand materials right to your fingertips. Beyond our in-depth article library, you'll find:

- Condition and topic specific videos to support and educate you in your healthcare decisions and choices
- Access information resources, such as Healthwise® Knowledgebase, an online health encyclopedia; calendars; tracking tools; and interactive modules

Talk to a Clinician 24 hours a day:
With Decision Power, you get the convenience of a single point of contact for any and every health question, goal or situation. The clinician you talk to – a trained professional such as a nurse – will present choices, explain options and support you based on your individual values, family needs, situation and preferences.

- **One-on-one consultations** with a trained clinician. All of our 24 hour clinicians have experience and know-how to help you with your primary concern while exploring and addressing the range of issues that may be related to and complicated by it.
- **Answers** to health questions 24 hours a day. However always call 9-1-1 or go straight to the emergency room in a life-threatening situation.
- **Techniques** for talking to your doctor and evaluating treatment options.
- **Pointers** for setting achievable health goals on topics such as weight management, tobacco cessation, stress reduction, cholesterol management, blood pressure control and more.
- **Guidance**/support for living with an ongoing illness such as asthma, diabetes, heart disease and depression, among others.
- **Specialized support** for end-stage diseases, severe trauma — expert nurse case managers work one-on-one with patients and families, facilitating any and all services that may be helpful — home care, hospice, skilled nursing, behavioral health, and more.

→**Doctor-patient connection.** Doctors know medicine. You know your body. With Decision Power, it's easy to learn what questions to ask, how to explain your preferences and to get the support you need from your doctor. The more you know, the easier it is to navigate complicated health choices and make the ones that are right for you.

Decision Power — use it whenever and as much as you like. Because when it comes to your health, there's more than one right answer.

Try it today! Log on to www.healthnet.com or call us toll-free at 1-800-893-5597 (TTY/TDD: 1-800-276-3821).

You have access to Decision Power® through your current enrollment with Health Net Health Plan of Oregon, Inc. or Health Net Life Insurance Company.

Decision Power is part of Health Net's Medicare Advantage benefit plans. But it is not affiliated with Health Net's provider network. Decision Power services, including clinicians, are additional resources that Health Net makes available to enrollees

Section 2.2 Extra "optional supplemental" benefits you can buy

Our Plan offers some extra benefits that are not covered by Original Medicare and are not included in your benefits package as a plan member. These extra benefits are called "**Optional Supplemental Benefits."** If you want these optional supplemental benefits, you must sign up for them and you may have to pay an additional premium for them. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.

How can you enroll in the Optional Supplemental Benefits?

Current members can purchase Optional Supplemental Benefits during the following election periods:

- from October 15, 2013 through December 31 2013, for a January 1, 2014 effective date; or
- from January 1, 2014 through January 31, 2014 for a February 1, 2014 effective date.

Current members who are already enrolled in Optional Supplemental Benefits can also switch to a different package at these times if the plan has more than one package available.

New members can purchase these Optional Supplemental Benefits until the end of the first month of their initial enrollment. Benefits will become effective the first of the following month.

Preventive Dental Plus Optional Supplemental Benefits includes preventive dental services, basic restorative dental services and non-surgical periodontal dental services for an additional monthly premium of $31.

To enroll, complete the Optional Supplemental Benefits Enrollment Form and mail it to:

Health Net Medicare Advantage
Attn.: Medicare Membership Department
PO Box 10420
Van Nuys, CA 91410-0420

Or, you may fax it to **1-866-214-1992**. If you need an Optional Supplemental Benefits Enrollment Form, call Member Services at the number on the back cover of this booklet.

How can you disenroll from the Optional Supplemental Benefits

You may disenroll from these Optional Supplemental Benefits at any time and switch back to the basic Medicare Advantage plan benefits. To disenroll from the Optional Supplemental Benefits send a letter to Health Net requesting to be disenrolled. You may also fax the letter to **1-866-214-1992**. It is important that you state your request is for disenrollment from the Optional Supplemental Benefits only, and the letter must be signed. We will then send you a letter that tells you when your Optional Supplemental Benefits will end. This is your Optional Supplemental Benefits **disenrollment date**. In most cases, your disenrollment date will be the first day of the month after the month we receive your request to discontinue these benefits.

For example, if we receive your request to discontinue these benefits during the month of February, your disenrollment date will be March 1. There is an exception: **If we receive your request between October 15 and November 30, you will be allowed to choose November 1, December 1 or January 1 as your effective date of disenrollment. If you do not choose an effective date, your disenrollment will be the first day of the month after the month we receive your request to discontinue these benefits**. Remember, while you are waiting for the discontinuation of your Optional Supplemental Benefits, they are still available to you as a member of our plan and are available up until the disenrollment effective date.

If you disenroll from Optional Supplemental Benefits, you cannot re-enroll in Optional Supplemental Benefits until the next Optional Supplemental Benefits election period. The Optional Supplemental Benefits election periods are shown earlier in this section under "How can you enroll in the Optional Supplemental Benefits."

If you disenroll from the Medicare Advantage plan, you will automatically be disenrolled from the Optional Supplemental Benefits.

Additional Information

If you fail to pay the monthly premium for the Optional Supplemental Benefits, you will lose the benefits but will remain enrolled in the Medicare Advantage plan. The Optional Supplemental Benefits included in this section are subject to the same appeals process as any other benefits. See Chapter 7 for information about making complaints.

Optional supplemental benefit premium, deductibles, copayments, and coinsurance do not apply to the maximum out-of-pocket payment amount for Medicare Part A and Part B covered medical services.

Optional Supplemental Benefit Information

Optional Supplemental Benefits	**What you must pay** when you get these services:	
	In-Network	**Out-of-Network**
Preventive Dental Plus Package		
Monthly Plan Premium and Other Important Information	You pay $31 each month in addition to your monthly plan premium as shown in Chapter 1, Section 4.1 and your Medicare Part B premium. There is a $35 combined in-network and out-of-network annual deductible for covered preventive, restorative, and non-surgical periodontal dental services. *◈	
Dental services **Diagnostic and Preventive Dental** • Periodic oral exams – two per year • Cleanings (adult prophylaxis) – two per year • Bitewing x-rays – one per year • Complete series or panoramic x-rays – once every 3 years[1] [1] Multi-year benefit may not be available in subsequent years. [2] Usual, Customary and Reasonable (UCR) means the maximum allowable amount for a dental service based on fees usually charged by providers for that service in the same geographic area. *The amounts you pay for these services do not count towards your in-network maximum out-of-pocket amount of $2,500.	$0 co-payment for listed diagnostic and preventive dental services	20% coinsurance of UCR[2] for diagnostic and preventive dental services (Health Net pays 80%). You pay the deductible and the difference between UCR[2] and billed charges.

Optional Supplemental Benefits	What you must pay when you get these services:	
	In-Network	Out-of-Network
◈The amounts you pay for these services do not count toward your combined maximum out-of-pocket amount of $5,100.		
Restorative Services • Amalgam (metal) fillings – one restoration per tooth surface every 3 years[1] • Resin composite fillings – one restoration per tooth surface every 3 years[1] [1] Multi-year benefit may not be available in subsequent years. [2] Usual, Customary and Reasonable (UCR) means the maximum allowable amount for a dental service based on fees usually charged by providers for that service in the same geographic area.	20% coinsurance for restorative services	20% coinsurance of UCR[2] for restorative services. (Health Net pays 80%). You pay the deductible and the difference between UCR[2] and billed charges.
Non-Surgical Periodontal Services • Perio scaling/root planing – two quadrants per visit • Full mouth debridement • Periodontal maintenance – two visits per year [2] Usual, Customary and Reasonable (UCR) means the maximum allowable amount for a dental service based on fees usually charged by providers for that service in the	50% coinsurance for periodontal services	50% coinsurance of UCR[2] for periodontal services. (Health Net pays 50%). You pay the deductible and the difference between UCR[2] and billed charges.

Optional Supplemental Benefits	**What you must pay** when you get these services:	
	In-Network	**Out-of-Network**
same geographic area.		
Please refer to the "Preventive Dental Plus Services" section below under "Optional Supplemental Benefit Information" for additional information on covered dental services including limitations and restrictions.	Members who elect to purchase these benefits will have an annual allowance of $1,250 for preventive dental services, basic restorative dental services and non-surgical periodontal dental services	

Preventive Dental Plus Services

As a member of this plan, you can get dental benefits beyond the Medicare-covered services offered in your core plan benefits by purchasing the optional supplemental benefits Preventive Dental Plus Package. To receive these added benefits, you must sign up for them and pay an additional premium. Additional dental benefits offered in this package include preventive dental services, basic restorative dental services and non-surgical periodontal dental services. There is a total annual benefit maximum of $1,250 and an annual $35 deductible.

Dental services are administered by Dental Benefit Providers, Inc. Dental services are covered as shown in the Optional Supplemental Benefit Chart in this section. You can see any licensed dentist to receive covered dental services. However, your cost-sharing may be higher when you receive covered services from out-of-network providers than from in-network providers.

Getting services from Health Net Dental In-Network providers

You may save money when using in-network providers (providers who are in Health Net Dental's PPO network). Health Net Dental in-network providers are listed in your *Provider Directory*. For up-to-date provider information, please contact Health Net Dental at 1-877-410-0176 (or TTY/TDD 1-800-855-2880 for the hearing and speech impaired) Monday through Friday, 5:00 a.m. to 8:00 p.m., Pacific time, except holidays. You may also contact the Health Net Medicare Advantage Member Services department at the telephone number located on the back cover of this booklet, or visit our Web site at www.healthnet.com.

Getting services from Out-of-Network Dental providers

Out-of-network benefits apply when covered services are received from a provider not participating in Health Net Dental's network. Health Net Dental will review claims received from out-of-network dental professionals, and payment will be issued if the services received are determined to have been medically necessary covered services.

What services are covered under Preventive Dental?

Preventive dental services are covered with the following limitations:

- Periodic oral exams – two per year
- Cleanings (adult prophylaxis) – two per year
- Bitewing x-rays – one per year
- Complete series or panoramic x-rays – once every 3 years[1]

[1] Multi-year benefits may not be available in subsequent years.

Dental procedure codes covered under Preventive Dental

ADA Code	Procedure Name
D0120	Periodic Oral Evaluation
D0140	Limited Oral Evaluation – Problem Focused
D0150	Comprehensive Oral Evaluation – New or Established Patient
D0210	Intraoral – Complete Series Including Bitewings
D0220	Intraoral – Periapical - First Film
D0230	Intraoral – Periapical - Each Additional Film
D0250	Extraoral – First Film
D0260	Extraoral – Each Additional Film
D0270	Bitewing – Single Film
D0272	Bitewings – Two Films
D0273	Bitewings – Three Films
D0274	Bitewings – Four Films
D0277	Vertical Bitewings – 7 To 8 Films
D0330	Panoramic Film
D1110	Prophylaxis Adults

What services are covered under Basic Restorative Dental?

Basic Restorative dental services are covered with the following limitations:

- Amalgam (metal) fillings – one restoration per tooth surface every 3 years[1]
- Resin composite fillings – one restoration per tooth surface every 3 years[1]

[1] Multi-year benefits may not be available in subsequent years.

Dental procedure codes covered under Basic Restorative Dental

ADA Code	Procedure Name
D2140	Amalgam – one surface primary/permanent
D2150	Amalgam – two surfaces primary/permanent
D2160	Amalgam – three surfaces primary/permanent
D2161	Amalgam – four surfaces primary/permanent
D2330	Resin composite – one surface anterior
D2331	Resin composite – two surfaces anterior
D2332	Resin composite – three surfaces anterior
D2335	Resin composite – four or more surfaces w/ incisal angle (anterior)
D2391	Resin composite – one surface posterior
D2392	Resin composite – two surfaces posterior
D2393	Resin composite – three surfaces posterior
D2394	Resin composite – four or more surfaces w/ incisal angle (posterior)

What services are covered under Periodontal Dental?

Non-surgical Periodontal dental services are covered with the following limitations:

- Perio scaling/root planning – two quadrants per visit
  - Two quadrants per visit, unless medically necessary
  - Limited to pocket depths of 4mm or more and radiographic signs of calculus, accumulation of subgingival calculus, and/or bleeding points
  - Inclusive with gingival flap procedure or osseous surgery on same date

- Full mouth debridement
  - Heavy calculus should be evident on most teeth
  - Not covered on same date as scaling and root planing, prophylaxis or any examination

- Periodontal maintenance – two visits per year
  - Prior history of periodontal therapy
  - Not eligible during the first 90 days after periodontal therapy
  - Reevaluation is required if no periodontal maintenance was received in the last 12 months

Dental procedure codes covered under Non-Surgical Periodontal Dental

ADA Code	Procedure Name
D4341	Periodontal Scaling/Root Planing – four or more contiguous teeth per quadrant
D4342	Periodontal Scaling/Root Planing – one to three teeth per quadrant
D4355	Full Mouth Debridement to enable comprehensive evaluation and diagnosis
D4910	Periodontal Maintenance – two per year

What Dental services are not covered by our Plan?

The following items and services listed below are excluded as part of either the core plan benefits or the optional supplemental benefits provided by Health Net Dental:

1. Any service or supply not defined within this document or in the *Evidence of Coverage* booklet.
2. Any procedure started before the effective date or after the termination date of the covered person's insurance.
3. Prescribed drugs, medications or analgesia; training in or supplies used for dietary counseling, oral hygiene or plaque control; nitrous oxide or sterilization charges; pulp caps or medicaments.
4. Treatment by anyone other than a dentist, except where performed by a duly qualified hygienist under the direction of a dentist.
5. Dental services which do not have uniform professional endorsement by the American Dental Association.
6. Expenses resulting from any intentionally self-inflicted injury or sickness.
7. Charges for professional services rendered by any individual who is related to the covered person by blood or marriage.
8. Any expenses compensable under any Workers' Compensation law or act, Employers' Liability law or by any governmental program, law or agency.
9. Care rendered within any facility of, or provided by: (1) the United States Government or any agency thereof or (2) any hospital or institution, which does not require the covered person to pay for such services in the absence of insurance.
10. Treatment of congenital malfunctions or malformations.
11. Cosmetic treatment (treatment primarily to enhance or change appearance) whether or not for psychological or emotional reasons.

How do I file a Health Net Dental claim?

When you see an out-of-network dentist, you will have to file a claim with Health Net Dental. Health Net Dental will pay your provider its share of the bill for any covered services that are determined to have been medically necessary and let you know what, if anything, you must pay your provider. Please call or write to the Health Net Dental customer service department for a claim form and claim filing instructions at the toll-free number, 1-877-410-0176 (or TTY/TDD 1-800-855-2880), Monday through Friday, 5:00 a.m. to 8:00 p.m., Pacific time, except holidays.

Attach your itemized bill to the claim form or letter, and mail to:

Health Net Dental
P.O. Box 30567
Salt Lake City, UT 84130-0567

The benefits included in this section are subject to the same appeals process as any other benefits. See Chapter 7 for information about making complaints.

SECTION 3 What benefits are not covered by the plan?

Section 3.1 Benefits we do *not* cover (exclusions)

This section tells you what kinds of benefits are "excluded." Excluded means that the plan doesn't cover these benefits.

The list below describes some services and items that aren't covered under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We won't pay for the excluded medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this booklet.)

In addition to any exclusions or limitations described in the Medical Benefits Chart, or anywhere else in this *Evidence of Coverage*, **the following items and services aren't covered under Original Medicare or by our plan:**

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.) Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.

- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care, such as cleanings, fillings or dentures. However, non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care. However, routine dental is offer as a supplemental benefit that you can buy. See Section 2.2 above.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Routine hearing exams, hearing aids, or exams to fit hearing aids.
- Radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery.
- Outpatient prescription drugs.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at a VA hospital and the VA cost sharing is more than

the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

Chapter 5. Asking us to pay our share of a bill you have received for covered medical services

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services

Section 1.1 If you pay our plan's share of the cost of your covered services, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. When you've received medical care from a provider who is not in our plan's network

When you received care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the plan directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. For more information about "balance billing," go to Chapter 4, Section 1.4.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan.

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

- Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Member Services are printed on the back cover of this booklet.)

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our Web site (www.healthnet.com) or call Member Services and ask for the form. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Mail your request for payment together with any bills or receipts to us at this address:

Health Net of Oregon
P.O. Box 14130
Lexington, KY 40512

You must submit your claim to us within one calendar year of the date you received the service, item, or drug.

Contact Member Services if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered.)
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the Section 5.3 in Chapter 7 that tells what to do if you want to make an appeal about getting paid back for a medical service.

Chapter 6. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1 We must provide information in a way that works for you (in languages other than English, in audio, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. This information is available for free in other languages. Please contact our Member Services at 1-888-445-8913 (TTY/TDD users should call 1-800-929-9955). Hours of operation 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. We can also give you information in audio, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TDD 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section 1.3 We must ensure that you get timely access to your covered services

You have the right to choose a provider for your care. As a plan member, you have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this booklet tells what you can do. (If we have denied coverage for your medical care and you don't agree with our decision, Chapter 7, Section 4 tells what you can do.)

Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.5 We must give you information about the plan, its network of providers, and your covered services

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back cover of this booklet):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers.**
    - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.
    - For a list of the providers in the plan's network, see the *Provider Directory*.
    - For more detailed information about our providers, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our Web site at www.healthnet.com.
- **Information about your coverage and the rules you must follow when using your coverage.**
    - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
    - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
    - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider.
    - If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details

on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)

- If you want to ask our plan to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

Section 1.6 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.

- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

In the state of Oregon, under the Oregon Health Care Decisions Act, advance directives may be any of the following: power of attorney, advance directive for health care, physician orders for life-sustaining treatment (POLST), or declaration for mental health treatment. For more information about advance directives, contact the Senior Health Insurance Benefits Assistance Program (SHIBA) at the number located in Chapter 2, Section 3 of this EOC. You can also call the Oregon Health Authority at 1-877-398-9238 or 1-503-947-2340 (National Relay Service: 711), or the Oregon Department of Consumer & Business Services at 1-503-378-4100 (National Relay Service: 711).

In the state of Washington, advance directives may be a durable power of attorney for health care or a health care directive (living will). For more information about Washington advance directives, call the Washington State Medical Association at 1-800-552-0612 or 1-206-441-9762 (National Relay Service: 711).

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. In Oregon, two adults must witness your signing the advance directive or your acknowledgement of your signing the advance directive. At least one of the witnesses must not be related to you by blood or marriage nor entitled to any portion of your estate, nor be an owner, operator or employee of a health care facility where you are a patient or resident. Your attending physician and attorney-in-fact may not serve as witnesses.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that Health Net, a doctor or hospital did not follow the instructions in it, you may file a complaint with your local Office for Civil Rights.

Office for Civil Rights
U.S. Department of Health & Human Services
2201 Sixth Avenue, M.S. RX-11
Seattle, WA 98121-1831

The telephone number is 1-800-368-1019 or 1-206-615-2290 (TDD:1-800-537-7697).

Please be aware of the following:

- Health Net is required to ensure that whether you have executed an advance directive is documented in a prominent part of your current medical record.
- Health Net is required to comply with State law on advance directives.
- Health Net must educate its staff about its policies and procedures for advance directives.
- Health Net must provide for community education regarding advance directives.

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 7, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.8 You have the right to make recommendations about our member rights and responsibilities policy

If you have any questions or concerns about the rights and responsibilities or if you have suggestions to improve our member rights policy share your thoughts with us by contacting Member Services.

Section 1.9 Evaluation of new technologies

New technologies include procedures, drugs, biological product, or devices that have recently been developed for the treatment of specific diseases or conditions, or are new applications of existing procedures, drugs, biological products, and devices. New technologies are considered investigational if there is no conclusive medical and scientific evidence in published peer-reviewed medical literature that the drug, biological product, device, or procedure has a beneficial effect on health outcomes, there is no clearance from a federal, governmental regulatory body, or other governmental agency (e.g., U.S. Food and Drug Administration [FDA]) for final and unrestricted market approval for use in the treatment of a specified condition, and not generally accepted by the medical community.

Health Net, Inc. follows Medicare's National and Local Coverage Determinations when applicable. In the absence of a Medicare coverage determination, Health Net assesses technology through an established process for recognizing and evaluating advances in new technologies and new applications of existing technologies which should be included in applicable benefit plans and to ensure members have access to safe and effective care. Health Net, Inc. may rely upon published evaluations and clinical recommendations of recognized experts (e.g., national medical associations, independent medical panels, technology assessment organizations, and practicing physicians). Such experts base their evaluations and findings on the scientific quality of the supporting evidence and rationale for the new technologies or new applications. Health Net, Inc.'s Medical Advisory Council has the responsibility for assessing new technology and new applications and for medical policy decisions.

Section 1.10 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TDD 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.11 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
    - You can visit the Medicare Web site to read or download the publication "Medicare Rights & Protections." (The publication is available at: http://www.medicare.gov/Pubs/pdf/11534.pdf).
    - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). We're here to help.

- ***Get familiar with your covered services and the rules you must follow to get these covered services.*** *Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.*
    - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.

- ***If you have any other health insurance coverage in addition to our plan, you are required to tell us.*** *Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).*
    - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health benefits you get from our plan with any other health benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- ***Tell your doctor and other health care providers that you are enrolled in our plan.*** *Show your plan membership card whenever you get your medical care.*
- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***
    - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Participate in the development of mutually agreed upon treatment plans, and follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- ***Be considerate.*** *We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.*
- ***Pay what you owe.*** *As a plan member, you are responsible for these payments:*
    - You must pay your plan premiums to continue being a member of our plan.
    - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
    - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services.
    - If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.

        - If you disagree with our decision to deny coverage for a service, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.

- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).*
    - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
    - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
    - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.

- ***Call Member Services for help if you have questions or concerns.*** *We also welcome any suggestions you may have for improving our plan.*
    - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
    - For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

BACKGROUND

COVERAGE DECISIONS AND APPEALS

MAKING COMPLAINTS

BACKGROUND

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare Web site (http://www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.	**No.** My problem is not about benefits or coverage.
Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals."**	Skip ahead to **Section 9** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service, or other concerns."**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical services, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a service is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2

Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services** (phone numbers are printed on the back cover of this booklet).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.** For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under State law.
    - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's Web site at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our Web site at www.healthnet.com). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are three different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 6** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"
- **Section 7** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal

? Have you read Section 4 of this chapter (*A guide to the basics of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay*). To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.

3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
    - NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
        - Chapter 7, Section 6: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
        - Chapter 7, Section 7: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
    - For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section of this chapter, **Section 5.2**.
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an **appeal**. (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to **Section 5.5** of this chapter.

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms When a coverage decision involves your medical care, it is called an **"organization determination."**

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a "fast coverage decision."

Legal Terms A "fast coverage decision" is called an **"expedited determination."**

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care*.

Generally, we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard coverage decision means we will give you an answer within 14 days** after we receive your request.

- **However, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

If your health requires it, ask us to give you a "fast coverage decision"

- **A fast coverage decision means we will answer within 72 hours.**
  - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from

out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.

- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.

- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)
  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

*Deadlines for a **"fast"** coverage decision*

- Generally, for a fast coverage decision, we will give you our answer **within 72 hours**.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.

- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested,** we will send you a detailed written explanation as to why we said no.

*Deadlines for a **"standard"** coverage decision*

- Generally, for a standard coverage decision, we will give you our answer **within 14 days of receiving your request.**
  - We can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
  - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our coverage decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

<u>Step 3:</u> If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms	An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start an appeal, you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.**
    - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's Web site at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our Web site at www.healthnet.com). While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be sent to the Independent Review Organization for dismissal.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
    - You have the right to ask us for a copy of the information regarding your appeal.

- If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

Legal Terms	A "fast appeal" is also called an **"expedited reconsideration."**

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

*Deadlines for a **"fast" appeal***

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

*Deadlines for a **"standard" appeal***

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days.**
    - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
    - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How a Level 2 Appeal is done

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**. You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

*If you had a "fast" appeal at Level 1, you will also have a **"fast" appeal** at Level 2*

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 72 hours of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

*If you had a "standard" appeal at Level 1, you will also have a **"standard" appeal** at Level 2*

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
    - There is a certain dollar amount that must be in dispute to continue with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a

certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 5 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services*. Chapter 5 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)

- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in part 5.3 of this section. Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**." Our plan's coverage of your hospital stay ends on this date.
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay and to know who will pay for it.
   - Where to report any concerns you have about the quality of your hospital care.
   - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms	The written notice from Medicare tells you how you can **"request an immediate review."** Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 6.2 below tells you how you can request an immediate review.)

2. **You must sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.

- If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Member Services (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

Section 6.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Step 1: Contact the Quality Improvement Organization in your state and ask for a "fast review" of your hospital discharge. You must act quickly.

Legal Terms	A "fast review" is also called an **"immediate review."**

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare about Your Rights*) tells you how to reach this organization. (Or find the name, address, and

phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
    - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
    - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

Ask for a "fast review":

- You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms	A "**fast review**" is also called an "**immediate review**" or an "**expedited review**."

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms	This written explanation is called the "**Detailed Notice of Discharge."** You can get a sample of this notice by calling Member Services (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.) Or you can see a sample notice online at http://www.cms.hhs.gov/BNI/

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after

noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 6.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 6.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms	A "fast" review (or "fast appeal") is also called an **"expedited appeal"**.

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
  - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate* Appeal

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1 *This section is about three services only:* **Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services**

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 10, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 10, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 7.2 We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.
   - The written notice tells you the date when we will stop covering the care for you.
   - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms	In telling you what you can do, the written notice is telling how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.5 below tells how you can request a fast-track appeal.)

Legal Terms	The written notice is called the "**Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or see a copy online at http://www.cms.hhs.gov/BNI/

2. **You must sign the written notice to show that you received it.**
   - You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan that it's time to stop getting the care.

Section 7.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care*.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day that the reviewers inform us of your appeal, you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms	This notice of explanation is called the "**Detailed Explanation of Non-Coverage.**"

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms	A "fast" review (or "fast appeal") is also called an **"expedited appeal"**.

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast" review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a "fast

review," we are allowed to decide whether to agree to your request and give you a "fast review." But in this situation, the rules require us to give you a fast response if you ask for it.)

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate* Appeal

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines,

you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written

response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the Administrative Law Judge says yes to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the judge's decision.
    - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	The **Appeals Council** will review your appeal and give you an answer. The Appeals Council works for the Federal government.

- **If the answer is yes, or if the Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Appeals Council's decision.
    - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Appeals Council denies the review request, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.

- If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal.

- This is the last step of the administrative appeals process.

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

? If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 9.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Quality of your medical care

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Member Services has treated you?
- Do you feel you are being encouraged to leave the plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors or other health professionals? Or by our Member Services or other staff at the plan?
    - Examples include waiting too long on the phone, in the waiting room, or in the exam room.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Information you get from us

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

The next page has more examples of possible reasons for making a complaint

Possible complaints
(continued)

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-8 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 9.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

- What this section calls a **"complaint"** is also called a **"grievance."**
- Another term for **"making a complaint"** is **"filing a grievance."**
- Another way to say "**using the process for complaints"** is "**using the process for filing a grievance."**

Section 9.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. 1-888-445-8913 (TTY/TDD users should call 1-800-929-9955). 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- If you ask for a written response, file a written complaint (grievance), or if your complaint is related to quality of care, we will respond to you in writing. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaint. We call this the Grievance Procedure.** To make a complaint, or if you have questions about this procedure, please call Member Services at the phone number above. Or, you may mail or fax us a written request to the address or fax number listed under Appeals for Medical Care or Complaints about Medical Care in Chapter 2 of this booklet.
    - You need to file your complaint within 60 calendar days after the event. You can submit your Grievance, formally, in writing or via fax at the address or fax number listed under Appeals for Medical Care or Complaints about Medical Care in Chapter 2 of this booklet.
    - We must notify you of our decision about your complaint as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.
    - In certain cases, you have the right to ask for a fast review of your complaint. This is called the Expedited Grievance Procedure. You are entitled to a fast review of your complaint if you disagree with our decision in the following situations:
        - We deny your request for a fast review of a request for medical care.
        - We deny your request for a fast review of an appeal of denied services.
        - We decide additional time is needed to review your request for medical care.
        - We decide additional time is needed to review your appeal of denied medical care.
    - You may submit this type of complaint by phone by calling Member Services at the phone number on the back cover of this booklet. You may also submit the complaint to us in writing or by fax at the address or fax number listed under Appeals for Medical Care or Complaints about Medical Care in Chapter 2 of this booklet. Once we receive the expedited grievance (complaint), a Clinical Practitioner will review the case to determine the reasons for the denial of your request for a fast review or if the

case extension was appropriate. We will notify you of the decision of the fast case orally and in writing within 24 hours of receiving your complaint.

- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.

- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

Legal Terms	What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).

    - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

    - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you

make a complaint to this organization, we will work with them to resolve your complaint.

- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

Chapter 8. Ending your membership in the plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in our plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
    - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
    - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the annual Medicare Advantage Disenrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Coordinated Election Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your

coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:

- Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
- Original Medicare *with* a separate Medicare prescription drug plan.
- *– or –* Original Medicare *without* a separate Medicare prescription drug plan.

- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited

You have the opportunity to make *one* change to your health coverage during the annual **Medicare Advantage Disenrollment Period**.

- **When is the annual Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.

- **What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?** During this time, you can cancel your Medicare Advantage Plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare during this period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.

- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of our plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples; for the full list, you can contact the plan, call Medicare, or visit the Medicare Web site (http://www.medicare.gov):
  - Usually, when you have moved.

  - If you have the Oregon Health Plan (Medicaid) or Washington State Health Care Authority (Medicaid).
  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term care hospital.
  - If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.

- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the ***Medicare & You 2014*** handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare Web site (http://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- --*or*--You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).

If you would like to switch from our plan to:	This is what you should do:
	• You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from our plan when your coverage in Original Medicare begins.

SECTION 4 Until your membership ends, you must keep getting your medical services through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care through our plan.

- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Our plan must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Our plan must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.

  - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Member Services are printed on the back cover of this booklet.)

- If you become incarcerated (go to prison).

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

Health Net Aqua (PPO) is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 9 for information about how to make a complaint.

Chapter 9. Legal notices

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, *our plan*, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Recovery of benefits paid by Health Net under your Health Net Aqua (PPO) plan

When you are injured

If you are ever injured through the actions of another person, or yourself (responsible party), Health Net will provide benefits for all covered services that you receive through this Plan. However, if you receive money or are entitled to receive money because of your injuries, whether through a settlement, judgment or any other payment associated with your injuries, Health Net or the medical providers retain the right to recover the value of any services provided to you through this Plan.

As used throughout this provision, the term responsible party means any party actually or potentially responsible for making any payment to a Member due to a Member's injury, illness or condition. The term responsible party includes the liability insurer of such party or any insurance coverage.

Some examples of how you could be injured through the actions of a responsible party are:

- You are in a car accident;
- You slip and fall in a store.

Health Net's rights of recovery apply to any and all recoveries made by you or on your behalf from the following sources, including but not limited to:

- Payments made by a third party or any insurance company on behalf of a third party;
- Uninsured or underinsured motorist coverage;
- Personal injury protection, no fault or any other first party coverage;
- Workers Compensation or Disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' insurance coverage, umbrella coverage;
- Medical expenses incurred as a result of medical malpractice; and
- Any other payments from any other source received as compensation for the responsible party's actions.

By accepting benefits under this Plan, you acknowledge that Health Net has a first priority right of subrogation and reimbursement that attaches when this Plan has paid for health care benefits for expenses incurred due to the actions of a responsible party and you or your representative recovers or is entitled to recover any amounts from a responsible party.

By accepting benefits under this Plan, you also grant Health Net an assignment of your right to recover medical expenses from any coverage available to the extent of the full cost of all covered services provided by the Plan and you specifically direct such carriers to directly reimburse the Plan on your behalf.

By accepting benefits under this Plan, you also grant Health Net a first priority lien on any recovery, settlement or judgment, or other source of compensation and all reimbursement due Health Net for the full cost of benefits paid under the Plan that are associated with injuries through a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss. Health Net may recover the full cost of all benefits provided by this Plan without regard to any claim of fault on the part of the Member, whether by comparative negligence or otherwise. No attorney fees may be deducted from Health Net's recovery, and Health Net is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue the claim or lawsuit against any responsible party.

Steps you must take

If you are injured because of a responsible party, you must cooperate with Health Net and/or the medical providers' efforts to recover its expenses, including:

- Telling Health Net and the medical providers the name and address of the responsible party, if you know it, the name and address of your lawyer, if you are using a lawyer, the

name and address of any insurance company involved with your injuries and describing how the injuries were caused.
- Completing any paperwork that Health Net or the medical providers may reasonably require to assist in enforcing the lien.
- Promptly responding to inquiries from Health Net about the status of the case and any settlement discussions.
- Notifying Health Net immediately upon you or your lawyer receiving any money from the responsible parties, any insurance companies, or any other source.
- Pay the health care lien from any recovery, settlement or judgment, or other source of compensation and all reimbursement due to Health Net for the full cost of benefits paid under the Plan that are associated with injuries through a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss;
- Do nothing to prejudice Health Net's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery the full cost of all benefits paid by the plan; and

Hold any money that you or your lawyer receive from the responsible parties, or from any other source, in trust, and reimbursing Health Net and the medical providers for the amount of the lien as soon as you are paid.

SECTION 5 Independent contractors

The relationship between Health Net and each participating provider is an independent contractor relationship. Participating providers are not employees or agents of Health Net and neither Health Net, nor any employee of Health Net, is an employee or agent of a participating provider. In no case will Health Net be liable for the negligence, wrongful act, or omission of any participating or other health care provider. Participating physicians, and not Health Net, maintain the physician-patient relationship with the member. Health Net is not a provider of care.

SECTION 6 Health care plan fraud

Health care plan fraud is defined as a deception or misrepresentation by a provider, Member, employer or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by filing a claim that contains a false or deceptive statement is guilty of insurance fraud.

If you are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if you know of or suspect any illegal activity, call our plan's toll-free Fraud Hotline at 1-800-977-3565. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

SECTION 7 Circumstances beyond Health Net's control

To the extent that a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant medical group personnel, or other similar events not within the control of Health Net, results in Health Net's facilities or personnel not being available to provide or arrange for services or benefits under this *Evidence of Coverage*, Health Net's obligation to provide such services or benefits shall be limited to the requirement that Health Net make a good faith effort to provide or arrange for the provision of such services or benefits within the resulting limitations on the availability of its facilities or personnel.

SECTION 8 Notice of privacy practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION AND NONPUBLIC PERSONAL FINANCIAL INFORMATION* ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

*Nonpublic personal financial information includes personally identifiable financial information that you provided to us to obtain insurance 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.

This Notice tells you about the ways in which Health Net (referred to as "we" or "the Plan") may collect, use and disclose your protected health information and your rights concerning your protected health information. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

- **Payment.** We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to

process claims, to be reimbursed by another insurer that may be responsible for payment or for premium billing.

- **Health Care Operations.** We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or customer service.
- **Treatment.** We may use and disclose your protected health information to assist your health care providers (doctors, pharmacies, hospitals, and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.
- **Plan Sponsor.** If you are enrolled through a group health plan, we may provide non-identifiable summaries of claims and expenses for enrollees in your group health plan to the plan sponsor, which is usually the employer.

  If the plan sponsor provides plan administration services, we may also provide access to identifiable health information to support its performance of such services which may include but are not limited to claims audits or customer services functions. Health Net will only share health information upon a certification from the plan sponsor representing there are restrictions in place to ensure that only plan sponsor employees with a legitimate need to know will have access to health information in order to provide plan administration functions.

  We may also disclose protected health information to a person, such as a family member, relative, or close personal friend, who is involved with your care or payment. We may disclose the relevant protected health information to these persons if you do not object or we can reasonably infer from the circumstances that you do not object to the disclosure; however, when you are not present or are incapacitated, we can make the disclosure if, in the exercise of professional judgment, we believe the disclosure is in your best interest.

Other Permitted or Required Disclosures

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.
- **Public Health Activities.** We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury, or disability.
- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose protected health information to government agencies about abuse, neglect, or domestic violence.
- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g., California Department of Health Services) for activities authorized by law.
- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request, or other lawful process.

- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Coroners, Funeral Directors, Organ Donation.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
- **Research.** Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

Other Uses or Disclosures with an Authorization

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

Your Rights Regarding Your Protected Health Information

You have certain rights regarding protected health information that the Plan maintains about you.

- **Right to Access Your Protected Health Information.** You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment, and case or medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying, and mailing your requested information, but we will tell you the cost in advance.
- **Right to Amend Your Protected Health Information.** If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by the Plan, as is often the case for health

information in our records, or you ask to amend a record that is already accurate and complete.

If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision, and we have the right to rebut that statement.

- **Right to an Accounting of Disclosures by the Plan.** You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

  Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.

- **Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. ***We may not agree to your request.*** If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

- **Right to Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.

- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting our Privacy Office. See the end of this Notice for the contact information.

Health Information Security

Health Net requires its employees to follow the Health Net security policies and procedures that limit access to health information about members to those employees who need it to perform their job responsibilities. In addition, Health Net maintains physical, administrative, and technical security measures to safeguard your protected health information.

Changes to This Notice

We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. We also post a copy of our current Notice on our Web site at **www.healthnet.com**. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new effective date.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the Department of Health and Human Services. All complaints to the Plan must be made in writing and sent to the Privacy Office listed at the end of this Notice.

We support your right to protect the privacy of your protected health information. ***We will not retaliate against you or penalize you for filing a complaint.***

Contact the Plan

If you have any complaints or questions about this Notice or you want to submit a written request to the Plan as required in any of the previous sections of this Notice, please contact:

Address:
Health Net Privacy Office
Attention: Director, Information Privacy
P.O. Box 9103
Van Nuys, CA 91409

You may also contact us at:
Telephone: **1-800-522-0088**
Fax: **1-818-676-8314**
Email: **Privacy@healthnet.com**

Chapter 10. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – A set time each fall when members can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measure your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the 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.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. See Chapter 4, Section 1.3 for information about your combined maximum out-of-pocket amount.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. (This is in addition to the plan's monthly premium.) Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed "copayment" amount that a plan requires when a specific service is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

Covered Services – The general term we use in this EOC to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Deductible – The amount you must pay for health care before our plan begins to pay.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable Medical Equipment – Certain medical equipment that is ordered by your doctor for medical reasons. Examples are walkers, wheelchairs, or hospital beds.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Grievance - A type of complaint you make about us or one of our network providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. See Chapter 4, Section 1.3 for information about your in-network maximum out-of-pocket amount.

Low Income Subsidy (LIS) – See "Extra Help."

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE plan, or a Medicare Advantage Plan.

Medicare Advantage Disenrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2014.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases, coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Optional Supplemental Benefits – Non-Medicare covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. You must voluntarily elect Optional Supplemental Benefits in order to get them.

Organization Determination - The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. The Medicare Advantage plan's network provider or facility has also made an organization determination when it provides you with an item or service, or refers you to an out-of-network provider for an item or service. Organization determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts, Part A (Hospital Insurance) and Part B (Medical Insurance), and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Out-of-network providers are paid using Medicare Allowable Cost, or if there is no defined Medicare Allowable Cost, 60% of billed charges. Any of your coinsurance cost sharing will be the coinsurance amounts indicated in the Medical Benefits Chart and will be calculated from the Medicare Allowable Cost or reduced billed charges. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for "cost sharing" above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's "out-of-pocket" cost requirement.

PACE plan – A PACE (Program of All-inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in

their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Physician of Choice (POC) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. Some people may call a POC a "Primary Care Physician" or "PCP". See Chapter 3, Section 2.1 for information about Physicians of Choice.

Prior Authorization – Approval in advance to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's

also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Care – Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Health Net Aqua (PPO) Member Services

CALL	1-888-445-8913 Calls to this number are free.8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY/TDD	1-800-929-9955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	1-866-214-1992
WRITE	Health Net Medicare Programs P.O. Box 10420 Van Nuys, CA 91410-0420
WEB SITE	www.healthnet.com

The State Health Insurance Assistance Program

The State Health Insurance Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

For contact information, please see Chapter 2, Section 3 of this booklet.