Member Handbook

What you need to know about your benefits

Health Net Combined Evidence of Coverage (EOC) and Disclosure Form

2020

Other languages and formats

Other languages

You can get this Member Handbook and other plan materials for free in other languages. Call 1-800-675-6110 (TTY: 711). The call is toll free. Read this Member Handbook to learn more about health care language assistance services, such as interpreter and translation services.

Other formats

You can get this information for free in other auxiliary formats, such as braille, 18-point font large print and audio. Call 1-800-675-6110 (TTY: 711). The call is toll free.

Interpreter services

You do not have to use a family member or friend as an interpreter. For free interpreter, linguistic and cultural services and help available 24 hours a day, 7 days a week, or to get this handbook in a different language, call

1-800-675-6110 (TTY: 711). The call is toll free.

English: If you, or someone you're helping, has questions about Health Net Community Solutions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-675-6110 (TTY: 711).

Arabic:

إذا كان لديك أو شخص ما تساعده أية استفسارات عن Health Net Community Solutions, لديك الحق في تلقي المساعدة والمعلومات بلغتك مجاناً .للتحدث إلى مترجم فوري، اتصل على الرقم 1-800-675-6110 (TTY: 711).

Armenian: Եթե դուք կամ որևէ մեկը, ում դուք օգնում եք, հարցեր ունեք Health Net Community Solutions-ի մասին, դուք իրավունք ունեք ստանալ օգնություն և ձեր լեզվով անվճար տեղեկություններ: Թարգմանչի հետ խոսելու համար զանգահարեք 1-800-675-6110 (TTY: 711) հեռախոսահամարով

Chinese (Traditional): 如果您或您協助的人士對 Health Net Community Solutions 有疑問，您有權免費取得以您的語言提供的協助及資訊。如欲取得口譯員協助，請致電 1-800-675-6110 (TTY: 711)

Panjabi (Punjabi): ਜੇ ਤੁਹਾਡੇ, ਜਾਂ ਕਿਸੇ ਅਜਿਹੇ ਵਿਅਕਤੀ, ਜਿਸਦੀ ਤੁਸੀਂ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, ਦੇ Health Net Community Solutions (ਹੈਲਥ ਨੈਟ ਸਾਮੂਦਾਇਕ ਸਮਾਧਾਨ) ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਹੱਕ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ਿਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ 1-800-675-6110 (TTY: 711) 'ਤੇ ਫ਼ੋਨ ਕਰੋ।

Hindi यदि आप, या कोई व्यक्ति जिसकी आप मदद कर रहे हैं, के Health Net Community Solutions (स्वास्थ्य नैट सामुदायिक समाधान) के बारे में प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क मदद प्राप्त करने और जानकारी प्राप्त करने का अधिकार है। एक अनुवादक से बात करने के लिए, 1-800-675-6110 (TTY: 711) पर कॉल करें।

Hmong (White): Yog koj, lossis lwm tus koj pab, muaj lus nug txog Health Net Community Solutions, koj muaj txoj cai tau kev pab thiab ntaub ntawv ua koj hom lus tsis muaj nqi them. Xav nrog ib tug neeg txhais lus, hu 1-800-675-6110 (TTY: 711).

Japanese: あなたご自身またはあなたが援助している方がHealth Net Community Solutionsに関する質問をお持ちの場合、あなたには無料で日本語によるサポートと情報を得る権利があります。通訳とお話になるには、1-800-675-6110（TTY：711）までお電話ください。

Korean: 귀하 또는 귀하가 도와드리고 있는 분이 Health Net Community Solutions 에 관한질문이 있을 경우, 귀하에게는 무료로 본인이 구사하는 언어로 도움과 정보를 받을 권리가 있습니다. 통역사와 통화하려면 1-800-675-6110 (TTY: 711) 번으로 전화해 주십시오.

Laotian: ຖ້າທ່ານ ຫຼື ບຸກຄົນໃດທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອຢູ່ ມີຄຳຖາມກ່ຽວກັບ Health Net Community Solutions, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ໃຫ້ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍທີ່ບໍ່ເສຍຄ່າ.ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໂທຫາເບີ 1-800-675-6110 (TTY: 711).

Cambodian (Khmer): ប្រសិនបើលោកអ្នក ឬនរណាម្នាក់ដែលលោកអ្នកកំពុងជួយមានសំណួរអំពី Health Net Community Solutions នោះលោកអ្នកមានសិទ្ធិទទួលបានជំនួយ និងព័ត៌មានជាភាសារបស់លោកអ្នកដោយឥតគិតថ្លៃ។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែភាសា សូមហៅទូរស័ព្ទទៅលេខ 1-800-675-6110 (TTY: 711) ។

Persian (Farsi):

اگر شما یا شخصی که به وی کمک می کنید، سؤالاتی در مورد شما حق دارید، دارید که کمک و اطلاعات را به زبان خودتان Health Net Community Solutions 1-800-675-6110 (TTY: 711) و به طور رایگان دریافت کنید. برای گفتگو با مترجم شفاهی، با شماره تماس بگیرید.

Call Member Services at 1-800-675-6110 (TTY: 711).
Health Net is here 24 hours a day, 7 days a week. The call is toll free.
Or call the California Relay Line at 711. Visit online at www.healthnet.com.

Russian: Если у Вас или у кого-то, кому Вы помогаете, есть вопросы о плане Health Net Community Solutions, Вы имеет право бесплатно получить необходимые сведения в переводе на Ваш язык. Для того чтобы воспользоваться помощью устного переводчика, позвоните по телефону 1-800-675-6110 (TTY: 711).

Spanish: Si usted, o alguna persona a la que asiste, tiene preguntas sobre Health Net Community Solutions, tiene derecho a obtener ayuda e información en su idioma sin cargo. Para hablar con un intérprete, llame al 1-800-675-6110 (TTY: 711).

Tagalog: Kung ikaw o ang isang taong tinutulungan mo ay mayroong mga tanong tungkol sa Health Net Community Solutions, mayroon kang karapatang makakuha ng tulong at impormasyon na nasa wika mo nang walang babayaran. Para makipag-usap sa isang interpreter, tumawag sa 1-800-675-6110 (TTY: 711).

Thai: หากคุณ หรือคนที่คุณกำลังให้ความช่วยเหลือ มีคำถามเกี่ยวกับ Health Net Community Solutions
คุณมีสิทธิที่จะขอรับความช่วยเหลือและข้อมูลเป็นภาษาของคุณได้ โดยไม่มีค่าใช้จ่าย หากต้องการคุยกับล่าม โทร 1-800-675-6110 (TTY: 711)

Vietnamese: Nếu quý vị, hoặc một người nào đó quý vị đang giúp đỡ, có thắc mắc về Health Net Community Solutions, quý vị có quyền nhận được trợ giúp và thông tin bằng ngôn ngữ của quý vị miễn phí. Để trao đổi với phiên dịch viên, hãy gọi số 1-800-675-6110 (TTY: 711).

Notice of non-discrimination

Discrimination is against the law. Health Net follows state and federal civil rights laws. Health Net does not unlawfully discriminate, exclude people or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation.

Health Net provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats and other formats)
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Health Net at 1-800-675-6110 (TTY: 711). We are open 24 hours a day, 7 days a week.

If you believe that Health Net has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity or sexual orientation, you can file a grievance with Health Net Customer Contact Center. You can file a grievance in person, in writing, by phone or by email:

Health Net Appeals & Grievances
P.O. Box 10348
Van Nuys, CA 91410
1-800-675-6110 (TTY: 711)
Fax: 1-877-831-6019
www.healthnet.com for online submissions

If you need help filing a grievance, Health Net Customer Contact Center can help you.

You can also file a civil rights complaint with the California Department of Health Care Services Office of Civil Rights in writing, by phone or by email:

Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413
1-916-440-7370 (TTY 711 California State Relay)
Email: CivilRights@dhcs.ca.gov

You can get complaint forms at http://www.dhcs.ca.gov/Pages/Language_Access.aspx.

If you believe you have been discriminated against on the bases of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights in writing, by phone or online:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 (TTY 1-800-537-7697)
Complaint Portal: https://ocrportal.hhs.gov/ocr/cp/wizard_cp.jsf

You can get complaint forms at http://www.hhs.gov/ocr/office/file/index.html.

Welcome to Health Net!

Thank you for joining Health Net. Health Net is a health plan for people who have Medi-Cal. Health Net works with the State of California to help you get the health care you need.

Member Handbook

This Member Handbook tells you about your coverage under Health Net. Please read it carefully and completely. It will help you understand and use your benefits and services. It also explains your rights and responsibilities as a member of Health Net. If you have special health needs, be sure to read all sections that apply to you.

This Member Handbook is also called the Combined Evidence of Coverage (EOC) and Disclosure Form. It is a summary of Health Net rules and policies and based on the contract between Health Net and Department of Health Care Services (DHCS). If you would like to learn exact terms and conditions of coverage, you may request a copy of the complete contract from Member Services.

Call 1-800-675-6110 (TTY: 711) to ask for a copy of the contract between Health Net and DHCS. You may also ask for another copy of the Member Handbook at no cost to you or visit the Health Net website at www.healthnet.com to view the Member Handbook. You may also request, at no cost, a copy of the Health Net non-proprietary clinical and administrative policies and procedures, or how to access this information on the Health Net website.

Contact us

Health Net is here to help. If you have questions, call 1-800-675-6110 (TTY: 711). Health Net is here 24 hours, 7 days a week. The call is toll free.

You can also visit online at any time at www.healthnet.com.

Thank you,
Health Net
21281 Burbank Blvd.
Woodland Hills, CA 91367

Call Member Services at 1-800-675-6110 (TTY: 711).
Health Net is here 24 hours a day, 7 days a week. The call is toll free.
Or call the California Relay Line at 711. Visit online at www.healthnet.com.

Table of contents

1. Getting started as a member

How to get help

Health Net wants you to be happy with your health care. If you have any questions or concerns about your care, Health Net wants to hear from you!

Member services

Health Net Member Services is here to help you. Health Net can:

- Answer questions about your health plan and covered services
- Help you choose or change a primary care provider (PCP)
- Tell you where to get the care you need
- Offer interpreter services if you do not speak English
- Offer information in other languages and formats

If you need help, call 1-800-675-6110 (TTY: 711). Health Net is here 24 hours, 7 days a week. The call is toll free.

You can also visit online at any time at www.healthnet.com.

Who can become a member

You qualify for Health Net because you qualify for Medi-Cal and live in one of these counties: Kern, Los Angeles, Sacramento, San Diego, San Joaquin, Stanislaus, or Tulare. You may also qualify for Medi-Cal through Social Security. Social Security Administration / Supplemental Social Income (SSI) can be contacted at 1-800-772-1213 (TTY: 1-800-325-0778).

For questions about enrollment, call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077). Or visit https://www.healthcareoptions.dhcs.ca.gov.

Transitional Medi-Cal

Transitional Medi-Cal is also called “Medi-Cal for working people.” You may be able to get transitional Medi-Cal if you stop getting Medi-Cal because:

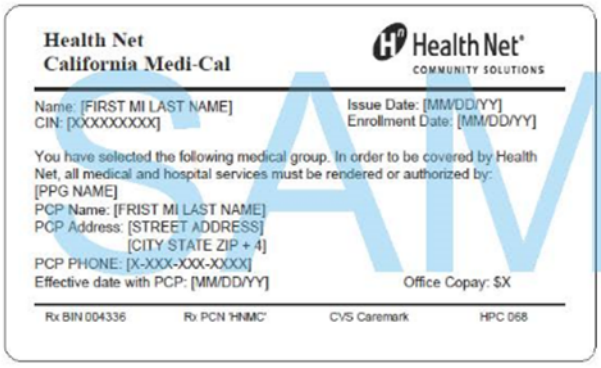
- You started earning more money.
- Your family started receiving more child or spousal support.

You can ask questions about qualifying for Medi-Cal at your local county health and human services office. Find your local office at www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx or call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077).

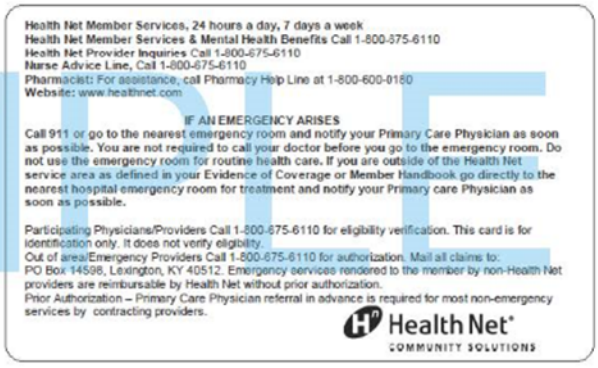
Identification (ID) cards

As a member of Health Net, you will get a Health Net ID card. You must show your Health Net ID card and your Medi-Cal Benefits Identification Card (BIC) when you get any health care services or prescriptions. You should carry all health cards with you at all times. Here is a sample Health Net ID card to show you what yours will look like:

FRONT PANEL OF ID CARD



BACK PANEL OF ID CARD



- Your Health Net ID card has important information on it, including: Your Primary Care Provider’s (PCP) name (or the name of your Clinic or Medical Group). This information does not appear on ID cards for Members who have both Medicare (Part A and Part B) and Medi-Cal coverage. The PCP information will say “See Your Medicare Doctor.” This information also does not appear on ID cards for newborns who have been assigned a CIN by DHCS. The PCP information will say “No Primary MD.”
- Your PCP’s address and phone number. This information does not appear on ID

cards for Members who have both Medicare (Part A and Part B) and Medi-Cal coverage. The PCP information will say “See Your Medicare Doctor.” This information also does not appear on ID cards for newborns who have been assigned a CIN by DHCS. The PCP information will say “Please Call Member Services.”

- If your PCP and/or medical group information is wrong or if you have changed your PCP and/or medical group since your last ID card was issued, call Member Services at 1-800-675-6110 (TTY: 711) to get a new card with the correct PCP information.
- If you have any questions regarding your ID card, please call Member services at 1-800-675-6110 (TTY: 711).

Here’s what to do with your ID card:

- Check to make sure the information on your ID card is correct. If anything on your ID card is wrong, call Member Services at 1-800-675-6110 (TTY: 711) right away. If your name is not spelled right or incorrect, we will connect you to your county Department of Public Social Services office to get it fixed.

Show your ID card whenever you:

- have a doctor’s appointment,
- go to the Hospital,
- need Urgent Care/Emergency Services, or
- pick up a Prescription.

If you do not get your Health Net ID card within a few weeks of enrolling, or if your card is damaged, lost or stolen, call Member Services right away. Health Net will send you a new card for free. Call 1-800-675-6110 (TTY: 711). Once you get your new ID card, you should destroy any old ID cards or cards that are no longer valid to protect your identity.

Ways to get involved as a member

Health Net wants to hear from you. Each year, Health Net has meetings to talk about what is working well and how Health Net can improve. Members are invited to attend. Come to a meeting!

Community Advisory Committee

Health Net has a group called Community Advisory Committee. This group is made up

of consumers, Health Net Members, and community agencies. Joining this group is voluntary. The group talks about how to improve Health Net policies and is responsible for:

- Input on Health Net's quality improvement and health education efforts
- Input on Health Net's cultural and linguistic services program
- Identification of barriers to care due to culture, discrimination, language, or disability.

If you would like to be a part of this group, call 1-800-675-6110 (TTY: 711).

Public Policy Committee

Health Net has a group called the Public Policy Committee. This group is made up of health plan members and providers. Joining this group is voluntary. The group talks about how to improve Health Net policies and is responsible for:

- Giving advice to the Health Net Board of Directors on policy issues that affect the health plan and our members.

If you would like to be a part of this group, call 1-800-675-6110 (TTY 711)

You can also call Member Services if you have any questions about these groups.

2. About your health plan

Health plan overview

Health Net is a health plan for people who have Medi-Cal in these service areas: Kern, Los Angeles, Sacramento, San Diego, San Joaquin, Stanislaus, or Tulare. Health Net works with the State of California to help you get the health care you need.

You may talk with one of the Health Net Member Services representatives to learn more about the health plan and how to make it work for you. Call 1-800-675-6110 (TTY: 711).

When your coverage starts and ends

When you enroll in Health Net, you should receive a Health Net member ID card within two weeks of enrollment. Please show this card every time you go for any service under Health Net.

Your care through Health Net starts when your enrollment in a Health Plan is complete. You can start using your Medi-Cal Benefits through Health Net on your effective date of coverage. Your effective date of coverage is the 1st day of the month following completion of enrollment in a Health Plan. Check the Health Net Member ID card mailed to you for the effective date of coverage.

You may ask to end your Health Net coverage and choose another health plan at any time. For help choosing a new plan, call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077). Or visit https://www.healthcareoptions.dhcs.ca.gov. You can also ask to end your Medi-Cal.

Sometimes Health Net can no longer serve you. Health Net must end your coverage if:

- You move out of the county or are in prison
- You no longer have Medi-Cal
- You qualify for certain waiver programs
- You need a major organ transplant (excluding kidneys and corneal transplants)

- You are in a long-term care facility in excess of two months (excluding members in the Los Angeles and San Diego counties)
- You take part in any fraud having to do with the services, benefits or facilities of our plan.

Indian Health Services

If you are an American Indian, you have the right to get health care services at Indian health service facilities. You may also stay with or disenroll from Health Net while getting health care services from these locations. American Indians have a right to not enroll in a Medi-Cal managed care plan or may leave their health plans and return to regular (fee-for-service) Medi-Cal at any time and for any reason.

To find out more, please call Indian Health Services at 1-916-930-3927 or visit the Indian Health Services website at www.ihs.gov.

How your plan works

Health Net is a health plan contracted with DHCS. Health Net is a managed care health plan. Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of care. Health Net works with doctors, hospitals, pharmacies and other health care providers in the Health Net service area to give health care to you, the member.

Member services will tell you how Health Net works, how to get the care you need, how to schedule provider appointments, and how to find out if you qualify for transportation services.

To learn more, call 1-800-675-6110 (TTY: 711). You can also find member service information online at www.healthnet.com.

Changing health plans

You may leave Health Net and join another health plan at any time. Call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077) to choose a new plan. You can call between 8:00 a.m. and 6:00 p.m. Monday through Friday. Or visit https://www.healthcareoptions.dhcs.ca.gov.

It takes 15 to 45 days to process your request to leave Health Net. To find out when

Health Care Options has approved your request, call 1-800-430-4263 (TTY 1-800-430-7077).

If you want to leave Health Net sooner, you may ask Health Care Options for an expedited (fast) disenrollment. If the reason for your request meets the rules for expedited disenrollment, you will get a letter to tell you that you are disenrolled.

Beneficiaries that can request expedited disenrollment include, but are not limited to, children receiving services under the Foster Care or Adoption Assistance programs; members with special health care needs, including, but not limited to major organ transplants; and members already enrolled in another Medi-Cal, Medicare or commercial managed care plan.

You may ask to leave Health Net in person at your local county health and human services office. Find your local office at https://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx. Or call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077).

College students who move to a new county

If you move to a new county in California to attend college, Health Net will cover emergency services in your new county. Emergency services are available to all Medi-Cal enrollees statewide regardless of county of residence.

If you are enrolled in Medi-Cal and will attend college in a different county, you do not need to apply for Medi-Cal in that county. There is no need for a new Medi-Cal application as long as you are still under 21 years of age, are only temporarily out of the home and are still claimed as a tax dependent in the household.

When you temporarily move away from home to attend college there are two options available to you. You may:

- Notify your local county social services office that you are temporarily moving to attend college and provide your address in the new county. The county will update the case records with your new address and county code in the State's database. If Health Net does not operate in the new county, you will have to change your health plan to the available options in the new county. For questions and to prevent any delay in enrolling in the new health plan, call Health Care Options at 1-800-430-4263 (TTY 1-800-430-7077).

  OR

- Choose not to change your health plan when you temporarily move to attend

college in a different county. You will only be able to access emergency room services in the new county. For routine or preventive health care, you would need to use the Health Net regular network of providers located in the head of the household's county of residence.

Continuity of care

If you now go to providers who are not in the Health Net network, in certain cases you may get continuity of care and be able to go to them for up to 12 months. If your providers do not join the Health Net network by the end of 12 months, you will need to switch to providers in the Health Net network.

How to keep seeing your doctor if you are a new member

If you have just joined our plan for the first time, you may ask to keep seeing your out-of-network provider (including PCP and Specialist) for up to 12 months. This is called a "continuity of care" benefit. To qualify for this benefit, the following conditions must be met:

- You must have seen the out-of-network provider at least once during the twelve (12) months before the date of your Enrollment with our plan, for a non-emergency visit;
- The out-of-network provider must agree to the our usual payment rate or the Medi-Cal payment rate;
- The out-of-network provider is a California State Plan approved provider.

If your request meets these conditions, we will approve your request and allow you to see your provider for up to 12 months.

The continuity of care benefit includes only those services covered by our plan, but does not include :

- Durable Medical Equipment
- Transportation
- Other ancillary services, and
- Services provided by Fee-for-Service Medi-Cal program and not covered by the plan.

To request continuity of care please call 1-800-675-6110
(TTY: 711).

Continuity of care for seniors and persons with disabilities

Seniors and Persons with Disabilities who have just joined our plan may ask to keep seeing their doctor if there is an active Medi-Cal Fee-For-Service treatment authorization request.

Our plan will honor any active Medi-Cal Fee-For-Service treatment authorization for up to 60 days from the date you join our plan or until our plan completes a new assessment. To request continuity of care please call 1-800-675-6110 (TTY: 711).

Continuity of care for members transitioning from Covered California

If you have just joined our plan due to a required switch from Covered California to Medi-Cal Managed Care, you have the right to complete previously approved and medically necessary care from your treating provider:

- For up to 60 days from the date you join our plan, or
- Until our plan completes a new assessment without a request by you or the provider.

In addition, you can request continuity of care from your out-of-network provider for up to 12 months from the date you join our plan. See the *"How to keep seeing your provider if you are a new member"* section above for more information.

To request continuity of care please call 1-800-675-6110 (TTY: 711).

Continuity of care for children receiving Behavioral Health Treatment (BHT)

Children who get Behavioral Health Treatment can keep seeing their out-of-network Behavioral Health provider for up to 12 months. They must have an existing relationship with the Behavioral Health provider. This means the Member has seen that provider at least once during the 6 months before enrollment in our plan or transition from a Regional Center. To request continuity of care please call 1-800-675-6110 (TTY: 711).

Providers who leave Health Net

If your provider stops working with Health Net, you may be able to keep getting services from that provider. This is another form of continuity of care. Health Net provides continuity of care services for:

- Services provided by your doctor, including specialists and hospitals. You can keep getting covered services if your doctor agrees to the continuity of care conditions, and has been treating you for any of the following:
    - Acute condition (a serious and sudden condition that lasts a short time like a heart attack or pneumonia) – For the time the condition lasts.
    - Serious Chronic (long-term) condition – For up to 12 months. Usually until you complete a course of treatment and your doctor can safely transfer you to another provider.
    - Pregnancy – During the pregnancy and immediate post-partum care (six weeks after giving birth).
    - Maternal mental health (For up to 12 months from the diagnosis or from the end of pregnancy, whichever occurs later).
    - Terminal illnesses/conditions – For the length of the illness.
    - Children ages birth to 36 months – For up to 12 months.
    - You have surgery or other procedures approved by our plan as part of a documented course of treatment. This treatment was set to occur within 180 days of the time the doctor or Hospital stops working with our plan or within 180 days of the time you began coverage with us.

Health Net does **not** provide continuity of care services if you do not meet the conditions above. In addition, the continuity of care benefit does not include the following services:

- Durable Medical Equipment
- Transportation
- Other ancillary services, and
- Services provided by Fee-for-Service Medi-Cal program and not covered by the plan.

To learn more about continuity of care and eligibility qualifications, call 1-800-675-6110 (TTY: 711).

Costs

Member costs

Health Net serves people who qualify for Medi-Cal. Health Net members do **not** have to pay for covered services. You will not have premiums or deductibles. For a list of covered services, go to "Benefits and services."

For members with a share of cost

You may have to pay a share of cost each month. The amount of your share of cost depends on your income and resources. Each month you will pay your own medical bills until the amount that you have paid equals your share of cost. After that, your care will be covered by Health Net for that month. You will not be covered by Health Net until you have paid your entire share of cost for the month. After you meet your share of cost for the month, you can go to any Health Net doctor. If you are a member with a share of cost, you do not need to choose a PCP.

How a provider gets paid

Health Net pays providers in these ways:

- Capitation payments
  - Health Net pays some providers a set amount of money every month for each Health Net member. This is called a capitation payment. Health Net and providers work together to decide on the payment amount.
- Fee-for-service payments
  - Some providers give care to Health Net members and then send Health Net a bill for the services they provided. This is called a fee-for-service payment. Health Net and providers work together to decide how much each service costs.
- Health Net also pays providers for meeting certain quality benchmarks.

To learn more about how Health Net pays providers, call 1-800-675-6110 (TTY: 711).

Asking Health Net to pay a bill

If you get a bill for a covered service, call Member Services right away at 1-800-675-6110 (TTY: 711).

If you pay for a service that you think Health Net should cover, you can file a claim. Use a claim form and tell Health Net in writing why you had to pay. Call 1-800-675-6110 (TTY: 711) to ask for a claim form. Health Net will review your claim to decide if you can get money back.

3. How to get care

Getting health care services

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

You can begin to get health care services on your effective date of coverage. Always carry your Health Net ID card and Medi-Cal BIC card with you. Never let anyone else use your Health Net ID card or BIC card.

New members must choose a primary care provider (PCP) in the Health Net network. The Health Net network is a group of doctors, hospitals and other providers who work with Health Net. You must choose a PCP within 30 days from the time you become a member in Health Net. If you do not choose a PCP, Health Net will choose one for you.

You may choose the same PCP or different PCPs for all family members in Health Net.

If you have a doctor you want to keep, or you want to find a new PCP, you can look in the Provider Directory. It has a list of all PCPs in the Health Net network. The Provider Directory has other information to help you choose a PCP. If you need a Provider Directory, call 1-800-675-6110 (TTY: 711). You can also find the Provider Directory on the Health Net website at www.healthnet.com.

If you cannot get the care you need from a participating provider in the Health Net network, your PCP must ask Health Net for approval to send you to an out-of-network provider.

Read the rest of this chapter to learn more about PCPs, the Provider Directory and the provider network.

Initial health assessment (IHA)

Health Net recommends that, as a new member, you visit your new PCP within the first 120 days for an initial health assessment (IHA). The purpose of the IHA is to help your PCP learn your health care history and needs. Your PCP may ask you some questions about your health history or may ask you to complete a questionnaire. Your PCP will

also tell you about health education counseling and classes that may help you.

When you call to schedule your IHA appointment, tell the person who answers the phone that you are a member of Health Net. Give your Health Net ID number.

Take your BIC card and your Health Net ID card to your appointment. It is a good idea to take a list of your medications and questions with you to your visit. Be ready to talk with your PCP about your health care needs and concerns.

Be sure to call your PCP's office if you are going to be late or cannot go to your appointment.

Routine care

Routine care is regular health care. It includes preventive care, also called wellness or well care. It helps you stay healthy and helps keep you from getting sick. Preventive care includes regular checkups and health education and counseling. In addition to preventive care, routine care also includes care when you are sick. Health Net covers routine care from your PCP.

Your PCP will:

- Give you all your routine care, including regular checkups, shots, treatment, prescriptions and medical advice
- Keep your health records
- Refer (send) you to specialists if needed
- Order X-rays, mammograms or lab work if you need them

When you need routine care, you will call your PCP for an appointment. Be sure to call your PCP before you get medical care, unless it is an emergency. For an emergency, call **911** or go to the nearest emergency room.

To learn more about health care and services your plan covers, and what it does not cover, read Chapter 4 in this handbook.

Urgent care

Urgent care is **not** for an emergency or life-threatening condition. It is for services you need to prevent serious damage to your health from a sudden illness, injury or complication of a condition you already have. Urgent care appointments require care within 48 hours. If you are outside Health Net's service area, urgent care services may be covered. Urgent care needs could be a cold, sore throat, fever, ear pain, sprained muscle or maternity services.

For urgent care, call your PCP. If you cannot reach your PCP, call 1-800-675-6110 (TTY: 711). Or you can call nurse advice line by calling the Member Services phone number at 1-800-675-6110 (TTY: 711). Choose the nurse 24-hour advice line option in the menu.

If you need urgent care out of the area, go to the nearest urgent care facility. You do not need pre-approval (prior authorization). If you need mental health urgent care, call the county Mental Health Plan's toll-free telephone number that is available 24 hours a day, 7 days a week. To find all counties' toll-free telephone numbers online, visit http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.

Emergency care

For emergency care, call **911** or go to the nearest emergency room (ER). For emergency care, you do **not** need pre-approval (prior authorization) from Health Net.

Emergency care is for life-threatening medical conditions. This care is for an illness or injury that a reasonable layperson (not a health care professional) with average knowledge of health and medicine could expect that, if you don't get care right away, your health (or your unborn baby's health) could be in danger, or a body function, body organ or body part could be seriously harmed. Examples include:

- Active labor
- Broken bone
- Severe pain, especially in the chest
- Severe burn
- Drug overdose
- Fainting
- Severe bleeding
- Psychiatric emergency condition

Do not go to the ER for routine care. You should get routine care from your PCP, who knows you best. If you are not sure if your medical condition is an emergency, call your PCP. You may also call the 24/7 nurse line by calling the Member Services phone number at 1-800-675-6110 (TTY: 711). Choose the nurse 24-hour advice line option in the menu.

If you need emergency care away from home, go to the nearest emergency room (ER), even if it is not in the Health Net network. If you go to an ER, ask them to call Health Net. You or the hospital to which you were admitted should call Health Net within 24 hours after you get emergency care. If you are traveling outside the U.S., other than

to Canada or Mexico, and need emergency care, Health Net will **not** cover your care.

If you need emergency transportation, call **911**. You do not need to ask your PCP or Health Net first before you go to the ER.

If you need care in an out-of-network hospital after your emergency (post-stabilization care), the hospital will call Health Net.

Remember: Do not call **911** unless it is an emergency. Get emergency care only for an emergency, not for routine care or a minor illness like a cold or sore throat. If it is an emergency, call **911** or go to the nearest emergency room.

Sensitive care

Minor consent services

If you are under 18 years old, you can go to a doctor without consent from your parents or guardian for these types of care:

- Outpatient mental health (only minors 12 years or older) for:
  - Sexual or physical abuse
  - When you may hurt yourself or others
- Pregnancy
- Family planning/birth control (except sterilization)
- Sexual assault
- HIV/AIDS prevention/testing/treatment (only minors 12 years or older)
- Sexually transmitted infections prevention/testing/treatment (only minors 12 years or older)
- Drug and alcohol abuse treatment (only minors 12 years or older)

The doctor or clinic does not have to be part of the Health Net network and you do not need a referral from your PCP to get these services. For help finding a doctor or clinic giving these services, or for help getting to these services, you can call 1-800-675-6110 (TTY: 711). You may also call the 24/7 nurse line by calling the Member Services phone number at 1-800-675-6110 (TTY: 711). Choose the nurse 24-hour advice line option in the menu.

Minors can talk to a representative in private about their health concerns by calling the 24/7 nurse line at 1-800-675-6110 (TTY: 711).

Adult sensitive services

As an adult, you may not want to go to your PCP for certain sensitive or private care. If so, you may choose any doctor or clinic for these types of care:

- Family planning
- HIV/AIDS testing
- Sexually transmitted infections

The doctor or clinic does not have to be part of the Health Net network. Your PCP does not have to refer you for these types of service. For help finding a doctor or clinic giving these services, you can call 1-800-675-6110 (TTY: 711). You may also call the 24/7 nurse line at 1-800-675-6110 (TTY: 711).

Advance directives

An advance health directive is a legal form. On it, you can list what health care you want in case you cannot talk or make decisions later on. You can list what care you do **not** want. You can name someone, such as a spouse, to make decisions for your health care if you cannot.

You can get an advance directive form at drugstores, hospitals, law offices and doctors' offices. You may have to pay for the form. You can also find and download a free form online. You can ask your family, PCP or someone you trust to help you fill out the form.

You have the right to have your advance directive placed in your medical records. You have the right to change or cancel your advance directive at any time.

You have the right to learn about changes to advance directive laws. Health Net will tell you about changes to the state law no longer than 90 days after the change.

Where to get care

You will get most of your care from your PCP. Your PCP will give you all of your routine preventive (wellness) care. You will also go to your PCP for care when you are sick. Be sure to call your PCP before you get non-emergency medical care. Your PCP will refer (send) you to specialists if you need them.

To get help with your health questions, you can also call the nurse line at 1-800-675-6110 (TTY: 711).

If you need urgent care, call your PCP. Urgent care is care you need within 48 hours but is not an emergency. It includes care for such things as cold, sore throat, fever, ear pain

or sprained muscle.

For emergencies, call **911** or go to the nearest emergency room.

Moral objection

Some providers have a moral objection to some services. This means they have a right to **not** offer some covered services if they morally disagree. If your provider has a moral objection, he or she will help you find another provider for the needed services. Health Net can also work with you to find a provider.

Some hospitals and other providers do not offer one or more of the services listed below. These services you or your family member might need may be covered under your plan contract:

- Family planning and contraceptive services, including emergency contraception
- Sterilization, including tubal ligation at the time of labor and delivery
- Infertility treatments
- Abortion

You should get more information before you enroll. Call the new doctor, medical group, independent practice association or clinic that you want. Or call Health Net at 1-800-675-6110 (TTY: 711) to make sure you can get the health care services you need.

Provider Directory

The Health Net Provider Directory lists providers that participate in the Health Net network. The network is the group of providers that work with Health Net.

The Health Net Provider Directory lists hospitals, pharmacies, PCPs, specialists, nurse practitioners, nurse midwives, physician assistants, family planning providers, Federally Qualified Health Centers (FQHCs), outpatient mental health providers, long-term services and supports (LTSS), Freestanding Birth Centers (FBCs), Indian Health Service Facilities (IHFs) and Rural Health Clinics (RHCs).

The Provider Directory has specific details as well, such as Health Net network provider names, addresses, phone numbers, business hours and languages spoken. It tells if the provider is taking new patients. It also gives the level of physical accessibility for the building, such as parking, ramps, stairs with handrails, and restrooms with wide doors and grab bars.

You can find the online Provider Directory at www.healthnet.com.

If you need a printed Provider Directory, call 1-800-675-6110 (TTY: 711).

Provider network

The provider network is the group of doctors, hospitals and other providers that work with Health Net. You will get your covered services through the Health Net network.

If your provider in the network, including a PCP, hospital or other provider, has a moral objection to providing you with a covered service, such as family planning or abortion, call 1-800-675-6110 (TTY: 711). Go to Chapter 3 for more about moral objections.

If your provider has a moral objection, he or she can help you find another provider who will give you the services you need. Health Net can also work with you to find a provider.

In network

You will use providers in the Health Net network for your health care needs. You will get preventive and routine care from your PCP. You will also use specialists, hospitals and other providers in the Health Net network.

To get a Provider Directory of network providers, call 1-800-675-6110 (TTY: 711). You can also find the Provider Directory online at www.healthnet.com.

For emergency care, call **911** or go to the nearest emergency room.

Except for emergency care, you may have to pay for care from providers who are out of network.

Out-of-network or Out-of-service area

Out-of-network providers are those that do not have an agreement to work with Health Net. Except for emergency care, you may have to pay for care from providers who are out of the network. If you need covered health care services, you may be able to get them out of the network at no cost to you as long as they are medically necessary and not available in the network.

If you need help with out-of-network services, call 1-800-675-6110 (TTY: 711).

If you are outside of the Health Net service area and need care that is **not** an emergency or urgent, call your PCP right away. Or call 1-800-675-6110 (TTY: 711).

For emergency care, call **911** or go to the nearest emergency room. Health Net covers out-of-network emergency care. If you travel to Canada or Mexico and need emergency services requiring hospitalization, Health Net will cover your care. If you are traveling internationally outside of Canada or Mexico and need emergency care, Health Net will **not** cover your care.

If you need health care services for a California Children's Services (CCS) eligible condition and Health Net does not have a CCS-paneled specialist in the network who can provide the care you need, you may be able to go to a provider outside of the provider network at no cost to you. To learn more about the CCS program, read the Benefits and Services chapter of this handbook.

If you have questions about out-of-network or out-of-service area care, call 1-800-675-6110 (TTY: 711). If the office is closed and you want help from a representative, call the nurse line at 1-800-675-6110 (TTY: 711).

Doctors

You will choose your doctor or a primary care provider (PCP) from the Health Net Provider Directory. The doctor you choose must be a participating provider. This means the provider is in the Health Net network. To get a copy of the Health Net Provider Directory, call 1-800-675-6110 (TTY: 711). Or find it online at www.healthnet.com.

You should also call if you want to check to be sure the PCP you want is taking new patients.

If you had a doctor before you were a member of Health Net, you may be able to keep that doctor for a limited time. This is called continuity of care. You can read more about continuity of care in this handbook. To learn more, call 1-800-675-6110 (TTY: 711).

If you need a specialist, your PCP will refer you to a specialist in the Health Net network.

Remember, if you do not choose a PCP, Health Net will choose one for you. You know your health care needs best, so it is best if you choose. If you are in both Medicare and Medi-Cal, you do not have to choose a PCP.

If you want to change your PCP, you must choose a PCP from the Health Net Provider Directory. Be sure the PCP is taking new patients. To change your PCP, call 1-800-675-6110 (TTY: 711).

Hospitals

In an emergency, call **911** or go to the nearest hospital.

If it is not an emergency and you need hospital care, your PCP will decide which hospital you go to. You will need to go to a hospital in the network. The hospitals in the Health Net network are listed in the Provider Directory. Hospital services, other than emergencies, require pre-approval (prior authorization).

Primary care provider (PCP)

You must choose a PCP within 30 days of enrolling in Health Net. Depending on your age and sex, you may choose a general practitioner, ob/gyn, family practitioner, internist or pediatrician as your primary care provider (PCP). A nurse practitioner (NP), physician assistant (PA) or certified nurse midwife may also act as your PCP. If you choose an NP, PA or certified nurse midwife, you may be assigned a doctor to oversee your care.

You can also choose an Indian Health Service Facility (IHF), Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) as your PCP. Depending on the type of the provider, you may be able to choose one PCP for your entire family who are members of Health Net.

If you do not choose a PCP within 30 days of enrollment, Health Net will assign you to a PCP. If you are assigned to a PCP and want to change, call 1-800-675-6110 (TTY: 711). The change happens the first day of the next month.

Your PCP will:

- Get to know your health history and needs
- Keep your health records
- Give you the preventive and routine health care you need
- Refer (send) you to a specialist if you need one
- Arrange for hospital care if you need it

You can look in the Provider Directory to find a PCP in the Health Net network. The Provider Directory has a list of IHFs, FQHCs and RHCs that work with Health Net.

You can find the Health Net Provider Directory online at www.healthnet.com. Or you can request a Provider Directory to be mailed to you by calling 1-800-675-6110 (TTY: 711). You can also call to find out if the PCP you want is taking new patients.

Choice of doctors and other providers

You know your health care needs best, so it is best if you choose your PCP.

It is best to stay with one PCP so he or she can get to know your health care needs. However, if you want to change to a new PCP, you can change anytime. You must choose a PCP who is in the Health Net provider network and is taking new patients.

Your new choice will become your PCP on the first day of the next month after you make the change.

To change your PCP, call 1-800-675-6110 (TTY: 711).

Health Net may ask you to change your PCP if the PCP is not taking new patients, has left the Health Net network or does not give care to patients your age. Health Net or your PCP may also ask you to change to a new PCP if you cannot get along with or agree with your PCP, or if you miss or are late to appointments. If Health Net needs to change your PCP, Health Net will tell you in writing.

If you change PCPs, you will get a new Health Net member ID card in the mail. It will have the name of your new PCP. Call Member Services if you have questions about getting a new ID card.

Los Angeles County Members only:

If you live in Los Angeles County, you can pick a PCP who is contracted with Health Net or our subcontracting plan, Molina Healthcare of California (Molina). If you pick a PCP who works with Molina, you will get your drugs from pharmacies contracted with Molina and use Molina's Preferred Drug List. To get a copy of Molina's Preferred Drug List, call Member Services at 1-800-675-6110 (TTY: 711).

If you need to see a Specialist, your PCP will refer you to a Molina contracting Specialist. Read the "Molina" Section of your Provider Directory to see which Pharmacies and vision providers you may use.

Appointments

When you need health care:

- Call your PCP
- Have your Health Net ID number ready on the call
- Leave a message with your name and phone number if the office is closed
- Take your BIC card and Health Net ID card to your appointment
- Ask for transportation to your appointment, if needed
- Ask for language assistance or interpretation services, if needed

- Be on time for your appointment
- Call right away if you cannot keep your appointment or will be late
- Have your questions and medication information ready in case you need them

If you have an emergency, call **911** or go to the nearest emergency room.

Payment

You do **not** have to pay for covered services. In most cases, you will not get a bill from a provider. You may get an Explanation of Benefits (EOB) or a statement from a provider. EOBs and statements are not bills.

If you do get a bill, call 1-800-675-6110 (TTY: 711). Tell Health Net the amount charged, the date of service and the reason for the bill. You are **not** responsible to pay a provider for any amount owed by Health Net for any covered service. Except for emergency care or urgent care, you may have to pay for care from providers who are not in the network. If you need covered health care services, you may be able to get them at an out-of-network provider at no cost to you, as long as they are medically necessary and not available in the network.

If you get a bill or are asked to pay a co-pay that you think you did not have to pay, you can also file a claim form with Health Net. You will need to tell Health Net in writing why you had to pay for the item or service. Health Net will read your claim and decide if you can get money back. For questions or to ask for a claim form, call 1-800-675-6110 (TTY: 711).

Referrals

Your PCP will give you a referral to send you to a specialist if you need one. A specialist is a doctor who has extra education in one area of medicine. Your PCP will work with you to choose a specialist. Your PCP's office can help you set up a time to go to the specialist.

Other services that may require a referral include in-office procedures, X-rays, lab work, and some services from a specialist.

Your PCP will start the referral process. Your PCP will know whether you need an authorization or whether you can make the appointment directly. If you have any questions about whether care from a Specialist or from a Hospital needs approval, you can call Member Services at 1-800-675-6110 (TTY: 711). Routine referrals take up to 5 working days to process ("working days" are Monday through Friday), but may take up to 28 calendar days (14 days from the date of the original request plus an additional 14

days if an extension is requested) if more information is needed from your PCP. In some cases, your PCP may ask to rush your referral. Expedited (rush) referrals may not take more than 72 hours. Please call our plan if you do not get a response by these times. If you have a health problem that needs special medical care for a long time, you may need a standing referral. This means you can go to the same specialist more than once without getting a referral each time.

If you have trouble getting a standing referral or want a copy of the Health Net referral policy, call 1-800-675-6110 (TTY: 711).

You do not need a referral for:

- PCP visits
- Ob/gyn visits
- Urgent or emergency care visits
- Adult sensitive services, such as sexual assault care
- Family planning services (to learn more, call California Family Planning Information and Referral Service at 1-800-942-1054)
- HIV testing and counseling (only minors 12 years or older)
- Treatment for sexually transmitted infections (only minors 12 years or older)
- Acupuncture (the first two services per month; additional appointments will need a referral)
- Chiropractic services (when provided by FQHCs and RHCs)
- Podiatry services (when provided by FQHCs and RHCs)
- Eligible dental services
- Initial mental health assessment
- Routine perinatal care from a doctor that works with Health Net
- Certified Nurse Midwife services
- Initial behavior health assessment from a behavioral health provider that works with Health Net

Minors also do not need a referral for:

- Outpatient mental health services for:
    - Sexual or physical abuse
    - When you may hurt yourself or others
- Pregnancy care
- Sexual assault care
- Drug and alcohol abuse treatment

Pre-approval

For some types of care, your PCP or specialist will need to ask Health Net for permission before you get the care. This is called asking for prior authorization, prior approval, or pre-approval. It means that Health Net must make sure that the care is medically necessary or needed.

Care is medically necessary if it is reasonable and necessary to protect your life, keeps you from becoming seriously ill or disabled, or reduces severe pain from a diagnosed disease, illness or injury.

The following services always need pre-approval, even if you receive them from a provider in the Health Net network:

- Hospitalization, if not an emergency
- Services out of the Health Net service area
- Outpatient surgery
- Long-term care at a nursing facility
- Specialized treatments

For some services, you need pre-approval (prior authorization). Under Health and Safety Code Section 1367.01(h)(2), Health Net will decide routine pre-approvals within 5 working days of when Health Net gets the information reasonably needed to decide.

For requests in which a provider indicates or Health Net determines that following the standard timeframe could seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function, Health Net will make an expedited (fast) pre-approval decision. Health Net will give notice as quickly as your health condition requires and no later than 72 hours after receiving the request for services.

Health Net does **not** pay the reviewers to deny coverage or services. If Health Net does not approve the request, Health Net will send you a Notice of Action (NOA) letter. The NOA letter will tell you how to file an appeal if you do not agree with the decision.

Health Net will contact you if Health Net needs more information or more time to review your request.

You never need pre-approval for emergency care, even if it is out of the network. This includes labor and delivery if you are pregnant.

Second opinions

You might want a second opinion about care your provider says you need or about your diagnosis or treatment plan. For example, you may want a second opinion if you are not

sure you need a prescribed treatment or surgery, or you have tried to follow a treatment plan and it has not worked.

If you want to get a second opinion, you can choose an in-network provider of your choice. If you are requesting a second opinion about a diagnosis that your PCP made, the second opinion shall be from another PCP within our plan's Network of Physicians. The second opinion can also be from a specialty Physician who is familiar with the medical problem you have. If you are requesting a second opinion about a Diagnosis that your Specialist made, a second opinion must come from any Independent Physician Association (IPA) or Medical Group within our plan's Network for the same specialty. If there is no "qualified health care professional" within your plan's Network, we will authorize (approve) a second opinion by a qualified provider outside the Network. Your PCP can refer you to a network provider for a second opinion. For help choosing a provider, call 1-800-675-6110 (TTY: 711).

Health Net will pay for a second opinion if you or your network provider asks for it and you get the second opinion from a network provider. You do not need permission from Health Net to get a second opinion from a network provider.

If there is no provider in the Health Net network to give you a second opinion, Health Net will pay for a second opinion from an out-of-network provider. Health Net will tell you within 5 business days if the provider you choose for a second opinion is approved. If you have a chronic, severe or serious illness, or face an immediate and serious threat to your health, including, but not limited to, loss of life, limb, or major body part or bodily function, Health Net will decide within 72 hours.

If Health Net denies your request for a second opinion, you may appeal. To learn more about appeals, go to page 88 in this handbook.

Women's health specialists

You may go to a women's health specialist within Health Net network for covered care necessary to provide women's routine and preventive health care services. You do not need a referral from your PCP to get these services. For help finding a women's health specialist, you can call 1-800-675-6110 (TTY: 711). You may also call the 24/7 nurse line at 1-800-675-6110 (TTY: 711)

Travel time and distance to care

Health Net must follow travel time and distance standards for your care. Those standards helps to make sure you are able to get care without having to travel too long

or too far from where you live. Travel time and distance standards are different depending on the county you live in.

If Health Net is not able to provide care to you within these travel time and distance standards, a different standard called an alternative access standard may be used. To see Health Net's time and distance standards for where you live, please, visit www.healthnet.com or call 1-800-675-6110 (TTY: 711).

If you need care from a specialist and that provider is located far from where you live, you can call Member Services at 1-800-675-6110 (TTY: 711) to get help finding care with a specialist located closer to you. If Health Net cannot find care for you with a closer specialist, you can request Health Net arrange transportation for you to see a specialist even if that specialist is located far from where you live. It is considered far if you cannot get to that specialist within the Health Net's travel time and distance standards for your county, regardless of any alternative access standard Health Net may use for your ZIP Code.

Timely access to care

Appointment Type	Must Get Appointment Within
Urgent care appointments that do not require pre-approval (prior authorization)	48 hours
Urgent care appointment that do require pre-approval (prior authorization)	96 hours
Non-urgent primary care appointments	10 business days
Non-urgent specialist	15 business days
Non-urgent mental health provider (non-doctor)	10 business days
Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition	15 business days
Telephone wait times during normal business hours	10 minutes

Appointment Type	Must Get Appointment Within
Triage – 24/7 services	24/7 services – No more than 30 minutes
Initial pre-natal care	10 business days

4. Benefits and services

What your health plan covers

This section explains all of your covered services as a member of Health Net. Your covered services are free as long as they are medically necessary and provided by an in-network provider. Your health plan may cover medically necessary services from an out-of-network provider. But you must ask Health Net for this. Care is medically necessary if it is reasonable and necessary to protect your life, keeps you from becoming seriously ill or disabled, or reduces severe pain from a diagnosed disease, illness or injury.

Health Net offers these types of services:

- Outpatient (ambulatory) services
- Emergency services
- Hospice and palliative care
- Hospitalization
- Maternity and newborn care
- Transgender services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory and radiology services, such as X-rays
- Preventive and wellness services and chronic disease management
- Mental health services
- Substance use disorder treatment services
- Pediatric services
- Vision services
- Non-emergency medical transportation (NEMT)
- Non-medical transportation (NMT)
- Long-term services and supports (LTSS)
- Telehealth services

Read each of the sections below to learn more about the services you can get.

Medi-Cal benefits

Outpatient (ambulatory) services

- ***Adult Immunizations***

  You can get adult immunizations (shots) from a network pharmacy or network provider without pre-approval. Health Net covers those shots recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

- ***Allergy care***

  Health Net covers allergy testing and treatment, including allergy desensitization, hyposensitization or immunotherapy.

- ***Anesthesiologist services***

  Health Net covers anesthesia services that are medically necessary when you receive outpatient care.

- ***Chiropractic services***

  Health Net covers chiropractic services, limited to the treatment of the spine by manual manipulation. Chiropractic services are limited to two services per month in combination with acupuncture, audiology, occupational therapy and speech therapy services. Health Net may pre-approve other services as medically necessary.

  The following members are eligible for chiropractic services:

  - Children under age 21;
  - Pregnant women through the end of the month that includes 60-days following the end of a pregnancy;
  - Residents in a skilled nursing facility, intermediate care facility, or subacute care facility; or
  - All members when services are provided at hospital outpatient departments, FQHC or RHC.

- ***Dialysis/hemodialysis services***

  Health Net covers dialysis treatments. Health Net also covers hemodialysis (chronic dialysis) services if your PCP and Health Net approve it.

- ***Outpatient surgery***

  Health Net covers outpatient surgical procedures. Those needed for diagnostic purposes, procedures considered to be elective, and specified outpatient medical procedures require pre-approval (prior authorization).

- ***Physician services***

  Health Net covers physician services that are medically necessary.

- ***Podiatry (foot) services***

  Health Net covers podiatry services as medically necessary for diagnosis and medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, including the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot.

- ***Treatment therapies***

  Health Net covers different treatment therapies, including:

  - Chemotherapy
  - Radiation therapy

Mental health services

- ***Outpatient mental health services***
  - The Health Net covers a member for an initial mental health assessment without requiring pre-approval (prior authorization). You may get a mental health assessment at any time from a licensed mental health provider in the Health Net network without a referral.
  - Your PCP or mental health provider will make a referral for additional mental health screening to a specialist within the Health Net network to determine your level of impairment. If your mental health screening results determine you are in mild or moderate distress or have impairment of mental, emotional

or behavioral functioning, Health Net can provide mental health services for you. Health Net covers these mental health services:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Development of cognitive skills to improve attention, memory and problem solving
- Outpatient services for the purposes of monitoring medication therapy
- Outpatient laboratory, medications, supplies and supplements
- Psychiatric consultation

- For help finding more information on mental health services provided by Health Net, call 1-800-675-6110 (TTY: 711).
- If your mental health screening results determine you may have a higher level of impairment and need specialty mental health services (SMHS), your PCP or your mental health provider will refer you to the county mental health plan to receive an assessment. To learn more, read "*What your health plan does not cover*" on page 60.

Emergency services

- ***Inpatient and outpatient services needed to treat a medical emergency***

  Health Net covers all services that are needed to treat a medical emergency that happens in the U.S. or requires you to be in a hospital in Canada or Mexico. A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:

  - Serious risk to your health; ***or***
  - Serious harm to bodily functions; ***or***
  - Serious dysfunction of any bodily organ or part; ***or***
  - In the case of a pregnant woman in active labor, meaning labor at a time when either of the following would occur:
    - There is not enough time to safely transfer you to another hospital before delivery.
    - The transfer may pose a threat to your health or safety or to that of your

unborn child.

- ***Emergency transportation services***

  Health Net covers ambulance services to help you get to the nearest place of care in emergency situations. This means that your condition is serious enough that other ways of getting to a place of care could risk your health or life. No services are covered outside the U.S., except for emergency services that require you to be in the hospital in Canada or Mexico.

Hospice and palliative care

Health Net covers hospice care and palliative care for children and adults, which help reduce physical, emotional, social and spiritual discomforts.

Hospice care is a benefit that services terminally ill members. It is intervention that focuses mainly on pain and symptom management rather than on a cure to prolong life.

Hospice care includes:

- Nursing services
- Physical, occupational or speech services
- Medical social services
- Home health aide and homemaker services
- Medical supplies and appliances
- Drugs and biological services
- Counselling services
- Continuous nursing services on a 24-hour basis during periods of crisis and as necessary to maintain the terminally ill member at home
- Inpatient respite care for up to five consecutive days at a time in a hospital, skilled nursing facility or hospice facility
- Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing facility or hospice facility

Palliative care is patient- and family-centered care that improves quality of life by anticipating, preventing and treating suffering. Palliative care does not require the member to have a life expectancy of six months or less. Palliative care may be provided at the same time as curative care.

Hospitalization

- ***Anesthesiologist services***

  Health Net covers medically necessary anesthesiologist services during covered hospital stays. An anesthesiologist is a provider who specializes in giving patients anesthesia. Anesthesia is a type of medicine used during some medical procedures.

- ***Inpatient hospital services***

  Health Net covers medically necessary inpatient hospital care when you are admitted to the hospital.

- ***Surgical services***

  Health Net covers medically necessary surgeries performed in a hospital.

Maternity and newborn care

Health Net covers these maternity and newborn care services:

- Breastfeeding education and aids
- Delivery and postpartum care
- Prenatal care
- Birthing center services
- Certified Nurse Midwife (CNM)
- Licensed Midwife (LM)
- Diagnosis of fetal genetic disorders and counseling
- Up to 20 sessions of counseling for pregnant or postpartum women to prevent perinatal depression

Case management

We understand some members have special needs. In those cases, Health Net offers our members case management services to assist with special healthcare needs. If you have special healthcare needs, behavioral health needs, are pregnant or have a disability, our case managers may be able to help you. Our case managers are registered nurses or social workers. They can help you understand major health problems and arrange care with your doctors. A case manager will work with you and your doctor to help you get the care you need.

This service is for members with sudden or complex medical conditions and who often

need to see several doctors. They may need medical supplies or help at home. Conditions may include:

- Injuries
- Cancer
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- End Stage Renal Disease
- Heart Failure
- Sickle cell disease
- Multiple sclerosis
- Kidney or renal disease
- HIV/AIDS
- Hemophilia
- Depression
- Anxiety

Prescription drugs

Covered drugs

Your provider can prescribe you drugs that are on the Health Net preferred drug list (PDL), subject to exclusions and limitations. The Health Net PDL is sometimes called a formulary. Drugs on the PDL are safe and effective for their prescribed use. A group of doctors and pharmacists update this list.

- Updating this list helps make sure the drugs on it are safe and effective.
- If your doctor thinks you need to take a drug that is not on this list, your doctor will need to call Health Net to ask for pre-approval before you get the drug.

Please note, having a drug on the PDL does not guarantee that your doctor will prescribe the drug for a particular medical condition. To find out if a drug is on the Health Net PDL or to get a copy of the PDL, call 1-800-675-6110 (TTY: 711). You may also find the PDL at www.healthnet.com.

Sometimes Health Net needs to approve a drug before a provider can prescribe it. Health Net will review and decide these requests within 24 hours.

- A pharmacist or hospital emergency room may give you a 72-hour emergency supply if they think you need it. Health Net will pay for the emergency supply.
- If Health Net says no to the request, Health Net will send you a letter that lets you

know why and what other drugs or treatments you can try.

Pharmacies

If you are filling or refilling a prescription, you must get your prescribed drugs from a pharmacy that works with Health Net. You can find a list of pharmacies that work with Health Net in the Health Net Provider Directory at www.healthnet.com. You can also find a pharmacy near you by calling 1-800-675-6110 (TTY: 711).

Once you choose a pharmacy, take your prescription to the pharmacy. Your provider may also send it to the pharmacy for you. Give the pharmacy your prescription with your Health Net ID card. Make sure the pharmacy knows about all medications you are taking and any allergies you have. If you have any questions about your prescription, make sure you ask the pharmacist.

Los Angeles County Members only:

If you live in Los Angeles County, you can pick a PCP who is contracted with our plan or our subcontracting plan, Molina Healthcare of California (Molina). If you pick a PCP who works with Molina, you will get your drugs from pharmacies contracted with Molina and use Molina's Preferred Drug List. To get a copy of Molina's Preferred Drug List, call Member Services at 1-800-675-6110 (TTY: 711).

Rehabilitative and habilitative services and devices

The plan covers:

- ***Acupuncture***

  Health Net covers acupuncture services to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition. Outpatient acupuncture services (with or without electric stimulation of the needles) are limited to two services per month, in combination with audiology, chiropractic, occupational therapy and speech therapy services. Health Net may pre-approve (prior authorization) additional services as medically necessary.

- ***Audiology (hearing)***

  Health Net covers audiology services. Outpatient audiology is limited to two services per month, in combination with acupuncture, chiropractic, occupational therapy and speech therapy services. Health Net may pre-approve (prior authorization) additional services as medically necessary.

- ***Behavioral health treatments***

  Behavioral health treatment (BHT) includes services and treatment programs, such as applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual.

  BHT services teach skills using behavioral observation and reinforcement, or through prompting to teach each step of a targeted behavior. BHT services are based on reliable evidence and are not experimental. Examples of BHT services include behavioral interventions, cognitive behavioral intervention packages, comprehensive behavioral treatment and applied behavioral analysis.

  BHT services must be medically necessary, prescribed by a licensed doctor or psychologist, approved by the plan, and provided in a way that follows the approved treatment plan.

- ***Cancer clinical trials***

  Health Net covers a clinical trial if it is related to the prevention, detection or treatment of cancer or other life-threatening conditions and if the study is conducted by the U.S. Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDC) or Centers for Medicare and Medicaid Services (CMS). Studies must be approved by the National Institutes of Health, the FDA, the Department of Defense or the Veterans Administration.

- ***Cardiac rehabilitation***

  Health Net covers inpatient and outpatient cardiac rehabilitative services.

- ***Cosmetic Surgery***

  Health Net does not cover cosmetic surgery to change the shape of normal structures of the body in order to improve appearance.

- ***Durable medical equipment (DME)***

  Health Net covers the purchase or rental of medical supplies, equipment and other services with a prescription from a doctor. Prescribed DME items may be covered as medically necessary to preserve bodily functions essential to activities of daily living or to prevent major physical disability. Health Net does not

cover comfort, convenience or luxury equipment, features and supplies.

- ***Enteral and parenteral nutrition***

  These methods of delivering nutrition to the body are used when a medical condition prevents you from eating food normally. Health Net covers enteral and parenteral nutrition products when medically necessary.

- ***Hearing aids***

  Health Net covers hearing aids if you are tested for hearing loss and have a prescription from your doctor. Health Net may also cover hearing aid rentals, replacements and batteries for your first hearing aid.

- ***Home health services***

  Health Net covers health services provided in your home, when prescribed by your doctor and found to be medically necessary.

- ***Medical supplies, equipment and appliances***

  Health Net covers medical supplies that are prescribed by a doctor. Health Net covers incontinence supplies when ordered by your doctor and provided by a supplier contracted with the plan.

- ***Occupational therapy***

  Health Net covers occupational therapy services, including occupational therapy evaluation, treatment planning, treatment, instruction and consultative services. Occupational therapy services are limited to two services per month in combination with acupuncture, audiology, chiropractic and speech therapy services. Health Net may pre-approve (prior authorization) additional services as medically necessary.

- ***Orthotics/prostheses***

  Health Net covers orthotic and prosthetic devices and services that are medically necessary and prescribed by your doctor, podiatrist, dentist, or non-physician medical provider. This includes implanted hearing devices, breast prosthesis/mastectomy bras, compression burn garments and prosthetics to restore function or replace a body part, or to support a weakened or deformed

body part.

- ***Ostomy and urological supplies***

  Health Net covers ostomy bags, urinary catheters, draining bags, irrigation supplies and adhesives. This does not include supplies that are for comfort, convenience or luxury equipment or features.

- ***Physical therapy***

  Health Net covers physical therapy services, including physical therapy evaluation, treatment planning, treatment, instruction, consultative services and application of topical medications.

- ***Pulmonary rehabilitation***

  Health Net covers pulmonary rehabilitation that is medically necessary and prescribed by a doctor.

- ***Reconstructive Services***

  Health Net covers surgery to correct or repair abnormal structures of the body to improve or create a normal appearance to the extent possible. Abnormal structures of the body are those caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease.

- ***Skilled nursing facility services***

  Health Net covers skilled nursing facility services as medically necessary if you are disabled and need a high level of care. These services include room and board in a licensed facility with skilled nursing care on a 24-hour per day basis.

- ***Speech therapy***

  Health Net covers speech therapy that is medically necessary. Speech therapy services are limited to two services per month, in combination with acupuncture, audiology, chiropractic, and occupational therapy. Health Net may pre-approve (prior authorization) additional services as medically necessary.

- ***Transgender Services***

  Health Net covers transgender services (gender-affirming services) as a benefit

when they are medically necessary or when the services meet the criteria for reconstructive surgery.

All covered benefits for the treatment for Gender Identity Disorder (GID) need pre-approval (prior authorization). The treatment follows the latest version of the World Professional Association for Transgender Health (WPATH) document, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* and Medi-Cal criteria. The member must have a diagnosis of gender dysphoria or GID that was made by an appropriate professional with training in this field and according to WPATH guidelines and Medi-Cal guidelines.

Covered benefits, include:

- Psychotherapy,
- Continuous hormonal therapy,
- Laboratory testing to monitor hormone therapy, and
- Gender reassignment surgery that is not cosmetic in nature.

Gender Reassignment Surgery (GRS) is covered when the member, diagnosed with GID:

- is at least 18 years of age,
- has capacity for fully informed consent,
- and WPATH criteria for surgery has been met.

Breast implant surgery (and related medically necessary services) for male-to-female members are covered only when a proper trial of hormone therapy has not enlarged the breast.

For more information, call Health Net Customer Contact Center at 1-800-675-6110 (TTY: 711).

Laboratory and radiology services

Health Net covers outpatient and inpatient laboratory and X-ray services when medically necessary. Various advanced imaging procedures are covered based on medical necessity. These services are covered when ordered by your doctor and provided by a provider contracted with the plan or in the event of an emergency.

Preventive and wellness services and chronic disease management

The plan covers:

- Advisory Committee for Immunization Practices recommended vaccines
- Family planning services
- Health Resources and Service Administration's Bright Futures recommendations
- Preventive services for women recommended by the Institute of Medicine
- Smoking cessation services
- United States Preventive Services Task Force A and B recommended preventive services

Family planning services are provided to members of childbearing age to enable them to determine the number and spacing of children. These services include some methods of birth control approved by the FDA. Health Net's PCP and ob/gyn specialists are available for family planning services.

For family planning services, you may also choose a doctor or clinic not connected with Health Net without having to get pre-approval from Health Net. Services from an out-of-network provider not related to family planning may not be covered. To learn more, call 1-800-675-6110 (TTY: 711).

Disease Management/Health Coaching

At Health Net, we strive to help our members get the treatment and social services they need, when they need them. We do this through education and personal help from care management staff. The goal of this service is to add the quality of your care and help you to improve your health. Our disease management programs include:

- Asthma
- Diabetes
- Heart failure

All of our programs are geared toward helping you understand and actively manage your health. We are here to help you with things like:

- How to take medicines
- What screening tests to get
- When to call the doctor

We will provide tools to help you learn and take control of your condition. For more

information or to self-refer, call Member Services at 1-800-675-6110 (For TTY, contact California Relay by dialing 711 and provide the Member Services number: 1-800-675-6110). You can ask to speak to a disease management health coach.

Diabetes Prevention Program

The Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program. It is designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with prediabetes. The program lasts one year. It can last for a second year for members who qualify. The program-approved lifestyle supports and techniques include, but are not limited to:

- Providing a peer coach
- Teaching self-monitoring and problem solving
- Providing encouragement and feedback
- Providing informational materials to support goals
- Tracking routine weigh-ins to help accomplish goals

Members must meet program eligibility requirements to join DPP. Call Health Net to learn more about the program and eligibility.

Substance use disorder services

The plan covers alcohol misuse screenings and behavioral health counseling interventions for alcohol misuse. Services for adults (age 18 and older) who have alcohol or other substance use disorder conditions are offered to you at no cost. The covered services for alcohol misuse are:

- One expanded screening for risky alcohol use per year (a screening tool that asks you for more information about your alcohol use)
- Three 15-minute intervention sessions per year to talk about risky alcohol use

The plan also covers inpatient treatment for Acute drug or alcohol overdose when medically necessary.

Pediatric services

The plan covers:

- Early and periodic screening, diagnostic and treatment (EPSDT) services.
- If you or your child are under 21 years old, Health Net covers well-child visits. Well-child visits are a comprehensive set of preventive, screening, diagnostic, and treatment services.

- Health Net will make appointments and provide transportation to help children get the care they need.
- Preventive care can be regular health check-ups and screenings to help your doctor find problems early. Regular check-ups help your doctor look for any problems with your medical, dental, vision, hearing, mental health, and any substance use disorders. Health Net covers screening services (including lead blood-level assessment) any time there is a need for them, even if it is not during your regular check-up. Also, preventive care can be shots you or your child need. Health Net must make sure that all enrolled children get needed shots at the time of any health care visit.
- When a problem physical or mental health issue is found during a check-up or screening, there may be care that can fix or help the problem. If the care is medically necessary and Health Net is responsible for paying for the care, then Health Net covers the care at no cost to you. These services include:
  - Doctor, nurse practitioner, and hospital care
  - Shots to keep you healthy
  - Physical, speech/language, and occupational therapies
  - Home health services, which could be medical equipment, supplies, and appliances
  - Treatment for vision and hearing, which could be eyeglasses and hearing aids
  - Behavioral Health Treatment for autism spectrum disorders and other developmental disabilities
  - Case management, targeted case management, and health education
  - Reconstructive surgery, which is surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function or create a normal appearance.
- If the care is medically necessary and Health Net is not responsible for paying for the care, then Health Net will help you get the right care you need. These services include:
  - Treatment and rehabilitative services for mental health and substance use disorders
  - Treatment for dental issues, which could be orthodontics
  - Private duty nursing services

Vision services

The plan covers:

- Routine eye exam once every 24 months; Health Net may pre-approve (prior authorization) additional services as medically necessary.
- Eyeglasses (frames and lens) once every 24 months; contact lens when required for medical conditions such as aphakia, aniridia, and keratoconus.

Non-emergency medical transportation (NEMT)

You are entitled to use non-emergency medical transportation (NEMT) when you physically or medically are not able to get to your medical, dental, mental health and substance use disorder appointment by car, bus, train or taxi, and the plan pays for your medical or physical condition. Before getting NEMT, you need to request the service through your doctor, and they will prescribe the correct type of transportation to meet your medical condition.

NEMT is an ambulance, litter van, wheelchair van or air transport. NEMT is not a car, bus or taxi. Health Net allows the lowest cost NEMT for your medical needs when you need a ride to your appointment. That means, for example, if you can physically or medically be transported by a wheelchair van, Health Net will not pay for an ambulance. You are only entitled to air transport if your medical condition makes any form of ground transportation impossible.

NEMT must be used when:

- It is physically or medically needed as determined with a written authorization by a doctor; or you are not able to physically or medically use a bus, taxi, car or van to get to your appointment.
- You need help from the driver to and from your residence, vehicle or place of treatment due to a physical or mental disability.
- It is approved in advance by Health Net with a written authorization by a doctor.

To ask for NEMT services that your doctor has prescribed, please call Health Net at 1-800-675-6110 (TTY: 711) at least 5 business days (Monday-Friday) before your appointment. For urgent appointments, please call as soon as possible. Please have your member ID card ready when you call.

Limits of NEMT

There are no limits for receiving NEMT to or from medical, dental, mental health and

substance use disorder appointments covered under Health Net when a provider has prescribed it for you. If the appointment type is covered by Medi-Cal but not through the health plan, your health plan will provide for or help you schedule your transportation.

What does not apply?

Transportation will not be provided if your physical and medical condition allows you to get to your medical appointment by car, bus, taxi or other easily accessible method of transportation. Transportation will not be provided if the service is not covered by Medi-Cal. A list of covered services is in this Member Handbook.

Cost to member

There is no cost when transportation is authorized by Health Net.

Non-medical transportation (NMT)

You can use non-medical transportation (NMT) when you are:

- Traveling to and from an appointment for a Medi-Cal service authorized by your provider.
- Picking up prescriptions and medical supplies.

Health Net allows you to use a car, taxi, bus or other public/private way of getting to your medical appointment for Medi-Cal-covered services. Health Net provides mileage reimbursement when transportation is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.

Before getting approval for mileage reimbursement, you must state to Health Net by phone, by email or in person that you tried to get all other reasonable transportation choices and could not get one. Health Net allows the lowest cost NMT type that meets your medical needs.

To request NMT services that your provider authorized, call Health Net at 1-800-675-6110 (TTY: 711) at least 5 business days (Monday-Friday) before your appointment or call as soon as you can when you have an urgent appointment. Please have your member ID card ready when you call.

Limits of NMT

There are no limits for receiving NMT to or from medical, dental, mental health and substance use disorder appointments when a provider has authorized it for you. If the

appointment type is covered by Medi-Cal but not through the health plan, your health plan will provide for or help you schedule your transportation.

What does not apply?

NMT does not apply if:

- An ambulance, litter van, wheelchair van, or other form of NEMT is medically needed to get to a covered service.
- You need assistance from the driver to and from the residence, vehicle or place of treatment due to a physical or medical condition.
- The service is not covered by Medi-Cal.

Cost to member

There is no cost when transportation is authorized by Health Net.

Long-term services and supports (LTSS)

Health Net covers these LTSS benefits for members who qualify:

- Skilled nursing facility services as approved by Health Net
- Home and Community Based Services (HCBS) as approved by Health Net

FOR LOS ANGELES AND SAN DIEGO COUNTIES ONLY

- **Multi-Purpose Senior Services Program (MSSP):** You may qualify for MSSP services if you are 65 years or older with a disability and are eligible for nursing facility placement but wish to remain at home. MSSP allows you to remain safely at home as an alternative to nursing facility placement. Services provided by MSSP may include:

  - Adult day care / support center
  - Housing assistance/ Minor home repair
  - Chore and personal care assistance
  - Protective supervision
  - Care management
  - Respite Care (in home and out-of-home)
  - Transportation
  - Meal services – Congregate / Home Delivered
  - Social reassurance / Therapeutic Counseling
  - Communication services/ Translation/ Interpretation
  - Environmental Accessibility Adaptations

- Personal Emergency Response System (PERS)/ Communication Device
- Money Management

- **Skilled Nursing Facility or "SNF" Care (Subacute/Intermediate Facility Care)** – Our plan covers Skilled Nursing Facility (SNF) services. SNF services may be available to you if you are physically disabled and require a high level of care. SNF Services must be prescribed by a physician or Certified Nurse Practitioner and provided in a licensed Skilled Nursing Facility (SNF). Covered Services include:
  - Skilled nursing care on a 24 hour per day basis.
  - Room and board (daily meals).
  - Case Management.
  - X-ray and laboratory procedures.
  - Physical, Speech, and Occupational Therapy.
  - Prescribed drugs and medications administration.
  - Medical supplies, appliances and equipment.

FOR ALL COUNTIES:

- **Community-Based Adult Services (CBAS)**: You may qualify for CBAS if you are 18 years and older, and need extra help because you have health problems that make it hard for you to take care of yourself. If you qualify, we will help you find a center that best meets your needs. If there is no CBAS center in your area, we will help you find other home and community based services.

  - You can get the following services at the CBAS center:
    - An individual assessment
    - Professional nursing services
    - Physical, occupational and speech therapies
    - Mental health services
    - Therapeutic activities
    - Social services
    - Personal Care
    - Meals
    - Nutritional counseling
    - Transportation to and from your home and the CBAS center

Care coordination for Managed Long Term Services and Support (MLTSS) members

- Our plan provides care coordination for members receiving Managed Long Term Services and Supports (MLTSS) in Los Angeles and San Diego Counties. When applicable or requested by the Member, our plan will develop Individual Care Plans (ICPs) for high-risk Members, and establish Interdisciplinary Care Teams

(ICTs). The ICP and ICT is built around the member's needs and ensures integration and coordination of the member's medical care and Long Term Services and Supports. For more information, call Member Services

Telehealth services

Health Net may be able to provide some of your services through telehealth. Telehealth is a way of receiving services without being in the same physical location as your provider. Telehealth may involve having a live video conversation with your provider. Or telehealth may involve sharing information with your provider without a live conversation. It is important that both you and your provider agree that the use of telehealth for a particular service is appropriate for you. You can contact Health Net to determine which types of services Health Net may be able to provide to you through telehealth.

Coordinated Care Initiative (CCI) benefits

For Los Angeles and San Diego Counties only

This is a list of minimum Coordinated Care Initiative (CCI) benefits. For details on CCI benefits, please go to the Coordinated Care Initiative (CCI) section of this handbook.

The plan covers:

- A network of providers working together for you
- A personal care coordinator who will make sure you get the care and support you need
- A customized review of your health needs and care plan
- One health insurance card
- A nurse advice line to call 24 hours a day, 7 days a week

What your health plan does not cover

Other services you can get through Fee-For-Service (FFS) Medi-Cal

Sometimes Health Net does not cover services, but you can still get them through FFS Medi-Cal. This section lists these services. To learn more, call 1-800-675-6110 (TTY: 711).

Specialty mental health services

County mental health plans provide specialty mental health services (SMHS) to Medi-Cal beneficiaries who meet medical necessity rules. SMHS may include these outpatient, residential and inpatient services:

- Outpatient services:
  - Mental health services (assessments, plan development, therapy, rehabilitation and collateral)
  - Medication support services
  - Day treatment intensive services
  - Day rehabilitation services
  - Crisis intervention services
  - Crisis stabilization services
  - Targeted case management services
  - Therapeutic behavioral services
  - Intensive care coordination (ICC)
  - Intensive home-based services (IHBS)
  - Therapeutic foster care (TFC)
- Residential services:
  - Adult residential treatment services
  - Crisis residential treatment services
- Inpatient services:
  - Acute psychiatric inpatient hospital services
  - Psychiatric inpatient hospital professional services
  - Psychiatric health facility services

To learn more about specialty mental health services the county mental health plan provides, you can call the county. To find all counties' toll-free telephone numbers online, visit http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.

Substance use disorder services

Except as shown under the "Medi-Cal benefits" subsection, all other alcohol and drug treatment services and Outpatient heroin detoxification services are not covered by Health Net. Members requiring these services will be referred to a Voluntary Inpatient Detox (VID) provider or their county alcohol and drug treatment program for treatment. Health Net will continue to work with your PCP to cover Primary Care and other services unrelated to the alcohol and substance abuse treatment and will coordinate services with the treatment program(s), as necessary.

Dental services

If you live in Los Angeles or Sacramento counties, Health Net offers a Medi-Cal dental plan for beneficiaries. Call 1-800-213-6991 for more information.

For members in other counties, Medi-Cal covers some dental services, including:

- Diagnostic and preventive dental hygiene (such as examinations, X-rays and teeth cleanings)
- Emergency services for pain control
- Tooth extractions
- Fillings
- Root canal treatments (anterior/posterior)
- Crowns (prefabricated/laboratory)
- Scaling and root planning
- Periodontal maintenance
- Complete and partial dentures
- Orthodontics for children who qualify

If you have questions or want to learn more about dental services, call Denti-Cal at 1-800-322-6384 (TTY 1-800-735-2922). You may also visit the Denti-Cal website at denti-cal.ca.gov.

Institutional long-term care

For Kern, Sacramento, San Joaquin, Stanislaus , and Tulare county members, Health Net covers long-term care in a nursing facility the month of admission into the facility and the month after that. Health Net does **not** cover long-term care if you stay longer.

Regular Medi-Cal covers your stay if it lasts longer than the month after you enter a facility. To learn more, call 1-800-675-6110 (TTY: 711).

Prescription drugs

Some drugs are not covered by Health Net, but you can still get them through FFS Medi-Cal.

- California Children's Services (CCS) is a state program for children up to 21 years old with certain diseases or health problems. Certain drugs for CCS covered diseases or health problems are not covered by Health Net. Doctors who are approved by CCS need to write the prescriptions. Pharmacies must bill CCS for drugs used to treat CCS covered diseases or health problems. If you are trying to get your prescription filled at the pharmacy and you are not yet in the CCS system, call Member Services at 1-800-675-6110 (TTY: 711). Member Services can help

refer you to the CCS program. They may also help you get an emergency supply of your drug if needed.

- Most antipsychotics, HIV-related drugs, coagulation factors, and alcohol, heroin detoxification and dependency treatment drugs are covered by FFS Medi-Cal, not Health Net. You still get a prescription from your doctor and the pharmacy will provide the drug. However, the pharmacy bills the state directly for these drugs.

Women, Infants and Children Program (WIC)

- The Women, Infants and Children (WIC) Supplemental Nutrition Program gives pregnant women and new mothers nutrition information and coupons to buy healthy foods. Ask your doctor, maternity nurse or Certified Nurse Midwife to find out more about WIC.

- WIC services are not covered by Health Net. However, we will help to refer you to the WIC program and will work with your doctor to make sure your doctor also refers you to the WIC program. As part of the referral process, your doctor will send the WIC program a current hemoglobin or hematocrit (blood test) laboratory value.

- As part of your initial health assessment, or, as part of the initial evaluation of a newly pregnant woman, your doctor will refer and document the referral of a pregnant, breastfeeding, or postpartum woman, or a parent or guardian of a child under the age of five, to the WIC program, as required by law (Title 42 CFR 431.635)

- You can find contact information for WIC under the *"Important numbers and words to know"* section in this handbook.

Early Start/Early Intervention

- The Early Start Program is for infants and toddlers from birth to 3 years who need early intervention services and have problems that may result in developmental delays, or who show signs of developmental delay. Some risk conditions are:

    - Asphyxia
    - Central nervous system infection
    - Prematurity

- For more information about Early Start/Early Intervention or a referral to the Regional Center for Early Start/Early Intervention, talk to your doctor or to our plan

Local Education Agency (LEA) assessment services

- The LEA provides certain health care assessment services through school programs. The LEA is your local public school. Children age 3 through 21 may get services without a referral from their PCP. The PCP should coordinate needed medical services with the LEA. LEA services may include:
    - Physical and Mental Health evaluations
    - Education and psychosocial assessments
    - Health and nutrition education
    - Developmental assessments
    - Physical and Occupational Therapy
    - Speech Therapy and audiology (hearing tests)
    - Counseling
    - Nursing services
    - School health aide services
    - Medical transportation

Members with developmental disabilities

REGIONAL CENTERS

- Regional Centers were created to meet the needs of people who are developmentally disabled. Disabling conditions include: mental retardation, epilepsy, autism, cerebral palsy, Down's Syndrome, speech and language delays. Regional Centers help their clients and families to find housing, day programs for adults, transportation, health care and social activities. Most of their services are free to Eligible clients. If you have a family member who was diagnosed with a disabling condition before the age of 18, your PCP will connect you with the local Regional Center.

Childhood lead poisoning screening

- Health Net covers a blood lead screening test for Members up to age 18 as part of routine Preventive Care. Children that test above a certain blood lead level are referred to the Childhood Lead Poisoning Prevention Program (CLPPP), California Children's Services (CCS), and/or the Local Health Department for further evaluation and treatment.

Direct observed therapy for the treatment of tuberculosis

- Our plan will refer Members identified with active tuberculosis who are at risk for

non-compliance for the treatment of tuberculosis to the Local Health Department for direct observed therapy. Members at risk for non-compliance include, but are not limited to, Members with demonstrated multiple drug resistance, Members whose treatment has failed or who have relapsed after completing a prior regimen, children and adolescents, and individuals who have demonstrated non-compliance (such as those who failed to keep office appointments). Health Net will provide all medically necessary Covered Services to Members with tuberculosis on direct observed therapy and will ensure joint case management and coordination of care with the Local Health Department.

Major Organ Transplants

- Health Net will refer Members identified as major organ transplant candidates to a Medi-Cal-approved transplant center and will cover the evaluation performed by the Medi-Cal-approved transplant center. Examples of major organ transplants are bone marrow transplants, heart transplants, liver transplants, lung transplants, heart/lung transplants, combined liver and kidney transplants, and combined liver and small bowel transplants. If you are accepted as a transplant candidate and Medi-Cal approves your transplant, you will be disenrolled from Health Net and go back to Fee-for-Service Medi-Cal. Health Net will continue to cover all medically necessary services until you are disenrolled. Members who are under 21 are referred to the California Children's Services (CCS) program for all transplant evaluations and Authorization.

  Health Net does not disenroll Members who need to receive a kidney or cornea transplant. We will provide all services, including the transplant itself, for Members who need these medically necessary transplants.

Additional services provided as Medi-Cal Benefits but not covered by our plan:

- Blood coagulation factors, such as Hemophilia blood coagulation factor.
- Long Term Care (except for Los Angeles or San Diego County Members. See "Long-term services and supports (LTSS)" section above for more details.)
- Pediatric day health care.
- State laboratory services under the State Serum Alpha-fetoprotein Testing program.
- Targeted Case Management.
- Voluntary Inpatient detoxification services in a general Acute care hospital.

Services you cannot get through Health Net or Medi-Cal

There are some services that neither Health Net nor Medi-Cal will cover, including:

- California Children's Services (CCS)
- All services excluded from Medi-Cal under state and/or federal law
- Routine circumcision, unless medically necessary
- Cosmetic surgery (surgery to change or reshape normal structures of the body in order to improve your look)
- Mental Health services or counseling for couples or families for relationship problems.
- Custodial Care
- Experimental Services
- Infertility
- Vaccines for sports, work or travel
- Personal comfort items (such as phones, television and guest tray) when in the Hospital
- Treatment for major alcohol problems. If you need services for major alcohol problems, you may be referred to the county alcohol and drug program.
- Pharmacy services:
  - Drugs that are experimental
  - Drugs that are investigational, except in certain cases.
  - Brand name drugs when a generic version is available, unless medically necessary
  - Drugs that are not allowed to be covered by law
  - Drugs used for cosmetic purposes or to grow hair
  - Any injectable drug that is not medically necessary and/or not prescribed by a doctor;
  - Drugs for losing weight, except as deemed medically necessary by a doctor;
  - Compounded drugs with alternatives on the drug list, without FDA-approved indications, or where an FDA-approved non-compounded alternative is available, unless medically necessary.
  - Over-the-counter cough and cold drugs (such as drugs to control coughs, or thin mucus)
  - Over-the-counter adult strength acetaminophen products
  - Drugs used to treat erectile dysfunction and/or sexual dysfunction
  - Drugs used to promote fertility

- Drugs over the quantity limits listed in the PDL
- Drugs bought outside of the United States
- Drugs bought from a pharmacy that does not work with Health Net or is outside of the state of California, unless:
  - You need a drug for emergency or urgent medical care
  - You must leave your home due to a federal disaster or other public health emergency
- Drugs that you paid for more than one calendar year ago.
- Drugs that are not approved by the Food and Drug Administration (FDA). You have the right to appeal or have an Independent Medical Review if we deny a drug because it is considered experimental or investigational.
- Drugs classified as less than effective by the Centers for Medicare and Medicaid Services with a Drug Efficacy Study Implementation (DESI) rating of 5 or 6
- Drugs covered by Medicare Part D, if you are eligible for Medicare
- Drugs prescribed by doctors that are not allowed to participate in the Medi-Cal program. Please note, an out-of-state doctor may prescribe a drug to you in an urgent or emergency situation.

- Vision Services:
  - Eyeglasses used for protective, cosmetic, or job-related purposes
  - Eyeglasses prescribed for other than the correction of refractive errors or binocular vision problems
  - Progressive Lenses
  - Multifocal contact lenses
  - Vision therapy or visual training
  - Prescription eyeglasses for a person who has and is able to wear contact lenses

Read each of the sections below to learn more. Or call 1-800-675-6110 (TTY: 711).

California Children's Services (CCS)

CCS is a state program that treats children under 21 years of age with certain health conditions, diseases or chronic health problems and who meet the CCS program rules. If Health Net or your PCP believes your child has a CCS condition, he or she will be referred to the CCS county program to be assessed for eligibility.

CCS program staff will decide if your child qualifies for CCS services. If your child qualifies to get this type of care, CCS providers will treat him or her for the CCS condition. Health Net will continue to cover the types of service that do not have to do with the CCS condition such as physicals, vaccines and well-child checkups.

Health Net does not cover services provided by the CCS program. For CCS to cover these services, CCS must approve the provider, services and equipment.

CCS does not cover all health conditions. CCS covers most health conditions that physically disable or that need to be treated with medicines, surgery or rehabilitation (rehab). CCS covers children with health conditions such as:

- Congenital heart disease
- Cancers
- Tumors
- Hemophilia
- Sickle cell anemia
- Thyroid problems
- Diabetes
- Serious chronic kidney problems
- Liver disease
- Intestinal disease
- Cleft lip/palate
- Spina bifida
- Hearing loss
- Cataracts
- Cerebral palsy
- Seizures under certain circumstances
- Rheumatoid arthritis
- Muscular dystrophy
- AIDS
- Severe head, brain or spinal cord injuries
- Severe burns
- Severely crooked teeth

The State pays for CCS services. If your child is not eligible for CCS program services, he or she will keep getting Medically necessary care from Health Net.

To learn more about CCS, call 1-800-675-6110 (TTY: 711).

Other programs and services for people with Medi-Cal

There are other programs and services for people with Medi-Cal, including:

- Coordinated Care Initiative (CCI) –For Los Angeles and San Diego counties

only
- Organ and tissue donation
- Diabetes Prevention Program (DPP)
- Health Homes Program (HHP)

Read each of the sections below to learn more about other programs and services for people with Medi-Cal.

Coordinated Care Initiative (CCI) -For Los Angeles and San Diego counties only

The California Coordinated Care Initiative (CCI) works to improve care coordination for dual eligibles (people who qualify for both Medi-Cal and Medicare). CCI has two main parts:

Cal MediConnect

The Cal MediConnect program aims to improve care coordination for dual eligibles. It lets them enroll in a single plan to manage all of their benefits, instead of having separate Medi-Cal and Medicare plans. It also aims for high-quality care that helps people stay healthy and in their homes for as long as possible.

Managed Long-Term Services and Supports (MLTSS)

All Medi-Cal beneficiaries, including dual eligibles, must join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including LTSS and Medicare wrap-around benefits.

To learn more about CCI, call 1-800-675-6110 (TTY: 711).

Organ and tissue donation

Anyone can help save lives by becoming an organ or tissue donor. If you are between 15 and 18 years old, you can become a donor with the written consent of your parent or guardian. You can change your mind about being an organ donor at any time. If you want to learn more about organ or tissue donation, talk to your PCP. You can also visit the United States Department of Health and Human Services website at organdonor.gov.

Health Homes Program

Health Net covers Health Homes Program (HHP) services for members with certain

chronic health conditions. These services are to help coordinate physical health services, behavioral health services, and community-based long-term services and supports (LTSS) for members with chronic conditions.

You may be contacted if you qualify for the program. You can also call Health Net, or talk to your doctor or clinic staff, to find out if you can receive HHP services.

You may qualify for HHP if:

- You have certain chronic health conditions. You can call Health Net to find out the conditions that qualify, and you meet one of the following:
    - You have three or more of the HHP eligible chronic conditions
    - You stayed in the hospital in the last year
    - You visited the emergency department three or more times in the last year; or
    - You do not have a place to live.

You do not qualify to receive HHP services if:

- You receive hospice services; or
- You have been residing in a skilled nursing facility for longer than the month of admission and the following month.

Covered HHP services

HHP will give you a care coordinator and care team that will work with you and your health care providers, such as your doctors, specialists, pharmacists, case managers and others, to coordinate your care. Health Net provides HHP services, which include:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care
- Individual and family support services
- Referral to community and social supports

Cost to member

There is no cost to the member for HHP services.

Care coordination

Health Net offers services to help you coordinate your health care needs at no cost to you. If you have questions or concerns about your health or the health of your child, call 1-800-675-6110 (TTY: 711).

Evaluation of new and existing technologies

New technologies include procedures, drugs, biological product, or devices that have been newly developed to treat specific illnesses or conditions, or are new ways of using current technologies.

Health Net keeps up with the change in technologies and treatments. To help decide if a new treatment or care should be added to your benefit plan, we review:

- The latest medical and scientific writings
- Recommendations by practicing doctors or nationally recognized medical associations
- Reports and publications of government agencies.

This work is done to be sure you have access to safe and effective care.

5. Rights and responsibilities

As a member of Health Net, you have certain rights and responsibilities. This chapter explains these rights and responsibilities. This chapter also includes legal notices that you have a right to as a member of Health Net.

Your rights

Health Net members have these rights:

- To be treated with respect, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- To be provided with information about the plan and its services, including Covered Services.
- To be able to choose a primary care provider within Health Net's network.
- To participate in decision making regarding your own health care, including the right to refuse treatment.
- To a candid discussion of appropriate or medically necessary treatment options for conditions, regardless of cost or benefit coverage.
- To make recommendations regarding the plan's member rights and responsibilities policy.
- To voice grievances, either verbally or in writing, about the organization or the care received.
- To receive care coordination.
- To request an appeal of decisions to deny, defer or limit services or benefits.
- To receive oral interpretation services for their language.
- To receive free legal help at your local legal aid office or other groups.
- To formulate advance directives.
- To request a State Hearing, including information on the circumstances under which an expedited hearing is possible.
- To disenroll upon request. Members that can request expedited disenrollment include, but are not limited to, those receiving services under the Foster Care or

Adoption Assistance Programs and those with special health care needs.
- To access Minor Consent Services.
- To receive written member-informing materials in alternative formats (such as braille, large-size print and audio format) upon request and in a timely fashion appropriate for the format being requested and in accordance with Welfare & Institutions Code Section 14182 (b)(12).
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand.
- To have access to and receive a copy of your medical records, and request that they be amended or corrected, as specified in 45 Code of Federal Regulations §164.524 and 164.526.
- Freedom to exercise these rights without adversely affecting how you are treated by Health Net, your providers or the State.
- To have access to family planning services, Freestanding Birth Centers, Federally Qualified Health Centers, Indian Health Service Facilities, midwifery services, Rural Health Centers, sexually transmitted disease services and Emergency Services outside Health Net's network pursuant to the federal law.

Your responsibilities

Health Net members have these responsibilities:

- **Act courteously and respectfully.** You are responsible for treating your doctor and all providers and staff with courtesy and respect. You are responsible for being on time for your visits or calling your doctor's office at least 24 hours before the visit to cancel or reschedule.
- **Give up-to-date, accurate and complete information.** You are responsible for giving correct information and as much information as you can to all of your providers, and to Health Net. You are responsible for getting regular check-ups and telling your doctor about health problems before they become serious.
- **Follow your doctor's advice and take part in your care.** You are responsible for talking over your health care needs with your doctor, developing and agreeing on goals, doing your best to understand

your health problems, and following the treatment plans and instructions you both agree on.

- **Use the Emergency Room only in an emergency.** You are responsible for using the emergency room in cases of an emergency or as directed by your doctor. Emergency Care is a service that you reasonably believe is necessary to stop or relieve sudden serious illnesses or symptoms, and injury or conditions requiring immediate diagnosis and treatment.
- **Report wrongdoing.** You are responsible for reporting health care fraud or wrongdoing to Health Net Community Solutions. You can do this without giving your name by calling Health Net Fraud and Abuse Hotline toll-free at 1-866-685-8664. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

Notice of privacy practices

A STATEMENT DESCRIBING HEALTH NET POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

***PLEASE REVIEW IT CAREFULLY*.**

Covered Entities Duties:

Health Net (referred to as “we” or “the Plan”) is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Health Net is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of your unsecured PHI. PHI 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.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

Health Net reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. Health Net will promptly revise and distribute this Notice whenever there is a material change to the following:

- Uses or disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice

We will make any revised Notices available on our website and in our Member Handbook.

Internal Protections of Oral, Written and Electronic PHI:
Health Net protects your PHI. We have privacy and security processes to help. These are some of the ways we protect your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how we may use or disclose your PHI without your permission or authorization:

- ***Treatment*** - We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making pre-approval (prior authorization) decisions related to your benefits.

- ***Payment*** - We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another

health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:

- processing claims
- determining eligibility or coverage for claims
- issuing premium billings
- reviewing services for medical necessity
- performing utilization review of claims

- ***Health Care Operations*** - We may use and disclose your PHI to perform our health care operations. These activities may include:
  - providing customer services
  - responding to complaints and appeals
  - providing case management and care coordination
  - conducting medical review of claims and other quality assessment
  - improvement activities

  In our health care operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its health care operations. This includes the following:
  - quality assessment and improvement activities
  - reviewing the competence or qualifications of health care professionals
  - case management and care coordination
  - detecting or preventing health care fraud and abuse

- ***Group Health Plan/Plan Sponsor Disclosures*** – We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

- ***Fundraising Activities*** – We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

- ***Underwriting Purposes*** – We may use or disclosure your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are

prohibited from using or disclosing your PHI that is genetic information in the underwriting process.

- ***Appointment Reminders/Treatment Alternatives*** - We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.

- ***As Required by Law*** - If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.

- ***Public Health Activities*** - We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclosure your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness of products or services under the jurisdiction of the FDA.

- ***Victims of Abuse and Neglect*** - We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.

- ***Judicial and Administrative Proceedings*** - We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:
  - an order of a court
  - administrative tribunal
  - subpoena
  - summons
  - warrant
  - discovery request
  - similar legal request

- ***Law Enforcement*** - We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:
  - court order
  - court-ordered warrant
  - subpoena
  - summons issued by a judicial officer
  - grand jury subpoena

We may also disclose your relevant PHI for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person.

- ***Coroners, Medical Examiners and Funeral Directors*** - We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.

- ***Organ, Eye and Tissue Donation*** - may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:
  - cadaveric organs
  - eyes
  - tissues

- ***Threats to Health and Safety*** - We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

- ***Specialized Government Functions*** - If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:
  - to authorized federal officials for national security and intelligence activities
  - the Department of State for medical suitability determinations
  - for protective services of the President or other authorized persons

- ***Workers' Compensation*** - We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

  Emergency Situations – We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.

- ***Inmates*** - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution

to provide you with health care, to protect your health or safety, or the health or safety of others, or for the safety and security of the correctional institution.

- ***Research*** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:

Sale of PHI – We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing – We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes – We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Individuals Rights

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

- ***Right to Revoke an Authorization*** - You may revoke your authorization at any time; the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.

- ***Right to Request Restrictions -*** You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment or health care operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for

payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.

- ***Right to Request Confidential Communications -*** You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies in the following circumstances: (1) the communication discloses medical information or provider name and address relating to receipt of sensitive services, or (2) disclosure of all or part of the medical information or provider name and address could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason for your request, but your request must clearly state that either the communication discloses medical information or provider name and address relating to receipt of sensitive services or that disclosure of all or part of the medical information or provider name and address could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where your PHI should be delivered.

- ***Right to Access and Receive Copy of your PHI -*** You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so**.** You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

- ***Right to Amend your PHI -*** You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

- ***Right to Receive an Accounting of Disclosures -*** You have the right to receive a list of instances within the last 6 years period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-

month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.

- ***Right to File a Complaint -*** If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice. For Medi-Cal member complaints, members may also contact the California Department of Health Care Services listed in the next section.

  You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-800-368-1019, (TTY: 1-866-788-4989) or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

- ***Right to Receive a Copy of this Notice -*** You may request a copy of our Notice at any time by using the contact information list at the end of the Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.

Contact Information

If you have any questions about this Notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone using the contact information listed below.

Health Net Privacy Office
Attn: Privacy Official
P.O. Box 9103
Van Nuys, CA 9140

Telephone: 1-800-522-0088
Fax: 1-818-676-8314
Email: Privacy@healthnet.com

If you believe that we have not protected your privacy and wish to complain, you may file a complaint by calling or writing:
Privacy Officer
c/o Office of Legal Services
California Department of Health Care Services
1501 Capitol Avenue, MS 0010
P.O. Box 997413
Sacramento, CA 95899-7413
Phone: 1-916-445-4646 or 1-866-866-0602 (TTY: TDD: 1-877-735-2929)
E-mail: Privacyofficer@dhcs.ca.gov

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW **FINANCIAL INFORMATION** ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect: We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information: We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, such as other insurers;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security: We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice:
If you have any questions about this notice:
Please **call the toll-free phone number on the back of your ID card** or contact Health Net at 1-800-522-0088.

Notice about laws

Many laws apply to this Member Handbook. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are state and federal laws about the Medi-Cal program. Other federal and state laws may apply too.

Notice about Medi-Cal as a payer of last resort

Sometimes someone else has to pay first for the services Health Net provides you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

DHCS has the right and responsibility to collect for covered Medi-Cal services for which Medi-Cal is not the first payer. If you are injured, and someone else is liable for your injury, you or your legal representative must notify DHCS within 30 days of filing a legal action or a claim. Submit your notification online:

- Personal Injury Program at http://dhcs.ca.gov/PI
- Workers Compensation Recovery Program at http://dhcs.ca.gov/WC

To learn more, call 1-916-445-9891.

The Medi-Cal program complies with state and federal laws and regulations relating to the legal liability of third parties for health care services to beneficiaries. Health Net will take all reasonable measures to ensure that the Medi-Cal program is the payer of last resort.

You must apply for and keep other health coverage (OHC) that is available to you for free or is state-paid coverage. If you do not apply for or keep no-cost or state-paid OHC, your Medi-Cal benefits and/or eligibility will be denied or stopped. If you do not report changes to your OHC promptly, and because of this, receive Medi-Cal benefits that you are not eligible for, you may have to repay DHCS.

Notice about estate recovery

The Medi-Cal program must seek repayment from the estates of certain deceased Medi-Cal members from payments made, including managed care premiums, nursing facility services, home and community-based services, and related hospital and prescription drug services provided to the deceased Medi-Cal member on or after the member's 55th birthday. If a deceased member does not leave an estate or owns nothing when they die, nothing will be owed.

To learn more about the estate recovery, call 1-916-650-0490. Or get legal advice.

Notice of Action

Health Net will send you a Notice of Action (NOA) letter any time Health Net denies, delays, terminates or modifies a request for health care services. If you disagree with the plan's decision, you can always file an appeal with Health Net.

Third Party Liability

Health Net will not make any claim for recovery of the value of Covered Services provided to a member when such recovery would result from an action involving the tort liability of a third party or casualty liability insurance, including workers' compensation awards and uninsured motorist coverage. However, Health Net will notify the DHCS of such potential cases, and will help the DHCS in pursuing the State's right to reimbursement of such recoveries. Members are obligated to assist Health Net and the DHCS in this regard.

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 providers, and not Health Net, maintain the physician-patient relationship with the member. Health Net is not a provider of health care.

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 1-866-685-8664. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

Circumstances beyond Health Net's control

To the extent that a natural disaster or emergency circumstances results in Health Net's facilities or personnel not being available to provide or arrange for services or benefits under this Member Handbook, 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 current availability of its facilities or personnel.

6. Reporting and solving problems

There are two kinds of problems that you may have with Health Net:

- A **complaint** (or **grievance)** is when you have a problem with Health Net or a provider, or with the health care or treatment you got from a provider
- An **appeal** is when you don't agree with Health Net's decision not to cover or change your services

You can use the Health Net grievance and appeal process to let us know about your problem. This does not take away any of your legal rights and remedies. We will not discriminate or retaliate against you for complaining to us. Letting us know about your problem will help us improve care for all members.

You should always contact Health Net first to let us know about your problem. Call us between 24 hours a day, 7 days a week at 1-800-675-6110 (TTY: 711) to tell us about your problem. We will review your grievance or appeal and let you know our decision. The "Complaints" and "Appeals" sections below show how to file your grievance or appeal, how fast we need to respond, and how you can ask for an expedited (fast) review.

If your grievance or appeal is still not resolved, or you are unhappy with the result, you can call the California Department of Managed Health Care (DMHC) at 1-888-HMO-2219 (TTY 1-877-688-9891).

The California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman can also help. They can help if you have problems joining, changing or leaving a health plan. They can also help if you moved and are having trouble getting your Medi-Cal transferred to your new county. You can call the Ombudsman Monday through Friday, between 8:00 a.m. and 5:00 p.m. at 1-888-452-8609.

You can also file a grievance with your county eligibility office about your Medi-Cal eligibility. If you are not sure who you can file your grievance with, call 1-800-675-6110 (TTY: 711).

To report incorrect information about your additional health insurance, please call Medi-

Cal Monday through Friday, between 8:00 a.m. and 5:00 p.m. at 1-800-541-5555.

Complaints

A complaint (or grievance) is when you have a problem or are unhappy with the services you are receiving from Health Net or a provider. There is no time limit to file a complaint. You can file a complaint with us at any time by phone, in writing or online.

- **By phone:** Call Health Net at 1-800-675-6110 (TTY: 711) between 24 hours a day, 7 days a week. Give your health plan ID number, your name and the reason for your complaint.
- **By mail:** Call Health Net at 1-800-675-6110 (TTY: 711) and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number and the reason for your complaint. Tell us what happened and how we can help you.

  Mail the form to:

  Health Net Appeals & Grievances
  P.O. Box 10348
  Van Nuys, CA 91410-0348

  Your doctor's office will have complaint forms available.
- **Online:** Visit the Health Net website. Go to www.healthnet.com.

If you need help filing your complaint, we can help you. We can give you free language services. Call 1-800-675-6110 (TTY: 711).

Within 5 days of getting your complaint, we will send you a letter letting you know we received it. Within 30 days, we will send you another letter that tells you how we resolved your problem. If you call Health Net about a grievance that is not about health care coverage, medical necessity, or experimental or investigational treatment, and your grievance is resolved by the end of the next business day, you may not receive a letter.

If you want us to make a fast decision because the time it takes to resolve your complaint would put your life, health or ability to function in danger, you can ask for an expedited (fast) review. To ask for an expedited review, call us at 1-800-675-6110 (TTY: 711). We will make a decision within 72 hours of receiving your complaint.

Appeals

An appeal is different from a complaint. An appeal is a request for Health Net to review and change a decision we made about coverage for a requested service. If we sent you a Notice of Action (NOA) letter telling you that we are denying, delaying, changing or ending a service, and you do not agree with our decision, you can file an appeal. Your PCP can also file an appeal for you with your written permission.

You must file an appeal within 60 calendar days from the date on the NOA you received. If you are currently getting treatment and you want to continue getting treatment, then you must ask for an appeal within 10 calendar days from the date the NOA was delivered to you, or before the date Health Net says services will stop. When you request the appeal, please tell us that you want to continue receiving services.

You can file an appeal by phone, in writing or online:

- **By phone:** Call Health Net at 1-800-675-6110 (TTY: 711) between 24 hours a day, 7 days a week. Give your name, health plan ID number and the service you are appealing.
- **By mail:** Call Health Net at 1-800-675-6110 (TTY: 711) and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, health plan ID number and the service you are appealing.

  Mail the form to:

  Health Net Appeals & Grievances
  P.O. Box 10348
  Van Nuys, CA 91410-0348

  Your doctor's office will have appeal forms available.
- **Online:** Visit the Health Net website. Go to www.healthnet.com.

If you need help filing your appeal, we can help you. We can give you free language services. Call 1-800-675-6110 (TTY: 711).

Within 5 days of getting your appeal, we will send you a letter letting you know we received it. Within 30 days, we will tell you our appeal decision.

If you or your doctor wants us to make a fast decision because the time it takes to resolve your appeal would put your life, health or ability to function in danger, you can ask for an expedited (fast) review. To ask for an expedited review, 1-800-675-6110 (TTY: 711). We will make a decision within 72 hours of receiving your appeal.

What to do if you do not agree with an appeal decision

If you filed an appeal and received a letter from Health Net telling you we did not change our decision, or you never received a letter telling you of our decision and it has been past 30 days, you can:

- Ask for a **State Hearing** from Department of Social Services, and a judge will review your case.
- Ask for an **Independent Medical Review (IMR)** from DMHC, and an outside reviewer who is not part of Health Net will review your case.

You will not have to pay for a State Hearing or an IMR.

You are entitled to both a State Hearing and an IMR. But if you ask for a State Hearing first, and the hearing has already happened, you cannot ask for an IMR. In this case, the State Hearing has the final say.

The sections below have more information on how to ask for a State Hearing or an IMR.

Independent Medical Reviews (IMR)

An IMR is when an outside reviewer who is not related to your health plan reviews your case. If you want an IMR, you must first file an appeal with Health Net. If you do not hear from your health plan within 30 calendar days, or if you are unhappy with your health plan's decision, then you may then request an IMR. You must ask for an IMR within 6 months from the date on the notice telling you of the appeal decision.

You may be able to get an IMR right away without filing an appeal first. This is in cases where your health is in immediate danger.

Here is how to ask for an IMR. The term "grievance" is for "complaints" and "appeals":

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-675-6110 (TTY: 711)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR

process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

State Hearings

A State Hearing is a meeting with people from the DSS. A judge will help to resolve your problem. You can ask for a State Hearing only if you have already filed an appeal with Health Net and you are still not happy with the decision or if you have not received a decision on your appeal after 30 days, and you have not requested an IMR.

You must ask for a State Hearing within 120 days from the date on the notice telling you of the appeal decision. Your PCP can ask for a State Hearing for you with your written permission and if he or she gets approval from DSS. You can also call DSS to ask the State to approve your PCP's request for a State Hearing.

You can ask for a State Hearing by phone or mail.

- **By phone:** Call the DSS Public Response Unit at 1-800-952-5253 (TTY 1-800-952-8349).
- **By mail**: Fill out the form provided with your appeals resolution notice. Send it to:

  California Department of Social Services
  State Hearings Division
  P.O. Box 944243, MS 09-17-37
  Sacramento, CA 94244-2430

If you need help asking for a State Hearing, we can help you. We can give you free language services. Call 1-800-675-6110 (TTY: 711).

At the hearing, you will give your side. We will give our side. It could take up to 90 days for the judge to decide your case. Health Net must follow what the judge decides.

If you want the DSS to make a fast decision because the time it takes to have a State Hearing would put your life, health or ability to function fully in danger, you or your PCP can contact the DSS and ask for an expedited (fast) State Hearing. DSS must make a decision no later than 3 business days after it gets your complete case file from Health

Net.

Fraud, waste and abuse

If you suspect that a provider or a person who gets Medi-Cal has committed fraud, waste or abuse, it is your right to report it.

Provider fraud, waste and abuse includes:

- Falsifying medical records
- Prescribing more medication than is medically necessary
- Giving more health care services than medically necessary
- Billing for services that were not given
- Billing for professional services when the professional did not perform the service

Fraud, waste and abuse by a person who gets benefits includes:

- Lending, selling or giving a health plan ID card or Medi-Cal Benefits Identification Card (BIC) to someone else
- Getting similar or the same treatments or medicines from more than one provider
- Going to an emergency room when it is not an emergency
- Using someone else's Social Security number or health plan ID number

To report fraud, waste and abuse, write down the name, address and ID number of the person who committed the fraud, waste or abuse. Give as much information as you can about the person, such as the phone number or the specialty if it is a provider. Give the dates of the events and a summary of exactly what happened.

Send your report to:

Special Investigations Unit
1370 Timberlake Manor Parkway
Chesterfield, MO 63017
1-866-685-8664

7. Important numbers and words to know

Important phone numbers

- Health Net Member Services 1-800-675-6110 (TTY: 711)
- **Disability Services**
  - Website: https://www.ada.gov/
  - California Relay Service (CRS): TTY/TDD: 711
  - Sprint 1-888-877-5379 (Voice)
  - MCI 1-800-735-2922 (Voice)
  - Americans Disabilities Act (ADA) Information: 1-800-514-0301 (Voice); 1-800-514-0383 (TDD)
- **Children's Services (CCS Program)**
  - Website: https://www.dhcs.ca.gov/services/ccs
  - Kern County: 1-661-868-0504
  - Los Angeles County: 1-800-288-4584
  - Sacramento County: 1-916-875-9900
  - San Diego County: 1-619-528-4000
  - San Joaquin County: 1-209-468-3900
  - Stanislaus County: 1-209-558-7515
  - Tulare County: 1-559-685-5800
- **Child Health and Disability Prevention (CHDP) Program**
  - Website: https://www.dhcs.ca.gov/services/chdp
  - Kern County: 1-661-321-3000
  - Los Angeles County: 1-800-993-2437
  - Sacramento County: 1-916-875-7151
  - San Diego County: 1-619-692-8808
  - San Joaquin County: 1-209-468-8335
  - Stanislaus County: 1-209-558-8860
  - Tulare County: 1-559-687-6915

- **California State Services**
  - DHCS Ombudsman Office: 1-888-452-8609 (website: https://www.dhcs.ca.gov)
  - Department of Social Services: 1-800-952-5253 (TDD: 1-800-952-8349) (website: https://www.cdss.ca.gov)
  - Department of Managed Health Care (DMHC): 1-888-466-2219 (1-888-HMO-2219) (website: http://dmhc.ca.gov/)
- **Women, Infants and Children (WIC):**
  - **Phone:** 1-888-942-9675
  - **Website:** https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/Program-Landing1.aspx
- **Social Security Administration**
  - Supplemental Social Income (SSI): 1-800-772-1213 (TTY: 1-800-325-0778)
  - Website: https://www.ssa.gov/
- **COUNTY OFFICES**
  - Website: http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx
  - Mental Health website: https://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx
  - **Kern County**
    Department of Human Services: 1-661-631-6807
    Mental Health Services: 1-800-991-5272
  - **Los Angeles County**
    Department of Public Social Services (DPSS)
    Central Help Line (includes language services): 1-877-481-1044
    DPSS Customer Service Center: 1-866-613-3777; 1-310-258-7400
    Los Angeles County Department of Mental Health: 1-800-854-7771
  - **Sacramento County**
    Department of Human Assistance: 1-916-874-3100
    Department of Health & Human Services (Mental Health): 1-888-881-4881
  - **San Diego County**
    Department of Health & Human Services: 1-866-262-9881
    San Diego Behavioral Health Division: 1-888-724-7240
  - **San Joaquin County**
    Department of Public Health: 1-209-468-3400
    Behavioral Health: 1-888-468-9370
    Human Services Agency: 1-209-468-1000
  - **Stanislaus County**
    Community Services Agency: 1-877-652-0734
    Behavioral Health & Recovery Services: 1-888-376-6246
  - **Tulare County**

Health & Human Services Agency: 1-800-540-6880
Department of Mental Health: 1-800-320-1616

Words to know

Active labor: The period of time when a woman is in the three stages of giving birth and either cannot be safely transferred in time to another hospital before delivery or a transfer may harm the health and safety of the woman or unborn child.

Acute: A medical condition that is sudden, requires fast medical attention and does not last a long time.

Appeal: A member's request for Health Net to review and change a decision made about coverage for a requested service.

Benefits: Health care services and drugs covered under this health plan.

California Children's Services (CCS): A program that provides services for children up to age 21 with certain diseases and health problems.

California Health and Disability Prevention (CHDP): A public health program that reimburses public and private health care providers for early health assessments to detect or prevent disease and disabilities in children and youth. The program helps children and youth who qualify have access to regular health care. Your PCP can provide CHDP services.

Case manager: Registered nurses or social workers who can help you understand major health problems and arrange care with your providers.

Certified Nurse Midwife (CNM): An individual licensed as a Registered Nurse and certified as a nurse midwife by the California Board of Registered Nursing. A certified nurse midwife is permitted to attend cases of normal childbirth.

Chronic condition: A disease or other medical problem that cannot be completely cured or that gets worse over time or that must be treated so you do not get worse.

Clinic: A facility that members can select as a primary care provider (PCP). It can be either a Federally Qualified Health Center (FQHC), community clinic, Rural Health Clinic (RHC), Indian Health Service Facility or other primary care facility.

Community-based adult services (CBAS): Outpatient, facility-based services for skilled nursing care, social services, therapies, personal care, family and caregiver training and support, nutrition services, transportation, and other services for members who qualify.

Complaint: A member's verbal or written expression of dissatisfaction about Health Net, a provider, or the quality of care or quality of services provided. A complaint is the same as a grievance.

Continuity of care: The ability of a plan member to keep getting Medi-Cal services from their existing provider for up to 12 months, if the provider and Health Net agree.

Coordination of Benefits (COB): The process of determining which insurance coverage (Medi-Cal, Medicare, commercial insurance or other) has primary treatment and payment responsibilities for members with more than one type of health insurance coverage.

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. Enrolled recipients choose their health care provider from among all COHS providers.

Copayment: A payment you make, generally at the time of service, in addition to the insurer's payment.

Coverage (covered services): The health care services provided to members of Health Net, subject to the terms, conditions, limitations and exclusions of the Medi-Cal contract and as listed in this Evidence of Coverage (EOC) and any amendments.

DHCS: The California Department of Health Care Services. This is the State office that oversees the Medi-Cal program.

Disenroll: To stop using this health plan because you no longer qualify or change to a new health plan. You must sign a form that says you no longer want to use this health plan or call HCO and disenroll by phone.

DMHC: The California Department of Managed Health Care. This is the State office that oversees managed care health plans.

Durable medical equipment (DME): Equipment that is medically necessary and ordered by your doctor or other provider. Health Net decides whether to rent or buy DME. Rental costs must not be more than the cost to buy. Repair of medical equipment is covered.

Early and periodic screening, diagnosis and treatment (EPSDT): EPSDT services are a benefit for Medi-Cal members under the age of 21 to help keep them healthy. Members must get the right health check-ups for their age and appropriate screenings to find health problems and treat illnesses early.

Emergency medical condition: A medical or mental condition with such severe symptoms, such as active labor (go to definition above) or severe pain, that someone

with a prudent layperson's knowledge of health and medicine could reasonably believe that not getting immediate medical care could:

- Place your health or the health of your unborn baby in serious danger
- Cause impairment to a body function
- Cause a body part or organ to not work right

Emergency room care: An exam performed by a doctor (or staff under direction of a doctor as allowed by law) to find out if an emergency medical condition exists. Medically necessary services needed to make you clinically stable within the capabilities of the facility.

Emergency medical transportation: Transportation in an ambulance or emergency vehicle to an emergency room to receive emergency medical care.

Enrollee: A person who is a member of a health plan and receives services through the plan.

Excluded services: Services not covered by Health Net; non-covered services.

Family planning services: Services to prevent or delay pregnancy.

Federally Qualified Health Center (FQHC): A health center in an area that does not have many health care providers. You can get primary and preventive care at an FQHC.

Fee-For-Service (FFS): This means you are not enrolled in a managed care health plan. Under FFS, your doctor must accept "straight" Medi-Cal and bill Medi-Cal directly for the services you got.

Follow-up care: Regular doctor care to check a patient's progress after a hospitalization or during a course of treatment.

Formulary: A list of drugs or items that meet certain criteria and are approved for members.

Fraud: An intentional act to deceive or misrepresent by a person who knows the deception could result in some unauthorized benefit for the person or someone else.

Freestanding Birth Centers (FBCs): Health facilities where childbirth is planned to occur away from the pregnant woman's residence that are licensed or otherwise approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan. These facilities are not hospitals.

Grievance: A member's verbal or written expression of dissatisfaction about Health Net, a provider, or the quality of care or services provided. A complaint is the same as a

grievance.

Habilitation services and devices: Health care services that help you keep, learn or improve skills and functioning for daily living.

Health Care Options (HCO): The program that can enroll you in or disenroll you from the health plan.

Health care providers: Doctors and specialists such as surgeons, doctors who treat cancer or doctors who treat special parts of the body, and who work with Health Net or are in the Health Net network. Health Net network providers must have a license to practice in California and give you a service Health Net covers.

You usually need a referral from your PCP to go to a specialist. Your PCP must get pre-approval from Health Net before you get care from the specialist.

You do **not** need a referral from your PCP for some types of service, such as family planning, emergency care, ob/gyn care or sensitive services.

Types of health care providers:

- Audiologist is a provider who tests hearing.
- Certified nurse midwife is a nurse who cares for you during pregnancy and childbirth.
- Family practitioner is a doctor who treats common medical issues for people of all ages.
- General practitioner is a doctor who treats common medical issues.
- Internist is a doctor with special training in internal medicine, including diseases.
- Licensed vocational nurse is a licensed nurse who works with your doctor.
- A counselor is a person who helps you with family problems.
- Medical assistant or certified medical assistant is a non-licensed person who helps your doctors give you medical care.
- Mid-level practitioner is a name used for health care providers, such as nurse-midwives, physician assistants or nurse practitioners.
- Nurse anesthetist is a nurse who gives you anesthesia.
- Nurse practitioner or physician assistant is a person who works in a clinic or doctor's office who diagnoses, treats and cares for you, within limits.
- Obstetrician/gynecologist (ob/gyn) is a doctor who takes care of a woman's health, including during pregnancy and birth.
- Occupational therapist is a provider who helps you regain daily skills and activities after an illness or injury.
- Pediatrician is a doctor who treats children from birth through the teen years.

- Physical therapist is a provider who helps you build your body's strength after an illness or injury.
- Podiatrist is a doctor who takes care of your feet.
- Psychologist is a person who treats mental health issues but does not prescribe drugs.
- Registered nurse is a nurse with more training than a licensed vocational nurse and who has a license to do certain tasks with your doctor.
- Respiratory therapist is a provider who helps you with your breathing.
- Speech pathologist is a provider who helps you with your speech.

Health insurance: Insurance coverage that pays for medical and surgical expenses by repaying the insured for expenses from illness or injury or paying the care provider directly.

Home health care: Skilled nursing care and other services given at home.

Home health care providers: Providers who give you skilled nursing care and other services at home.

Hospice: Care to reduce physical, emotional, social and spiritual discomforts for a member with a terminal illness (not expected to live for more than 6 months).

Hospital: A place where you get inpatient and outpatient care from doctors and nurses.

Hospitalization: Admission to a hospital for treatment as an inpatient.

Hospital outpatient care: Medical or surgical care performed at a hospital without admission as an inpatient.

Inpatient care: When you have to stay the night in a hospital or other place for the medical care you need.

Long-term care: Care in a facility for longer than the month of admission.

Managed care plan: A Medi-Cal plan that uses only certain doctors, specialists, clinics, pharmacies and hospitals for Medi-Cal recipients enrolled in that plan. Health Net is a managed care plan.

Medical home: A model of care that will provide better health care quality, improve self-management by members of their own care and reduce avoidable costs over time.

Medically necessary (or medical necessity): Medically necessary care are important services that are reasonable and protect life. This care is needed to keep patients from getting seriously ill or disabled. This care reduces severe pain by treating the disease, illness or injury. For members under the age of 21, Medi-Cal services includes care that

is medically necessary to fix or help a physical or mental illness or condition, including substance use disorders, as set forth in Section 1396d(r) of Title 42 of the United States Code.

Medicare: The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease (permanent kidney failure that requires dialysis or a transplant, sometimes called ESRD).

Member: Any eligible Medi-Cal member enrolled with Health Net who is entitled to receive covered services.

Mental health services provider: Licensed individuals who provide mental health and behavioral health services to patients.

Midwifery services: Prenatal, intrapartum, and postpartum care, including family planning care for the mother and immediate care for the newborn, provided by certified nurse midwives (CNM) and licensed midwives (LM).

Network: A group of doctors, clinics, hospitals and other providers contracted with Health Net to provide care.

Network provider (or in-network provider): Go to “Participating provider.”

Non-covered service: A service that Health Net does not cover.

Non-emergency medical transportation (NEMT): Transportation when you cannot get to a covered medical appointment by car, bus, train or taxi. Health Net pays for the lowest cost NEMT for your medical needs when you need a ride to your appointment.

Non-formulary drug: A drug not listed in the drug formulary.

Non-medical transportation: Transportation when traveling to and from an appointment for a Medi-Cal covered service authorized by your provider.

Non-participating provider: A provider not in the Health Net network.

Other health coverage (OHC): Other health coverage (OHC) refers to private health insurance. Services may include medical, dental, vision, pharmacy and/or Medicare supplemental plans (Part C & D).

Orthotic device: A device used as a support or brace affixed externally to the body to support or correct an acutely injured or diseased body part and that is medically necessary for the medical recovery of the member.

Out-of-area services: Services while a member is anywhere outside of the service area.

Out-of-network provider: A provider who is not part of the Health Net network.

Outpatient care: When you do not have to stay the night in a hospital or other place for the medical care you need.

Outpatient mental health services: Outpatient services for members with mild to moderate mental health conditions including:

- Individual or group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring medication therapy
- Psychiatric consultation
- Outpatient laboratory, supplies and supplements

Palliative care: Care to reduce physical, emotional, social and spiritual discomforts for a member with a serious illness.

Participating hospital: A licensed hospital that has a contract with Health Net to provide services to members at the time a member receives care. The covered services that some participating hospitals may offer to members are limited by Health Net's utilization review and quality assurance policies or Health Net's contract with the hospital.

Participating provider (or participating doctor): A doctor, hospital or other licensed health care professional or licensed health facility, including sub-acute facilities that have a contract with Health Net to offer covered services to members at the time a member receives care.

Physician services: Services given by a person licensed under state law to practice medicine or osteopathy, not including services offered by doctors while you are admitted in a hospital that are charged in the hospital bill.

Plan: Go to "Managed care plan."

Post-stabilization services: Services you receive after an emergency medical condition is stabilized.

Pre-approval (or prior-authorization): Your PCP must get approval from Health Net before you get certain services. Health Net will only approve the services you need. Health Net will not approve services by non-participating providers if Health Net believes you can get comparable or more appropriate services through Health Net providers. A referral is not an approval. You must get approval from Health Net.

Premium: An amount paid for coverage; cost for coverage.

Prescription drug coverage: Coverage for medications prescribed by a provider.

Prescription drugs: A drug that legally requires an order from a licensed provider to be dispensed, unlike over-the-counter (OTC) drugs that do not require a prescription.

Preferred drug list (PDL): A chosen list of drugs approved by this health plan from which your doctor may order for you. Also called a formulary.

Primary care: Go to “Routine care.”

Primary care provider (PCP): The licensed provider you have for most of your health care. Your PCP helps you get the care you need. Some care needs to be approved first, unless:

- You have an emergency.
- You need ob/gyn care.
- You need sensitive services.
- You need family planning care.

Your PCP can be a:

- General practitioner
- Internist
- Pediatrician
- Family practitioner
- Ob/gyn
- FQHC or RHC
- Nurse practitioner
- Physician assistant
- Clinic

Prior authorization (pre-approval): A formal process requiring a health care provider to get approval to provide specific services or procedures.

Prosthetic device: An artificial device attached to the body to replace a missing body part.

Provider Directory: A list of providers in the Health Net network.

Psychiatric emergency medical condition: A mental disorder in which the symptoms are serious or severe enough to cause an immediate danger to yourself or others or you are immediately unable to provide for or use food, shelter or clothing due to the mental disorder.

Public health services: Health services targeted at the population as a whole. These

include, among others, health situation analysis, health surveillance, health promotion, prevention services, infectious disease control, environmental protection and sanitation, disaster preparedness and response, and occupational health.

Qualified provider: Doctor qualified in the area of practice appropriate to treat your condition.

Reconstructive surgery: Surgery to correct or repair abnormal structures of the body to improve function or create a normal appearance to the extent possible. Abnormal structures of the body are those caused by a congenital defect, developmental abnormalities, trauma, infection, tumors, or disease.

Referral: When your PCP says you can get care from another provider. Some covered care services require a referral and pre-approval.

Routine care: Medically necessary services and preventive care, well child visits, or care such as routine follow-up care. The goal of routine care is to prevent health problems.

Rural Health Clinic (RHC): A health center in an area that does not have many health care providers. You can get primary and preventive care at an RHC.

Sensitive services: Medically necessary services for family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions.

Serious illness: A disease or condition that must be treated and could result in death.

Service area: The geographic area Health Net serves. This includes the counties of Kern, Los Angeles, Sacramento, San Diego, San Joaquin, Stanislaus, and Tulare.

Skilled nursing care: Covered services provided by licensed nurses, technicians and/or therapists during a stay in a Skilled Nursing Facility or in a member's home.

Skilled nursing facility: A place that gives 24-hour-a-day nursing care that only trained health professionals may give.

Specialist (or specialty doctor): A doctor who treats certain types of health care problems. For example, an orthopedic surgeon treats broken bones; an allergist treats allergies; and a cardiologist treats heart problems. In most cases, you will need a referral from your PCP to go to a specialist.

Specialty mental health services:

- Outpatient services:
  - Mental health services (assessments, plan development, therapy, rehabilitation and collateral)

  - Medication support services
  - Day treatment intensive services
  - Day rehabilitation services
  - Crisis intervention services
  - Crisis stabilization services
  - Targeted case management services
  - Therapeutic behavioral services
  - Intensive care coordination (ICC)
  - Intensive home-based services (IHBS)
  - Therapeutic foster care (TFC)
- Residential services:
  - Adult residential treatment services
  - Crisis residential treatment services
- Inpatient services:
  - Acute psychiatric inpatient hospital services
  - Psychiatric inpatient hospital professional services
  - Psychiatric health facility services

Terminal illness: A medical condition that cannot be reversed and will most likely cause death within one year or less if the disease follows its natural course.

Triage (or screening): The evaluation of your health by a doctor or nurse who is trained to screen for the purpose of determining the urgency of your need for care.

Urgent care (or urgent services): Services provided to treat a non-emergency illness, injury or condition that requires medical care. You can get urgent care from an out-of-network provider if network providers are temporarily not available or accessible.

Call Member Services at 1-800-675-6110 (TTY: 711).
Health Net is here 24 hours a day, 7 days a week. The call is toll free.
Or call the California Relay Line at 711. Visit online at www.healthnet.com
.